

MEMORANDUM

To: Deb Beck
Drug and Alcohol Service Providers Organization of Pennsylvania

From: Greg Heller

Dated: December 20, 2011

Re: Inpatient Non-Hospital Addiction Treatment and the Affordable Care Act

An inpatient non-hospital addiction treatment benefit must be included in the Affordable Care Act's package of essential health benefits. This memorandum explains why.

I. Overview

The Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") requires that the Secretary of Health and Human Services establish a set of essential health benefits that will be included in certain insurance policies and health plans. *See* ACA § 1301(a)(1)(B), 42 U.S.C. § 18021(a)(1)(B). The precise contents of the essential health benefits package are currently being developed by the Secretary of Health and Human Services. Both the process of developing the benefit package and the final result of that process – that is, the content of the benefit package itself – must comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Parity Act") and its implementing regulations. The Parity Act and its regulations require that the essential health benefits package include an inpatient non-hospital addiction treatment benefit.

At the most general level, the Parity Act functions as an antidiscrimination law. A plan cannot impose more restrictive treatment limitations on behavioral health and substance use disorder benefits

than it imposes on medical/surgical benefits. Once any behavioral health and substance use disorder benefits are included in a benefit package – and under the ACA such benefits must be included, *see* ACA § 1302(b)(1)(E), 42 U.S.C. § 18022(b)(1)(E) – they must be provided at a level and in a manner that complies with the Parity Act.

Part II of this Memorandum spells out why the essential health benefits package will and should comply with the Parity Act.

Part III addresses the substance of the Parity Act, and explains that the inclusion of an inpatient non-hospital addiction treatment benefit is required for two separate reasons. First, the Parity Act’s substantive standards regarding categories of benefits require inclusion of an inpatient non-hospital addiction treatment benefit. Second, the exclusion of such a benefit would violate the Parity Act’s prohibition against discriminatory nonquantitative treatment limitations.

Part III also explains that the Parity Act’s ban on discriminatory nonquantitative treatment limitations establishes important requirements for the decision-making process used by any plan designer – including the Secretary of Health and Human Services – in determining what will and will not be covered. Simply put, a plan designer is not allowed to condition the inclusion of a behavioral health benefit or a substance use disorder benefit on a search for, or the identification of, physical health cognates. A plan designer is not allowed to do this for the simple but absolutely fundamental reason that physical health treatments are not conditioned on the presence or identification of a

behavioral health or substance use disorder twin, or indeed on the presence or identification of any twin at all.¹

II. The Essential Health Benefits Package Must Comply with the Parity Act.

Representatives of the Secretary of Health and Human Services have confirmed, through informal guidance surrounding the development of the essential health benefits package, that these benefits will comply with, and are subject to, the requirements of the Parity Act. Because this guidance has not yet been formally promulgated, however, an explanation of the relationship between the Parity Act and the essential health benefits package is in order.

The ACA’s definition of “essential benefits” does not expressly refer to, or expressly require compliance with, the Parity Act. *See* ACA § 1302. But the ACA *does* expressly require that “qualified health plans” comply with the Parity Act. ACA § 1311(j), 42 U.S.C. § 18031(j) (The requirements of the Parity Act “shall apply to qualified health plans in the same manner and to the same extent as [it] applies to health insurance issuers and group health plans.”). Qualified health plans must include the essentials health benefits package. ACA § 1301(a)(1)(B), 42 U.S.C. § 18021(a)(1)(B). Qualified health plans are also the only health plans that can be offered through health benefit exchanges. These exchanges lie at the heart of the ACA’s plan to make health insurance more available and more affordable. Qualified health plans are also the only health plans eligible for the tax credits and cost-sharing provisions that are an integral part of the ACA and its

¹ Some previous discussions of the issue (including a previous memorandum written by me) have focused on a search for behavioral health counterparts to inpatient non-hospital addiction treatment. Such a search is an unnecessary detour in the hands of commentators, and a violation of the Parity Act in the hands of plan designers.

central goal of expanding the number of Americans who have health insurance. *See* ACA §§1401, 26 U.S.C. § 36 (tax credit), ACA § 1402, 42 U.S.C. § 18071 (cost sharing). So if a plan did not comply with the Parity Act, it would not qualify for exchange participation, tax credits, or cost sharing.

This determination that the essential health benefits package is subject to the Parity Act is also supported by more general policy considerations supporting addiction treatment – considerations that inform both the Parity Act and the Affordable Care Act.

With respect to the Parity Act, the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (the “Departments”) issued Interim Final Rules under the Parity Act in February, 2010. (The substantive content of these Interim Final Rules is discussed below.) *See* Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (Feb. 2, 2010) (codified at 29 C.F.R. pt. 2590, Treas. Reg. pt. 54, and 45 C.F.R. pt. 146) (hereinafter the “Interim Final Rules”).² As part of the rulemaking process the Secretary of Health and Human Services and the Secretary of Labor examined in detail the economic impact of the Parity Act, and set forth in a regulatory preface a summary of that analysis. The Secretaries covered in some detail the economic burdens of untreated and inadequately treated behavioral health conditions and substance use disorders. *See generally* 75 Fed. Reg. at 5419-27. These costs are an enormous burden on the economy as a whole, and are also a particular and

² While these are interim final rules and not final rules, they have the force and effect of final rules, until final rules are issued. *See generally Coalition for Parity, Inc. v. Sebelius*, 709 F.Supp.2d 10 (D.D.C. 2010) (dismissing a managed care industry challenge to the Interim Final Rules, and explaining the role and legal status of interim final rules).

very specific burden on the healthcare system, because individuals with untreated, or inadequately treated, behavioral health conditions and substance use disorders tend to have significantly higher medical/surgical health care needs.

In this regulatory submission, the Departments noted that substance use disorder treatment more than pays for itself, through reduction of other costs:

The returns on investment from treatment of substance use disorders can be large.³¹ Studies in Washington state clinics demonstrated that each dollar invested in inpatient and outpatient substance abuse treatment yielded returns of about 10 and 23 times their initial investments, respectively.³² California and Oregon state treatment systems demonstrated a sevenfold return in their investments.³³ Other studies show effects ranging from a return of one and a half times the cost in a large study of a treatment clinic in Chicago to a return of 5 times the initial investment for a treatment for mentally ill chemical abusers,³⁴ resulting in a net benefit of about \$ 85,000 per client for an investment of nearly \$ 20,000.³⁵

³¹ The Office of National Drug Control Policy has information on effective treatment and cost savings at <http://www.whitehousedrugpolicy.gov>.

³² French, M.T., H.J. Salome, A. Krupski, J.R. McKay, D.M. Donovan, A.T. McLellan, and J. Durrell. (2000). "Benefit-cost analysis of residential and outpatient addiction treatment in the State of Washington." *Evaluation Review*, 24(6), 609-634.

³³ Ettner, S.L., D. Huang, E. Evans, D.R. Ash, M. Hardy, M. Jourabchi, and Y. Hser. (2006). "Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment Pay for Itself?" *Health Services Research*, 41(1), 192-213.

³⁴ French, M.T., K.E. McCollister, S. Sacks, K. McKendrick, & G. De Leon. (2002). "Benefit cost analysis of a modified therapeutic community for mentally ill chemical abusers." *Evaluation and Program Planning*, 25, 137-148.

³⁵ The returns are the ratio of benefits to costs. Benefits include personal as well as societal benefits including increased employment and reduced crime.

75 Fed. Reg. at 5424 (footnotes and citations as in original).

This emphatic acknowledgment of the economic benefits of treating substance use disorders appears at the center of the Secretary’s exercise of rulemaking authority under the Parity Act.

Economic considerations have also, of course, been acknowledged as an important aspect of the Affordable Care Act itself. *See generally* Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Costs* (2011).

The strong economic case for the Parity Act and the treatment coverage it requires provides yet another reason supporting application of the Parity Act, separate and apart from the broader statutory rationales set forth above.

III. The Parity Act Requires Inclusion of an Inpatient Non-Hospital Addiction Treatment Benefit.

A. The Parity Act and its Implementing Regulations

Before turning to the specifics of the Parity Act and its application to inpatient non-hospital addiction treatment, a general overview of the applicable statutory and regulatory provisions is in order.

Under the Parity Act, a health plan or health insurer cannot impose financial requirements or treatment limitations on behavioral health care (more precisely, on “mental health or substance use disorder benefits”) that are more restrictive than “the predominant treatment limitations [or financial requirements] applied to substantially all medical and surgical benefits covered by the plan (or coverage).” 42 U.S.C. § 300gg-26(a)(3)(A)(ii).³ Furthermore, a health plan or health insurer cannot

³ In full, the section reads:

(3) Financial requirements and treatment limitations.

(A) In general. In the case of a group health plan or a health insurance issuer

impose any “separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.” *Id.*

While the Parity Act itself does not expressly refer to plan design or to available benefits, such a mention of plan design hardly seems necessary when the Parity Act is considered as a whole. Failing to include a particular type of behavioral health or substance use disorder treatment as an available benefit is a “treatment limitation” of the starkest nature. To put it another way, a benefit design excluding a particular benefit (such as, for example, inpatient non-hospital addiction treatment) is a numerical limitation on treatment. It is exactly like any other numerical treatment limitation, except that the number of days or sessions allowed is zero.

offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that--

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

42 U.S.C. § 300gg-26(a)(3).

Even if there were any question that the Parity Act extends to plan design – and there is not – it is addressed by the Interim Final Rules. As discussed in the following section, the Interim Final Rules expressly address benefit packages and plan design.

B. Benefit Design: The Interim Final Rules’ Classification Test

The Interim Final Rules contain only one provision that is expressly directed to benefits and plan design. That provision establishes a “Classification test,” which requires that if benefits are provided in a category for medical/surgical conditions, then benefits must be provided in the same category for behavioral health/substance use disorders.

More precisely, the Interim Final Rules state that “[i]f a plan provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided.” 45 C.F.R. § 146.136(c)(2)(ii) (Health and Human Services regulations); 29 C.F.R. § 2590.712(c)(2)(ii) (identically worded provision in ERISA regulations); Treas. Reg. § 54.9812-1T(c)(2)(ii) (identically worded provision in Department of the Treasury regulations). The prescribed classifications are:

- (1) Inpatient, in-network.
- (2) Inpatient, out-of-network
- (3) Outpatient, in-network
- (4) Outpatient, out-of-network
- (5) Emergency care
- (6) Prescription drugs

*Id.*⁴ Importantly, these are “the only classifications used in applying the rules of this paragraph (c)”.

Id. Below, I explain that this limitation on the number of classifications – they are “the only classifications used” – is absolutely essential, if the Parity Act is to mean anything at all. Furthermore, limiting the number of classifications in this way is the only way to create an enforceable set of rules that can be easily understood, and if necessary invoked, by patients and their families.

Under this standard, if medical/surgical benefits are provided in one of these classifications, then behavioral health and substance use disorder benefits must also be provided in that same classification.⁵ So if a plan or policy provides inpatient medical/surgical benefits, it must also provide inpatient behavioral health and substance use disorder benefits. The only question is whether inpatient treatment necessarily includes inpatient *non-hospital* rehabilitation treatment. It does.

⁴ Obviously, the inpatient categories are the categories that cover inpatient care.

⁵ The Interim Final Rules say “mental health *or* substance use disorder benefits must be provided” in each category – and they do not say “mental health *and* substance use disorder benefits.” To read this as a disjunctive statement, however, requiring only a behavioral health benefit or a substance use disorder benefit but not both, would stand squarely at odds with both the language and the purpose of the Parity Act. The statute applies to both behavioral health treatment and substance use disorder treatment. A health plan is not allowed to pick one of the two for compliance, and disregard the Parity Act for the other.

1. With Substance Use Disorder Treatment, Inpatient Treatment Includes Inpatient Non-Hospital Treatment.

Inpatient addiction treatment encompasses two very different care settings: (a) care that is provided in an inpatient hospital setting (such as a general acute care hospital or a specialty hospital); and (b) care that is provided in an inpatient *non-hospital* setting.

Inpatient *hospital* care is necessary only for the sickest patients, often those with a serious medical condition in addition to and apart from the substance use disorder itself.

Most patients, however, do not need this level of care. The overwhelming majority of inpatient addiction treatment is provided in an inpatient non-hospital setting. According to the Substance Abuse and Mental Health Services Administration’s 2009 National Survey of Substance Abuse Treatment Services (the most recent survey available), of those patients receiving inpatient treatment, 92% received treatment in non-hospital facilities and only 8% received that treatment in hospital facilities. National Survey of Substance Abuse Treatment Services (N-SSATS): 2009 Data on Substance Abuse Treatment Facilities (“NSSATS 2009”), at Table 5.2a.⁶

For another example, in Pennsylvania, according to data obtained from Pennsylvania Department of Health facility licensure records, 96% of the available inpatient addiction treatment beds are inpatient *non-hospital* beds and only 4% are inpatient *hospital* beds. Inpatient non-hospital

⁶ This report is available at <http://www.dasis.samhsa.gov/09nssats/nssats2k9web.pdf>. Other measures of treatment setting reflected in the 2009 NSSATS data are roughly similar. *See, e.g.*, Table 3.2 (Clients in treatment, by type of care received; for inpatient treatment, 92% are non-hospital and 8% are hospital); Tables 4.6 and 4.7 (designated beds for inpatient hospital and inpatient non-hospital; 88% are non-hospital and 12% are hospital); Table 4.16a (Facility licensing, certification, or accreditation by type of care offered; for inpatient treatment, 88% are non-hospital and 12% are hospital).

care is part of the continuum of care addressed in the American Society of Addiction Medicine's Patient Placement Criteria; is recognized by accrediting bodies such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities ("CARF"); and is an integral part of most states' licensing and regulatory regimes. This level of care is also recognized as an integral part of the continuum of care in the National Institute of Drug Abuse's PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH BASED GUIDE, available at <http://www.drugabuse.gov/PODAT/PODATIndex.html>.

The use of the word "residential" can sometimes create confusion, because it appears to cover both treatment settings and settings that are merely custodial, such as sober housing. As used by NSSATS, however, the term "residential" clearly refers to treatment and not to merely custodial settings. *See* NSSATS 2009 at 8 (noting exclusion of halfway houses "that did not provide substance abuse treatment"). This use of "residential" to refer to treatment is also found in accreditation standards. For example, CARF refers to residential treatment programs as programs "organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, 7 days a week Residential treatment services are organized to provide environments in which the persons reside and receive services from personnel who are trained in the delivery of services for persons with behavioral health disorders or related problems." CARF 2011 Behavioral Health Program Descriptions, at 13, available at <http://www.carf.org/programdescriptions/bh>.

Likewise, many who work in the addiction treatment field refer to inpatient non-hospital addiction treatment as “residential.” “Residential” as used by NSSATS, CARF, and many in the field refers to *treatment* settings, not merely custodial settings.

In order to avoid any confusion on the point, it seems sensible to use the term “inpatient non-hospital,” and not “residential.” This approach to terminology was taken in a recent paper from the Institute for Behavioral Health at Brandeis University, which addressed the effectiveness of residential addiction treatment and offered the term “non-hospital inpatient services” as “clarifying terminology” that would “alleviate some of the confusion between clinical and non-clinical residential services.” Sharon Reif, Constance M. Horgan, Amity E. Quinn, Deborah W. Garnick, and Dominic Hodgkin, *Adult Residential Treatment for Substance Use Disorders: Summary of the Evidence*, at 11 (November 8, 2010). It is also similar to terminology used in Pennsylvania’s licensing regime, which likewise refers to residential treatment as “inpatient non-hospital” treatment. *See also* 28 Pa. Code §§ 709.51-54 (Pennsylvania’s licensure standards for inpatient non-hospital treatment, applicable to freestanding facilities), 711.51-58 (Pennsylvania’s licensure standards for inpatient non-hospital treatment, applicable to facilities that are part of a health care facility).

Again, custodial care has no place in the analysis set forth in this memorandum, and use of the term inpatient non-hospital care avoids any possible confusion on the point.

**2. Failing to Include an Inpatient Non-Hospital
Addiction Treatment Benefit Violates the Parity
Act's Classification Test.**

Under the Classification test, if an inpatient, in-network benefit is provided for medical/surgical care, then an inpatient, in-network benefit must be provided for behavioral health and substance use disorder care.

The question, then, is what the term “inpatient” means. It seems obvious that the term must necessarily be read in the context of the medical care at issue. Nobody would suggest the Parity Act mandates that behavioral health and substance use disorder treatment be provided in precisely the same clinical setting as an acute care hospital that primarily treats medical/surgical conditions. Context matters, and the Classification test requires that the inpatient care be appropriate for the condition at issue.

Once it is recognized that the term “inpatient” imports the clinical demands of particular conditions, then it become obvious that the inpatient classification for substance use disorder treatment means – almost all the time – inpatient *non-hospital* treatment. The NSSATS data cited above establish this with utter clarity. It is simply not possible to maintain that inpatient substance use disorder treatment only means inpatient *hospital* treatment without ignoring the reality of addiction treatment. The overwhelming majority of the time, inpatient addiction treatment means inpatient *non-hospital* treatment.

An example from medical/surgical care further illustrates the point. Consider a medical/surgical benefit design that excluded coverage for a stay in an intensive care unit following an acute myocardial infarction. Much of the time an intensive care unit is an appropriate setting and

is in fact what is required by the standard of care. No plan would provide coverage for inpatient medical/surgical care, but then exclude coverage for this particular, commonly used type of inpatient care. And of course to comply with the Parity Act, if such a limitation is not present on the medical/surgical side, then it cannot be present on the behavioral health/substance use disorder side.

Defining “inpatient” in a way that excludes the most prevalent inpatient care setting would have real and immediate consequences for substance use disorder patients. Patients would fall between the cracks, because many patients who need inpatient addiction treatment and are too sick to be treated on an outpatient basis do not require inpatient hospital treatment. The result is that patients who require inpatient treatment are left without access to the care they need.

This is not an imagined hypothetical; it is an unfortunate reality already supported by anecdotal reports. A patient presenting at an inpatient non-hospital facility is told that he must seek care at an inpatient hospital facility, but if and when he arrives at the hospital facility he is told, quite accurately, that he does not meet the criteria for a hospital level of care. The practical effect is that the patient then receives no inpatient care at all. Even those patients who do meet hospital-level criteria at the time of admission hopefully become medically stable in short order, and then no longer meet the criteria for inpatient hospital care. If a patient is effectively barred from being transferred to an inpatient non-hospital setting, they will be discharged to an outpatient level of care that is not sufficiently intensive, setting the patient up for a return to active use and further progression of his disease – and setting the rest of society up for the inevitable costs and burdens of untreated addiction.

This is just one example of how definitional gamesmanship would completely undermine the Parity Act if allowed to flourish unchecked. For another example, a plan designer could interpret

“outpatient” care to refer to “outpatient care at general medical clinics,” or “outpatient care at general medical clinics affiliated with a hospital,” or “outpatient care provided at general medical clinics affiliated with a hospital and with 24-hour physician call coverage.” And under the latter gerrymandered view the only “outpatient” care required for behavioral health services would be outpatient care provided at general medical clinics affiliated with a hospital and with 24-hour physician call coverage. This would eliminate from coverage the vast majority of outpatient providers of behavioral health and substance use disorder treatment services.

This is precisely why the Interim Final Rules create six broad categories, and permit no further narrowing. The six listed categories are “the only classifications used”. By barring the creation of additional subcategories, the definitional games of “gotcha” described in the preceding three paragraphs can never get off the ground. The Interim Final Rules’ specification of these categories is neither accidental nor incidental; rather, it is absolutely essential to the creation of an enforceable, practically effective set of rules. And using these six broad classifications, the term inpatient clearly encompasses inpatient non-hospital treatment.

On this point, it is instructive to consider California’s parity law. Unlike the federal Interim Final Rules, the California parity law only requires inpatient hospital treatment. Cal. Health & Saf. Code § 1374.72 (2011). More precisely, the statute requires that benefits for severe mental illness “shall include . . . inpatient hospital services”. *Id.* § 1374.72(b)(2). At least one Court has read this list as exhaustive, and concluded that as a result the California parity law does not cover non-hospital treatment. *Daniel v. Blue Shield of California*, 2011 U.S. Dist. LEXIS 21578 (N.D. Cal. March 3, 2011), Slip op. at *20-21. While the *Daniel* decision may no longer be good law – a more recent

Ninth Circuit decision, *Harlick v. Blue Shield of California*, 2011 U.S. App. Lexis 17844 (9th Cir. Aug. 26, 2011), takes a much broader view of the California parity law, one that is not tethered to specific categories – the *Daniel* Court’s observation regarding the statutory language used to define the categories in the California parity law remains accurate. The California parity law refers to “inpatient hospital,” and not simply to “inpatient”. The federal Parity Act’s Interim Final Rules, by contrast, do cover inpatient treatment – both hospital and non-hospital – and are therefore broader than the California law in that respect. The drafters of the Interim Final Rules were certainly aware of the California Mental Health Parity Act (it was enacted in 1999) when they wrote and issued the Interim Final Rules, and if they had intended to require only inpatient hospital care, they certainly knew how to do so.

Even if the Classification Test did permit the creation of subcategories in this fashion, the inclusion of an inpatient non-hospital benefit would still be required, because even a fairly narrow conception of inpatient care finds specific cognates on the medical/surgical side that correspond directly to inpatient non-hospital addiction treatment. For just one example, inpatient but non-hospital care that is provided in skilled nursing facilities – which is care that is clearly covered as a medical surgical benefit under the Medicare program and under many other plans and policies – is in some respects very similar to inpatient non-hospital care for treatment of substance use disorders. The existence of such cognates has been addressed elsewhere, and that discussion will not be repeated here. For present purposes, the more important point is that this search for cognates on the medical surgical side of the ledger, while helpful, is not necessary. The Classification test on its face leaves no room for such analysis. The only legally appropriate question is “does the plan provide inpatient,

in-network care for medical/surgical conditions?” If so, then the plan must provide inpatient, in-network care for the treatment of substance use disorders. The only thing that might require clarification is the question of what “inpatient” means in the context of substance use disorder treatment. And as set forth above, “inpatient” means inpatient non-hospital treatment the overwhelming majority of the time.

C. Failing to Include an Inpatient Non-Hospital Addiction Treatment Benefit Would Violate the Parity Act’s Nonquantitative Treatment Limitations Test.

The Parity Act’s statutory language expressly prohibits treatment limitations that are more restrictive than corresponding limitations on medical/surgical benefits. The Interim Final Rules establish that this includes not only quantitative limitations – such as limitations on the number of visits or days of coverage – but also nonquantitative treatment limitations – such as “[m]edical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative”. Treas. Reg. § 54.9812(c)(4); 29 C.F.R. § 2590.712(c)(4)(ii)(A); 45 C.F.R. § 146.136(c)(4)(ii)(A). The Interim Final Rules prohibit the imposition of nonquantitative treatment limitations “unless, under the terms of the plan as written and in operation, any *processes, strategies, evidentiary standards, or other factors* used in applying the nonquantitative treatment limitation” to such benefits are “comparable, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical / surgical benefits in that classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.” Treas.

Reg. 54.9812(c)(4)(i) (emphasis added); 29 C.F.R. § 2590.712(c)(4)(ii)(A) (emphasis added); 45 C.F.R. § 146.136(c)(4)(ii)(A) (emphasis added).

The Classification test of course applies to plan design, but this more general standard prohibiting discriminatory nonquantitative treatment limitations applies to plan design also, because plan design inevitably involves “processes, strategies, evidentiary standards, [and] other factors.” Failing to include an inpatient non-hospital addiction treatment benefit would impermissibly violate this standard.

No plan categorically excludes benefits for a medical/surgical treatment that is – like inpatient non-hospital addiction treatment – (a) a recognized part of the continuum of care, and (b) used 80-90% of the time to treat a particularly severe episode of a common medical condition. It seems reasonable to assume that the essential benefits package would not exclude such a medical/surgical treatment either. And if processes, strategies, and evidentiary standards used in benefit design will not support the omission of such a benefit on the medical/surgical side, they will not support the omission of such a benefit on the behavioral health / substance use disorder side.

The nonquantitative treatment limitations test – just like the Classification test discussed above – does not turn on the presence or absence of medical/surgical cognates to inpatient non-hospital substance use disorder treatment. Again, while such comparisons are extremely helpful and strongly make the case for inclusion of an inpatient non-hospital addiction treatment benefit, and indeed make the case for inclusion of the entire continuum of care, there are additional reasons why such a benefit must be included that are completely separate from those comparisons.

The search for cognates is not only unnecessary; it is also a violation of the Parity Act. If the inquiry is used by a *plan designer* as part of the benefit design process, then the plan design process has imposed an improper nonquantitative treatment limitation.

The Parity Act prohibits the use of more restrictive “processes, strategies, evidentiary standards, [and] other factors” for substance use disorder benefits. And the process of establishing medical/surgical benefits does not include the search for cognates. The decision on whether a particular type of cardiac care will be covered does not depend on whether a similar type of care is covered for diabetes or for some other condition. It would be absurd to even suggest that a medical/surgical benefit should be conditioned on the presence of a similar-appearing treatment for any other condition – let alone the presence of a similar-appearing treatment for a substance use disorder. And if the presence of some similar cognate treatment is not part of the process for designing medical/surgical benefits, then the search for a medical/surgical twin cannot be made part of the process for designing behavioral health and substance use disorder benefits.

Thus, the very act of searching for cognates, and making the absence of a sufficiently close cognate a material part of the process for arriving at a decision to exclude a benefit, would violate the Parity Act. It seems reasonable to hope that the Secretary will bear this in mind as the essential benefits package is being formulated, and will not condition substance use disorder benefits – or any other benefit – on the existence of a medical/surgical twin.

For all these reasons, the Parity Act and its Interim Final Rules require that the essential health benefits package include inpatient non-hospital care for substance use disorders. Failing to include such a benefit would not only violate these important laws; it would also undermine the broader

promise of more widely available, more cost-effective, and more equitable health insurance coverage that is such an important part of both the Parity Act and the Affordable Care Act.