Question Presented
Will the Patient Protection and Affordable Care Act (ACA) provide funding and improve availability and accessibility of substance use disorder (SUD) treatment services?

Brief Answer
ACA may provide improved access to SUD treatment and services through several of its provisions, including those that:

- Increase access to health insurance generally;
- Require that most plans covering newly insured people include certain “essential benefits,” which will include SUD benefits;
- Require that SUD services be provided at parity with medical and surgical services; and
- Prohibit insurers from refusing to cover people with a history of SUD, or charge higher premiums because of such a history.

Analysis
This memorandum briefly summarizes ACA’s health care expansion mechanisms, describes the SUD benefits that these plans will be required to cover and briefly discusses other ACA provisions that have the potential to improve access to care for individuals with SUDs.

Insuring the Uninsured
Assuming that many of the individuals currently facing difficulty accessing SUD treatment are uninsured or underinsured, ACA’s expansion of insurance coverage is likely to increase their ability to access care. This expansion will be accomplished in multiple ways.

First, Medicaid will be expanded to include nearly all individuals under the age of 65 whose income falls at or below 133 percent of the federal poverty line (FPL). Although states will continue to administer the Medicaid program, most of the costs related to the newly eligible will be covered by the federal government under the new, national threshold for Medicaid eligibility.
Second, health insurance coverage will be expanded to require individuals who are not specifically exempt to purchase qualifying coverage. \(^5\) Employers with 50 or more employees will be assessed a fee of $2,000 per employee (in excess of 30 employees) if they do not offer qualified coverage and have at least one employee who receives a premium subsidy.

Third, to facilitate insurance coverage for those not covered by a group or public plan, exchanges through which individuals and small businesses can purchase qualified coverage will be created. Subsidies will be provided to individuals and families with incomes between 100-400 percent of FPL to pay premiums for insurance purchased through the exchanges. \(^6\)

The “Essential Health Benefits” Requirement

Under ACA, health insurance plans offered to most newly insured (and many currently insured) must cover certain essential health benefits beginning January 1, 2014. \(^7\) Essential health benefits must be part of the coverage offered within all health insurance exchanges. \(^8\) State-sponsored basic health programs and small group and individual plans offered outside of an exchange must meet the standard as well, as will Medicaid plans covering most persons newly eligible under the expanded coverage rules. \(^9\)

Essential benefits must be equal in scope to the benefits provided by a typical employer health plan, as determined by the U.S. Department of Health and Human Services (DHHS) based on information provided by the Department of Labor. \(^10\) Plans must also include coverage for a number of categories of services, including mental health and SUDs. \(^11\) DHHS will be issuing further guidance about what constitutes “essential health benefits.” When determining what services the essential health benefits provision will encompass, DHHS must take into account a number of factors, including “the health care needs of diverse segments of the population.” \(^12\) At DHHS’ request, the Institute of Medicine (IOM) will make recommendations on the criteria and methods for determining and updating the essential health benefits package. \(^13\)

The Substance Use Disorder Parity Requirement

ACA may also improve access to SUD services by extending the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) to require provision of SUD benefits at parity with medical and surgical benefits to most people who will gain insurance under ACA. All plans offered through exchanges and all benchmark and benchmark-equivalent Medicaid plans will be required to comply with MHPAEA. \(^14\) While MHPAEA does not apply to traditional fee for service Medicaid, Medicaid plans provided through managed care organizations must be in compliance with the law. \(^15\)

MHPAEA improves the Mental Health Parity Act (MHPA) by prohibiting plans that offer both medical/surgical benefits and SUD benefits from charging higher deductibles or copayments for substance use services or limiting the number or frequency of provider visits except to the extent that those limits are also imposed on substantially all medical and surgical benefits. \(^16\) It also prohibits plans from limiting the number or frequency of provider visits for SUD except to the extent that those limits are also imposed on substantially all medical and surgical benefits and requires that plans that provide out-of-network medical/surgical benefits also provide out-of-network SUD treatment. \(^17\)

Finally, regulations promulgated under the MHPAEA require that health plans that offer benefits for a specific substance use condition in any one of six classifications (inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs) also provide benefits for that condition in every other classification in which medical/surgical benefits are offered. \(^18\) For example, if a plan provides prescription coverage for treatment of opioid dependence and for outpatient in-network visits for any medical or surgical condition, it must then provide coverage for outpatient in-network visits related to opioid dependence at levels no more restrictive than those provided for other medical visits.

The Prohibition of Pre-existing Condition Exclusions

ACA may increase access to SUD benefits for individuals suffering from a history of SUD who previously have been denied health insurance coverage on the basis of a pre-existing condition. ACA initially requires establishment of Pre-
existing Condition Insurance Pools (PCIPs) to enroll persons who have been uninsured for at least six months and are having difficulty enrolling in insurance plans because of a pre-existing condition.\(^{19}\)

These PCIP plans will terminate on January 1, 2014 when group health plans or issuers that offer group or individual health insurance coverage will be prohibited from excluding individuals because of pre-existing conditions or discriminating against individuals who have a history of illness.\(^{20}\) Additionally, individual and small group policies will be prohibited from charging higher rates because of an enrollee’s health status.\(^{21}\) Finally, most insurers will be prohibited from imposing lifetime and annual limits on the dollar value of essential health benefits.\(^{22}\)

**Other Provisions**

Additional ACA provisions could indirectly impact SUD services. For example, beginning in 2011 states may opt to amend their Medicaid plans to incorporate “health homes” for certain individuals with chronic conditions.\(^{23}\) Substance use disorder is specifically listed as a chronic condition, and states are required to consult and coordinate with the Substance Abuse and Mental Health Services Administration to address “issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.”\(^{24}\) The “health homes” approach is designed to increase collaboration between providers and coordinate disease prevention and chronic disease management in a way that involves the patient. Since SUD treatment, particularly for those with concurrent conditions, is often hampered by lack of coordination between providers, health homes may improve the level of care.

Other provisions may help prevent SUDs as well. For example, some SUDs begin with improper or inadequate pain treatment. ACA provides funds to advance pain care research and treatment and to improve pain care treatment of health providers, among other things.\(^{25}\) Another provision creates Centers of Excellence for Depression, providing over $1 billion for research and treatment of depressive disorders.\(^{26}\) Additionally, ACA establishes several funding streams for investment in prevention programs, which should include SUD.\(^{27}\) Although there is no direct funding for SUD treatment, grants under some of these funding initiatives could be used for SUD treatment if evidence exists that such treatment prevents other diseases and conditions.

**Conclusion**

ACA should improve access to treatment for substance use disorders in a number of ways. Chief among these are the extension of health insurance to many previously uninsured people and requirements that most health plans covering newly insured people provide coverage for SUD on parity with medical and surgical care regardless of previous SUD diagnoses. Many other aspects of ACA should also help treat SUD, and funding may be available to prevent its occurrence.

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**SUPPORTERS**

The Network for Public Health Law is a national initiative of the Robert Wood Johnson Foundation with direction and technical assistance by the Public Health Law Center at William Mitchell College of Law.

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While the issue of availability and accessibility of treatment services also pertains to incarcerated individuals, the following analysis applies to persons who are not incarcerated. The ACA does not make any changes to the level or quality of care required to be provided to incarcerated individuals by the correctional system.

ACA § 2001(a)(1) (adding 42 USC § 1396a(a)(10)(A)(i)(VIII)).

Those who choose not to purchase such coverage will be required to pay a penalty of the greater of $695 per year per person (ACA § 1001, § 10101 (amending 42 U.S.C. § 300gg)).

ACA § 1401, ACA § 1001.


ACA § 1201 (amending 42 U.S.C. 300gg-6) (individual and small group market); Id. at § 2001(c) (amending 42 U.S.C. 1396u-7(b)) (Medicaid). Some categories of newly eligible people will be enrolled in traditional fee for service Medicaid plans, which are not required to cover essential health benefits. Id. at § 2001(a)(2) (adding 42 U.S.C. § 1396a(k)(1)). These categories are listed in 42 U.S.C. § 1396u-7(a)(2)(B).

ACA § 1302(B)(2).

The required services are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care. ACA § 1302(b)(1)(A-J) (codified at 42 U.S.C.A. § 18022(b)(1)(A-J)).

ACA § 1302(B)(4)(C). Notice and opportunity for public comment on these determinations must be provided, although no formal rulemaking procedure is specified.

The IOM is to "provide guidance on the policy principles and criteria for the Secretary to take into account when examining [qualified health plans] for appropriate balance among categories of care; the health care needs of diverse segments of the population; and nondiscrimination based on age, disability, or expected length of life; and offer advice on criteria and a process for periodically reviewing and updating the benefits package." Institute of Medicine, Determination of Essential Health Benefits (December 21, 2010, 9:27 AM), http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx.

ACA § 1311(j) (codified at 42 U.S.C.A. 1396u-7(b)(6)(A)).

See 42 U.S.C. § 1396u-2(b)(8). The MHPAEA does not apply to group health plans sold to employers with fewer than 50 employees or to plans in the individual market. See 29 U.S.C. § 1185a(c)(1).


Id. (adding §(3)(A)(ii) and §(5) to 29 U.S.C. 1185a).


ACA § 1101(a).

Id. at § 1101(g)(3).


ACA § 2703(a) (amending 42 U.S.C 1396w-4).

Id.

ACA § 4305 (Codified at 42 USC § 284a; 42 USCA § 294i).

ACA § 10410 (Codified at 42 USCA § 290bb–33).

The largest of these, the Prevention and Public Health Fund, is appropriated increasing amounts beginning with $500 million in FY 2010 up to $2 billion in FY2015 and thereafter. ACA § 4002 (42 USCA § 300u–11).