

CASAColumbia is a national nonprofit research and policy organization focused on improving the understanding, prevention, and treatment of substance use and addiction. They have identified a list of critical addiction-related health services to include in your insurance plans. This list is below, and the original list is available here: <https://www.centeronaddiction.org/sites/default/files/files/Recommendations-for-Healthcare-Providers.pdf>

In a 2013 report, *Addiction Medicine: Closing the Gap between Science and Practice*, CASAColumbia identified a list of critical addiction services that have been proven by research to effectively prevent risky substance use and treat and manage addiction. These evidence-based services are consistent with the recommendations of other leaders in this field who have reviewed the data,²³ including The Coalition for Whole Health's (CWH) *EHB Consensus Principles and Service Recommendations*,²⁴ which have the support of over 100 national and state-level mental health/addiction organizations.²⁵

The critical addiction-related health services to include in your insurance plans are:

- **Routine Screening and Brief Intervention (SBI) in Health Care Settings, Including Primary and Urgent Care.** All patients should be routinely screened for all forms of risky substance use—including tobacco, alcohol, illicit drugs and controlled prescription drugs—at the initial visit to a primary care (including family and internal medicine and pediatric), obstetric, mental health or specialty care physician, and then routinely thereafter, and upon admission into a hospital, emergency department or trauma care center. Age-appropriate screening tools should be used. As a part of these services, patients (and their families if appropriate) should be educated about the health consequences of risky substance use, the disease of addiction and risk factors for both.

For those who screen positive for risky substance use that does not meet the threshold of clinical addiction, a brief intervention (typically involving motivational interviewing techniques and substance-related education) is an effective, low-cost approach to reducing risky substance use.²⁶

Individuals showing signs of addiction should be referred for a full diagnostic evaluation.

- **Diagnostic Evaluation, Comprehensive Assessment and Treatment Planning.** For individuals showing signs of addiction, it is necessary to determine a clinical diagnosis including the stage and severity of the disease. If the disease is not present, they should receive a brief intervention. If the disease is present, a comprehensive assessment must be performed to evaluate co-occurring medical (including psychiatric) conditions and personal circumstances that may affect treatment success. The results of the diagnostic evaluation and comprehensive assessment create the foundation for an effective treatment plan that is individualized and tailored to the patient, identifies the pharmaceutical and behavioral therapies needed and the appropriate level/setting of care. Diagnosis and treatment planning should be conducted using standardized and validated instruments. Providing treatment, including specialty care as needed, is critical to managing the condition and preventing further health and social consequences.²⁷
- **Stabilization.** As a precursor to treatment, the patient's condition should be stabilized via cessation of substance use, including medically-supervised withdrawal management (detoxification) when necessary. Stabilization alone is not treatment for addiction. After stabilization, connecting patients with services to treat and manage their addiction is a critical step in assuring that stabilization services are clinically and financially effective.

All patients should be evaluated to: a) determine the presence and severity of withdrawal symptoms using standardized instruments, b) assess potentially complicating co-occurring medical—including psychiatric—conditions, c) detect (through the use of drug testing) any substances present or recently used in the patient's body and d) establish the patient's withdrawal history. A trained physician should determine the appropriate setting (e.g., patient's home, physician's office, non-hospital treatment facility, hospital, intensive outpatient/partial hospitalization program) for stabilization based on the results of the diagnosis and evaluation. Patients should be supported through withdrawal (with the use of medication when necessary) to re-establish a state of physiological stability. Once stabilized, all patients should receive addiction treatment immediately.

- **Addiction Treatment.** Qualified health care professionals should deliver evidence based addiction treatments, accompanied by treatment for co-occurring health (including psychiatric) conditions. Depending on the severity of the patient's disease and the general health status of the patient, the use of medications, psychosocial therapies or both in combination may be necessary. All services necessary to coordinate addiction treatment with other health care services also should be covered.
 - **Pharmaceutical therapies.** Pharmaceutical therapies can be an important component of addiction treatment.²⁸ Individual factors, including genetic and biological characteristics and environmental and psychological risk factors, may determine how effective a certain type of pharmaceutical intervention will be for an individual with addiction. All FDA-approved medications designed to treat and manage addiction should be covered within the parameters of EHB.

These medications include, but are not limited to:

1. Campral (acamprosate), naltrexone formulations and Antabuse (disulfiram) for addiction involving alcohol
2. Zyban (bupropion), Chantix (varenicline), and the five FDA-approved forms of nicotine replacement therapy (NRT), including patch, gum, lozenge, nasal spray and inhaler for addiction involving nicotine
3. Naltrexone formulations, methadone, and buprenorphine formulations (including Suboxone) for addiction involving opioids

The above medications have different mechanisms of action and should not be considered interchangeable members of the same “class.” Physicians, using their clinical judgment, have the authority to prescribe medications that are not FDA approved specifically to treat addiction, just as is the case when physicians treat other illnesses; these medications should also be covered.

Benefits should include all clinical services required for patients to access the pharmacotherapies, such as physician visits for medical management of pharmaceutical therapies as well as coverage for treatment at licensed opioid treatment programs when required for access to a medication modality (e.g., methadone to treat addiction involving opioids).

- **Psychosocial Therapies.** Psychosocial therapies are critical components of almost every treatment regimen; when combined with pharmaceutical treatments they enhance treatment efficacy.²⁹ Psychosocial therapies must be tailored to individual patient characteristics, such as age, gender, and sexual orientation. Evidence-based psychosocial therapies include, but are not limited to:
 1. Cognitive-Behavioral Therapy (CBT)
 2. Motivational Interviewing (MI) and Motivational-Enhancement Therapy (MET)
 3. Community Reinforcement Approach (CRA)
 4. Contingency management/motivational incentives
 5. Behavioral couples/family therapy
 6. Multidimensional family therapy
 7. Functional family therapy
- **Level/Setting and Length of Treatment.** The appropriate level/setting of care should be determined by the results of a diagnostic evaluation and a comprehensive assessment, and should be documented in an individual treatment plan

At a minimum, health plans should cover the following levels/settings of care where evidence-based services are provided:

1. Outpatient treatment
2. Intensive outpatient treatment
3. Partial hospitalization
4. Inpatient hospitalization
5. A range of non-hospital residential treatment environments (including low intensity, high-intensity, and population specific)

The medically-indicated length of treatment varies depending on the severity and complexity of the patient's disease and other factors. Length of treatment should be flexible, contingent on periodic evaluation of the patient's progress. Blanket limitations on allowed visits or lengths of stay do not accord with best practices for treating cases of addiction that are chronic and relapsing.

States also should keep in mind that many people with addiction have co-occurring health (including psychiatric) conditions; often these co-occurring conditions must be treated concurrently for any treatment to be successful. States should include addiction treatment services and levels/setting of care that allow for concurrent treatment of all health conditions.³⁰

- **Monitoring, Support and Continuing Care.** Because addiction can be a chronic, relapsing disease, monitoring, support and continued care services are essential to help the patient maintain the progress achieved during the initial phase of addiction treatment and to prevent relapse. Ongoing pharmaceutical and psychosocial therapies are often indicated to manage the disease, as for persons with other chronic conditions like diabetes or hypertension. Follow-up appointments to monitor progress and disease management services to promote patients' adherence to a treatment regimen and management of their disease contribute to positive outcomes. As is the case with other chronic diseases (e.g., various cancers), periodic revisits to monitor the patient's status and to assure that a state of remission remains (or, alternately stated, to assure that there are no early/undetected signs of relapse not well-appreciated by the patient) should be covered within the EHB.

Benefits should include the full range of services required to manage a chronic condition, including continued pharmaceutical and psychosocial therapy services, supervised by a physician and including follow-up appointments to monitor progress; disease management services to promote patients' adherence to a treatment regimen; and case management services to connect patients with resources, including peer support (e.g., AA/NA/Smart Recovery/etc.), auxiliary services—such as legal, educational, vocational, housing, child care and family supports as well as nutrition and exercise counseling. Peer support programs, like AA and NA, are an important adjunct to treatment; however, these programs do not constitute treatment themselves.

MHPAEA applies to employment-based large group health plans and health insurance issuers choosing to provide mental health and substance use disorder coverage and requires that limitations on such benefits not be more restrictive than limitations on medical and surgical benefits. For more information go to www.hhs.gov/parity