

# **Constructive Disruption for the Treatment of Substance Use Disorders: The Parity and the Affordable Care Acts**

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## **1.0 INTRODUCTION**

We are at a watershed moment in behavioral health. Substance abuse and mental health treatment and policies are poised to be positively transformed in the coming years. The implementation of the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (Parity Act) will ultimately bring about the functional integration of care for substance use and behavioral health disorders into the rest of health care, ensure that these illnesses are cared for equally with other medical disorders and significantly improve outcomes for patients and society. Through this constructive disruption in the current segregated health care system, we expect growing public understanding about addiction and mental illness, more active and informed consumerism and a demand for more research and higher-quality treatment for these disorders.

## 2.0 HISTORICAL CONTEXT

For over 40 years, substance abuse has effectively been segregated from the rest of medicine; care has been restricted by design to just those with severe, chronic and complex problems of addiction, and that care has been delivered almost entirely by freestanding addiction treatment programs with little to no involvement with the rest of health care. There has been no insurance coverage, and therefore no interest by the rest of health care in prevention, early intervention or office-based management of lower-severity (but higher-prevalence) cases of medically harmful substance use.

Segregation has been obviously bad for addiction treatment. It has led to separate facilities with treatment methods and cultures that are not well aligned with the rest of medicine, and to the general perception that these disorders were not "real" medical illnesses. And though it is less obvious, segregation has been equally harmful to mainstream health care. There has been essentially no integration of knowledge about substance abuse management into the treatment of other clearly related areas of specialty medicine such as pain management, cancer, diabetes, asthma or hypertension. Medical (but also nursing and pharmacy) schools have failed to train clinicians in the needed skills, implicitly deepening the segregation and resultant stigma and producing well-documented, system-wide failures to manage the 40–60

million cases of medically harmful use that reduce the quality, worsen the outcomes and increase the costs of general medical care.

This historically segregated model of care delivery will be disrupted with the implementation of the ACA and the Parity Act. These two acts require health insurers to cover—and health care organizations to provide—prevention, screening and brief interventions for the full spectrum of substance use disorders, not just addiction. Together, these acts require that care for substance use disorders have the same type, duration and range of services and patient financial burden as the care currently available to patients with comparable physical illnesses. Beyond the new range of coverage available, this legislation expands the venues for care delivery into new medical and community-based settings such as primary care, hospital and general medical clinics, employee assistance programs, community clinics, rehabilitation facilities, schools and colleges, in homes and through various electronic media. Under the new legislation, most health care plans will be “carving in” behavioral health care under their major medical benefits with the goal of improving total health outcomes and reducing overall health care costs (Federal Register, 2013). In other words, there is a new incentive to prevent, intervene early and treat substance use disorders within the context of overall health.

# **3.0 HOW INSURANCE FINANCING HAS DEFINED THE DISEASE OF ADDICTION**

It is easy to miss the full significance of the new legislation because it merely applies the same standards of care to substance use disorders that have long been in place for other physical illnesses. But as discussed above, addictions have never been considered, treated or insured like other illnesses. Most private insurance plans never covered addiction treatment at all. Over 80 percent of addiction treatment financing has come from government sources (state block grants, the VA, etc.), with only about 12 percent coming from private insurance (U.S. Dept. of Health and Human Services Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). But in an effort to limit health care costs, even government insurance coverage has always been restricted to just the most advanced and severe form of a substance use problem: addiction. Coverage for the less severe but far more prevalent forms of substance use disorders has never been included. To illustrate the impact of these insurance and financing policies on societal perception and clinical management of substance use disorders, we now consider them in the context of another acquired, chronic, physical illness: adult onset diabetes.

## **3.1 Understanding Addiction Policy Impact through Comparison with Another Illness**

Suppose that in an effort to save health care dollars, insurance reimbursement was reserved for just the most severe, complex and chronic cases within the glucose regulation disorder continuum. For example, care might be restricted to just those who had lost their eyesight, or toes or fingers, as a result of the condition—the “truly” diabetic. A seemingly beneficial result of such a policy would be to eliminate the 79 million adults with early signs of diabetes (pre-diabetes) and at least two-thirds of the 26 million adults who meet the current diagnostic criteria for diabetes—reducing current cases to about 6–9 million of the most severely affected adults (National Diabetes Information Clearinghouse, 2011), and with that, the direct costs of providing diabetes care.

But let’s look more closely at how that insurance decision would affect how we think about and address diabetes. Such a policy would essentially eliminate prevention and early intervention efforts with what is now known as pre-diabetes. In contrast, a restricted insurance and treatment policy would be a boon for the instrument and measurement developers, particularly those concerned with diagnosis. Efforts to create instruments and criteria to identify true diabetics with perfect sensitivity and specificity would be highly sought after by insurers. There would likely be heated psychological and sociological discussions about the importance of not “labeling” as diabetic those who merely had less severe “glucose regulation problems.”

These policies would also have broader effects on the types of insurance available for treating diabetes over the years that followed the policy change. Remember that in the United States, most health insurance decisions have come from employers and their human resources departments. Because the suggested health insurance policy would increase the severity and complexity of the defined patient population, it would reduce the proportion of them who were employed. Responsible human resources managers would correctly question the need for diabetes coverage for such a small number of employees. In turn, the reductions in covered patients would reduce the size of the relevant commercial health care service markets that drive the discovery and production of new medications, psychosocial therapies, medical devices and clinical support software. These examples of innovation are critical forces for progress in treating any disease. Soon the differences between the diabetic population and the general medical population would be so significant that it would make both financial and clinical sense to carve out reimbursement for this group, and to make special credential requirements for treatment sites and providers of this type of "specialty care."

Beyond the market changes described, there would be an important perceptual change among health care professionals and the public at large. Those who qualified for diabetes treatment using the new definition would

likely be obese, have multiple co-occurring physical and psychiatric problems, demonstrate poor self-management and scattered treatment compliance and have failed to heed the stern warnings of families, friends and clinicians over the years. These chronically ill diabetic patients would come to define and represent the illness of diabetes. Individuals still in the early course of diabetic progression would not believe that they had anything in common with the true diabetics, fostering problem denial and treatment refusal. Of equal importance, generalist clinicians would have less involvement and experience with the full spectrum of glucose regulation problems during their training and likely only come into contact with (or at least recognize) the most severe, "true" diabetics. That kind of distorted clinical experience could leave clinicians mistakenly thinking that they had learned about diabetes and understood the illness, that they could easily recognize those affected without screening tools and that they would have little to offer patients with any form of the disease.

### **3.2 What's the Point?**

The purpose of comparing addiction with another acquired, chronic, physical disease is to illustrate how profoundly health care insurance decisions can influence the very core of public and professional understanding about a disease. By extension, many of the characteristics of addicted patients that are now thought to be cardinal

clinical features of the illness may actually be sociological and character features of the nonrepresentative segment of the affected population who are eligible for the available, segregated insurance and treatment. This hypothetical example also sets the context for the following discussion about the key elements of the ACA and the Parity Act, and how their implementation has the potential to affect not only the nature and types of care available for substance use disorders but also the ways these disorders are understood and acted upon by the public.

## **4.0 EXPECTABLE EFFECTS OF THE ACA AND PARITY ACTS ON THE PREVENTION AND TREATMENT OF SUBSTANCE USE DISORDERS**

The broad package of incentives, regulations and initiatives within the ACA will dramatically change all of health care in this country. And the Parity Act ensures that the ways in which these changes are applied to mental health and substance use disorders are on par with the changes in the rest of health care. For the first time, substance use disorders will be insured like other physical illnesses, and thus, care will increasingly be provided by the same clinicians who are now practicing general health care. Consumers should ultimately receive care for many of their mental and substance use problems where they receive the rest of their health care. The implications are

significant, and in the text that follows, we discuss three specific results that can be expected from this “constructive disruption.”

## **4.1 New populations will be covered**

At present, there are about 23–25 million adults who meet the DSM IV diagnostic criteria for substance abuse or dependence, but only about 10 percent of them receive any type of treatment, usually from the 11,000 specialty care programs in the United States.

With the implementation of ACA, an additional 12 percent of adults with the most severe form of substance use disorder—addiction—will likely be eligible for coverage through the expansion of Medicaid benefits. This increase in addicted patients who have access to health care insurance coverage has been much discussed within the addiction treatment field. But what has been missed is the much larger segment of patients (approximately 40–60 million Americans) who fall below the diagnostic threshold for addiction but suffer from a less severe form of substance use disorder, which will now also be covered by health insurance. This is by far the largest segment of affected—and now insured—individuals. But aside from screening and brief interventions, there has been little research on the clinical characteristics and needs of this very large “pre-addiction” population, with premorbid or early manifestations of less-severe chronic alcohol and other drug problems. This is obviously an important area

for future research.

## **4.2 New settings and providers of care will offer accessible care**

The addition of care for such a large number of patients with varying degrees and types of medically harmful substance use represents an enormous clinical challenge. At a purely quantitative level, it is not possible for the current specialty care treatment system to accommodate these newly eligible patients. At a qualitative level, it is likely that the type of intensive care currently available in that system would be neither necessary for nor appreciated by the newly eligible population.

At a systems level, the most-impacted setting for new types of early identification and intervention for this population will be primary care. It has always been in the clinical interests of primary care providers to address emerging substance use problems. This is because unaddressed medically harmful substance use is pervasive throughout all parts of medicine, from approximately 20 percent prevalence in most primary care clinics to over 60 percent prevalence in more intensive, expensive settings such as hospitals and emergency room settings (Reid, Fiellin, & O'Connor, 1999; Saitz, Horton, Sullivan, Moskowitz, & Samet, 2003). But with ACA implementation, it will be in the regulatory and financial interests of primary care to address these cases.

This is an obviously important area for the expanded training of health care workers, but also for clinical, implementation and health services research.

Implementation research is needed to find practical ways to fit screening interventions into contemporary care structures, systems and provider efficacy and work flow. What are the nature, duration, prevalence and severity of substance use problems among general medical and surgical patients? To what extent do these substance use problems interfere with general medical and surgical procedures, and their costs? What types of substance abuse interventions, therapies and medications are most acceptable to general medical and surgical patients—and to the health care staffs who treat them? Does the concurrent treatment of low- to mid-severity substance use interfere with or complement general medical and surgical care? Does it improve general medical outcomes and costs?

### **4.3 New types and components of care will be reimbursed**

Because care for the full spectrum of substance use disorders is now a mandated, essential part of the ACA, and because substance use disorders are recognized as chronic illnesses, we must develop and validate a chronic care model for the management of substance use disorders. Evidence-based guidelines, standing orders for treatments and tests, chronic disease management

strategies and continuous outcome monitoring will likely also be used to manage substance use problems.

It is well documented that most currently practicing physicians and nurses have not been well educated or trained to screen, identify or treat these "new" problems. New teaching and training methods will be needed, and soon. In addition, there should be new opportunities for counselors, social workers and psychologists to work in primary care settings. Again, there are important opportunities for research on the best methods for training and sustaining clinical behavioral change among health care professionals. There are additional opportunities for operations research on the most effective organizational and institutional incentives to make these new clinical care activities a routine part of the work day.

This is an area in which the Parity Act will also become increasingly important as a force for shaping the nature and amount of care provided for substance use disorders. The Parity Act mandates that substance use care options be covered just as they would be for comparable physical illnesses. The exact specifications regarding which therapies, medications and other interventions will be covered in each state, and how and at what duration/dose/frequency and what financial rate, have yet to be decided. This process will likely be lengthy, contentious and potentially litigious. However, the guiding principles of coverage have been clearly stated in the

CMS final rule (Federal Register, 2013). This rule offers a blueprint for estimating what will likely be covered when the ACA and Parity Acts are fully implemented.

For example, federal Medicaid guidelines for diabetes care cover a wide variety of individually administered screening and preventive services, delivered by various professionals (e.g., nurse educators, nurses, social workers, etc.), that are now covered as pre-diabetes services. Diagnosis and assessment, again by a variety of professionals, are also covered. All FDA-approved medications for the treatment of diabetes are covered, although there are many state restrictions on payment arrangements. Laboratory testing for disease progression, medication side effects, disease monitoring and detection of commonly co-occurring health problems are covered. Individual patient visit benefits are also covered at hospital clinics, outpatient private offices, in homes and even through tele-monitoring. Clinical evaluation of outcomes is covered to both determine disease progression and adjust treatments based on individual patient response.

## **5.0 WHAT DOES THIS MEAN FOR THE TRADITIONAL ADDICTION TREATMENT FIELD?**

One thing is clear—ACA and Parity Act legislation will profoundly change the market for substance use treatment services. First, as care for substance use disorders becomes integrated into mainstream health

care, addiction treatment providers will have to become proficient in understanding insurance coding and billing procedures and will likely have to have dedicated personnel who handle these important tasks online. This could be a very significant cultural and operational change for many traditional addiction treatment providers who have historically received their funding from block grants. According to the most recent data, fewer than one-third of substance use treatment providers currently bill Medicaid or other health insurance for services (SAMHSA, 2010).

As the market expands, it is likely that traditional mental health providers and perhaps providers of general rehabilitation medicine services will expand to reach out and serve the newly eligible population of patients with substance use disorders. Though these sectors have less direct clinical experience with addicted patients, they have experience in working with other medical specialties and medical care organizations. Thus, the new insurance coverage will yield new sources of competition in the health care marketplace.

Of particular importance to all providers will be the ability to offer an attractive and evidence-based set of treatment services to the new, more diverse, educated and savvy population of insured patients. The well-established failure of the traditional addiction specialty programs to offer evidence-based medications, individual therapies and continuing care services (Knudsen, Abraham, &

Roman, 2011, Table 3; McGlynn et al., 2003; McLellan, Carise, & Kleber, 2003) has been variously attributed to treatment philosophy, ideology, inadequate economic resources and/or workforce limitations. Regardless, the new marketplace is likely to be much more sophisticated, and payers and referral sources are likely to know more about state-of-the-art care methods—and to justifiably ask for proof of effectiveness. In this sense, traditional addiction treatment providers currently have the clear historical and experiential advantage—but Kodak and Polaroid once held similar technological and experiential precedence in the camera industry (Kimberly & McClellan, 2006).

It is also likely that all providers of substance use disorder care will have to be able to integrate their care into the Chronic Care Management (CCM) model that has become the standard for managing virtually all other chronic illnesses (Bodenheimer, Wagner, & Grumbach, 2002; Wagner, Austin, & Von Korff, 1996). This will not be easy; one early trial of an adapted CCM model had only limited success with treating alcohol- and opioid-addicted patients (Saitz et al., 2013). The traditional addiction treatment programs will have to “medicalize” their care, adopting more of chronic care’s methods, language and clinical specialties to their care patterns. At the same time, the rest of health care, particularly chronic illness care, may wish to adopt many of the kinds of inexpensive but effective peer assistance and behavioral change

strategies that have been mainstays of addiction treatment for decades (White & Evans, 2014).

## **6.0 SUMMARY AND CONCLUSIONS**

Addiction has historically been considered the product of poor behavioral choices, an irresponsible, hedonistic lifestyle and/or an impulsive, antisocial personality. Based on these early concepts, the United States designed and financed a separate treatment system for this “condition.” That system was purposely made independent from the rest of mainstream health care.

While that decision may have been necessary to initiate and organize care decades ago, those policy decisions have had longer-term negative consequences, including poor understanding and acceptance of substance use disorders among mainstream health care professionals and an acute-care-oriented treatment and insurance model that has made it virtually impossible for the specialty care system to meet the public’s demands for enduring reductions in substance use and the associated public health and public safety problems that plague our society. In short, the system and the patients treated within it have been stigmatized, segregated and marginalized.

The changes in health care organization and financing driven by the Affordable Care Act and the Parity Act have been specifically designed to end the separate and

unequal treatment of substance use disorders. Skeptics may reasonably note that mainstream health care has never shown either the ability or the inclination to integrate care for these stigmatized disorders. Many may doubt that true integration will ever happen, but this is a bad bet. At least four powerful forces will push for full integration.

First, the failure to identify and address harmful substance use within general medicine now accounts for over \$120 billion in wasted medical care, rapid rehospitalizations, poor adherence to treatment plans and drug-drug interactions that require emergent care (Obama, 2011). The country can no longer afford this willful neglect, and the ACA has included substance use disorders as one of only nine “essential services.” This designation carries substantial financial incentives. Thus, there will be significant pressure on health plans and health care systems to integrate and provide the full spectrum of care.

Second, integration of previously segregated illnesses into mainstream health care has happened before—many times; examples include tuberculosis, breast cancer, depression and AIDS. History shows that a combination of new scientific findings, innovative and effective treatment options, improved technology and promotional legislation produced this type of integration before.

Third, the reorganization of care under the Chronic Care

Management model has created new, larger and more coordinated care teams and new recognition of the importance of behavioral health in comprehensive treatment. Many of these teams now include behavioral health specialists, making the teams now more capable of managing health problems such as substance use disorders.

The final and perhaps most important force for integration is the creation of new and very powerful market forces. The current national treated population is approximately 2.5 million patients annually, treated at approximately 11,000 sites and involving fewer than 5,000 specialist physicians (SAMHSA, 2010). With the provisions of ACA and the Parity Act, over 50 million individuals with substance use disorders will be eligible for a new range of services, potentially involving 500,000 primary care physicians, a 20-fold increase. This is the kind of market that could inspire the creation of new screening tools, medications, therapies, monitoring systems and other clinical management services. These forces are simply too powerful, and the clinical needs simply too great, for things to continue as they have for the past 40 years.

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