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State Benchmark Plan Coverage of Opioid Use Disorder Treatments and Services: Trends and Limitations

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**STATE BENCHMARK PLAN COVERAGE OF
OPIOID USE DISORDER TREATMENTS AND SERVICES:
TRENDS AND LIMITATIONS**

Stacey A. Tovino*

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I. INTRODUCTION

Legislation, regulation, scholarship, and journalism addressing the opioid crisis have focused on a number of front-end management strategies, including opioid production quotas,¹ opioid taxes,² drug labeling,³ risk evaluation and mitigation strategies,⁴ marketing restrictions,⁵ physician prescribing practices,⁶ prescription drug monitoring programs,⁷ prescription

1. See, e.g., Scott Burris et al., *Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone to Prevent Opioid Overdose*, 1 DREXEL L. REV. 273, 286 (2009) (discussing production quotas as well as eradication programs, border controls, and street-level disruptions as supply-side interventions that can help interfere with the production and distribution of opioids and other drugs).

2. See, e.g., Editorial, *Kill Cuomo's Cockamamie 'Opioid Tax'*, N.Y. POST (Mar. 22, 2018, 7:09 PM), <https://nypost.com/2018/03/22/kill-cuomos-cockamamie-opioid-tax> (criticizing Governor Andrew Cuomo's proposed two-cents-per-milligram opioid tax, also known as an "opioid epidemic surcharge," and questioning whether pharmaceutical companies would actually pay the tax).

3. See, e.g., Patricia J. Zettler, Margaret Foster Riley & Aaron S. Kesselheim, *Implementing a Public Health Perspective in FDA Drug Regulation*, 73 FOOD & DRUG L.J. 221, 221 (2018) (discussing the FDA's influence on provider and patient behavior through drug labeling).

4. See, e.g., Hilary Homenko, *Rehabilitating Opioid Regulation: A Prescription for the FDA's Next Proposal of an Opioid Risk Evaluation and Mitigation Strategy (REMS)*, 22 HEALTH MATRIX 273, 290–313 (2012) (discussing the FDA's authority to require a risk evaluation and mitigation strategy (REMS) as part of a drug approval application; applying REMS to the opioid crisis).

5. See, e.g., Ameet Sarpatwari et al., *The Opioid Epidemic: Fixing a Broken Pharmaceutical Market*, 11 HARV. L. & POL'Y REV. 463, 472–73 (2017) ("[I]neffective penalties for illegal marketing incentivized [opioid manufacturers] to make misleading claims.").

6. See, e.g., Kelly K. Dineen, *Addressing Prescription Opioid Abuse Concerns in Context: Synchronizing Policy Solutions to Multiple Complex Public Health Problems*, 40 L. & PSYCH. REV. 1 (2016) (examining prescription opioid policy in light of available morbidity and mortality data and suggesting areas of policy priority that better align with evidence); Kelly K. Dineen, *Definitions Matter: Defining Inappropriate Prescribing to Shape Effective Opioid Policy and Reduce Patient Harm*, 67 KAN. L. REV. (forthcoming 2019) (assessing opioid prescribing policy and the lack of definitions for inappropriate prescribing; offering a new framework for inappropriate prescribing); Kelly K. Dineen & James M. Dubois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?* 42 AM. J. L. & MED. 1, 7–52 (2016) (reviewing cases of inappropriate prescribing and suggesting a new framework for describing and categorizing inappropriate prescribers).

7. See, e.g., Jennifer Oliva, *Prescription Drug Policing: The Right to Protected Health Information Privacy Pre- and Post-Carpenter*, 69 DUKE L.J. (forthcoming 2020) (arguing that

safety alert systems,⁸ maximum initial opioid prescription quantities,⁹ continuing opioid education for opioid prescribers,¹⁰ and temporary restraining orders for improper opioid prescribers.¹¹ Back-end crisis-management strategies, including needle exchange programs,¹² safe injection sites,¹³ opioid reversal agent availability,¹⁴ medication-assisted treatment,¹⁵ mobile health care services,¹⁶ mobile application-mediated prescription

courts are more likely to rule that warrantless Drug Enforcement Agency (DEA) searches of sensitive health care data stored in prescription drug monitoring program (PDMP) databases violate the Fourth Amendment post-*Carpenter v. United States*).

8. See, e.g., *Rx Safety Alert Systems*, MCKESSON, <https://www.mckesson.com/about-mckesson/fighting-opioid-abuse/rx-safety-alert-system> (last visited Mar. 18, 2019). McKesson is developing a prescription safety alert system, which is a “nationwide clinical alert system that uses patient prescription history to identify patients at risk for opioid overuse, abuse, addiction or misuse. The system would provide proactive, real-time clinical alerts, integrated into pharmacist workflow, across state lines.” *Id.*

9. See, e.g., An Act Relating to Regulation of Opioid Drugs, OKLA. S.B. 1446, § 5 (eff. Nov. 1, 2018) (prohibiting practitioners from issuing an initial prescription for an opioid drug in a quantity exceeding a seven-day supply for treatment of acute pain in an adult patient or a patient under the age of eighteen; further requiring any opioid prescription for acute pain to be for the lowest effective dose of the immediate-release version of the opioid drug).

10. See, e.g., *id.* § 1(C) (requiring Oklahoma licensed physicians who have DEA numbers to take at least one hour of continuing education in the area of pain management or opioid addiction prior to license renewal).

11. See, e.g., Alex Ebert, *DOJ Restraining Orders Strip Docs' Opioid Prescribing Rights (1)*, BLOOMBERG L. NEWS (Aug. 22, 2018, 3:40 PM), <https://news.bloomberglaw.com/health-law-and-business/doj-restraining-orders-strip-docs-opioid-prescribing-rights-1> (reporting that the U.S. Department of Justice (DOJ) is using civil temporary restraining orders to prevent physicians from writing improper opioid prescriptions while under investigation for illegal conduct; also reporting that the DOJ used the emergency orders against two Ohio physicians who were allegedly caught giving opioids to undercover patients who did not need the opioids).

12. See, e.g., Melissa Vallejo, Note, *Safer Bathrooms in Syringe Exchange Programs: Injecting Progress into the Harm Reduction Movement*, 118 COLUM. L. REV. 1185, 1211–24 (2018) (advocating for safe bathrooms as part of syringe exchange programs).

13. See, e.g., Alex H. Kral & Peter J. Davidson, *Addressing the Nation's Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S.*, 53 AM. J. PREVENTIVE MED. 919, 919 (2017) (“[Safe injection sites are] legally sanctioned locations that provide a hygienic location for individuals to inject pre-obtained drugs while observed by trained staff. They have the dual aims of increasing the safety of individuals who inject drugs and reducing the public nuisance [associated with public injection].”).

14. See, e.g., Corey S. Davis & Derek H. Carr, *The Law and Policy of Opioids for Pain Management, Addiction Treatment, and Overdose Reversal*, 14 IND. HEALTH L. REV. 1, 27–28 (2017) (examining patient access to naloxone, an opioid reversal agent).

15. See, e.g., Page M. Smith, *Implementing Medicaid Health Homes to Provide Medication Assisted Treatment to Opioid Dependent Medicaid Beneficiaries*, 106 KY. L.J. 111, 133 (2017) (assessing the application of the Medicaid health home model in terms of delivering medication assisted treatment to Medicaid recipients).

16. See, e.g., Jacob Dawson, *Public Gives Input on Federal Grant to Combat Opioids in N.H.*, CONCORD MONITOR (Aug. 15, 2018), <https://www.concordmonitor.com/Public-gives->

cognitive behavioral therapy tools,¹⁷ national recovery housing best practices,¹⁸ integrated treatment for individuals with concurrent mental disorders,¹⁹ information sharing with families and caregivers during opioid overdoses,²⁰ and even sharply-written letters by medical examiners to prescribing physicians following a patient's death due to overdose²¹ have also received significant attention. Less attention has been paid, however, to state benchmark health plan coverage of opioid use disorder treatments and services.

This Article helps to fill this gap by surveying state benchmark plan coverage of opioid use disorder treatments and services and by identifying trends and limitations relevant thereto. This Article proceeds as follows: Part II provides background information regarding opioid use disorder and the treatments and services available for individuals with this disorder.²² Part III reviews federal mental health parity law and federal mandatory mental health and substance use disorder law as applied to insurance coverage of treatments and services for opioid use disorder, with a focus on the Affordable Care Act's

input-to-DHHS-about-opioid-grant-funds-19451667 (reporting public input regarding the opioid crisis; noting public desire for better mobile services).

17. See, e.g., Press Release, Food & Drug Admin., FDA Clears Mobile Medical App to Help Those with Opioid Use Disorder Stay in Recovery Programs (Dec. 10, 2018) ("Today, the U.S. Food and Drug Administration cleared a mobile medical application (app) to help increase retention (the amount of time a patient participates) in an outpatient treatment program for individuals with opioid use disorder (OUD). The reSET-O app is a prescription cognitive behavioral therapy intended to be used in addition to outpatient treatment under the care of a health care professional, in conjunction with treatment that includes buprenorphine and contingency management.").

18. See, e.g., SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 7031 (2018) [hereinafter SUPPORT Act] ("The Secretary [of the federal Department of Health and Human Services (Secretary)], in consultation with [other] individuals and entities . . . shall identify or facilitate the development of best practices, which may include model laws for implementing suggested minimum standards for operating recovery housing.").

19. See, e.g., Allison Petersen et al., *State Legislative Responses to the Opioid Crisis: Leading Examples*, 11 J. HEALTH & LIFE SCI. L. 30, 66 (2018) (discussing targeted case management, including insurance coverage thereof, for patients with co-occurring mental health and substance use disorders, including opioid use disorder).

20. See, e.g., SUPPORT Act, *supra* note 18, § 7052 ("The Secretary . . . shall annually notify health care providers regarding permitted disclosures under federal health privacy laws during emergencies, including opioid overdoses, of certain health information to families, caregivers, and health care providers.").

21. See, e.g., Margot Sanger-Katz, *Here's a Cheap Way to Fight Drug Misuse: Send Doctors a Sharp Letter*, N.Y. TIMES (Sept. 5, 2018), <https://www.nytimes.com/2018/09/05/upshot/letters-to-doctors-opioid-research.html> ("Two studies find that nudges [sharply-written letters to [prescribing] physicians following a patient's death from opioids] can lead to more scrupulous prescribing.").

22. *Infra* Part II.

(ACA's) state benchmark health plan selection requirement and the effect on that requirement of a recent federal district court opinion striking down the ACA.²³ Appendix A documents state benchmark plan limitations potentially applicable to individuals with opioid use disorder,²⁴ and Part IV analyzes these trends.²⁵ A conclusion clarifies how the invalidation of the entire ACA could affect insurance coverage of opioid use disorder treatments and services going forward.²⁶

II. BACKGROUND INFORMATION REGARDING OPIOID USE DISORDER

"Opioids include [both] prescription analgesics as well as [the] products of the poppy plant [(*Papaver somniferum*)], including opium, morphine, and codeine."²⁷ Although physicians prescribe opioids to relieve conditions and symptoms such as pain, cough, and diarrhea, opioids can also produce feelings of euphoria and tranquility that may lead some individuals to continue taking them, notwithstanding health risks associated with opioid use and abuse.²⁸ In the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (APA) defines opioid use disorder as the:

[P]roblematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following [criteria], occurring within a twelve month period: (1) Opioids are often taken in larger amounts or over a longer period of time than intended; (2) There is a persistent desire or unsuccessful efforts to cut down or control opioid use; (3) A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects; (4) Craving, or a strong desire to use opioids; (5) Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home; (6) Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids; (7) Important social, occupational or recreational activities are given up or reduced because of opioid use; (8) Recurrent opioid use in situations in which

23. *Infra* Part III.

24. *Infra* Appendix A.

25. *Infra* Part IV.

26. *Infra* Part V.

27. Marc A. Schuckit, *Treatment of Opioid-Use Disorders*, 375 N. ENGL. J. MED. 357, 357 (2016).

28. *Id.*

it is physically hazardous; (9) Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids; (10) Tolerance, as defined by either . . . [a] need for markedly increased amounts of opioids to achieve intoxication or desired effect [or] [a] markedly diminished effect with continued use of the same amount of an opioid . . . [and] (11) Withdrawal, as manifested by . . . [t]he characteristic opioid withdrawal syndrome . . . [or] [o]pioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.²⁹

Individuals who exhibit two or three criteria over a twelve month period may be diagnosed with mild opioid use disorder.³⁰ Individuals who exhibit four or five criteria may be diagnosed with moderate opioid use disorder and individuals with six or more criteria may be diagnosed with severe opioid use disorder.³¹ Opioid use disorder is one of several opioid-related disorders recognized by the APA and the opioid-related disorders are one of ten sets of substance-related disorders catalogued in the DSM-5.³²

Opioid use disorder is associated with a number of health concerns, including lack of mucous membrane secretions, slowing of gastrointestinal activity, impairment of visual acuity, peripheral edema, and infections such as cellulitis, bacterial endocarditis, tuberculosis, hepatitis, and HIV.³³ Opioid use disorder is also associated with a heightened risk for attempted or completed suicide, as well as death due to accidental overdose, AIDS, and other medical complications.³⁴ An estimated seventeen-thousand deaths each year in the United States relate to opioid use,³⁵ and individuals with current or past opioid use disorder number approximately three million in the United States and sixteen million worldwide.³⁶ Opioid use disorder has a high global burden of

29. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 541 (5th ed. 2013) [hereinafter DSM-5].

30. *Id.* at 542.

31. *Id.*

32. The DSM-5's other substance-related disorder sets include those related to alcohol, caffeine, cannabis, hallucinogens, inhalants, sedatives, hypnotics, anxiolytics, stimulants, tobacco, and the other (or unknown) substance-related disorders. *Id.* at Table of Contents.

33. *Id.* at 544–45.

34. *Id.* at 545.

35. Schuckit, *supra* note 27.

36. *Id.*; Steven Ross Johnson, *Opioid Use Disorder Cases Triple Government's Early Estimates*, MODERN HEALTHCARE (Sept. 14, 2018), <https://www.modernhealthcare.com/article/20180914/NEWS/180919929> (“As many as 6 million people in the U.S. are experiencing opioid use disorder, nearly three times higher than the federal government’s estimate of 2.1 million . . .”).

disease; indeed, almost eleven million life-years have been lost due to opioid use-associated health problems.³⁷

Treatment of an opioid overdose may involve the administration of an opioid reversal agent such as naloxone, which can be given through intravenous, intramuscular, endotracheal, or subcutaneous routes.³⁸ As discussed in more detail in Appendix A and Part III of this Article, approximately two-fifths of state benchmark plans do not cover any opioid reversal agents.

Treatment of opioid use disorder also may involve medically supervised opioid withdrawal, which is the administration of medication to an opioid-dependent individual to reduce the severity of withdrawal symptoms that occur when the individual stops using opioids.³⁹ Withdrawal symptoms include drug cravings, anxiety, restlessness, gastrointestinal distress, diaphoresis, and tachycardia.⁴⁰ Medications used to reduce the severity of these symptoms include opioid agonists such as methadone, partial agonists such as buprenorphine, mixed agonist/antagonists such as buprenorphine and naloxone, and alpha-adrenergic agonists such as clonidine.⁴¹ Opioid withdrawal can be medically supervised in the inpatient and outpatient settings, although inpatient supervision is associated with higher opioid abstinence rates.⁴² As discussed in more detail in Appendix A and Part III of this Article, some state benchmark plans expressly cover these medications while others expressly limit coverage of these medications in all or certain settings.

37. Schuckit, *supra* note 27.

38. See, e.g., Shane R. Mueller et al., *A Review of Opioid Overdose Prevention and Naloxone Prescribing: Implications for Translating Community Programming into Clinical Practice*, 36 SUBSTANCE ABUSE 240, 240 (2015) (“Naloxone hydrochloride (naloxone), an opioid antagonist, is the standard of care for treatment of opioid induced respiratory depression. . . . [This review] summarized and classified existing publications on overdose education and naloxone distribution to identify evidence of effectiveness and opportunities for translation into conventional medical settings.”).

39. See generally Anthony Plunkett et al., *Opioid Maintenance, Weaning and Detoxification Techniques: Where We Have Been, Where We Are Now and What the Future Holds.*, 3 PAIN MGMT. 277, 277–84 (2013) (thoroughly discussing medically supervised opioid withdrawal).

40. Kevin A. Sevarino, *Medically Supervised Opioid Withdrawal During Treatment for Addiction*, UPTODATE, <https://www.uptodate.com/contents/medically-supervised-opioid-withdrawal-during-treatment-for-addiction> (last updated Feb. 13, 2019).

41. Gavin Bart, *Maintenance Medication for Opiate Addiction: The Foundation of Recovery*, 31 J. ADDICTIVE DISEASES 207, 207–13 (2012).

42. See generally Herbert D. Kleber, *Pharmacological Treatments for Opioid Dependence: Detoxification and Maintenance Options*, 9 DIALOGUES IN CLINICAL NEUROSCIENCE 455, 456 (2007) (discussing opioid withdrawal methods).

Treatment of opioid use disorder also may include psychosocial interventions, which are non-medical interventions that are designed to help patients control urges to use opioids.⁴³ These interventions include—but are not limited to—contingency management, relapse prevention, general cognitive behavior therapy, and treatments combining cognitive behavior therapy and contingency management.⁴⁴ These interventions can take place during individual, couples, family, and/or group counseling sessions, and can occur in both the inpatient and outpatient settings,⁴⁵ including in the psychiatric hospital,⁴⁶ substance abuse treatment facility,⁴⁷ residential treatment program,⁴⁸ partial hospitalization program,⁴⁹ intensive outpatient treatment therapy program,⁵⁰ and traditional outpatient clinic settings. Some

43. See generally Lissa Dutra et al., *A Meta-Analytic Review of Psychosocial Interventions for Substance Use Disorders*, 165 AM. J. PSYCHIATRY 179, 179 (2008) (identifying and discussing psychosocial interventions for substance use disorders).

44. *Id.*

45. *Id.*

46. See ANTHEM BLUECROSS BLUESHIELD, HEALTH CERTIFICATE OF COVERAGE M-112 (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/IN-BMP.zip> (last visited Mar. 14, 2019) (presenting Indiana benchmark plan defining a psychiatric hospital as a facility that, for compensation, is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of behavioral health conditions).

47. ANTHEM BLUECROSS BLUESHIELD, BLUE CHOICE: CERTIFICATE OF COVERAGE 66 (2015), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_ME.zip (last visited Mar. 14, 2019) (presenting Maine benchmark plan defining a substance abuse treatment facility as a residential or nonresidential institution that is licensed or certified as a substance abuse treatment facility, that provides care to one or more patients for alcoholism and/or drug dependency, and that is a freestanding unit or a designated unit of another licensed health care facility).

48. See BLUE CROSS OF IDAHO, ENROLLEE CERTIFICATE 37 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_ID.zip (last visited Mar. 14, 2019) (presenting Idaho benchmark plan defining a residential treatment program as a facility that provides long-term or severe mental disorders or substance use disorders with residential care twenty-four hours per day).

49. See BLUECROSS BLUESHIELD OF LA., GROUP HEALTH BENEFIT PLAN: PPO GROUP CARE 16 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_LA-4816.zip (last visited Mar. 14, 2019) (presenting Louisiana benchmark plan defining a partial hospitalization program (PHP) as a “structured and medically supervised day, evening and/or night treatment program” that is provided to patients at least four hours per day and at least three days per week; further explaining that PHP “services are of essentially the same nature and intensity (including medical and nursing) as would be provided in a hospital” except that the patient is in the program less than twenty-four (24) hours/day and the patient is not considered a “resident” of the PHP).

50. See UNITEDHEALTHCARE OF KY., CERTIFICATE OF COVERAGE, RIDERS, AMENDMENTS, AND NOTICES 65 (2013), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/KY-BMP.zip> (last visited Mar. 14, 2019) (presenting Kentucky benchmark plan defining intensive outpatient treatment (IOT) as a “structured outpatient mental

individuals with opioid use disorder also may find mutual support groups, also known as peer-based recovery support groups and mutual aid groups, such as Narcotics Anonymous, helpful in recovering from opioid use disorder.⁵¹ As discussed in more detail in Appendix A and Part III of this Article, some state benchmark plans expressly cover psychosocial interventions while others expressly limit coverage of psychosocial interventions as well as mutual support groups.

Opioid maintenance therapy is another approach to treating opioid use disorder. Designed to “block the euphoric and sedating effects of dependent opioids,” to “relieve the cravings,” and to “permit the patient to participate [more fully] in society,”⁵² opioid maintenance therapy may include methadone, buprenorphine, or naltrexone.⁵³ When taken as directed, these medications can be both cost effective and clinically effective in reducing nonmedical opioid use as well as public health and safety problems relating to opioid use, including infectious diseases, death due to overdose, and crime.⁵⁴ As discussed in more detail in Appendix A and Part III of this Article, some state benchmark plans expressly cover these opioid maintenance therapies while others expressly limit their coverage.

health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week”).

51. See WILLIAM L. WHITE, NARCOTICS ANONYMOUS AND THE PHARMACOTHERAPEUTIC TREATMENT OF OPIOID ADDICTION IN THE UNITED STATES 11 (2011) (discussing the perspective of Narcotics Anonymous regarding opioid addiction treatment, including opioid maintenance therapy).

52. See generally Christie Choo, *Medications Used in Opioid Maintenance Treatment*, 34 U.S. PHARMACIST 40, 42 (2009) (discussing treatment options for patients on opioid maintenance therapy); Karen Dugosh et al., *A Systematic Review on the Use of Psychosocial Interventions in Conjunction with Medications for the Treatment of Opioid Addiction*, 10 J. ADDICTION MED. 91, 91–92 (2016) (discussing medications used as part of opioid maintenance therapy).

53. See generally AM. SOC’Y OF ADDICTION MED., ADVANCING ACCESS TO ADDICTION MEDICATIONS: IMPLICATIONS FOR OPIOID ADDICTION TREATMENT 123 (2013) (“The three pharmacotherapies have all shown clear clinical evidence of effectiveness in reducing opioid use and opioid use-related symptoms of withdrawal and craving as well as risk of infectious diseases and crime—when used as part of a comprehensive treatment approach and in appropriate doses.”); M.M. Sunilkumar & Kshelle Lockman, *Practical Pharmacology of Methadone: A Long-Acting Opioid*, 24 INDIAN J. PALLIATIVE CARE 10, 10 (2018) (“Methadone is a naturally long-acting analgesic with unique pharmacodynamic and pharmacokinetic properties compared to other opioids . . . to treat severe pain.”).

54. AM. SOC’Y OF ADDICTION MED., *supra* note 53.

III. MENTAL HEALTH PARITY LAW & MANDATORY MENTAL HEALTH AND SUBSTANCE USE DISORDER LAW

Historically—and until quite recently—both public health care programs and private health plans distinguished between physical and mental disorders and provided inferior insurance benefits for treatment of all mental disorders, including opioid use disorder.⁵⁵ For example, Medicare Part B formerly imposed a fifty percent beneficiary coinsurance on outpatient mental health services—including individual, family, and group psychotherapy services—compared to the twenty percent beneficiary coinsurance traditionally applied to outpatient non-mental health services.⁵⁶ Many private health plans also used to provide inferior health insurance benefits for individuals with mental disorders by completely excluding their treatments and services from coverage or by providing less comprehensive coverage. For example, Kaiser Permanente’s 2012 Small Group Colorado Health Benefit Plan (Kaiser Plan) provided insurance coverage of “biologically-based mental illnesses,” but the Kaiser Plan only included six illnesses, including schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder within that

55. The Author has reviewed the history of mental health insurance disparities in a number of prior articles addressing the legal rights of individuals with gambling disorder and other mental health conditions. *See, e.g.*, Stacey A. Tovino, *A Right to Care*, 70 ALA. L. REV. 185, 211–12 (2018); Stacey A. Tovino, *Dying Fast: Suicide in Individuals with Gambling Disorder*, 10 ST. LOUIS U. J. HEALTH L. & POL’Y 159, 159, 163–64 (2016); Stacey A. Tovino, *Gambling Disorder, Vulnerability, and the Law: Mapping the Field*, 16 HOUS. J. HEALTH L. & POL’Y 101, 107–09 (2016); Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TUL. L. REV. 191, 191, 213–14 (2014). The discussion of mental health parity law in this Part II is taken with permission, and with several recent updates as well as technical and conforming changes, from these and the Author’s other prior works in this area.

56. *See* Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 102, Stat. 2494, 2498 (codified as amended at 42 U.S.C. § 1395l(c)(1) (2012)) (calculating Medicare incurred expenses as only 62.5% of the outpatient expenses associated with the treatment of mental, psychoneurotic, and personality disorders). Until 2010, Medicare was thus responsible for only 50% (i.e., 62.5% x 80%, with 80% being the Medicare approved amount) of the cost of most outpatient mental health services, and the Medicare beneficiary was responsible for the remaining 50%. *See id.* In 2008, President George W. Bush signed into law the Medicare Improvements for Patients and Providers Act of 2008, Section 102 of which increased Medicare’s portion of incurred expenses for outpatient mental health services to 68.75% in 2010 and 2011 (resulting in a 45% beneficiary coinsurance), 75% in 2012 (resulting in a 40% beneficiary coinsurance), 81.25% in 2013 (resulting in a 35% beneficiary coinsurance), and 100% in 2014 and thereafter (resulting in a 20% coinsurance). *See id.* Since 2014, Medicare has been paying 80% of (and Medicare beneficiaries are only paying a 20% coinsurance on) all outpatient mental health services.

definition.⁵⁷ Neither opioid use disorder nor any other substance-related disorder was included in that definition. Likewise, UnitedHealthcare's traditional Certificate of Coverage provided coverage for "[b]iologically-based [m]ental illnesses," but also defined the phrase to include schizophrenia, bipolar disorder, pervasive developmental disorder, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder.⁵⁸ Again, neither opioid use disorder nor any other substance-related or addictive disorder was included in that definition.

Although many states enacted parity laws designed to put mental health conditions on equal footing with non-mental health conditions, some of these parity laws specifically excluded substance-related and addictive disorders from protection as well.⁵⁹ As an illustration, New Mexico's long-standing parity law requires group health plans in New Mexico to provide "mental health benefits" and to provide them at parity with "medical and surgical benefits."⁶⁰ However, the New Mexico law specifically excludes treatments for "substance abuse" and "chemical dependency" from the definition of "mental health benefits."⁶¹

During the past twenty-five years, developments in federal health insurance law have eliminated some—but not all—of these mental health benefit disparities, including opioid use disorder benefit disparities; however, a December 14, 2018, federal district court opinion striking down the ACA will reverse some of these advances. As background, President Bill Clinton signed the federal Mental Health Parity Act (MHPA) into law on September 26, 1996.⁶² As originally enacted, MHPA prohibited large group health plans that offered medical and surgical benefits as well as mental health benefits from imposing more stringent lifetime and annual spending limits on their offered mental health benefits.⁶³ For example, MHPA would have prohibited a covered large group health plan from imposing a \$20,000 annual cap or a

57. KAISER PERMANENTE, 2011 COLORADO HEALTH BENEFIT PLAN DESCRIPTION FORM: PLAN 230—CITY AND COUNTY OF DENVER—GROUP #00075 3, 6 (2006) (defining "biologically based mental illness care").

58. See UNITEDHEALTHCARE INS. CO., CERTIFICATE OF COVERAGE 17–18, <https://www.uhc.com/content/dam/uhc-dot-com/en/Legal/PDF/MY-7.pdf> (last visited Mar. 14, 2019).

59. See generally Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOU. J. HEALTH L. & POL'Y 455, 458–59 (2011) (summarizing trends in state mental health parity laws).

60. See N.M. STAT. ANN. § 59A-23E-18(A) (West, Westlaw through Ct. 40 of 1st Reg. Sess. of 54th Legis. (2019)).

61. *Id.* § 59A-23E-18(F).

62. See Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874, 2944 (codified as amended at 29 U.S.C. § 1185a (2012)).

63. *Id.* § 712(a)(1)–(2).

\$100,000 lifetime cap on mental health care if the plan had no annual or lifetime caps for medical and surgical care or if the plan had higher caps—such as a \$50,000 annual cap or a \$500,000 lifetime cap—for medical and surgical care.⁶⁴

The application and scope of MHPA were very limited, however. As originally enacted, MHPA regulated only insured and self-insured group health plans of large employers, then defined as those employers that employed an average of fifty-one or more employees.⁶⁵ MHPA thus did not apply to the group health plans of small employers.⁶⁶ MHPA also did not apply to individual health plans, the Medicare Program, Medicaid non-managed care plans, or any self-funded, nonfederal governmental plan whose sponsor opted out of MHPA.⁶⁷ In terms of its substantive provisions, MHPA was neither a mandated offer nor a mandated benefit law; that is, nothing in MHPA required a large group health plan to actually offer or provide any mental health benefits for mental health conditions such as opioid use disorder.⁶⁸ Health plans were thus free—even after the enactment of MHPA—simply not to provide any benefits for opioid use disorder or any other mental health condition.⁶⁹ Indeed, individuals with substance use and addictive disorders—including opioid use disorder—were specifically excluded from MHPA’s modest lifetime and annual spending cap protections.⁷⁰ Finally, MHPA did not require parity between medical and surgical benefits and

64. *See id.*

65. *See id.* § 712(c)(1)(A)–(B) (applying in each case to “a group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan of a small employer”).

66. *See id.* (exempting from the MHPA application group health plans of small employers; defining small employers as those “who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year”).

67. *See* 42 U.S.C. § 300gg-21(a)(2)(A) (2012 & Supp. I 2017) (permitting sponsors of self-insured nonfederal governmental health plans to opt out of particular federal requirements); 45 C.F.R. § 146.180(a)(1)(v) (2018) (permitting sponsors of self-insured nonfederal governmental health plans to opt out of federal mental health parity requirements).

68. Mental Health Parity Act § 712(b)(1), 110 Stat. at 2944–45 (codified as amended at 42 U.S.C. § 300gg-26(b)(1) (2012)) (“Nothing in this section shall be construed . . . as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits.”).

69. *See id.*

70. *See id.* §§ 712(a)(1)(B), (c)(4) (“The term ‘mental health benefits’ means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.”).

mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations.⁷¹

Because of these limitations, President George W. Bush expanded MHPA twelve years later by signing into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).⁷² MHPAEA built on MHPA by expressly protecting individuals with substance-related and addictive disorders, including opioid use disorder, and by imposing comprehensive parity requirements on large group health plans.⁷³ In particular, MHPAEA provided that any financial requirements (including deductibles, copayments, coinsurance, and other out-of-pocket expenses)⁷⁴ and treatment limitations (including inpatient day and outpatient visit limitations as well as non-quantitative treatment limitations such as medical necessity requirements)⁷⁵ that large group health plans imposed on mental health and substance use disorder benefits must not have been any more restrictive than the predominant financial requirements and treatment limitations imposed by the plan on substantially all medical and surgical benefits.⁷⁶ MHPAEA thus would have prohibited a large group health plan from imposing higher deductibles, copayments, or coinsurances, or lower inpatient day and outpatient visit maximums, on individuals seeking care for any mental health or substance use disorder listed in the current edition of the DSM or the World Health Organization's International Classification of Diseases (ICD).⁷⁷ The previous sentence is very important: if a covered large

71. *See id.* § 712(b)(2) (“Nothing in this section shall be construed . . . as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage . . .”).

72. *See* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (codified as amended at 26 U.S.C. § 9812 (2012); 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012 & Supp. 1 2017)) [hereinafter MHPAEA].

73. *See id.* § 512(a)(4) (adding a new definition of “substance use disorder benefits”); *see also id.* § 512(a)(1) (regulating the financial requirements and treatment limitations that are applied to both mental health and substance use disorder benefits).

74. *See id.* § 512(a)(1) (including within the definition of “financial requirements” “deductibles, copayments, coinsurance, and out-of-pocket expenses”).

75. *See id.* § 512(a)(1)(B)(iii) (including within the definition of “treatment limitations” “limits on the frequency of treatment, number of visits, days of coverage, [and] other similar limits on the scope or duration of treatment”).

76. *See id.* § 512(a)(1)(A)(i) (requiring both financial requirements and treatment limitations applicable to mental health and substance use disorder benefits to be “no more restrictive than the predominant financial requirements” and treatment limitations “applied to substantially all [physical health benefits] covered by the plan”).

77. *See, e.g.,* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,242 (Nov. 13, 2013) (to be

group health plan actually offered insurance benefits for opioid use disorder, then the DSM's and the ICD's recognition and listing of opioid use disorder meant that the health plan would be prohibited from imposing higher financial requirements or more stringent treatment limitations on individuals seeking treatments and services for this condition.

Like MHPA, MHPAEA's application and scope were initially limited. As originally enacted, MHPAEA regulated only insured and self-insured group health plans of large employers, defined as those employers that employ an average of fifty-one or more employees.⁷⁸ MHPAEA, like MHPA, did not apply to small group health plans, individual health plans, the Medicare Program, Medicaid non-managed care plans, or any self-funded, nonfederal governmental plans whose sponsors had opted out of MHPAEA.⁷⁹ In terms of its substantive provisions, MHPAEA was neither a mandated offer nor a mandated benefit law; that is, nothing in MHPAEA required a covered group health plan to actually offer or provide any benefits for conditions such as opioid use disorder.⁸⁰

codified at 45 C.F.R. pts. 146 and 147). This rule adopted the MHPAEA requirement that a plan's definition of "mental health benefits" and "substance use disorder benefits" be "consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines)".

78. See MHPAEA, *supra* note 72, Pub. L. No. 110-343, 122 Stat. 3881, 3889 (codified as amended at 26 U.S.C. § 9812(c)(1) (2012)); 29 U.S.C. § 1185a(c) (2012). See also 42 U.S.C. § 300gg-26 (2012 & Supp. I 2017) ("[The MHPAEA applies only to] group health plan[s] (or health insurance coverage offered in connection with such . . . plan[s]) . . .").

79. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., CTR. FOR CONSUMER OVERSIGHT & INS. OVERSIGHT, THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA), https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html (last visited Jan. 14, 2019) ("MHPAEA does not apply directly to small group health plans . . ."). The Centers for Medicare and Medicaid Services has explained that Medicare and Medicaid are not issuers of health insurance: "They are public health plans through which individuals obtain health coverage. . . . However, . . . Medicaid benchmark benefit plans . . . require compliance with certain requirements of MHPAEA." *Id.* "Non-Federal governmental employers that provide self-funded group health plan coverage to their employees (coverage that is not provided through an insurer) may elect to exempt their plan (opt-out) from the requirements of MHPAEA . . ." *Id.* See also Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 406–07 (2010) ("[The MHPAEA] applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care, the State Children's Health Insurance Program, and state and local government plans," omitting Medicaid non-managed care plans).

80. See MHPAEA, *supra* note 72, § 512(a)(1) (regulating only those group health plans that offer both physical health and mental health benefits); *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CTRS. FOR MEDICAID & MEDICARE SERVS., https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_fact_sheet.html (last visited Mar. 16, 2019) ("Self-insured non-Federal government employer[]"

In late March 2010, President Obama responded to this limitation by signing the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (HCERA) into law (as consolidated, the Affordable Care Act (ACA)).⁸¹ Best known for its controversial (and now repealed) individual health insurance mandate,⁸² the ACA had two other sets of provisions that related to mental health parity and mandatory mental health and substance use disorder benefits. These provisions—until they were struck down by a federal district court on December 14, 2018—improved upon some of the limitations of MHPA and MHPAEA.

The first set of relevant ACA provisions extended MHPA's and MHPAEA's mental health parity provisions to the individual and small group health plans offered on and off the ACA-created health insurance exchanges.⁸³ After the ACA, many individual and small group health plans that previously discriminated against individuals with opioid use disorder through higher deductibles, copayments, and coinsurance rates—as well as lower inpatient day and outpatient visit limitations—were required to comply with MHPA and MHPAEA.

Legislation subsequent to the ACA continued to expand and promote compliance with MHPA and MHPAEA. For example, the 21st Century Cures Act (hereinafter “Cures Act”), signed into law by President Obama on December 13, 2016, required the Secretary of Health and Human Services (HHS), the Government Accountability Office, and/or other federal agencies, as appropriate, to issue a number of guidance documents, action plans, and

plans can opt out of the federal parity law); *see also Mental Health Parity Law*, TRANSAMERICA CTR. FOR HEALTH STUDIES, <https://www.transamericacenterforhealthstudies.org/health-wellness/mental-health-guide/mental-health-parity-law> (last visited Apr. 12, 2019) (The MHPAEA's requirements do not apply to “[s]mall employer health plans” created before March 23, 2010, “[s]elf-insured non-federal government employee plans,” “[c]hurch-sponsored plans,” “[r]etiree-only plans,” TriCare, Medicare, and “[t]raditional Medicaid (fee-for-service, non-managed care)”).

81. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

82. *Id.* § 5000A(a), 124 Stat. at 244. This law added the following to the Internal Revenue Code: “An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.” *Id.*

83. *Id.* § 1311(j) (“[MHPAEA] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.”). *See also id.* § 1562(c)(4) (identifying the conforming and technical changes that will be made to former 42 U.S.C. 300gg-5, now codified at 42 U.S.C. § 300gg-26); CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 12 (2011) (“The Affordable Care Act also specifically extends MHPAEA to the individual market.”).

reports addressing compliance with MHPA and MHPAEA.⁸⁴ By further example, the SUPPORT Act, signed into law by President Trump on October 24, 2018, required the Children's Health Insurance Program (CHIP) to comply with MHPA and MHPAEA.⁸⁵

On December 14, 2018, however, the United States District Court for the Northern District of Texas struck down the entire Affordable Care Act,⁸⁶ including the ACA provisions extending MHPA's and MHPAEA's mental health parity provisions to the individual and small group health plans offered on and off the ACA-created health insurance exchanges. To the extent that this District Court opinion (hereinafter "District Court Opinion") stands, the ACA's extension of mental health parity to individual and small group health plans is no longer valid.

The second set of relevant ACA provisions required certain health plans to actually provide mental health and substance use disorder benefits. That is, the ACA required individual and small group health plans,⁸⁷ exchange-offered qualified health plans,⁸⁸ state basic health plans,⁸⁹ and Medicaid benchmark plans⁹⁰ to offer "[m]ental health and substance use disorder services, including behavioral health treatment" in addition to nine other categories of essential health benefits (EHBs).⁹¹ Even before the District Court Opinion, not every individual with health insurance benefited from these ten required EHB categories because some health plans, including self-insured health plans and grandfathered health plans, were exempt from the requirement to provide the ten EHBs.⁹² In some states, such as Nevada, only

84. 21st Century Cures Act, Pub. L. No. 114-255, § 13001, 130 Stat. 1033, 1278 (2016); *id.* § 13002, 130 Stat. at 1283 (requiring an action plan); *id.* § 13004, 130 Stat. at 1286 (requiring a Government Accountability Office report).

85. SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. § 5021 (2018).

86. *See Texas v. United States*, 340 F. Supp. 3d 579, 618–19 (N.D. Tex. 2018) (declaring the ACA's individual mandate unconstitutional and further declaring the remaining provisions of the ACA "inseverable" and therefore "invalid"); *see id.* at 615 ("In sum, the Individual Mandate 'is so interwoven with [the ACA's] regulations that they cannot be separated. None of them can stand.'" (internal citations omitted)).

87. *See Patient Protection and Affordable Care Act*, § 1201(2)(A) (codified at 42 U.S.C. § 300gg-6(a) (2012)).

88. *See id.* § 1301(a)(1)(B) (adding new 42 U.S.C. § 18021(a)(1)(B) (2012)).

89. Individuals eligible for state basic health plan coverage include individuals who are not eligible for Medicaid and whose household income falls between 133% and 200% of the federal poverty line for the family involved. *Id.* § 1331(e)(1)(B).

90. *Id.* § 2001(c)(3) (adding new 42 U.S.C. § 1396u-7(b)(5)–(6) (2012)).

91. *Id.* § 1302(b)(1)(A)–(J).

92. *See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act*, 75 Fed. Reg. 34,538, 34,562 (June 17, 2010) (codified at 29 C.F.R. § 2590 (2013)) (adopting 29 C.F.R. § 2590.715-1251(a), which defines "[g]randfathered health plan coverage"

a small percentage of state residents were covered by a health plan that was required to comply with the ACA's EHB mandate, leaving the vast majority of residents without federally-mandated mental health and substance use disorder benefits post-ACA but pre-District Court Opinion.⁹³

For those health plans that were required by the ACA to provide benefits within the ten EHB categories, the ACA's statutory EHB requirements were unclear as to whether particular benefits—such as opioid use disorder benefits—were included. As a result, HHS issued its first set of final regulations implementing the ACA's EHB requirements on February 25, 2013 (2013 Final Regulations).⁹⁴ The 2013 Final Regulations required states to select (or be defaulted into) a benchmark plan⁹⁵ that was sold in 2012 and that provided coverage for the ten EHB categories, including mental health and substance use disorder services,⁹⁶ and that served as a reference plan for health plans in each state. According to the 2013 Final Regulations, health plans in the state to which the EHB requirements applied were required to provide health benefits “substantially equal” to those provided by the state's benchmark plan, including the benchmark plan's covered benefits and excluded benefits.⁹⁷ Thus, the question of whether (and the extent to which) a particular health insurance policy or plan was responsible for providing (between years 2014 and 2016) benefits for a particular mental disorder—

as “coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010”); *id.* at 34,559 (explaining that Public Health Service Act § 2707 does not apply to grandfathered health plans); *id.* at 34,567–68 (adopting 29 C.F.R. § 2590.715-1251(c)(1), which states that “the provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans”); U.S. DEP'T LABOR, APPLICATION OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS ACT TO GRANDFATHERED PLANS 1 (2010) (explaining that ACA's essential benefit package requirement is not applicable to grandfathered plans); INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 19 (2012) (listing the health plan settings to which ACA's EHB requirement do not apply); COMMONWEALTH FUND, THE ESSENTIAL HEALTH BENEFITS PROVISIONS OF THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PEOPLE WITH DISABILITIES 3 (2011) (“The act exempts large-group health plans, as well as self-insured [Employee Retirement Income Security Act] plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements.”).

93. See e-mail from Glenn Shippey, Nev. Div. of Ins., to Author (Apr. 8, 2016, 3:33 PM PT) (on file with author) (“Please note that fewer than 10% of Nevadans are covered under an individual or small group policy in the state, and large employers are not required to provide coverage for essential health benefits.”) [hereinafter Shippey E-mail].

94. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, and 156).

95. *Id.* at 12,866 (adopting 45 C.F.R. § 156.100).

96. *Id.* (adopting 45 C.F.R. § 156.110(a)(5)).

97. *Id.* at 12,867 (adopting 45 C.F.R. § 156.115(a)).

such as opioid use disorder—required an analysis of the applicability of the ACA’s EHB provision to the policy or plan as well as the content of the state’s selected benchmark plan.

The State of Nevada’s First Benchmark Plan can be used to illustrate the application of these rules. Nevada’s first benchmark plan was the Health Plan of Nevada Point of Service Group 1 C XV 500 HCR Plan (Nevada’s First Benchmark Plan).⁹⁸ If Nevada’s First Benchmark Plan included opioid use disorder benefits, then individual, small group, and other ACA-covered health plans in Nevada were responsible for providing these benefits in years 2014, 2015, and 2016.⁹⁹ On the other hand, if Nevada’s First Benchmark Plan did not include opioid use disorder benefits on March 31, 2012, then benefits for this disorder were not considered EHBs in Nevada, and individuals with opioid use disorder did not have coverage in years 2014, 2015, and 2016 unless their health plans voluntarily included such benefits¹⁰⁰ or unless they accessed separate state funds (only available in some states) for relevant treatments and services.¹⁰¹

Nevada’s First Benchmark Plan included coverage of both inpatient and outpatient services for substance abuse disorder, without limitation.¹⁰² Because opioid use disorder is one type of substance abuse disorder, Nevada’s First Benchmark Plan thus required health plans that were required to comply with the ACA’s EHB requirements to provide coverage for medically necessary inpatient and outpatient treatments for opioid use disorder in years 2014, 2015, and 2016.

In regulations published on February 27, 2015 (the 2015 Final Regulations), HHS required states to select a new benchmark plan that was sold in 2014 and that would be effective for years 2017, 2018, and 2019 (Second Benchmark Plan).¹⁰³ The deadline for states to select that Second

98. CTRS. FOR MEDICARE & MEDICAID SERVS., NEVADA EHB BENCHMARK PLAN 1, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Nevada-Benchmark-Summary.pdf> (last visited Mar. 14, 2019).

99. See Shippey E-mail, *supra* note 93 (explaining the application of the EHB requirements in the State of Nevada).

100. See AMANDA CASSIDY, STATES HAVE DETERMINED THE MINIMUM SET OF BENEFITS TO BE INCLUDED IN INDIVIDUAL AND SMALL-GROUP INSURANCE PLANS. WHAT’S NEXT? 2 (2013) (“HHS has indicated that [the benchmark plan] approach may be changed in 2016 and in future years based on evaluation and feedback.”).

101. Cf. SARAH A. ST. JOHN ET AL., UNLV CTR. FOR DEMOCRATIC CULTURE, PROBLEM GAMBLING AND TREATMENT IN NEVADA (Dmitri N. Shalin ed., 2012) (discussing problem gambling treatments that are partially or fully supported by the State of Nevada).

102. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 98, at 3.

103. See, e.g., Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812 (Feb. 27, 2015).

Benchmark Plan was June 1, 2015.¹⁰⁴ Nevada, for example, selected the Health Plan of Nevada Solutions Health Maintenance Organization Platinum 15/0/90% Plan.¹⁰⁵ Nevada's Second Benchmark Plan again covered inpatient and outpatient services for "substance abuse disorder," including opioid use disorder, although the Second Benchmark Plan set forth two limitations on such coverage.¹⁰⁶ First, the plan required prior authorization for all "non-routine" outpatient substance abuse treatments.¹⁰⁷ Second, the plan required prior authorization for all "inpatient" substance abuse treatment as well.¹⁰⁸

On April 17, 2018, HHS published a third rule on this topic (the 2018 Final Regulations) giving states the option to select a new (i.e., third) benchmark plan that would become effective in the year 2020. However, the 2018 Final Regulations took a slightly different approach compared to the 2013 and 2015 Final Regulations.¹⁰⁹ In particular, the 2018 Final Regulations gave each state the flexibility to change the state's second benchmark plan by: (1) selecting another state's second benchmark plan; (2) replacing one or more categories of the state's current EHBs with the same category or categories of EHBs set forth in another state's second benchmark plan; or (3) selecting an entirely new benchmark plan so long as the new benchmark plan did not exceed the generosity of the most generous among a set of comparison plans, including the state's second benchmark plan and any of the state's options for a second benchmark plan.¹¹⁰ State selections were due July 2, 2018.¹¹¹ Interestingly, only one state (Illinois) selected a new (i.e., third) benchmark

104. See, e.g., *Essential Health Benefits*, NEV. DIV. OF INS., DEP'T BUS. & INDUS., <http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Essential-Health-Benefits> (last visited Nov. 2, 2018) (identifying Nevada's benchmark plan selections); JoAnn Volk, *States Need to Select Essential Health Benefit Benchmark Plans for 2017 Soon!*, GEO. U. HEALTH POL'Y INST., CTR. FOR CHILDREN & FAMILIES (May 7, 2015), <https://ccf.georgetown.edu/2015/05/07/states-need-select-essential-health-benefit-benchmark-plans-2017-soon> (referencing the June 1, 2015 deadline for states to select an EHB benchmark for small employer and individual coverage available in 2017).

105. CTRS. FOR MEDICARE & MEDICAID SERVS., NEVADA 2017 EHB BENCHMARK PLAN 1 (2017), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NV-BMP.zip> (last visited Mar. 14, 2018).

106. *Id.* at 3.

107. *Id.*

108. *Id.*

109. See generally Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018) (to be codified at 45 C.F.R. pt. 147, 153–58).

110. *Id.* at 17,068 (creating new 45 C.F.R. § 156.111(a)).

111. *Id.* at 17,020.

plan as permitted by the 2018 Final Regulations.¹¹² All of the other states kept their second benchmark plans, which will now remain in effect through the end of year 2020, pending, of course, the outcome of any appeals of the District Court Opinion.¹¹³

To the extent the District Court Opinion is affirmed, the ACA's EHB and benchmark selection requirements will fall. Remember, however, that the second benchmark plans were selected by states from preexisting health insurance plans that were already being sold in each state independent of the ACA. Plans like these will continue to be sold post-District Court Opinion. Therefore, these benchmark plans are helpful for understanding current and typical coverage of treatments and services for opioid use disorder. To this end, Appendix A and Part III below survey all current benchmark plans, including the second benchmark plans of all fifty states and the District of Columbia, as well as the third benchmark plan of Illinois. As discussed in more detail below, these benchmark plans demonstrate substantial variation in terms of their opioid use disorder coverage and limitations.

IV. DISCUSSION OF STATE BENCHMARK PLANS

A. Only One State Took Advantage of the Opportunity Which the 2018 Final Regulations Presented to Improve Opioid Use Disorder Coverage

At the outset, it is important to note that only one state—Illinois—took advantage of the opportunity presented by the 2018 Final Regulations¹¹⁴ to select a new benchmark plan that would improve insurance coverage of opioid use disorder treatments and services in that state. As discussed in Part II, all fifty states and the District of Columbia had the opportunity to change their second benchmark plans by: (1) selecting another state's second benchmark plan; (2) replacing one or more categories of the state's current EHBs with the same category or categories of EHBs set forth in another state's second benchmark plan; or (3) selecting an entirely new benchmark plan so long as

112. THE ACCESS TO CARE AND TREATMENT (ACT) PLAN 2, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020-BPM-IL.zip> [hereinafter Illinois Third Benchmark Plan] (last visited Mar. 14, 2019).

113. *See Texas v. United States*, 340 F. Supp. 3d 579, 615 (Dec. 14, 2018) ("In sum, the Individual Mandate 'is so interwoven with [the ACA's] regulations that they cannot be separated. None of them can stand.'" (internal citations omitted)); *id.* at 619 (declaring the ACA's individual mandate unconstitutional; further declaring the remaining provisions of the ACA "inseverable" and therefore "invalid").

114. *See generally* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018).

the new benchmark plan did not exceed the generosity of the most generous among a set of comparison plans, including the state's second benchmark plan and any of the state's options for a second benchmark plan.¹¹⁵ This opportunity was open through July 2, 2018.¹¹⁶ Illinois selected an entirely new benchmark plan (The Illinois Access to Care and Treatment (ACT) Plan) in accordance with the third option made available by the 2018 Final Regulations.¹¹⁷

The ACT Plan contains four new opioid-related provisions. First, it covers "at least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50 MME or higher."¹¹⁸ In contrast, Illinois' Second Benchmark Plan covered zero (or no) opioid reversal agents.¹¹⁹ Second, the ACT Plan removes barriers to the prescription of medication-assisted treatment (MAT) of opioid use disorder by removing prior authorization requirements, dispensing limits, first-fail policies, and lifetime limit requirements otherwise applicable to MAT of opioid use disorder.¹²⁰ Third, the ACT Plan covers tele-psychiatry, including for opioid use disorder.¹²¹ Finally, the ACT Plan limits opioid prescriptions for acute pain to no more than seven days.¹²² Although Illinois was the only state to take advantage of the opportunity to incorporate opioid-specific provisions the state believed would help combat the opioid crisis, the District Court Opinion striking down of the ACA—if affirmed—will neutralize the impact of this missed opportunity in other states.¹²³

115. *Id.* at 17,068 (creating new 45 C.F.R. § 156.111(a)).

116. *Id.* at 17,020.

117. Illinois Third Benchmark Plan, *supra* note 112.

118. *Id.* at 32.

119. BLUECROSS BLUE SHIELD OF ILL., ILLINOIS EHB BENCHMARK PLAN 5, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/IL-BMP.zip> (last visited Mar. 14, 2018) (showing that Illinois' Second Benchmark Plan included coverage of zero (0) opioid reversal agents) [hereinafter Illinois Second Benchmark Plan].

120. Illinois Third Benchmark Plan, *supra* note 112, at 21 ("Benefits for Buprenorphine products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder shall not include prior authorization, dispensing limits, fail first policies, or lifetime limit requirements.").

121. *Id.* at 11 ("Benefits are available when . . . you utilize telepsychiatry care (care may be provided by either a prescriber or licensed therapist).").

122. *Id.* at 31 ("Short-term opioid prescriptions for acute pain will be provided for no more than 7 days.").

123. *See infra* Part V.

B. Many State Benchmark Plans Provide Comprehensive Substance Use Disorder Benefits

At the outset, it is also important to note that many state benchmark plans—as currently written—contain comprehensive mental health and substance use disorder benefits that: (1) can be accessed by individuals with opioid use disorder; and (2) contain no limitations other than those that apply equally to physical health benefits. Missouri’s Second Benchmark Plan, for example, covers a wide variety of mental health and substance use disorder services, including: (1) inpatient services delivered in a hospital or other inpatient facility, including “psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation”; (2) outpatient services delivered in an outpatient department of a hospital as well as during an outpatient office visit; (3) day treatment services, defined as those services that are “more intensive than outpatient visits but less intensive than an overnight stay in [a] [h]ospital”; and (4) residential treatment services, defined as specialized twenty-four-hour treatment services provided in a licensed residential treatment center or intermediate care facility, including observation and assessment by a psychiatrist, rehabilitation, therapy, education, recreational, and social activities.¹²⁴ These covered services may be provided by a psychiatrist, psychologist, neuropsychologist, licensed clinical social worker, mental health clinical nurse specialist, licensed marriage and family therapist, or licensed professional counselor.¹²⁵ Although Missouri’s Second Benchmark Plan does impose a thirty percent coinsurance on in-network substance use disorder care and a fifty percent coinsurance on out-of-network substance use disorder care,¹²⁶ the plan imposes the same coinsurance percentages on non-mental health and non-substance use disorder care,¹²⁷ thus raising no issues under the financial requirement provisions set forth in federal mental health parity law, as discussed in Part II.¹²⁸

The same is true of many other state benchmark plans as well. Virginia’s Second Benchmark Plan covers: (1) “[i]npatient [s]ervices in a hospital or other facility,” including “individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient’s diagnosis and treatment, convulsive therapy, detoxification, and

124. ANTHEM BLUECROSS BLUESHIELD, CERTIFICATE OF COVERAGE: SILVER DIRECTACCESS PLUS 50 (2015), https://downloads.cms.gov/ccio/2017%20Benchmark%20Summary_MO_revised%20508.zip (last visited Mar. 14, 2019).

125. *Id.* at 50–51.

126. *Id.* at 16.

127. *See supra* note 124 and accompanying text.

128. *Id.* at 15.

rehabilitation”; (2) “[o]utpatient [s]ervices consisting of treatment in an outpatient department of a [h]ospital and office visits,” including “individual psychotherapy, group psychotherapy, psychological testing and medication management visits”; (3) partial day services; and (4) residential treatment facility services, including “observation and assessment by a psychiatrist” as well as “rehabilitation, therapy, education, and recreational or social activities.”¹²⁹ Virginia’s Second Benchmark Plan covers these services regardless of whether they are provided by a psychiatrist, psychologist, neuropsychologist, licensed clinical social worker, mental health clinical nurse specialist, licensed marriage and family therapist, or licensed professional counselor.¹³⁰ Although Virginia’s Second Benchmark Plan does impose a \$500 copayment per day—up to a maximum of \$1,500 per admission—on inpatient substance use disorder care,¹³¹ Virginia imposes the same copayments on inpatient care for physical health conditions.¹³² The copayments thus do not violate federal mental health parity law, as discussed in Part II, although they may raise an issue regarding the association between cost and access to inpatient substance use disorder care.¹³³ Because plans like the Missouri and Virginia plans will continue to be sold even if the District Court Opinion is affirmed, some insureds will continue to benefit from comprehensive mental health and substance use disorder benefits.

C. Some State Benchmark Plans Expressly Acknowledge and/or Require Compliance with Mental Health Parity Laws

Some state benchmark plans expressly acknowledge the concept of mental health parity and/or expressly require compliance with mental health parity laws—in particular—with inpatient, outpatient, or prescription drug

129. ANTHEM BLUECROSS BLUESHIELD, CERTIFICATE OF COVERAGE: ANTHEM PREMIER DIRECTACCESS 47 (2014), https://downloads.cms.gov/ccio/BMP%20Summary_VA.zip (last visited Mar. 14, 2019).

130. *Id.* at 47–48.

131. *Id.* at 19.

132. *Id.* at 18.

133. Many state benchmark plans impose considerable copayments or coinsurance amounts on substance use disorder care. For example, California’s Second Benchmark Plan applies a \$400 per day copayment on inpatient mental health care services, including inpatient detoxification services. However, California’s Second Benchmark Plan applies the same \$400 per day copayment on inpatient non-mental health care. *See* KAISER FOUND. HEALTH PLAN, KAISER PERMANENTE FOR SMALL BUSINESSES: \$30 COPAYMENT PLAN 1–2 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_CA.zip (last visited Mar. 14, 2019). The high copayments and coinsurance amounts applicable to substance use disorder care thus do not violate mental health parity law although they raise an issue regarding the association between cost-sharing, access to health care, and health itself.

contexts. For example, Idaho's Second Benchmark Plan states the following with respect to coverage of inpatient care: "The benefits provided for [i]npatient hospital services and [i]npatient medical services in this section are also provided for the care of [m]ental or [n]ervous [c]onditions, [a]lcoholism, [s]ubstance [a]buse or [a]ddiction, or any combination of these."¹³⁴ Idaho's Second Benchmark Plan contains a parallel statement in the context of outpatient care coverage: "The benefits provided for [o]utpatient [h]ospital [s]ervices and [o]utpatient [m]edical [s]ervices in this section are also provided for [m]ental or [n]ervous [c]onditions, [a]lcoholism, [s]ubstance [a]buse or [a]ddiction, or any combination of these."¹³⁵ Kansas' Second Benchmark Plan contains a parallel statement in the context of prescription drug coverage: "Psychotherapeutic drugs used for the treatment of [m]ental [i]llness and [s]ubstance [u]se [d]isorders [are covered] under terms and conditions not less favorable than coverage provided for other Prescription Drugs."¹³⁶

Some state benchmark plans expressly acknowledge the concept of mental health parity and/or expressly require compliance with mental health parity laws in all contexts—without specifying application to the inpatient, outpatient, or prescription drug contexts. For example, Massachusetts' Second Benchmark Plan states: "The financial requirements and treatment limits for your mental health or substance abuse coverage can be no more restrictive than those for your medical and surgical coverage."¹³⁷ Similarly, the New Jersey Benchmark Plan states: "Horizon BCBSNJ [(Blue Cross Blue Shield of New Jersey)] pays benefits for the [c]overed [c]harges a [c]overed [p]erson incurs for the treatment of [m]ental [i]llness or [s]ubstance [a]buse the same way Horizon BCBSNJ would for any other Illness, if such treatment is prescribed by a [p]ractitioner."¹³⁸ Likewise, the Indiana Benchmark Plan states: "Coverage for the treatment of behavioral health and substance abuse conditions is provided in compliance with state and federal law."¹³⁹ The

134. BLUE CROSS OF IDAHO, *supra* note 48, at 10.

135. *Id.*

136. BLUE CROSS BLUE SHIELD OF KAN., COMPREHENSIVE MAJOR MEDICAL: GROUP CERTIFICATE 29 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_KS-4816.zip (last visited Mar. 14, 2019).

137. BLUE CROSS BLUE SHIELD OF MASS., HMO BLUE NEW ENGLAND: \$2,000 DEDUCTIBLE 5 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MA_4816.zip (last visited Mar. 14, 2019).

138. HORIZON BLUE CROSS BLUE SHIELD OF N.J., SMALL GROUP HEALTH CARE BENEFITS POLICY 63 (2014), <https://downloads.cms.gov/cciio/bmp-summary-nj.zip> (last visited Mar. 14, 2019).

139. ANTHEM BLUECROSS BLUESHIELD, *supra* note 46, at M-13, M-24–25. *See also* UNITEDHEALTHCARE OF KY., *supra* note 50, at II ("Benefits for mental health conditions and

Montana Benchmark Plan is very succinct in this respect: “Benefits for [c]hemical [d]ependency will be paid as any other illness.”¹⁴⁰

On the other hand, some benchmark plans contain no provisions requiring compliance with mental health parity law. For example, the Second Benchmark Plans of Alabama,¹⁴¹ the District of Columbia,¹⁴² Georgia,¹⁴³ and Wyoming¹⁴⁴ contain no provisions requiring compliance with state and/or federal mental health parity law.

D. Prior Authorization Is the Most Common Substance Use Disorder Coverage Limitation

Prior authorization (also called—with slight variation in meaning—prior certification, prior approval, or prior review [hereinafter prior authorization]) is the most common substance use disorder coverage limitation. That is, many state benchmark plans require an insured to request and obtain prior authorization for outpatient, inpatient, and/or other substance use disorder services from the individual’s health plan. Without such prior authorization, substance use disorder coverage may be denied, limited, or delayed. The twenty-eight states that contain some type of prior authorization requirement potentially applicable to substance use disorder care—including opioid use disorder care—include Arizona, Arkansas, Colorado, Connecticut, the District of Columbia, Florida, Hawaii, Idaho, Illinois (Second Benchmark Plan only), Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, and

substance use disorder conditions that are [c]overed [h]ealth [s]ervices under the [p]olicy must be treated in the same manner and provided at the same level as [c]overed [h]ealth [s]ervices for the treatment of other [s]ickness or [i]njury.”).

140. BLUECROSS BLUESHIELD OF MONT., BLUE PREFERRED GOLD PPO 007 at 33 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_MT.zip (last visited Mar. 14, 2019).

141. See BLUE CROSS BLUE SHIELD OF ALA., 320 PLAN (2017), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_AL-4816.zip (last visited Mar. 14, 2019).

142. See GROUP HOSPITALIZATION AND MED. SERVS., BLUE PREFERRED PPO \$1,000 – 100%/80% (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/BMP-Summary_DC-4816.zip (last visited Mar. 14, 2019).

143. See HUMANA EMP. HEALTH PLAN OF GA., CERTIFICATE OF COVERAGE, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/GA-BMP.zip> (last visited Mar. 14, 2019).

144. See BLUECROSS BLUESHIELD OF WYO., BLUESelect PPO, https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_WY_revised.zip (last visited Mar. 14, 2019).

Wisconsin.¹⁴⁵ These prior authorization requirements are described in more detail at Appendix A.¹⁴⁶ Connecticut's Second Benchmark Plan is noteworthy because its prior authorization requirement applies only to "outpatient treatment of opioid dependence," but not to outpatient treatment of any other substance use disorder.¹⁴⁷ Why the Connecticut Plan singles out opioid use disorder—but not other substance use disorders—for prior authorization is unclear. Whether these prior authorization requirements violate mental health parity law depends on whether they are enforced and whether parallel prior authorization requirements exist in the context of offered non-mental health benefits.¹⁴⁸

E. Many Benchmark Plans Cover No Opioid Reversal Agents

The ACA requires each state benchmark plan to list the number of covered drugs in each United States Pharmacopeia (USP) category and class.¹⁴⁹ USP categories relevant to opioids and opioid use disorder include analgesics and anti-addiction agents.¹⁵⁰ Within the analgesics category, classes relevant to opioids include long-acting analgesics and short-acting analgesics.¹⁵¹ Within the anti-addiction agent category, classes relevant to opioid use disorder include opioid dependence treatments and opioid reversal agents.¹⁵² Although there is substantial variation among benchmark plans, a review of Appendix A shows that many state benchmark plans cover approximately the following number of drugs in each relevant USP categories

145. *See infra* Appendix A (summarizing relevant prior authorization requirements in the third column).

146. *See infra* Appendix A.

147. CONNECTICARE INS. CO., CONNECTICARE FLEX POS PLAN 82 (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/CT-BMP.zip> (last visited Mar. 14, 2019).

148. *See* U.S. DEP'T HEALTH & HUMAN SERVS., WARNING SIGNS- PLAN OR POLICY NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLS) THAT REQUIRE ADDITIONAL ANALYSIS TO DETERMINE MENTAL HEALTH PARITY COMPLIANCE 2 (explaining that this analysis is required); Also noting that prior authorization requirements applicable to mental health care can serve as a "red flag" that a plan or issuer may be imposing an impermissible non-quantitative treatment limitation (NQTL) on mental health care and that: "Further review of the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to both [mental health and substance use disorder] and med/surg benefits will be required to determine parity compliance. Note that these plan/policy terms do not automatically violate the law, but the plan or issuer will need to provide evidence to substantiate compliance." *Id.* at 2.

149. *See infra* Appendix A (listing categories and classes relevant to opioids and opioid use disorder for all states and the District of Columbia).

150. *See infra* Appendix A.

151. *See infra* Appendix A.

152. *See infra* Appendix A.

and classes: (1) ten long-acting opioid analgesics; (2) twelve short-acting opioid analgesics; (3) two opioid dependence treatments; and (4) one opioid reversal agent.¹⁵³

That said, the Second Benchmark Plans of the following twenty states, as written, cover zero (i.e., no) opioid reversal agents: Alabama, Alaska, Arkansas, Florida, Hawaii, Illinois, Iowa, Louisiana, Michigan, Minnesota, Mississippi, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, and Wisconsin.¹⁵⁴ If a state benchmark plan covers zero drugs within a particular USP class, such as the opioid reversal agent class, regulations implementing the ACA require plans that must comply with the ACA's EHB provision to disregard the benchmark plan's zero coverage and to cover at least one drug per USP class.¹⁵⁵ Before the District Court Opinion, then, plans required to comply with the EHB provision were required to cover at least one opioid reversal agent. However, when the District Court Opinion struck down the ACA, it struck down the EHB provision within the ACA. The result is that, if the District Court Opinion is affirmed, health plans in all states may permissibly cover zero opioid reversal agents unless some other non-ACA law—such as a state mandated benefit law—requires coverage of one or more opioid reversal agents.

It is noteworthy that the Third Benchmark Plan selected by Illinois, which would be effective in 2020, does cover one opioid reversal agent.¹⁵⁶ As noted above, Illinois' Second Benchmark Plan covered zero opioid reversal agents.¹⁵⁷ Illinois may have made this change to respond to the opioid crisis. That said, if the District Court Opinion is affirmed, health plans in Illinois could revert to covering zero opioid reversal agents.

153. BLUECROSS BLUESHIELD OF MONT., MONTANA 2017 EHB BENCHMARK PLAN 1, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_MT.zip (last visited Mar. 14, 2019) (covering this typical number of drugs in each category and class).

154. See *infra* Appendix A.

155. 45 C.F.R. § 156.122(a)(1) (2018) (“A health plan does not provide essential health benefits unless it: (1) Subject to the exception in paragraph (b) of this section, covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan.”).

156. See Illinois Third Benchmark Plan, *supra* note 112, at 7, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020-BPM-IL.zip> (last visited Mar. 14, 2019).

157. See Illinois Second Benchmark Plan, *supra* note 119.

F. Some State Benchmark Plans Limit Coverage of Residential Treatment Facility Care

Some state benchmark plans expressly cover services provided to individuals with substance use disorders in a residential treatment facility.¹⁵⁸ Other state benchmark plans expressly exclude from coverage: (1) services provided to individuals with mental health conditions in general (or substance use disorders in particular) in a residential treatment facility, and/or (2) residential treatment services provided in another facility, such as a chemical dependency facility. Illustrative plans with exclusions include the Second Benchmark Plans of Alabama,¹⁵⁹ Florida,¹⁶⁰ Michigan,¹⁶¹ Minnesota,¹⁶²

158. See CAREFIRST BLUECHOICE, BLUECHOICE HMO HSA-HRA \$1,500 at B30 (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/MD-BMP.zip> (last visited Mar. 14, 2019).

159. BLUECROSS BLUESHIELD OF ALA., *supra* note 141, at 15–16.

160. BLUE CROSS BLUE SHIELD OF FLA., BLUEOPTIONS: SMALL EMPLOYER MASTER POLICY HEALTH CARE REFORM ENDORSEMENT 1–2 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_FL-4816.zip (last visited Mar. 14, 2019).

161. PRIORITYHEALTH, PRIORITYHMO 26 (2014), https://downloads.cms.gov/files/CCIIO/2017_benchmark_summary_mi_033117.zip (last visited Mar. 14, 2019) (excluding services provided in a “residential” facility).

162. HEALTHPARTNERS, FOR SMALL EMPLOYERS BENEFITS CHART 8 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MN.zip (last visited Mar. 14, 2019) (excluding from coverage residential treatment services).

Nebraska,¹⁶³ North Dakota,¹⁶⁴ Rhode Island,¹⁶⁵ South Carolina,¹⁶⁶ Texas,¹⁶⁷ and Utah.¹⁶⁸

Other state benchmark plans limit, but do not completely exclude form coverage, substance use disorder care provided in a residential treatment facility. For example, Iowa's Second Benchmark Plan covers services provided for chemical dependency in a residential treatment facility, but only when such services are provided "on an intensive outpatient basis, or for partial hospitalization treatment, or for treatment that is provided as an inpatient at an acute level of care requiring medically monitored 24-hour registered nursing care under the supervision of a medical director."¹⁶⁹ South Dakota's Second Benchmark Plan contains a similar limitation; that is, benefits for care provided in residential treatment facilities are only available if "treatment is provided as an inpatient at an acute level of care with 24-hour registered nursing care under the supervision of a medical director."¹⁷⁰ Oregon's Second Benchmark Plan limits coverage of services provided in a

163. BLUECROSS BLUESHIELD OF NEB., BLUEPRIDE PLUS 28 (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NE-BMP.zip> (last visited Mar. 14, 2019).

164. BLUE CROSS BLUE SHIELD OF N.D., BLUECARE 90 500 at 28, 36, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ND-BMP.zip> (last visited Mar. 14, 2019) (excluding from coverage residential treatment services for insureds twenty-one-years-of-age and older).

165. BLUE CROSS BLUE SHIELD OF R.I., SUBSCRIBER AGREEMENT: VANTAGEBLUE RX S3/12/35/60/100, at 26–27 (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/RI-BMP.zip> (last visited Mar. 14, 2019) (excluding from coverage "extended stay/long term residential . . . programs").

166. BLUECROSS BLUESHIELD OF S.C., BUSINESS BLUE 31 (2008), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_SC-4816.zip (last visited Mar. 14, 2019).

167. BLUECROSS BLUESHIELD OF TEX., YOUR HEALTH CARE BENEFITS PROGRAM: SAMPLE RSH3 48 (2010), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/TX-BMP.zip> (last visited Mar. 14, 2019) (excluding from coverage "[r]esidential level of treatment for Chemical Dependency in a Chemical Dependency Treatment Center").

168. PUB. EMP. HEALTH PROGRAM, UTAH BASIC PLUS PLAN 32 (2013), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_UT-4816.zip (last visited Mar. 14, 2019).

169. WELLMARK IOWA, COVERAGE MANUAL: COMPLETEBLUE 2000 B BlueRx Essentials 15 (2014), https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_IA.zip (last visited Mar. 14, 2019).

170. WELLMARK S.D., BLUESELECT BLUERX PREFERRED 15–16 (2013), https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_SD.zip (last visited Mar. 14, 2019).

residential facility to forty-five days.¹⁷¹ The Second Benchmark Plans of Idaho and Vermont require prior authorization for services provided in a residential treatment facility.¹⁷²

G. Some State Benchmark Plans Exclude Methadone from Coverage

Some state benchmark plans expressly cover methadone as a treatment or service for opioid use disorder. Washington's Second Benchmark Plan, for example, covers "[p]rescription [m]edications that are prescribed and dispensed through a substance use disorder treatment facility (such as methadone)."¹⁷³ Maryland's Second Benchmark Plan covers "[m]ethadone [m]aintenance."¹⁷⁴ Minnesota's Second Benchmark Plan covers "opiate replacement therapy including methadone and buprenorphine treatment."¹⁷⁵

Other state benchmark plans expressly exclude methadone from coverage. Alabama's Second Benchmark Plan excludes "[s]ervices related to narcotic maintenance therapy such as methadone maintenance therapy" when care is coordinated by an Expanded Psychiatric Services (EPS) provider.¹⁷⁶ Arkansas' Second Benchmark Plan expressly excludes from coverage "[m]edications used to sustain or support an addiction or substance dependency."¹⁷⁷ Delaware's Second Benchmark Plan includes methadone in its list of "What Is Not Covered."¹⁷⁸ Kentucky's Second Benchmark Plan excludes "[m]ethadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents."¹⁷⁹ Rhode Island's Second Benchmark Plan provides that, "[t]his agreement does NOT cover

171. PACIFICSOURCE HEALTH PLANS, PREFERRED CODEDUCT VALUE 3000+35/70% 0812 TIERED VALUE RX 10/50/75 0812, at 19–20 (2014), https://downloads.cms.gov/ccio/2017%20Benchmark%20Summary_OR.zip (last visited Mar. 14, 2019).

172. BLUE CROSS OF IDAHO, *supra* note 48, at 8; BLUECROSS BLUESHIELD OF VT., STANDARD CDHP PLAN CERTIFICATE 2 (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/VT-BMP.zip> (last visited Mar. 14, 2019).

173. REGENCE BLUESHIELD, REGENCE DIRECT POLICY: INDIVIDUAL GROUP NUMBER: 38005001 18 (2017), <https://www.assets.regence.com/policy/2017/WA/Silver3000PreferredWashington-dv.pdf> (last visited Mar. 14, 2019).

174. CAREFIRST BLUECHOICE, *supra* note 158, at C-8.

175. HEALTHPARTNERS, *supra* note 162, at 7.

176. BLUE CROSS BLUE SHIELD OF ALA., *supra* note 141, at 15.

177. HEALTH ADVANTAGE, GOLD: POINT OF SERVICE EVIDENCE OF COVERAGE 37 (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Arkansas-BMP.zip> (last visited Mar. 14, 2019).

178. HIGHMARK BLUE CROSS BLUE SHIELD DEL., SMALL GROUP HEALTH PLAN: SHARED COST EPO \$2000-100 PLAN 44–45 (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_DE-4816.zip (last visited Mar. 14, 2019).

179. UNITEDHEALTHCARE OF KY., *supra* note 50, at 34.

methadone clinics and treatments,” and further provides that “[m]ethadone dispensed to treat chemical dependency is NOT covered.”¹⁸⁰ Wisconsin’s Second Benchmark Plan expressly excludes from coverage “[m]ethadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.”¹⁸¹ Although Massachusetts’ Second Benchmark Plan does not exclude methadone from coverage, the Massachusetts Plan does apply a prior authorization requirement to such coverage.¹⁸²

H. Some State Benchmark Plans Exclude Mutual Support Groups from Coverage

Some state benchmark plans exclude mutual support groups from coverage. For example, Alaska’s Second Benchmark Plan excludes from coverage “voluntary support groups, such as Alanon or Alcoholics Anonymous.”¹⁸³ Connecticut’s Second Benchmark Plan excludes from coverage “[n]on-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).”¹⁸⁴ Rhode Island’s Second Benchmark Plan is similar: “This agreement does NOT cover the following substance abuse treatment services: [r]ecreation therapy, non-medical self-care, or self-help training (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA) meetings/services).”¹⁸⁵ As a practical matter, AA, NA, and many other mutual support groups have no dues or fees (although they may take voluntary collections during meetings),¹⁸⁶ so this exclusion is only relevant to individuals who attend mutual support groups that charge members to participate.

180. BLUE CROSS BLUE SHIELD OF R.I., *supra* note 165, at 27, 81 (emphasis removed).

181. UNITEDHEALTHCARE INS., UNITEDHEALTHCARE CHOICE PLUS 31, https://www.cms.gov/CCHIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_WI-4816.zip (last visited Mar. 14, 2019).

182. BLUE CROSS & BLUE SHIELD OF MASS., *supra* note 137, at 14–15.

183. PREMIERA BLUE CROSS BLUE SHIELD OF ALASKA, HERITAGE SELECT ENVOY 28 (2014), https://www.cms.gov/CCHIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_AK.zip (last visited Mar. 14, 2019).

184. CONNECTICARE INS. CO., *supra* note 147, at 55.

185. BLUE CROSS BLUE SHIELD OF R.I., *supra* note 165, at 26 (emphasis removed).

186. *Frequently Asked Questions from People New to AA, How Much Does AA Membership Cost?*, ALCOHOLICS ANONYMOUS, <https://aa.org.au/new-to-aa/frequently-asked-questions> (last visited Mar. 14, 2019) (“There are no dues or fees for AA membership. An AA group will usually have a collection during the meeting to cover expenses, such as rent, coffee etc., Members are free to contribute as much or as little as they wish.”).

I. Two Benchmark Plans Establish Quantitative Treatment Limitations Applicable Only to Mental Health and Substance Use Disorder Benefits

The Second Benchmark Plan of Alabama limits individuals seeking inpatient mental health and substance use disorder care to coverage of thirty inpatient days and twenty outpatient visits per year.¹⁸⁷ Because the Alabama plan does not appear to contain comparable limitations applicable to non-mental health and non-substance use disorder care, these quantitative treatment limitations may violate mental health parity law. The Second Benchmark Plan of Mississippi contains similar quantitative treatment limitations; that is, seven inpatient days and twenty outpatient days per year.¹⁸⁸ Because the Mississippi plan does not appear to contain comparable limitations applicable to non-mental health and non-substance use disorder care, these limitations may likewise violate mental health parity law.

J. One Benchmark Plan Expressly Excludes Coverage for Chemical Dependency Treatments and Services

The Second Benchmark Plan of Alaska defines “chemical dependency” as “an illness characterized by physiological or psychological dependency, or both, on alcohol or a state-regulated controlled substance.”¹⁸⁹ The Alaska plan excludes from coverage: (1) “chemical dependency services and supplies related to the diagnosis or treatment of chemical dependency”,¹⁹⁰ (2) treatments for chemical dependency provided in the emergency room other than “medically necessary detoxification services” provided in the emergency room;¹⁹¹ and (3) treatments for chemical dependency provided in the inpatient hospital setting, other than “medically necessary detoxification services” provided in the inpatient hospital setting.¹⁹²

In addition to these general chemical dependency exclusions, the Second Benchmark Plan of Alaska contains specific exclusions that include opioid treatments and services. That is, the Alaska plan excludes coverage of diagnoses and treatments for substance abuse codes 303.0 through 305.9,

187. BLUE CROSS BLUE SHIELD OF ALA., *supra* note 141, at 15–16.

188. BLUE CROSS & BLUE SHIELD OF MISS., PLAN DESCRIPTION NETWORK BLUE 13, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MS-4816.zip (last visited Mar. 14, 2019).

189. PREMIER BLUE CROSS BLUE SHIELD OF ALASKA, *supra* note 183, at 53.

190. *Id.* at 28.

191. *Id.* at 12.

192. *Id.* at 13.

among other codes.¹⁹³ The DSM-IV, the edition of the DSM to which the plan refers for purposes of definitions and other references, codes opioid dependence as 304 and opioid abuse as 305.5.¹⁹⁴ The result is that diagnostic and treatment services for opioid use disorder are not covered under the Alaska plan. In terms of its opioid use disorder coverage, the Alaska plan is the most restrictive plan among all the state benchmark plans that the Author has reviewed.

V. CONCLUSIONS

The extent to which a health insurance policy or plan must provide coverage for treatments and services—and parity in such coverage—for individuals with opioid use disorder following the December 14, 2018, United States District Court for the Northern District of Texas opinion (District Court Opinion) is relatively complex. First, it is important to note that the invalidation of the entire ACA—to the extent affirmed by the United States Court of Appeals for the Fifth Circuit and/or the United States Supreme Court—does not invalidate the original Mental Health Parity Act (MHPA), which President Clinton signed into law in 1996, or the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, which President George W. Bush signed into law in 2008. The District Court Opinion also does not invalidate the 21st Century Cures Act, signed into law by President Obama in 2016, or the SUPPORT Act, which President Trump signed into law in 2018. Health plans that are governed by these four federal laws—as well as analogous state laws—must continue to comply with the mental health parity requirements set forth in these laws notwithstanding the District Court Opinion.

However, the District Court Opinion’s invalidation of the entire ACA—to the extent affirmed—includes an invalidation of the essential health benefits provision and the related requirement for states to select a benchmark plan to which individual health plans, small group health plans, and other health plans in the state must provide substantially similar benefits. The invalidation of the ACA also means that the expansion of mental health parity law provided for in the ACA no longer applies. In summary—and to the extent the District Court Opinion is affirmed—mental health parity law will revert to MHPA as expanded by MHPAEA, the 21st Century Cures Act, the SUPPORT Act, and more stringent state law.

193. *Id.* at 30, 56 (defining psychiatric services under the plan and exclusions therefrom).

194. See AM. PSYCH. ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., 1990).

To the extent the District Court Opinion is affirmed, the ACA's EHB and benchmark selection requirements also will fall. Remember, however, that the Second Benchmark Plans were selected by the states from preexisting health insurance plans that were already being sold in each state independent of the ACA. Plans like these likely will continue to be sold post-ACA. Therefore, these benchmark plans are helpful for understanding current and typical health plan coverage (and limitations of such coverage) of opioid use disorder treatments and services.

The research presented in Appendix A to this Article reveals several points and trends relating to state benchmark plan coverage of opioid use disorder treatments and services. First, only one state—Illinois—took advantage of the opportunity presented by the 2018 Final Regulations to improve coverage of opioid use disorder treatments and services. To the extent the District Court Opinion is affirmed, however, the benefits of this opportunity will be lost for residents of Illinois. Second, many benchmark plans do provide comprehensive substance use disorder benefits that appear to be at parity with offered physical health care benefits. Third, some state benchmark plans expressly acknowledge or expressly require compliance with state and/or federal mental health parity laws. Fourth, prior authorization is the most common substance use disorder coverage limitation set forth in state benchmark plans. More than half of all states impose some type of prior authorization requirement on individuals seeking some form of substance use disorder care in at least one inpatient or outpatient context. Fifth, approximately two-fifths of benchmark plans cover no opioid reversal agents, although regulations implementing the ACA—which soon could be invalidated—require some health plans in these states to cover at least one opioid reversal agent. Sixth, some benchmark plans exclude or limit coverage of residential treatment facility care. Seventh, some state benchmark plans exclude methadone from coverage. Eighth, two states' (Alabama's and Mississippi's) benchmark plans establish quantitative treatment limitations applicable to inpatient and outpatient mental health and substance use disorder care that do not appear to apply to non-mental health and non-substance use disorder care. As such, these limitations may violate mental health parity law. Finally, one state's (Alaska's) benchmark plan excludes coverage of all chemical dependency care, including opioid use disorder care. In the context of individuals with opioid use disorder, Alaska's benchmark plan is the most limiting of all the benchmark plans reviewed by the Author.

The Author, who is trained in law and the medical humanities but not in epidemiology or public health, hopes this research is helpful to those who study the social determinants of health. To the extent a lack of health insurance coverage of opioid use disorder treatments and services is associated with a lack of access to health care and/or health itself, the coverage limitations

identified in this Article may be worthy of review and modification by relevant stakeholders and policymakers.

APPENDIX A
SECOND STATE BENCHMARK PLAN
LIMITATIONS ON OPIOID AND/OR
SUBSTANCE USE DISORDER COVERAGE

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
1. AL	Blue Cross and Blue Shield of Alabama: 320 Plan ¹⁹⁵	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics Opioid Analgesics, Short-acting: 14; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5). 2. <u>Inpatient Quantitative Service Limitation.</u> The plan covers up to 30 days per year for mental health disorders, detoxification, and rehabilitation (P.15). 3. <u>Outpatient Quantitative Treatment Limitation.</u> The plan covers up to 20 outpatient visits per calendar year for mental health and substance use disorder care. (P.16). 4. <u>EPS Exclusions.</u> The plan contains an exclusion for patients who care is coordinated by an Expanded Psychiatric Service (EPS) for “Services related to narcotic maintenance therapy such as methadone maintenance therapy” and

195. See BLUE CROSS BLUE SHIELD OF ALA., *supra* note 141; CTRS. FOR MEDICARE & MEDICAID SERVS., ALABAMA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_AL-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>care provided in a residential psychiatric facility. (P.15).</p> <p>5. <u>Non-EPS Exclusion</u>. The plan contains an exclusion for patients whose care is not coordinated by an EPS for “Services or supplies furnished by a substance abuse facility (including a substance abuse residential treatment facility).” (P.16).</p>
2. AK	Premera Blue Cross Blue Shield of Alaska: Alaska Heritage Select Envoy ¹⁹⁶	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 12; (2) Analgesics Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 1; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.7).</p> <p>2. <u>Definition of Chemical Dependency</u>. The plan defines chemical dependency as “an illness characterized by physiological or psychological dependency, or both, on alcohol or a state-regulated controlled substance.” (P.53).</p> <p>3. <u>General Chemical Dependency Exclusion</u>. The plan excludes “chemical dependency services and supplies related to the diagnosis or treatment of chemical dependency,” “treatment of non-dependent alcohol or drug use or abuse,”</p>

196. See CTRS. FOR MEDICARE & MEDICAID SERVS., ALASKA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_AK.zip (last visited Mar. 14, 2019); PREMERA BLUE CROSS BLUE SHIELD OF ALASKA, *supra* note 183.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>and “voluntary support groups, such as Alanon or Alcoholics Anonymous.” (P.28).</p> <p>4. <u>Emergency Room Coverage Exclusion.</u> The plan’s emergency room care benefit does not cover treatment of chemical dependency other than “medically necessary detoxification services.” (P.12).</p> <p>5. <u>Inpatient Hospital Coverage Exclusion.</u> The plan’s inpatient hospital care benefit does not cover “the treatment of chemical dependency” other than “medically necessary detoxification services.” (P.13).</p> <p>6. <u>Opioid Dependence and Opioid Abuse Exclusion.</u> The plan excludes coverage of “diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.” The DSM-IV, which is the edition referenced in the plan, codes opioid dependence as 304 and opioid abuse as 305.5. (P.30, 56).</p>
3. AZ	The State of Arizona: EPO Employee Health Plan ¹⁹⁷	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 14; (2) Analgesics Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 3; (4) Anti-Addiction: Substance Abuse</p>

197. *See* BENEFIT OPTIONS, EPO PLAN (2014), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_AZ-4816.zip (last visited Mar. 14, 2019); CTRS. FOR MEDICARE & MEDICAID SERVS., ARIZONA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_AZ-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.13).</p> <p>2. <u>Pre-Certification Required for Inpatient Care</u>. The plan requires pre-certification for inpatient mental health and substance abuse services. (P.19).</p> <p>3. <u>Exclusions</u>. The plan excludes coverage of the following mental health and substance abuse services: (1) any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically appropriate and otherwise covered under the plan; (2) treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain; (3) treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice; and (4) biofeedback for reasons other than pain management. (P.55).</p>
4. AR	HMO Partners, Inc.: Small Group Gold 1001-1 ¹⁹⁸	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 5; (2) Analgesics Opioid Analgesics, Short-acting: 11; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse</p>

198. See CTRS. FOR MEDICARE & MEDICAID SERVS., ARKANSAS 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCHIO/Resources/Data-Resources/Downloads/Arkansas-BMP.zip> (last visited Mar. 14, 2019); HEALTH ADVANTAGE, *supra* note 177.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.6).</p> <p>2. <u>Prior Approval</u>. “Coverage for many Health Interventions for the treatment of Mental Illness and Substance Abuse are subject to Prior Approval from the Company.” (P.17).</p> <p>3. <u>Exclusion for Abuse of Medications</u>. “Medications, drugs or substances used in an abusive, destructive or injurious manner are not covered, except when caused by a mental or physical illness.” (P.30).</p> <p>4. <u>Exclusion for Medications Used to Sustain or Support Addiction</u>. “Medications used to sustain or support an addiction or substance dependency are not covered.” (P.37).</p> <p>5. <u>Exclusion for Neurofeedback</u>. The plan excludes neurofeedback, including for drug addiction. (P.35).</p>
5. CA	Kaiser Foundation Health Plan, Inc.: Small Group HMO ¹⁹⁹	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 3; (2) Analgesics Opioid Analgesics, Short-acting: 7; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 1; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.6).</p>

199. See CTRS. FOR MEDICARE & MEDICAID SERVS., CALIFORNIA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_CA.zip (last visited Mar. 14, 2019); KAISER FOUND. HEALTH PLAN, *supra* note 133.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
6. CO	Kaiser Foundation Health Plan of Colorado: State Employee Health Plan ²⁰⁰	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 3; (2) Analgesics Opioid Analgesics, Short-acting: 7; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 1; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.11). 2. <u>Referral Required for Residential Rehabilitation and Outpatient Services.</u> Residential rehabilitation and outpatient services require a referral by a Plan physician. (P.9). 3. <u>Chemical Dependency Services Exclusion.</u> The plan excludes “[chemical dependency] Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.” (P.9). 4. <u>Unique Statement.</u> “Members who are disruptive or abusive may have their membership terminated for cause.” (P.9). 5. <u>Pre-Approval for Chemical Dependency Inpatient Services and Partial Hospitalization.</u> “We cover inpatient services and partial hospitalization in a residential rehabilitation program approved by Kaiser Permanente for the

200. See CTRS. FOR MEDICARE & MEDICAID SERVS., COLORADO 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_CO-4816.zip (last visited Mar. 14, 2019); KAISER FOUND. HEALTH PLAN OF COLO., EVIDENCE OF COVERAGE (2013), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_CO-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		treatment of alcoholism, drug abuse or drug addiction.” (P.9).
7. CT	ConnectiCare Insurance Company, Inc.: ConnectiCare Flex POS Plan ²⁰¹	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5). 2. <u>Pre-authorization Required for Outpatient Visits</u>. “Pre-Authorization is required for some outpatient treatment for mental health and alcohol and substance abuse services, including office visits, subsequent to an evaluation.” (P.34). Pre-authorization is specifically required for “outpatient treatment of opioid dependence” (P.82), but not other substance use disorders. 3. <u>Supportive Counseling Exclusion</u>. “Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).” (P.55).
8. DE	Highmark Blue Cross Blue Shield Delaware, Inc.:	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-

201. See CTRS. FOR MEDICARE & MEDICAID SERVS., CONNECTICUT 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_CO-4816.zip (last visited Mar. 14, 2019); CONNECTICARE INS. CO., *supra* note 147.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
	Small Group Health Plan Shared Cost EPO \$2000/100 Plan ²⁰²	<p>acting: 11; (2) Analgesics Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5).</p> <p>2. <u>Behavioral Health Facility Exclusion.</u> The plan excludes from coverage “[c]ertain mental health and substance abuse services, including . . . care at behavioral health facilities.” (P.45).</p> <p>3. <u>Exclusion for Places Solely for Drug Addiction or Alcoholism.</u> The plan excludes from the definition of hospital care (and most inpatient hospital care is covered) care delivered in “places solely for care of drug addiction or alcoholism.” (P.73). It is not clear whether care for drug addiction is covered under a separate provision.</p> <p>4. <u>Methadone Exclusion.</u> The plan excludes methadone from coverage. (P.45).</p>
9. DC	Group Hospitalization and Medical Services, Inc.: Blue Preferred PPO \$1,000 – 100%/80% ²⁰³	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics Opioid Analgesics, Short-acting: 12; (3) Anti-</p>

202. See CTRS. FOR MEDICARE & MEDICAID SERVS., DELAWARE 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_DE-4816.zip (last visited Mar. 14, 2019); HIGHMARK BLUE CROSS BLUE SHIELD DEL., *supra* note 178.

203. See CTRS. FOR MEDICARE & MEDICAID SERVS., DISTRICT OF COLUMBIA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/BMP-Summary_DC-4816.zip (last visited Mar. 14, 2019); GROUP HOSPITALIZATION & MED. SERVS., *supra* note 142.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5).</p> <p>2. <u>Pre-Authorization Required for Hospital Admissions</u>. “Hospital admissions must be authorized or approved by the Mental Health and Substance Abuse Management Program.” (Pgs. B-30, B-50).</p> <p>3. <u>Outpatient Exclusions</u>: “Outpatient Mental Health and Substance Abuse Coverage is not provided for: (A) Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director; (B) Intellectual disability, after diagnosis; (C) Psychoanalysis.” (P.B-62).</p> <p>4. <u>Inpatient Exclusions</u>. “Inpatient Mental Health and Substance Abuse Coverage is not provided for: (A) Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director; (B) Custodial Care; (C) Admissions solely for observation or isolation.” (P.B-62).</p>
10. FL	Blue Cross and Blue Shield of Florida: BlueOptions 5462 ²⁰⁴	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-</p>

204. See BLUE CROSS BLUE SHIELD OF FLA., *supra* note 160; CTRS. FOR MEDICARE & MEDICAID SERVS., FLORIDA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_FL-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>acting: 10; (2) Analgesics Opioid Analgesics, Short-acting: 13; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5).</p> <p>2. <u>Exclusion</u>. “Expenses for prolonged care and treatment of Substance Dependency in a specialized inpatient or residential treatment facility or inpatient confinements that are primarily intended as a change of environment are excluded.” (P.2-15).</p> <p>3. <u>Default Exclusion</u>. “All Inpatient Rehabilitation Services for Substance Dependency, drug and alcohol related diagnoses (except as otherwise covered in the Substance Dependency category), Pain Management, and respiratory ventilator management Services are excluded.”</p> <p>4. <u>Prior Authorization Required</u>. “You or your Physician will be required to obtain prior coverage authorization from us for Mental Health and Substance Dependency Care and Treatment Services.” (Endorsement at P.2).</p> <p>5. <u>Other Exclusions</u>. An amendment to the plan also excludes the following: “Services for court-ordered care or testing, or required as a condition of parole or probation; . . . inpatient stays that are primarily intended as a change of environment; and inpatient (overnight) mental health services received in a residential treatment facility.” (Endorsement at P.1–2).</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
11. GA	Humana Employers Health Plan of Georgia, Inc.: Georgia HMO Premier 14, Copay Option 22 ²⁰⁵	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.4).
12. HI	Hawaii Medical Service Association: Preferred Provider Plan 2010 ²⁰⁶	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.4). 2. <u>Pre-Certification Required for Residential Care Facilities Outside Hawaii</u> . (P.46).
13. ID	Blue Cross of Idaho Health Service, Inc.:	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug

205. See CTRS. FOR MEDICARE & MEDICAID SERVS., GEORGIA 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/GA-BMP.zip> (last visited Mar. 14, 2019); HUMANA EMP. HEALTH PLAN OF GA., *supra* note 143.

206. See CTRS. FOR MEDICARE & MEDICAID SERVS., HAWAII 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_HI-4816.zip (last visited Mar. 14, 2019); HMSA BLUE CROSS BLUE SHIELD OF HAW., GUIDE TO BENEFITS: PREFERRED PROVIDER PLAN 2010 https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_HI-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
	Preferred Blue PPO Small Group ²⁰⁷	<p>category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 9; (2) Analgesics Opioid Analgesics, Short-acting: 13; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.6).</p> <p>2. <u>Prior Authorization Required for Certain Mental Health and Substance Use Disorder Services.</u> Prior authorization is required for the following mental health and substance abuse services: outpatient Psychotherapy services after the tenth (10th) visit (does not include medication management services); intensive Outpatient Program (IOP); partial hospitalization program (PHP); residential treatment program; psychological testing/neuropsychological evaluation testing; electroconvulsive therapy (ECT) (8).</p> <p>3. <u>Non-Emergency Pre-Admission Notification Required for Inpatient Admissions.</u> The plan requires the insured to pre-notify the plan of non-emergency, inpatient admissions, including those to a general hospital, an alcohol or substance abuse treatment facility, a psychiatric hospital, or any other facility. (P.4).</p>

207. See BLUE CROSS OF IDAHO, *supra* note 48; CTRS. FOR MEDICARE & MEDICAID SERVS., IDAHO 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_ID.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
14A. IL (2017- 2019)	Blue Cross Blue Shield of Illinois: Blue PPO Gold 011 ²⁰⁸	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5).</p> <p>2. <u>Pre-authorization Required for “Maximum Benefits.”</u> “In order to receive maximum benefits under this Certificate, you must Preauthorize your [inpatient and outpatient services] for treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit.” (Pgs. 39–40).</p>
14B. IL (2020)	Illinois Access to Care and Treatment Plan ²⁰⁹	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>: The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics Opioid Analgesics, Short-acting: 14; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 4; (4) Anti-Addiction: Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.7).</p>

208. See BLUECROSS BLUESHIELD OF ILL., PARTICIPATING PROVIDER OPTION, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/IL-BMP.zip> (last visited Mar. 14, 2019); Illinois Second Benchmark Plan, *supra* note 119.

209. See CTRS. FOR MEDICARE & MEDICAID SERVS., ILLINOIS EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020-BPM-IL.zip> (last visited Mar. 14, 2019); Ill. Third Benchmark Plan, *supra* note 112.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>2. <u>Four New Opioid-Specific Provisions.</u> The Illinois Access to Care and Treatment Plan contains four new opioid-specific provisions when compared to the state's Second Benchmark Plan, in effect from 2017–2019. These provisions: (1) limit opioid prescriptions for acute pain to no more than 7 days (“Short-term opioid prescriptions for acute pain will be provided for no more than 7 days.”); (2) remove barriers to prescribing Buprenorphine or brand equivalent products for medication assisted treatment of opioid use disorder through prohibition on prior authorization, dispensing limits, and fail first policies for Buprenorphine or brand equivalent products for medication assisted treatment of opioid use disorder (“Benefits for Buprenorphine products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder shall not include prior authorization, dispensing limits, fail first policies, or lifetime limit requirements.”); (3) provide for coverage of at least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher (“Benefits will be provided for at least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50 MME or higher.”); and (4) provide coverage for tele-psychiatry. (Summary at Pgs. 6; 21, 31, 32).</p>
15. IN	Anthem Insurance Companies, Inc.:	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
	Legacy PPO, Blue 6.0 Blue Access PPO Option 14, Rx G ²¹⁰	category and class counts: (1) Opioid Analgesics, Long-acting: 14; (2) Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 3; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.6).
16. IA	Wellmark, Inc.: CompleteBlue 2000 ²¹¹	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 5; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5). 2. <u>Residential Treatment Facility Limitation.</u> The plan contains a limitation for chemical dependency services provided in a residential treatment facility; that is, such services are covered only when provided “on an intensive outpatient basis, or for partial hospitalization treatment, or for treatment that is provided as an inpatient at an acute level of care requiring medically monitored 24-hour registered nursing care under the supervision of a medical director.” (P.15).

210. See ANTHEM BLUECROSS BLUESHIELD, *supra* note 46; CTRS. FOR MEDICARE & MEDICAID SERVS., INDIANA 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/IN-BMP.zip> (last visited Mar. 14, 2019).

211. See CTRS. FOR MEDICARE & MEDICAID SERVS., IOWA 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_IA.zip (last visited Mar. 14, 2019); WELLMARK IOWA, *supra* note 169.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
17. KS	Blue Cross and Blue Shield of Kansas, Inc.: Comprehensive Major Medical - Blue Choice ²¹²	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 10; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.8).
18. KY	UnitedHealthcare of Kentucky, Ltd.: Choice Plus ²¹³	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 11; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5). 2. <u>Exclusion for Certain Substance Use Disorder Services</u> . The plan excludes the following substance use disorder services: (1) Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; (2) Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine,

212. See BLUE CROSS BLUE SHIELD OF KAN., *supra* note 136; CTRS. FOR MEDICARE & MEDICAID SERVS., KANSAS 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_KS-4816.zip (last visited Mar. 14, 2019).

213. See CTRS. FOR MEDICARE & MEDICAID SERVS., KENTUCKY 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/KY-BMP.zip> (last visited Mar. 14, 2019); UNITEDHEALTHCARE OF KY., *supra* note 50.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>or their equivalents; (3) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; (4) Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following: (a) Not consistent with generally accepted standards of medical practice for the treatment of such conditions; (b) Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; (c) Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time; and (d) Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks."</p> <p>3. <u>Requirement of a Mental Health/Substance Use Disorder Designee.</u> The plan requires an organization or individual called a Mental Health/Substance Use Disorder Designee that is designated by the plan to provide or arrange for mental health and substance use disorder services (and to determine coverage) under the policy. (P.15).</p>
19. LA	Louisiana Health Service & Indemnity Company:	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
	GroupCare PPO Plan, Copay 80/60 \$1,000 ²¹⁴	category and class counts: (1) Opioid Analgesics, Long-acting: 10; (2) Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5). 2. <u>Pre-Authorization Required for Inpatient Treatment of Substance Use Disorder.</u> “Inpatient treatment for substance abuse must be Authorized as provided in the Care Management Article of this Benefit Plan, when coverage for alcohol and/or drug abuse is provided.” (P.33).
20. ME	Anthem Health Plans of Maine (Anthem BCBS): PPO Off Exchange, Blue Choice, \$30.00, \$2,500 Deductible ²¹⁵	1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 14; (2) Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 3; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at 5). 2. <u>Prior Authorization Required for Inpatient Substance Abuse Treatment.</u> “Authorization for Inpatient Mental Health and Substance Abuse services

214. See BLUECROSS BLUESHIELD OF LA., *supra* note 49; CTRS. FOR MEDICARE & MEDICAID SERVS., LOUISIANA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_LA-4816.zip (last visited Mar. 14, 2019).

215. See ANTHEM BLUECROSS BLUESHIELD, *supra* note 47; CTRS. FOR MEDICARE & MEDICAID SERVS., MAINE 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_ME.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		must be obtained through the behavioral health care manager.” (P.14).
21. MD	CareFirst BlueChoice, Inc.: BlueChoice HMO HSA/HRA \$1,500 ²¹⁶	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 10; (2) Opioid Analgesics, Short-acting: 2; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at 6). 2. <u>Prior Authorization Required for Coverage of Inpatient Hospital Admissions for Mental Health and Substance Use Disorder Services</u>. “Hospital admissions must be authorized or approved by the Mental Health and Substance Abuse Management Program. Prior authorization will be obtained by contracting providers.” (P.B-30).
22. MA	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.: HMO Blue New England Deductible \$2,000 ²¹⁷	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 14; (2) Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments:

216. See CAREFIRST BLUECHOICE, *supra* note 158; CTRS. FOR MEDICARE & MEDICAID SERVS., MARYLAND 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/MD-BMP.zip> (last visited Mar. 14, 2019).

217. See BLUE CROSS BLUE SHIELD OF MASS., *supra* note 137; CTRS. FOR MEDICARE & MEDICAID SERVS., MASSACHUSETTS 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MA_4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>3; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at 5).</p> <p>2. <u>Prior Authorization Required for Coverage of Methadone.</u> (P.15).</p> <p>3. <u>Prior Authorization Required for Inpatient Mental Health Services.</u> “To receive coverage for inpatient services for a mental condition, you and your mental health provider must receive approval from Blue Cross Blue Shield HMO Blue as outlined in this Subscriber Certificate before you enter a general or mental hospital or substance abuse treatment facility for inpatient care.” (P.45).</p> <p>4. <u>Exclusion for Wilderness and Similar Therapies.</u> The plan excludes from covered mental health and substance abuse services that “are performed in educational, vocational, or recreational settings; and ‘outward bound-type,’ ‘wilderness,’ ‘camp,’ or ‘ranch’ programs.” (P.45).</p>
23. MI	PriorityHealth: PriorityHMO ²¹⁸	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 12; (2) Opioid Analgesics, Short-acting: 13; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 3; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.4).</p>

218. See CTRS. FOR MEDICARE & MEDICAID SERVS., MICHIGAN 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/files/CCIIO/2017_benchmark_summary_mi_033117.zip (last visited Mar. 14, 2019); PRIORITYHEALTH, *supra* note 161.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>2. <u>Prior Approval Required for Inpatient Substance Abuse Services.</u> “Inpatient substance abuse services (including partial hospitalization) require Prior Approval from our Behavioral Health Department, except in a Medical Emergency.” (P.27).</p> <p>3. <u>Other Exclusions.</u> “Care provided in a home, residential or institutional facility, or other facility on a temporary or permanent basis is not Covered, including the costs of living and being cared for in . . . transitional living centers, non-licensed programs, or therapeutic boarding schools . . . [and] costs for care that is . . . custodial, designed to keep you from continuing unhealthy activities or typically provided by community mental health services programs.” (P.26).</p>
24. MN	HealthPartners, Inc.: Small Group Product 2, HLPT-129123512 ²¹⁹	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 4; (2) Opioid Analgesics, Short-acting: 7; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 1; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.4).</p> <p>2. <u>Exclusion for Professional Services Associated with Substance Abuse Intervention.</u> The plan excludes professional services associated with</p>

219. See CTRS. FOR MEDICARE & MEDICAID SERVS., MINNESOTA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCHIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MN.zip (last visited Mar. 14, 2019); HEALTHPARTNERS, *supra* note 162.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>substance abuse interventions. The plan defines a substance abuse intervention as a gathering of family and/or friends to encourage a person covered under this contract to seek substance abuse treatment. (GMC at P.14).</p> <p>3. <u>Exclusion for Halfway Houses and Similar Facilities.</u> The plan excludes coverage of care provided in halfway houses, extended care facilities, and residential treatment facilities. (BC at P.8).</p>
25. MS	Blue Cross Blue Shield of Mississippi: Network Blue ²²⁰	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 8; (2) Opioid Analgesics, Short-acting: 13; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5).</p> <p>2. <u>Prior Authorization Required for Substance Abuse Benefits.</u> “No Benefits will be provided unless Provider receives Prior Authorization from Company.” (P.53).</p> <p>3. <u>Exclusion for Certain Illnesses and Injuries.</u> “Benefits will not be provided for the following: illness or injury which is caused by the Member’s use or possession of any drug or other</p>

220. See BLUE CROSS & BLUE SHIELD OF MISS., *supra* note 188; CTRS. FOR MEDICARE & MEDICAID SERVS., MISSISSIPPI 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MS-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>controlled substance which Member does not lawfully possess.” (P.66).</p> <p>4. <u>Quantitative Treatment Limitation for Inpatient Drug Abuse Services.</u> The plan establishes a quantitative treatment limitation for inpatient drug abuse services of seven (7) days per year. (P.13).</p> <p>5. <u>Quantitative Treatment Limitation for Outpatient Drug Abuse Services.</u> The plan establishes a quantitative treatment limitation for outpatient drug abuse services of twenty (20) days per year. (P.13).</p> <p>6. <u>Quantitative Financial Requirement for Drug Abuse Services.</u> “Coinsurance for Covered Services incurred for the treatment of alcohol abuse, drug abuse and Temporomandibular/Craniomandibular Joint Disorder cannot be used toward satisfying the Medical Out-of-pocket of this Benefit Plan. Once the Medical Out-of-pocket amount has been satisfied, Company will not pay 100% of the Allowable Charges for services incurred for treatment and care of alcohol abuse, drug abuse and Temporomandibular/Craniomandibular Joint Disorder.” (P.36).</p>
26. MO	Healthy Alliance Life Co. (Anthem BCBS): PPO On Exchange ²²¹	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid</p>

221. See ANTHEM BLUECROSS BLUESHIELD, *supra* note 124; CTRS. FOR MEDICARE & MEDICAID SERVS., MISSOURI 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_MO_revised%20508.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		Analgesics, Long-acting: 11; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5).
27. MT	Blue Cross and Blue Shield of Montana: Blue Preferred Gold PPO 007 ²²²	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 10; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.6).
28. NE	Blue Cross and Blue Shield of Nebraska: SG BCBSNE 2 Tier (Blue Pride Plus), Blue Pride Plus Option 102 Gold ²²³	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 10; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5).

222. See BLUECROSS BLUESHIELD OF MONT., *supra* note 140; CTRS. FOR MEDICARE & MEDICAID SERVS., MONTANA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_MT.zip (last visited Mar. 14, 2019).

223. See BLUE CROSS BLUE SHIELD OF NEB., *supra* note 163; CTRS. FOR MEDICARE & MEDICAID SERVS., NEBRASKA 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NE-BMP.zip> (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<ol style="list-style-type: none"> 2. <u>Pre-Certification Required for Inpatient Substance Use Disorder Services.</u> The plan states that Inpatient Services for Mental Illness or Substance Dependence and Abuse must be Certified by BCBSNE. (P.17). 3. <u>Exclusion for Residential Treatment Programs.</u> The plan excludes mental health and substance use disorder care provided in a residential treatment program. (P.28). 4. <u>Exclusion from the Definition of Outpatient Program.</u> The plan excludes from the definition of Outpatient Program “Residential Treatment Programs or day rehabilitation programs for Mental Illness, or Residential Treatment Programs, halfway house or methadone maintenance programs for Substance Dependence and Abuse.” (P.58).
29. NV	Health Plan of Nevada, Inc.: HPN Solutions HMO Platinum 15/0/90% ²²⁴	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 11; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5). 2. <u>Prior Authorization Required.</u> “All Inpatient and non-routine Outpatient

224. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 105, HEALTH PLAN OF NEV., HEALTH PLAN OF NEV., SMALL BUSINESS EVIDENCE OF COVERAGE (2014), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NV-BMP.zip> (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		non-Emergency Mental Health, Severe Mental Illness, and Substance Abuse Services, including Intensive outpatient program treatment, Outpatient electro-convulsive treatment, Psychological testing and Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management” require prior authorization and review. (Pgs. 12, 20).
30. NH	Anthem: Matthew Thornton Blue HMO ²²⁵	1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 11; (2) Opioid Analgesics, Short-acting: 14; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5).
31. NJ	Horizon Healthcare Services, Inc.: Advantage EPO Silver 100/50 ²²⁶	1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 10; (2) Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse

225. See ANTHEM BLUECROSS BLUESHIELD, GUIDED ACCESS CERTIFICATE OF COVERAGE (2014), https://downloads.cms.gov/ccio/2017%20Benchmark%20Summary_NH.zip (last visited Mar. 14, 2019); CTRS. FOR MEDICARE & MEDICAID SERVS., NEW HAMPSHIRE 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/ccio/2017%20Benchmark%20Summary_NH.zip (last visited Mar. 14, 2019).

226. See CTRS. FOR MEDICARE & MEDICAID SERVS., NEW JERSEY 2017 EHB BENCHMARK PLAN, <https://downloads.cms.gov/ccio/bmp-summary-nj.zip> (last visited Mar. 14, 2019); HORIZON BLUE CROSS BLUE SHIELD OF N.J., *supra* note 138.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		Treatment Agents: Opioid Reversal Agents: 1 (Summary at P.5).
32. NM	Presbyterian Health Plan, Inc.: Individual Silver C HMO ²²⁷	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Opioid Analgesics, Long-acting: 9; (2) Opioid Analgesics, Short acting: 10; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents Opioid Reversal Agents: 0 (Summary at P.5). 2. <u>Exclusions Applicable to Substance Use Disorders.</u> The plan contains exclusions for treatments in a halfway house, codependency, bereavement, pastoral/spiritual and sexual counseling, court-ordered treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, and any treatment for Alcoholism and/or Substance Abuse services after the maximum episodes of treatment allowed under this Agreement have been completed is not Covered. (P.78).
33. NY	Oxford Health Insurance, Inc.: Oxford EPO ²²⁸	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug

227. See CTRS. FOR MEDICARE & MEDICAID SERVS., NEW MEXICO 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_NM-4816.zip (last visited Mar. 14, 2019); PRESBYTERIAN HEALTH PLAN, SUBSCRIBER AGREEMENT AND GUIDE TO YOUR MANAGED CARE PLAN (2013), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_NM-4816.zip (last visited Mar. 14, 2019).

228. See CTRS. FOR MEDICARE & MEDICAID SERVS., NEW YORK 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NY-BMP.zip> (last visited Mar. 14, 2019); OXFORD HEALTH INS., CERTIFICATE OF COVERAGE (2014),

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>category and class counts: (1) Opioid Analgesics, Long-acting: 12; (2) Opioid Analgesics, Short-acting: 15; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5).</p> <p>2. <u>Outpatient Treatment Limitations</u>. The plan covers outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency; however, that coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>and/or substance use and/or dependency. (P.46).</p> <p>3. <u>Inpatient Treatment Limitations</u>. The plan covers inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. (P.46).</p> <p>4. <u>Quantitative Treatment Limitations for Family Counseling</u>. The plan covers up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.</p>
34. NC	Blue Cross and Blue Shield of North Carolina:	<p>1. <u>Quantitative Treatment Limitations Applicable to Prescription Opioids and Treatments for Opioid Use Disorder</u>.</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
	Blue Options PPO ²²⁹	<p>The plan establishes the following quantitative treatment limitations: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics: Opioid Analgesics, Short-acting: 14; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.6).</p> <p>2. <u>Prior Review Required</u>. “For mental health and substance abuse services, BCBSNC delegates the administration of these benefits to Magellan Behavioral Health, which is not associated with BCBSNC. You must contact Magellan Behavioral Health directly and request prior review for inpatient and certain outpatient services, except in emergencies.” (P.6).</p> <p>3. <u>Substance Use Disorder Exclusions</u>. The plan excludes counseling with relatives about a patient and inpatient confinements that are primarily intended as a change of environment. (P.33).</p>

229. See BLUECROSS BLUESHIELD OF N.C., BENEFIT BOOKLET FOR EMPLOYEES OF BLUE OPTIONS SMALL GROUP FOR BLUE OPTIONS (2012), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_NC.zip (last visited Mar. 14, 2019); CTRS. FOR MEDICARE & MEDICAID SERVS., NORTH CAROLINA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_NC.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
35. ND	Blue Cross Blue Shield of North Dakota: BlueCare Gold 90 500 ²³⁰	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1 (Summary at P.8). 2. <u>Preauthorization Required for Inpatient, Intensive Outpatient, and Residential Treatment for Substance Use Disorder Services.</u> (Pgs. 14, 34). 3. <u>Exclusions:</u> “No benefits are available for non-inpatient pharmacological detoxification management, Including Outpatient, Intensive Outpatient Program (IOP), Partial Hospitalization program (PHP) setting, or Residential Treatment detoxification.” (28). “No benefits are available for the Residential Treatment of substance abuse for Members age 21 and older.” (P.28).

230. See BLUE CROSS BLUE SHIELD OF N.D., *supra* note 164; CTRS. FOR MEDICARE & MEDICAID SERVS., NORTH DAKOTA 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ND-BMP.zip> (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
36. OH	Community Insurance Company (Anthem BCBS): Blue Access (PPO) - Standard Opt D55 ²³¹	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 14; (2) Analgesics: Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 3; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.14). 2. <u>Exclusions.</u> The plan excludes: • Custodial Care, convalescent care or rest cures; • Domiciliary care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included; • Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution; • Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if psychotherapy is

231. See ANTHEM BLUECROSS BLUESHIELD, HEALTH CERTIFICATE OF COVERAGE (2015), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_OH-4816.zip (last visited Mar. 14, 2019); CTRS. FOR MEDICARE & MEDICAID SERVS., OHIO 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_OH-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		included; and • Wilderness camps. (P. M-52).
37. OK	Blue Cross Blue Shield of Oklahoma: Blue Options PPO Gold 002 ²³²	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.6). 2. <u>Pre-authorization Required for Certain Substance Use Disorder Services</u>. All Inpatient services related to treatment of drug addiction and substance abuse or alcoholism must be Preauthorized by the Plan. Preauthorization is also required for the following Outpatient Psychiatric

232. See BLUECROSS BLUESHIELD OF OKLA., CERTIFICATE OF BENEFITS, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_OK-4816.zip (last visited Mar. 31, 2019); CTRS. FOR MEDICARE & MEDICAID SERVS., OKLAHOMA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-Benchmark-Summary_OK-4816.zip (last visited Mar. 31, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		Care Services: Psychological testing; Neuropsychological testing; Electroconvulsive therapy; and Intensive Outpatient Treatment. (Pgs. 5–6).
38. OR	PacificSource Health Plans: 3000+35/70% 0812 Tiered Value Rx 10/50/75 0812 ²³³	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics: Opioid Analgesics, Short-acting: 13; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents Opioid Reversal Agents: 1. (Summary at P.4). 2. <u>Prior Authorization for Inpatient Mental Health Services Required.</u> (P.29). 3. <u>Limitations and Exclusions Applicable to Chemical Dependency Services.</u> (1) “Benefits for long-term residential mental health programs exceeding 45 days of treatment per calendar year will not be authorized”; (2) A second opinion may be required for a medical necessity determination. Pacific Source will notify

233. See CTRS. FOR MEDICARE & MEDICAID SERVS., OREGON 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_OR.zip (last visited Mar. 14, 2019); PACIFICSOURCE HEALTH PLANS, *supra* note 171.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>the patient when this requirement is applicable; (3) Pacific Source must be notified of an emergency admission within two business days; (4) treatment of substance abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine. (Pgs. 19–20).</p> <p>4. <u>Exclusions Applicable to Mental Health Services</u>. (1) Court-ordered screening interviews or drug or alcohol treatment programs; (2) Marital/partner counseling; and (3) Support groups (P.28).</p>
39. PA	Keystone Health Plan East, Inc.: Keystone Gold Premier HMO ²³⁴	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.6).</p> <p>2. <u>Pre-Approval Required for IOP and PHP Services</u>. “All Intensive Outpatient Program and Partial Hospitalization services must be approved by the Health Benefit Plan.” (P.33).</p> <p>3. <u>Exclusions Applicable to Mental Health Care</u>. “For any Mental Health Care,</p>

234. See CTRS. FOR MEDICARE & MEDICAID SERVS., PENNSYLVANIA 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/PA-BMP.zip> (last visited Mar. 31, 2019); INDEPENDENCE BLUE CROSS, WELCOME KIT, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/PA-BMP.zip> (last visited Mar. 31, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>Serious Mental Illness Health Care, or Alcohol or Drug Abuse And Dependency modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as: Alternative Therapies/Complementary Medicine and obesity control therapy except as otherwise provided in this Program; Non-medical services, such as vocational rehabilitation or employment counseling, for the treatment of Alcohol or Drug Abuse and Dependency in an acute care Hospital.” (P.70).</p>
40. RI	<p>Blue Cross Blue Shield of Rhode Island: VantageBlue 100/60 1500/3000 RX 3/12/35/60/100 WOPD²³⁵</p>	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics Opioid Analgesics, Long-acting: 10; (2) Analgesics: Opioid Analgesics, Short-acting: 15; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.4). 2. <u>Exclusion for Methadone Clinics and Methadone Treatments</u>. “This agreement does NOT cover methadone clinics and treatments.” (P.26). “Methadone dispensed to treat chemical dependency is NOT covered.” (P.81).

235. See BLUE CROSS BLUE SHIELD OF R.I., *supra* note 165; CTRS. FOR MEDICARE & MEDICAID SERVS., RHODE ISLAND 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/RI-BMP.zip> (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions <i>(and Limitations Thereto)</i>
		<p>3. <u>Pharmacy Limitation.</u> “We may limit your selection of a pharmacy to one (1) network pharmacy. Those members subject to this restriction include, but are not limited to, members that have a history of: being prescribed prescription drugs by multiple physicians; having prescriptions drugs filled at multiple pharmacies; being prescribed certain long acting opioids and other controlled substances, either in combination or separately, that suggests a need for monitoring due to: quantities dispensed; daily dosage range; or the duration of therapy exceeds reasonable and established thresholds.” (Pgs. 57–58).</p> <p>4. <u>Substance Use Disorder Exclusions.</u> “This agreement does NOT cover the following substance abuse treatment services: Recreation therapy, non-medical self-care, or self-help training (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA) meetings/services); Telephone consultations (See Section 4.16); Therapeutic recreation programs, extended stay/long term residential or wilderness programs; services provided in any covered program that are reviewed by us and we decide are recreation therapy programs, wilderness programs, educational programs, complimentary programs, or non-clinical services (examples of services that are not covered include, but is not limited to, Tai Chi, yoga, personal training, meditation, and internet based support/education); Computer based/internet /social media services and/or programs. This agreement does NOT cover substance abuse treatment</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>when: the provider does NOT meet our eligibility and/or credentialing requirements; the program is not approved by us for benefit coverage; or treatment is rendered at facilities that are not approved and/or licensed by the state in which the facility is located. This agreement does NOT cover methadone clinics and treatments.” (Pgs. 26–27).</p>
41. SC	Blue Cross and Blue Shield of South Carolina: Business Blue Complete ²³⁶	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 14; (2) Analgesics Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 3; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5). 2. <u>Preauthorization Required for Inpatient and Outpatient Substance Use Disorder Care</u>. “Preauthorization for Mental Health Services and Substance Abuse care – Companion Benefit Alternatives, Inc. (CBA) must preapprove any inpatient or outpatient treatment for Mental Health Services and Substance Abuse care. When Approval isn’t

236. See BLUECROSS BLUESHIELD OF S.C., *supra* note 166; CTRS. FOR MEDICARE & MEDICAID SERVS., SOUTH CAROLINA 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_SC-4816.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>obtained for inpatient Mental Health Services and Substance Abuse care, we'll deny covered charges for room and board. If a Preferred Blue Hospital doesn't get Approval for you, it can't bill you for room and board charges. When Approval isn't obtained for outpatient Mental Health Services and Substance Abuse care, we'll reduce Benefits as shown in your Schedule of Benefits. If a Preferred Blue Provider doesn't get Approval for you, it can't bill you for the reduction. An All Other Provider, however, can bill you for the penalty." (P.12).</p> <p>3. <u>Exclusions.</u> The plan does not cover: "Sanitarium care or rest cures; long-term, residential care for the treatment of Mental Health Services or Substance Abuse care; and custodial care or domiciliary care (care meant simply to help those who can't care for themselves, such as, but not limited to, help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not require continuous attention of trained Medical Personnel)." (P.31).</p> <p>4. <u>Financial Limitation on Substance Use Disorder Care.</u> "Coinsurance on Mental Health Services, Substance Abuse care and Spinal Subluxation Services do not apply toward your Out-of-pocket Maximums. These services will be paid as shown in your Schedule of Benefits regardless of Out-of-pocket Maximums." (P.19). "Except for claims for Mental Health Services, Substance</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>Abuse care and Spinal Subluxation Services (if shown in your Schedule of Benefits), there is a limit to the amount of Coinsurance you must pay each Benefit Period if shown in your Schedule of Benefits for Preferred Blue Providers and All Other Providers. This is called your Out-of-pocket Maximum. It protects you from having to spend large sums of your own money on health care. Once you reach the Out-of-pocket Maximum if shown in your Schedule of Benefits, claims for covered services (except for Mental Health Services, Substance Abuse care and Spinal Subluxation Services (if shown in your Schedule of Benefits)) are paid at the amount shown in the Out-of-pocket Expenses section of your Schedule of Benefits for the rest of the Benefit Period.” (P.7).</p>
42. SD	Wellmark of South Dakota: Blue Select Primary PCP/NonPCP Copay Plan ²³⁷	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics: Opioid Analgesics, Short-acting: 14; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 1; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P5).</p>

237. See *WELLMARK S.D.*, *supra* note 170; CTRS. FOR MEDICARE & MEDICAID SERVS., SOUTH DAKOTA 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_SD.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>2. <u>Quantitative Treatment Limitation Applicable to Inpatient Chemical Dependency Services</u>. The plan covers thirty (30) days per benefit year of inpatient chemical dependency services (although an exception exists for alcoholism, in which case there is no limitation) (P.10).</p> <p>3. <u>Residential Treatment Facility Limitation</u>. “For treatment in a residential treatment facility, benefits are available only if treatment is provided as an inpatient at an acute level of care with 24-hour registered nursing care under the supervision of a medical director.” (Pgs. 15–16).</p>
43. TN	BlueCross BlueShield of Tennessee: Small Group Shop HDHP, SG Gold 13S ²³⁸	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5).</p> <p>2. <u>Prior Authorization Required for Inpatient Substance Use Disorder Treatments</u>. “IMPORTANT NOTE: All inpatient treatment (including Acute, residential, and partial hospitalization</p>

238. See BLUECROSS BLUESHIELD OF TENN., EVIDENCE OF COVERAGE (2013), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017_Benchmark-Summary_TN.zip (last visited Mar. 14, 2019); CTRS. FOR MEDICARE & MEDICAID SERVS., TENNESSEE 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017_Benchmark-Summary_TN.zip (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>and intensive outpatient treatment) requires Prior Authorization. If You receive inpatient treatment, including treatment for substance abuse, that did not receive Prior Authorization, and You sign a Provider's waiver stating that You will be responsible for the cost of the treatment, You will not receive Plan benefits for the treatment. You will be financially responsible, according to the terms of the waiver." (P.54).</p> <p>3. <u>Exclusion for Court-Ordered Treatment.</u> The plan does not cover: "Court ordered examinations and treatment, unless Medically Necessary." (P.55).</p>
44. TX	Blue Cross Blue Shield of Texas: Blue Choice PPO RSH3 ²³⁹	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5).</p> <p>2. <u>Preauthorization Required for Certain Treatments of Chemical Dependency.</u> "Preauthorization is required [for [certain] treatment of chemical dependency." (Pgs. 3, 14, 15, and Amendment).</p>

239. See BLUE CROSS BLUE SHIELD OF TEX., *supra* note 167; CTRS. FOR MEDICARE & MEDICAID SERVS., TEXAS 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/TX-BMP.zip> (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>3. <u>Facility Limitation for Inpatient Treatment of Chemical Dependency.</u> “Inpatient treatment must be provided in a Chemical Dependency Treatment Center.” (P.3)</p> <p>4. <u>Quantitative Treatment Limitation for Treatment of Chemical Dependency.</u> “Three separate series of treatments for each covered individual per lifetime.” (P.3). “Coverage for treatment of Chemical Dependency will be limited to a maximum of three separate series of treatments for each covered individual.” (P.30).</p> <p>5. <u>Residential Level of Treatment Exclusion.</u> The plan does not cover “Residential level of treatment for Chemical Dependency in a Chemical Dependency Treatment Center.” (P.48); “Residential level of treatment for Chemical Dependency in a Chemical Dependency Treatment Center.” (P.48).</p>
45. UT	Public Employees Health Program (PEHP): Utah Basic Plus Plan ²⁴⁰	<p>1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 8; (2) Analgesics: Opioid Analgesics, Short-acting: 14; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5).</p>

240. See CTRS. FOR MEDICARE & MEDICAID SERVS., UTAH 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP->

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>2. <u>Preauthorization Required for all Inpatient Mental Health Admissions.</u> (P.41).</p> <p>3. <u>Substance Use Disorder Limitations.</u> The plan establishes the following limitations applicable to treatment of substance use disorders: “(1) Benefits for group family counseling will be payable under Mental Health for the primary patient. Benefits will not be considered separate for each individual family Member; (2) When an inpatient stay spans an old and new plan year, hospital benefits will be based on the old plan year provisions. Actual number of days used, however, will apply to specific plan years; (3) Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed; (4) Only one visit per Provider of the same specialty per day is payable.” (P.32).</p> <p>4. <u>Mental Health Exclusions.</u> The plan establishes the following exclusions applicable to mental health conditions: “1. Inpatient treatment for Mental Health without Pre-authorization, if required by the Member’s plan; 2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances;</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>3. mental or emotional conditions without manifest psychiatric disorder or non-specific conditions; 4. Wilderness programs; 5. Inpatient treatment for behavior modification, enuresis, or encopresis; 6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations; 7. Occupational or recreational therapy; 8. Hospital leave of absence charges; 9. Sodium amobarbital interviews; 10. Residential treatment programs; 11. Tobacco abuse; 12. Routine drug screening, except when ordered by a treating physician.” (P.32).</p>
46. VT	The Vermont Health Plan, LLC: HMO Silver CDHP Plan ²⁴¹	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.4). 2. <u>Prior Approval Required for Inpatient, Partial-Inpatient, Intensive Outpatient, and Residential Treatment Substance Use Disorder Benefits</u>. (P.2). 3. <u>Least Restrictive Setting Requirement</u>. “We Cover substance abuse treatment

241. See BLUECROSS BLUESHIELD OF VT., *supra* note 172; CTRS. FOR MEDICARE & MEDICAID SERVS., VERMONT 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/VT-BMP.zip> (last visited Mar. 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>services only if you get Medically Necessary Care in the least restrictive setting.” (P.16).</p> <p>4. <u>Exclusions</u>. “We provide no substance abuse treatment benefits for: services ordered by a court of law (unless we deem them Medically Necessary); non-traditional, alternative therapies such as eye movement desensitization, Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories; treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required; services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs, that focus on education, socialization, delinquency or Custodial Care (see Definitions), as noted in General Exclusions; Custodial Care, including housing that is not integral to a Medically Necessary level of care or care solely to comply with a court order, to obtain shelter, to deter runaway or truant behavior or to achieve family respite, unless such care is Medically Necessary (see Definitions), as noted in General Exclusions; and biofeedback, pain management, stress reduction classes and pastoral counseling.” (Pgs. 16–17).</p>
47. VA	Anthem Health Plans of Virginia (Anthem BCBS):	<p>1. <u>Relevant Prescription Drug Category and Class Counts</u>. The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
	Premier DirectAccess PPO ²⁴²	acting: 14; (2) Analgesics: Opioid Analgesics, Short-acting: 16; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 3; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1 (Summary at P.16).
48. WA	Regence BlueShield: Regence Group Direct Gold + ²⁴³	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 11; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1 (Summary at P.5). 2. <u>Hypnotherapy Exclusion.</u> The plan excludes from coverage: “Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, mental health and substance use disorders or for anesthesia purposes.” (P.21).
49. WV	Highmark Blue Cross Blue Shield West Virginia:	<ol style="list-style-type: none"> 1. <u>Relevant Prescription Drug Category and Class Counts.</u> The plan contains the following relevant prescription drug category and class counts: (1)

242. See ANTHEM BLUECROSS BLUESHIELD, *supra* note 129; CTRS. FOR MEDICARE & MEDICAID SERVS., VIRGINIA 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/cciio/BMP%20Summary_VA.zip (last visited Mar. 14, 2019).

243. See REGENCE BLUESHIELD, *supra* note 173; CTRS. FOR MEDICARE & MEDICAID SERVS., WASHINGTON 2017 EHB BENCHMARK PLAN, <https://www.assets.regence.com/policy/2017/WA/Silver3000PreferredWashington-dv.pdf> (last visited Mar 14, 2019).

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
	Shared Cost Blue PPO grp NON-X, Gold Shared Cost PPO \$1000 ²⁴⁴	Analgesics: Opioid Analgesics, Long-acting: 11 (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5). 2. <u>Treatability Required</u> . “We do not pay benefits for Mental Illness that cannot be treated. We will, pay benefits to determine if the disorder or illness can be treated. Your Physician must certify that there is a reasonable likelihood that your treatment will be of substantial benefit and substantial improvement is likely.” (P.32).
50. WI	UnitedHealthcare Insurance Company: Choice Plus ²⁴⁵	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: (1) Analgesics: Opioid Analgesics, Long-acting: 12; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 0. (Summary at P.5). 2. <u>Prior Authorization Requirement</u> . “For Non-Network Benefits for a scheduled

244. See CTRS. FOR MEDICARE & MEDICAID SERVS., 2017 EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/WV-BMP.zip> (last visited Mar. 14, 2019); HIGHMARK BLUE CROSS BLUE SHIELD W. VA., WV GROUP GOLD SHARED COST PPO \$1000: HEALTH CARE CERTIFICATE, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/WV-BMP.zip> (last visited Mar. 14, 2019).

245. See CTRS. FOR MEDICARE & MEDICAID SERVS., WISCONSIN 2017 EHB BENCHMARK PLAN, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_WI-4816.zip (last visited Mar. 14, 2019); UNITEDHEALTHCARE INS., *supra* note 181.

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.” (P.21).</p> <p>3. <u>Exclusions.</u> The plan excludes coverage for: Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents; Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following: Not consistent with generally accepted standards of medical practice for the</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		<p>treatment of such conditions; Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time; and Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. (P.31).</p> <p>4. <u>Student Limitation.</u> "Coverage will be provided for the Mental Health clinical assessments of Dependent Full-time Students attending school in the State of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a provider designated by the Mental Health/Substance Use Designee and who is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. If outpatient Mental Health/Substance Use Disorder Services are recommended, coverage will be provided for a maximum of 5 visits at an outpatient treatment facility or other provider designated by the Mental Health/Substance Use Disorder Designee, that is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. Coverage for the outpatient services will not be provided, if the recommended treatment would prohibit the Dependent from attending school on</p>

State	Benchmark Plan (Issuer/Group: Product)	Mental Health and Substance Use Disorder Coverage Provisions (and Limitations Thereto)
		a regular basis or if the Dependent is no longer a Full-time Student.” (P.14).
51. WY	Blue Cross Blue Shield of Wyoming: BlueSelect PPO Silver for Employer Groups ²⁴⁶	1. <u>Relevant Prescription Drug Category and Class Counts</u> . The plan contains the following relevant prescription drug category and class counts: Analgesics: Opioid Analgesics, Long-acting: 10; (2) Analgesics: Opioid Analgesics, Short-acting: 12; (3) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments: 2; (4) Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents: 1. (Summary at P.5).

246. See BLUECROSS BLUESHIELD OF WYO., *supra* note 144; CTRS. FOR MEDICARE & MEDICAID SERVS., WYOMING 2017 EHB BENCHMARK PLAN, https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_WY_revised.zip (last visited Mar. 14, 2019).