



ASAM American Society of
Addiction Medicine

Public Policy Statement on Third-Party Payment for Addiction Treatment

Purpose

Patients who suffer from chronic medical conditions like addiction can achieve remission and sustain recovery when high quality, coordinated whole-person care is readily available and affordable. Insurance coverage for health care can make access more attainable by making it more affordable.

This policy statement addresses some of the key issues facing clinicians and third-party payers as they work together for the benefit of patients to solve the real-world practical problems of access to care, reimbursement for professional services, insurance benefit design, and health plan clinician network adequacy.

With the United States addressing the epidemic of addiction, ASAM recognizes that making treatment more available and accessible by removing economic and administrative barriers to entry into and retention in treatment will improve the public health as well as the wellbeing of individuals.

Aligning with the Quadruple Aimⁱ principles of better outcomes, lower costs, improved patient experience and improved clinician experience, this public policy statement aims to:

1. Encourage alignment between payers and clinicians around improving outcomes for patients receiving addiction treatment across the entire continuum.
2. Collaborate to reduce the overall cost of healthcare services by working with clinicians and payers to ensure that patients with addiction receive the right care at the right time in the right treatment intensity and at the right service locations.
3. Optimize the patient experience by advocating for access to evidence-based high quality, patient-centered and respectful care that improves the functional level of persons with addiction in all aspects of their lives so they may enhance their contributions to their families, their work, and their communities and their own well-being.
4. Optimize the clinician experience and reduce clinician burnout by advocating for appropriate reimbursement and workable utilization management processes for psychosocial and medication treatment across the treatment continuum.

Background

Most health care services in America are paid for via a third party: not the patient and not the clinician but a fiscal intermediary, most often an insurance company or health plan. Roughly 300 million Americans are covered by some form of health insurance, with roughly one-third of those being a governmental plan such as Medicare, Medicaid, TRICARE, or CHAMPVA, and two-thirds being a commercial plan (which could be an HMO).ⁱⁱ In 2018, about 180 million lives were covered by an employment-based health plan and about 35 million were covered by an individually purchased policy. Most persons are not aware that the majority of employment-based health coverage is not via a commercial insurance company from whom an employer or union purchases policies on behalf of workers; about 45 million people are covered by a health insurance policy purchased through their employment, but 135 million people are covered by their employer or union directly,ⁱⁱⁱ with risk assumed by the employer or union and claims payment via a third party administrator. These self-insured vehicles for providing health care coverage to workers and dependents are called ERISA-exempt plans.

As of 2014, 46 percent of substance use disorder treatment was financed by private insurance (18%), Medicare (6%) or Medicaid (21%), with the remainder financed by state and local governments, federal block grants, and patient out-of-pocket payments.^{iv} Comparatively, in 2013, about three-quarters of all general health care purchased in the United States was paid for by private insurance, Medicare, or Medicaid.^v The historical separation of substance use disorder and mental health treatment services from mainstream medical care has resulted in less robust overall coverage for these services. Historical policies such as the Medicaid Institutions for Mental Diseases (IMD) exclusion further limit access to treatment. The IMD exclusion prohibits the use of federal Medicaid financing for care provided to Medicaid beneficiaries aged 21-65 in mental health and substance use disorder residential treatment facilities with more than 16 beds.

Additionally, there are a number of administrative rules of the Centers for Medicare and Medicaid Services (CMS) governing participation in the Medicare program that make it difficult or impossible for addiction clinicians to receive third-party payment from Medicare, and thus they will not accept Medicare patients into their care. These have to do with the categories of non-physician clinicians who are acceptable to the Medicare program, the level of supervision required for non-physician clinicians, and definitions of psychotherapy. The result is that most residential treatment programs, partial hospitalization programs, and intensive outpatient programs not owned and operated by a general hospital or in which there is not a physician directly facilitating therapy groups cannot access reimbursement from the Medicare program. Only as of 2020 did Medicare change its rules to allow for services in Opioid Treatment Programs to be covered by Medicare, but office-based opioid treatment, especially with integrated counseling, can remain challenging to get approved for Medicare payments.

In 2008 the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) legislated parity between benefits for the treatment of addiction and mental health disorders and benefits for the treatment of other medical conditions but did not mandate that plans include mental health or addiction treatment coverage. The 2010 Affordable Care Act declared substance use disorders as an "Essential Health Benefit" and required non-

grandfathered individual and small group market plans to cover services to prevent and treat substance-related disorders. It also extended MHPAEA parity protections to plans sold through state health insurance exchanges. As a result, access to addiction and mental health care has improved, but it is still far from universal. Health insurance benefit structures that do not align with the chronic disease nature of addiction persist in the marketplace.

Despite improvements in coverage and legislative reforms such as MHPAEA and the Affordable Care Act, addiction treatment services are still frequently “carved out” of health insurance policies and managed by separate behavioral health plans. Under this structure, insurance risk pools, clinician networks, and utilization management processes for mental health and addiction care are separated from the risk pools, clinician networks, and utilization management processes for general medical conditions. As a result, treatment for addiction and co-occurring physical and/or mental health conditions may be limited or not coordinated. Further, the full benefits of treating addiction (such as improvement in other health conditions or reduced risk for medical complications) aren’t fully realized, and, when realized, accrue to the general medical risk pool rather than to the carved-out behavioral health risk pool.

Moreover, a 2017 report by Milliman^{vi}, updated in 2019,^{vii} found that the promises of parity have not been actualized. Out-of-network systems and clinicians – those clinicians who are not contracted with payers to provide care to beneficiaries – are utilized at a rate five to ten times higher for mental health and addiction services compared with medical-surgical services, with resulting higher co-pays for patients and consequent delayed help-seeking by patients. Data from this report also demonstrated that payments for professional services are significantly lower for mental health and addiction care compared with medical-surgical care. Overall, even though alcohol and drug use and addiction are among the leading causes of death and disability in the United States,^{viii} insurance plans spend 1% or less of total health expenditures on the treatment of addiction.

In an ideal world, health insurance companies and other payers would aid a patient with addiction by authorizing, in a convenient manner for all stakeholders, the right treatment at the right level of care for the right length of time. This assumes an understanding that addiction is a chronic, life-threatening medical disease requiring acute stabilization and continuing care to manage waxing and waning symptoms, with the patient striving for long-term recovery and addressing occasional relapses with return to more intensive and/or higher levels of care when needed. Managed Care Organizations and their utilization review processes have the potential, however, to limit access to treatment by restricting access to benefits and having an authorization process so complex that the clinician and the patient are discouraged from seeking treatment that is truly medically necessary. A recent U.S. District Court ruling identified a major insurer as assuming an “acute care” concept of addiction treatment applying utilization management criteria that authorized only acute episodes of care and blocked access to intensive and longer-term interventions that would be considered “medically necessary” per more objective criteria.^{ix} Ultimately, when looking to the goal of improving the health status of populations, there needs to be more utilization of evidence-based practices for addiction treatment, such as medications for opioid use disorder, and third-party payers should foster rather than inhibit that increased utilization.

Even for those patients with insurance policies that cover addiction treatment services, access to needed care may be compromised by narrow networks that do not include sufficient or geographically available addiction clinicians or programs, utilization management techniques such as prior authorization for addiction treatment medications, acute-care model benefit design, and/or high deductibles and copays.^x

Plans that require high cost-sharing from beneficiaries, such as high deductible plans, can also be a major barrier to addiction treatment. The nature of addiction and the symptoms of the disease frequently result in patients having no available funds to pay for treatment when they accept the need for treatment. Failure to initiate treatment early may result in the exacerbation of symptoms as well as job and/or housing loss, additional medical complications and family disruption.

Regrettably, some states still allow intoxication exclusion laws which permit insurers to include a provision in insurance policies that allows them to deny coverage for the treatment of injuries "sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."^{xi} Other states expressly prohibit these clauses in insurance contracts.^{xii} A review of 2017 Affordable Care Act plans identified 14 states with at least one plan with an intoxication exclusion.^{xiii} These policies have the perverse effect of discouraging clinicians from addressing a patient's substance use at all or leading to intentional decisions to avoid collecting blood alcohol levels or urine drug tests in acute care settings, and thus preventing potential opportunities for clinical intervention for a patient's substance use disorder.

There has been a long and unfortunate tradition to consider addiction involving nicotine use, whether via combustible or non-combustible delivery systems, to be something other than addiction, and to consider health care services to address nicotine use, such as smoking cessation interventions, to be something not conceptualized or covered as part of addiction treatment. This persists in most settings to this day, with many addiction treatment programs not integrating treating of addiction involving nicotine use into their treatment plans, and insurance plans considering nicotine-related treatment interventions to be "not a covered benefit" despite the huge contribution of nicotine and tobacco product use to morbidity and mortality and life expectancy. Particularly because persons with addiction and mental disorders have rates of addiction involving nicotine use that far exceed rates among other adults, it is imperative that nicotine use be addressed clinically and that insurance benefits facilitate the provision of such services. Addiction involving nicotine use should be treated and third-party payers should pay for appropriately designed services. ASAM recognizes that addiction involving nicotine use is the most common form of addiction in the United States, with chronic tobacco use causing significant illness and disability, as well as more than 480,000 premature deaths annually in this country alone.^{xiv} This exceeds the number of premature deaths attributed to the use of alcohol (88,000/year^{xv}) or other drugs (at least 70,000/year^{xvi}). Tobacco use-related health care expenses, absenteeism, and lost productivity cost the nation an estimated \$289 billion per year.^{xvii} Each employee who smokes costs the employer nearly \$6,000 per year.^{xviii}

Many of the adverse health effects of tobacco use are common knowledge. Surveys indicate up to 70% of active smokers want to quit,^{xix} but relapse has been the rule rather than the exception. Such persistence of behavior, despite adverse consequences, is characteristic of addiction. Importantly, addressing addiction involving nicotine use can support recovery from addiction involving other substances.^{xx}

Improved third-party reimbursement for the treatment of addiction involving nicotine use would make treatment more accessible to individuals with limited resources and would facilitate treatment at earlier stages. Earlier treatment would reduce overall long-term health care costs and other expenses. If the federal government were to offer tax credits for costs related to treatment of addiction involving nicotine use, we believe that savings in health care costs paid by governmental sources for medical complications of tobacco use would offset the economic costs of such tax credits.

There are many special populations (such as persons with addiction who are pregnant or who have co-occurring medical problems such as HIV disease) that face unique challenges in receiving addiction treatment, sometimes due to problems with delivery system design or capacity but at other times due to insurance plan design. An example is individuals transitioning back into the community after incarceration. Data show a significant increase in mortality risk for persons with addiction involving opioid use among this group. Both private and public insurance plans stop coverage when persons are incarcerated; but re-establishing coverage upon release is necessary for persons to re-establish medication treatment for addiction involving opioid use. Pilot programs exist which enroll eligible individuals in Medicaid before release from incarceration and ensure seamless transitions of care and coverage. In order to save lives, such reforms to eliminate gaps in medication management should become the norm so as to lower rates of overdose and death in this population.

Progress is being made to move health insurance away from encounter- or service-based payment structures and toward value-based systems that reward quality care as measured by evidence-based processes and desirable clinical outcomes. Alternative Payment Models (APMs) with bundled payments for addiction treatment services tied to measurable treatment milestones or outcomes are being explored and piloted. These are promising steps toward a future when addiction treatment is fully integrated into mainstream health care and payment policies foster ready access to evidence-based treatment in a chronic disease model.

Recommendations:

The American Society of Addiction Medicine recommends:

1. **Benefit plans should be comprehensive** and reflective of the complexity of the disease of addiction. In both public and private sectors, plans should cover the entire continuum of clinically effective and appropriate services provided by licensed and certified professionals, including all levels of care defined by *The ASAM Criteria*, and should provide coverage at parity with those benefits covering general medical

illnesses, with the same provisions, lifetime benefits, and catastrophic coverage. Federal- or state-sponsored plans that provide coverage for persons who are otherwise uninsured must not exclude coverage for the diagnosis, prevention, treatment, and maintenance-of-remission of addiction.

2. **Addiction care should be considered an essential health benefit** in all health insurance plans: individual policies, group policies, ERISA-exempt health plans, and in government-sponsored plans such as Medicare, Medicaid, TRICARE, CHAMPVA, and in all government employee health benefit plans. Aligned with this, governmental health systems such as the Veterans Health System and the Indian Health Service, which directly offer care rather than paying for care through an insurance vehicle, should include a full range of services for addiction care, including care for addiction involving nicotine use, in their service delivery systems.
3. **Medical necessity criteria** that determine coverage of addiction treatment services should follow generally accepted standards of care as defined by national medical specialty society-developed guidelines. Third-party payers should use nationally recognized addiction treatment and placement criteria such as *The ASAM Criteria* for medical necessity determinations for addictive, substance-related, and co-occurring conditions so that such treatment is individualized and takes place at the most appropriate level of care (intensity of service) for the most appropriate length of time (duration of services). Coverage and utilization management should allow for appropriate chronic disease management and not provide coverage or affirmative utilization decisions only for acute interventions.
4. **Treatment of co-occurring disorders** should be encouraged and not discouraged by insurance benefit and health care delivery system designs. When patients present with addiction along with physical and/or psychiatric co-morbidities, they should have access to clinicians who can address the needs of the whole person in a collaborative and integrated fashion. Integrated treatment services for addiction, mental health conditions, and general medical conditions including chronic pain, infectious diseases and obstetrical care, should be covered, reimbursed and incentivized.
5. **The continuum of care** for addiction treatment services should allow for patient placement based on objective and research-validated criteria. This continuum of care should include, when indicated,
 - a. professional assessment;
 - b. detoxification including withdrawal management/stabilization and intoxication management;
 - c. treatment in intensive outpatient settings, non-hospital-based residential settings or hospital-based settings;
 - d. ongoing treatment in long-term care settings;
 - e. ongoing outpatient care for addiction management; and

- f. provision for the use of medications for addiction treatment in all ambulatory and non-ambulatory settings.
- 6. **Health insurance benefit design** should include coverage for specialty treatment, primary care services and emergency services for addiction and related disorders, including prevention and brief intervention services, rather than there being a requirement that services be coded as treatment of a medical complication of substance use.
- 7. **The nature of addiction as a chronic disease** should be respected by the utilization management process such that both psychosocial and medication treatment for addiction are covered without medical necessity assertions that arbitrarily impose limitations on the intensity and/or duration of care.
- 8. **Benefit plans should consider reimbursing emerging best practices** as part of the continuum of available services, such as peer recovery support services and certified recovery homes when they support the full range of evidence-based services for addiction.
- 9. **At a minimum, pharmacy benefit management** should not require prior authorization for the initial prescription of medications used acutely for addiction management, withdrawal management, intoxication management, or overdose management. FDA-approved pharmacotherapies to treat substance-related disorders should be allowable as treatment options when medically necessary and should not be categorically excluded as treatment options for persons covered under government-funded or commercial health insurance plans. Every pharmacy benefit plan should include access to FDA-approved medications for each specific substance use disorder and each unique class of pharmaceutical agent and FDA-approved route of administration for each disorder. For benefit plans that require copayments or cost sharing, at least one agent in each class should be placed in the most affordable tier.
- 10. **High deductible insurance plans** can present significant barriers to initiating and continuing treatment of addiction, withdrawal syndromes and co-occurring disorders. Insurance policies should contain provisions to ensure that the deductible is not a barrier to urgent treatment for addiction.
- 11. **The carve-out model of managed care**, in which network construction and reimbursement rates for clinicians, utilization management processes, and risk-pool design for payers that are developed separately for behavioral health care and general medical care, does not result in optimum care for addiction and co-occurring general medical disorders, and thus the carve-out model should be eliminated and replaced with an integrated model in which quality, outcomes, and cost savings apply to and accrue for all medical care, including addiction care. The savings gained in general medical services utilization as a result of early and effective addiction treatment should

not accrue solely to general medical service budgets and risk pools. Instead, benefit models should allow behavioral health data to integrate patient-level data with medical plan data to allow quality, outcomes and care coordination to be evaluated for improvement in patient care and total costs; any cost savings should apply to and accrue for all medical care, including addiction care.

12. **Clinician networks** should not be so restrictive that patients have too few geographically accessible options to care for their addiction-related disorder, or so exclusionary that care by an appropriately knowledgeable physician and system of care is not reasonably available. Patients should not be in the circumstance of needing to access out-of-network clinicians due to an inadequacy of addiction service clinicians who are in-network. Inadequate networks and phantom networks should both be forbidden by law and regulation. Enforcement of appropriate network design should include meaningful penalties for non-compliance.
13. **Payer credentialing processes** should ensure parity among medical specialties and allow for consideration of established pathways for certification in treating addiction-related disorders when making decisions for inclusion in clinician panels and networks. Certification in Addiction Medicine by the American Board of Preventive Medicine, the American Osteopathic Association, the American Society of Addiction Medicine, or the American Board of Addiction Medicine, or certification in Addiction Psychiatry by the American Board of Psychiatry and Neurology, should all be considered sufficient credentials for inclusion in clinician panels for the treatment of addiction-related disorders.
14. **Payer care management and utilization management processes** for addiction care should be transparent, publicly available and easily accessed by all stakeholders, including clinicians, patients, and regulators. Medical necessity criteria, level of care guidelines, and clinical appeal processes regarding addiction treatment denial decisions should be convenient and expeditious. Legislative mandates for transparency in utilization management for addiction care should be enforced by regulation.
15. **Clinicians who perform care management and utilization management functions for payers** should be qualified to review service requests for addiction care. Managed care case managers, utilization managers, and medical directors involved in the review process should have sufficient training, experience and credentials in addiction care. Physicians who review appeals of denials of authorization for coverage and payment for addiction care should be certified as addiction physician specialists or subspecialists (see ASAM Public Policy Statement on How to Identify a Physician Recognized for Expertness in the Diagnosis and Treatment of Addiction and Substance-related Health Conditions).^{xxi}

16. **The Institutions for Mental Diseases (IMD) exclusion** should be amended to allow federal Medicaid funds to serve persons with addiction in those residential and inpatient settings that provide FDA-approved medications for addiction treatment and that can demonstrate that patient assessments, clinical services, level-of-care and length-of-stay recommendations are evidence-based and aligned with nationally recognized addiction treatment and placement criteria such as *The ASAM Criteria*.
17. **Medicare** should cover the entire continuum of addiction treatment services and withdrawal management services, putting an end to its current exclusions that result in barriers to access to residential, partial hospitalization, and intensive outpatient and even general outpatient services.
18. **Coverage for a full range of behavioral and pharmacological treatments for addiction involving nicotine use, whether combustible or non-combustible,** should be a part of private and public health benefit plans. Third-party payers and health plan administrators are encouraged to make coverage for the treatment of addiction involving nicotine use available to all group and individual enrollees. This should be viewed as coverage for treatment of a primary medical problem, addiction involving the use of nicotine, and not solely as a preventive service.
19. **FDA-approved pharmacotherapies** for tobacco use disorder should be covered by private and public health plans and not relegated to self-pay for patients from over-the-counter access points only.
20. **Employers** are advised to request coverage for the prevention and treatment of addiction involving nicotine use among the health benefits they purchase for employees. Unions are advised to include coverage for the prevention and treatment of addiction involving nicotine use among the health benefits provided for their members, either directly or through collective bargaining.
21. **Specific tax credits** for expenses related to the treatment of addiction should be granted as a mechanism for government to encourage the treatment of addiction. These credits should appropriately apply whether the expenses be incurred by an individual or an employer.
22. **Incarcerated individuals** who are facing release and re-entry to the community should be able to have health insurance coverage placed in force for a workable period of time prior to release so that medical management of chronic diseases such as addiction can be established without gaps in coverage (gaps which, in the case of addiction involving opioid use, have been shown to contribute to avoidable overdose deaths).

23. **States should prohibit insurers from including intoxication exclusion provisions** in health care benefit plans.
24. **Alternative Payment Models (APMs)** for the payment of health services which emphasize payment for quality and outcomes rather than payment for quantities of services offered should be expanded to include payment for the acute treatment and chronic disease management of addiction and related disorders. Such models should address payment for evaluation and management of the primary disease of addiction and payment for evaluation and management of the medical complications of addiction, and not carve out addiction treatment services from general medical care services. Quality measures and target outcomes for addiction should support coordinated, whole-person care and should align with other general medical care benchmarks.

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