

The Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA):

Addressing Co-Occurring Substance Use Disorder Services for Transition-Aged Youth



Substance use, which almost always begins in adolescence, is the most expensive public health problem in the U.S. today. Youth with mental health conditions are more likely than other youth to have a substance use disorder (SUD)¹ and substance use may indicate an undiagnosed mental illness. Reasons for this higher risk include attempts to self-medicate to alleviate distressing symptoms, lower impulse control, greater difficulty resisting peer pressure, and acting-out or defiant behaviors.²

Access to quality services that address both mental health and SUDs has been hampered by limited insurance, and lack of 1) knowledge about services, 2) available services, and 3) incentives for quality standards for treatment. In 2012, only about 10 percent of 1.6 million youth aged 12 to 17 needing SUD treatment in a specialty facility received treatment. Over half of those people aged 12 years and older who sought SUD treatment did not receive it because of cost or lack of insurance, or not knowing where to go. The rest were hindered by stigma, transportation issues, time constraints, and a perceived lack of readiness to get help.³ For those who got treatment, few received services that met evidence-based practice standards, or integrated mental health and SUD treatment.⁴ Implementation of the Patient Protection and Affordable Care Act (ACA), along with the Mental Health Parity and Addiction Equity Act (MHPAEA), has the potential to greatly improve access to and quality of services for youth and young adults.

ACA: BENEFITS FOR MENTAL HEALTH AND SUD SERVICES

Thomas McLellan, former Science Advisor and Deputy Director of the White House Office of National Drug Control Policy, and CEO and founder of the Treatment Research Institute believes that ACA will have the most profound effect on addiction as an illness, revolutionizing SUD treatment.⁵ Fully implemented on January 1, 2014, ACA guarantees coverage for mental health and SUDs as an essential health benefit (EHB) and recognizes these disorders as chronic illnesses, paving the way to coverage of services available for other chronic conditions.

ACA⁶ firmly places mental health and SUDs in the medical arena by including their 1) treatment as an EHB, 2) definition as chronic diseases, and 3) screening in medical settings. ACA further improves access to quality care for youth and young adults with co-occurring disorders by:

1. allowing young adults to be covered by their parents' insurance until age 26 (this provision has been in effect since September, 2010);
2. facilitating coverage for vulnerable, low income young adults not covered by a parent's insurance policy through Medicaid coverage to age 26 and outreach to help youth obtain coverage in states;
3. prohibiting denial of coverage for pre-existing mental health, behavioral health, or substance use conditions;

4. eliminating annual and lifetime limits that would deny access to treatment;
5. incentivizing use of the most effective practices and providing coverage for medication and non-medication effective practices; and
6. supporting prevention, early detection and referral by medical providers and school-based health centers.

MHPAEA: EQUIVALENCE OF BENEFITS

MHPAEA,⁷ signed into law in 2008, guarantees that mental health and SUD benefits, if provided, be consistent with financial requirements and treatment limitations of medical/ surgical benefits. ACA, by making these services an EHB, guarantees coverage for these services, with the exception of grandfathered small group plans, and the gaps in coverage of low income populations who fall in the 138 percentile of the federal poverty level in states that do not adopt Medicaid expansion. Application to Medicaid and the Child Health Insurance Program (CHIP) were addressed separately by letter⁸ and further guidance is forthcoming on the application of MHPAEA to Medicaid expansion. The



final rules for MHPAEA implementation, published in November 2013, go into effect on July 1, 2014, affecting most plans at the start of the new plan year on January 1, 2015. The final rules clarify that:

1. treatment limits or financial coverage requirements for copays or deductibles that are more restrictive for mental health and SUD services than for medical/ surgical services are prohibited;
2. if plans cover mental health and SUD services, coverage generally includes inpatient and outpatient services, emergency care, and prescription drugs. Within categories such as these, plans can treat preferred and non-preferred providers differently;
3. deductibles for mental health and SUD services cannot be calculated separately from other services in the same category;
4. parity applies to intermediate level mental health and SUD services such as residential treatment and intensive outpatient services;
5. the same type of processes must be employed for management of health and SUD and medical/ surgical benefits, such as determining medical necessity or requiring preauthorization;
6. ACA's prohibition of annual or lifetime dollar limits on EHBs overrules limits allowed under MHPAEA, which only apply to provisions that are not EHBs;
7. federal parity laws do not pre-empt more stringent state parity laws; and
8. medical necessity determinations and reasons for denial of reimbursement or payment of services with respect to mental health and SUDs must be made available to participants and beneficiaries.

HOW ACA AND MHPAEA AFFECT SERVICES FOR CO-OCCURRING DISORDERS

The impact that ACA and MHPAEA will have on mental health and SUDs, and behavioral health treatment can be grouped into six areas.

1. *Essential Health Benefits*. By making mental health and SUD services, including behavioral health treatment, one of 10 EHBs these services must be covered by qualified health plans, with the exception of grandfathered individual and small group plans. This provision will greatly expand access to coverage for youth and young adults who were previously unable to obtain treatment due to lack of insurance coverage.

2. ***Mental Health and Substance Use Disorder Treatment Parity.*** Parity means that benefits for mental health and SUDs cannot be treated differently from benefits for other medical services. While MHPAEA does not require coverage of these services, ACA does. Therefore, together ACA and MHPAEA ensure benefits and parity for mental health and SUD services covered by qualified health plans. However, state differences in coverage of mental health and substance use disorder benefits will need close monitoring.⁹
3. ***Mental Health and Substance Use Disorders as Chronic Disease.*** Identification as chronic conditions assures that the full spectrum of services available for the prevention, identification, treatment, and ongoing management of other chronic illnesses, such as diabetes, will be available to individuals at risk of, with early signs of, or diagnosed with a mental health or substance use disorder. This is critical for SUDs which have been treated as acute illnesses with limited coverage for inpatient or outpatient services, without coverage for early intervention or long term management, which has been demonstrated to yield the best recovery outcomes.¹⁰
4. ***Prohibition of Denial of Coverage for Pre-Existing Conditions.*** Individuals can no longer be denied coverage because of pre-existing mental health or substance use disorders. Consequently, more people may be willing to use their insurance to seek treatment for mental health or substance use concerns since they will not be risking potential loss of coverage.
5. ***Screening and Prevention Services.*** As with any progressive, chronic illness, prevention and early intervention can make the difference between high cost intensive treatment in response to a crisis and low cost problem reduction before the disease progresses. ACA includes new benefits for screening and prevention services, such as depression screening. Support for school-based health centers includes prevention and early intervention services. Ideally, medical practitioners, who will be able to bill for screening and prevention services, will implement evidence-based brief interventions for substance use disorders, such as Screening, Brief Intervention, Referral, and Treatment (SBIRT) and Motivational Interviewing (MI), which have demonstrated success in changing behavior.^{11,12}
6. ***Impact on Quality of Care and Evidence-Based Practice.*** ACA includes incentives and provisions



to improve quality of care and outcomes. Measures to reward quality include financial incentives for 1) improved health outcomes resulting from quality reporting, 2) implementation of best practices and evidence-based medicine, 3) reduction of health disparities, and 4) the risk of non-payment for hospital readmissions associated with the treated condition within 30 days of discharge. Although risk of non-payment is specified for hospital re-admissions, it remains to be seen how these incentives may be applied to intermediate care residential treatment.

ANTICIPATED TREATMENT ACCESS ISSUES

Although ACA establishes conditions of coverage and supports for implementation, access to SUD services may, at least initially, be seriously hampered by untrained medical personnel and insufficient treatment providers.

Physicians and other medical staff rarely receive training in SUDs. Despite requirements, they may be unskilled in screening, or unprepared to follow up on positive findings. ACA includes resources for training and integrating medical and behavioral health provider practices, but it will take time for practitioners to adopt changes successfully.

SUD services are already stretched to capacity, even without the influx of individuals representing the unmet need for services. Long waiting lists often exist for detoxification and treatment, and rural and underserved areas often have no services available nearby. In addition to support for provider training, ACA incentivizes referral to effective specialty providers. The broader availability of insurance benefits for these services may promote their increased availability.

There is some concern that SUD treatment providers may elect to operate as private pay only. ACA includes

incentives for enhanced reimbursement based on quality of care, but also has increased electronic health record (EHR) and reporting requirements that present cost concerns for providers. Challenges with uptake of EHRs and concerns about confidentiality and protection of patient data also cloud the issue of how treatment providers will respond. The success of early identification and treatment referral will depend on sufficient availability of specialty providers who take insurance.

CONCLUSION

For transition-aged youth with co-occurring disorders, ACA provides the means to obtain screening, early intervention, treatment at the appropriate levels of care relative to level of illness, quality care, care coordination, and long term disease management. Together, these factors offer the promise of early intervention before substance use disorders progress to life threatening levels; effective treatment; and ongoing medical and behavioral supports to increase successful long term recovery.

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