Foundation *for* Opioid Response Efforts

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Issue Brief

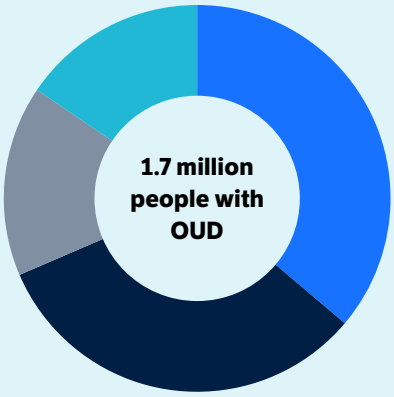
Is Treatment for Opioid Use Disorder Affordable for Those with Public or Private Health Coverage?

By Kristi Martin

In 2019, some 1.7 million individuals in the U.S. were living with opioid use disorder (OUD) and most (an estimated 84 percent) had health coverage, either through private insurance, Medicare, or Medicaid.[1] In recent years, more insurers have begun to cover medications for opioid use disorder (MOUD), one of the most effective strategies for **preventing opioid overdose**. That trend, along with the expansion of eligibility for Medicaid and mental health and substance use treatment parity laws have led to **increases** in the number of primary care and behavioral health providers offering MOUD, thus **expanding access to this lifesaving treatment**. Still, evidence suggests that people with either public or private health coverage continue to face **barriers in accessing OUD treatment**, including benefit limits and high out-of-pocket costs.

Breakdown Among Those Diagnosed with OUD by Insurance Source

- Covered by Medicaid: 615,000
- Covered by private insurance: 550,000
- Uninsured: 271,000
- Covered by Medicare: 264,000



Source: National Survey of Drug Use and Health, 2019. Available at: **https://nsduhweb.rti.org/respweb/homepage.cfm**.

Because opioid use disorder is a chronic condition, treatment with MOUD is often not a one-time event or short-term; treatment costs may be incurred for months or years. Recent **evidence** suggests that duration mediates the effectiveness of MOUD, with people who stay in treatment for 15 months or longer having better outcomes than those who stay in treatment for shorter periods.

KEY TAKEAWAYS

1 Even though 84 percent of people with OUD have health coverage through private insurance, Medicare, or Medicaid, benefit limits and out-of-pocket costs prevent some from accessing MOUD.

2 Cost-sharing and utilization management tools, such as prior authorization, can impede access to timely MOUD treatment.

3 Requiring public and private insurers to cover all FDA-approved medications for OUD would expand access to evidence-based treatment for more Americans.

This issue brief provides an overview of the coverage and costs of several different forms of MOUD (buprenorphine, buprenorphine-naloxone, and naltrexone) for individuals with private insurance, Medicare, or Medicaid. It does not include analysis of methadone treatment because of its more limited availability through opioid treatment programs certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) compared to other forms of MOUD. It identifies inconsistencies in policy among private and public insurance programs and makes recommendations for promoting more equitable coverage of MOUD for all insured patients.

FEDERAL LAWS HAVE EXPANDED ACCESS TO MOUD

In 2010, the Affordable Care Act (ACA) deemed mental health and substance use disorder services essential health benefits for most private insurance. The ACA also required these services to be compliant with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, which generally requires health insurance coverage for mental health services to be offered at comparable levels with covered medical and surgical benefits.

More recently, other bipartisan legislation has sought to respond to the opioid crisis. The Comprehensive Addiction and Recovery Act of 2016 (CARA) provided grant funding to expand access to and use of MOUD. The 21st Century Cures Act (Cures Act) of 2016 funded various mental health and substance use activities, including grant funding for states to offer MOUD. The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) of 2018 includes several provisions to meet the needs of Medicare and Medicaid beneficiaries, including efforts to expand provider capacity, increase telehealth services, and make coverage for MOUD more comprehensive and affordable.

Summary Table of Medications for Opioid Use Disorder

MOUD	Formulations	Setting	Estimated Monthly Costs Without Insurance
Buprenorphine (brand names include Probuphine, Sublocade, Brixadi)	Extended release injectable, film, patch, implant, tablet	Buprenorphine initiation may take place in an office or home setting.	• $1,161–$3,483 for injectable • $183–$451 for film • $81–$215 for patch • $206 for implant • $106–$189 for tablet
Buprenorphine-naloxone (brand names include Zubsolv, Suboxone, Bunavail)	Film, tablet	Buprenorphine-naloxone initiation may take place in an office or home setting.	• $112–$518 for film • $92–$549 for tablet
Naltrexone (brand names include Vivitrol, Revia)	Extended release injectable, tablet	Naltrexone can be prescribed in any setting by any health care provider with the authority to prescribe medication.	• $700–$1,100 for injectable • $25–$60 for tablet

Source: Information was compiled from publicly available sources, including the American Society of Addiction Medicine's National Practice Guidelines for Treatment of Opioid Use Disorder, Centers for Medicare and Medicaid Services Drug Spending Dashboards, 46Brooklyn Research, and GoodRx.

PRIVATE COVERAGE

In 2019, nearly 550,000 individuals diagnosed with OUD were covered by private insurance, with 94 percent receiving health insurance through their employer.[2] Nearly **60 percent** of retail prescriptions for buprenorphine are paid for by private health insurance, with Florida, Georgia, Kansas, and Louisiana representing more than 70 percent of claims. During the COVID-19 pandemic, there has also been an **upward trend** in prescriptions for MOUD for those covered by private insurance.

As noted above, the **ACA mandates** coverage of substance use disorder services by most private health insurance and MHPAEA requires that the cost sharing and treatment limitations for MOUD, if covered by a health plan, must be comparable to and no more restrictive than medications for other medical or surgical needs. An analysis by the Centers for Medicare and Medicaid Services (CMS) found that most — but not all — qualified health plans available on the health insurance marketplaces **provided comprehensive coverage for MOUD services**. CMS has encouraged but **not required** all qualified health plans to provide comprehensive coverage; instead, the agency requires qualified health plans to cover one drug in each class. A review of drug formularies in 39 states revealed that, while many qualified health plans sold on health insurance marketplaces cover all four MOUD drugs, not all do. In 2018, 2,553 of the plans (95%) cover all four of these drugs; 105 plans (4%) cover three; and 25 plans (<1%) cover two.

Coverage does not mean people have affordable access to OUD treatment. In 2018, the average cost sharing for MOUD services was $728 per year while the median coinsurance was 20 percent per visit.

A **study** found that cost sharing for MOUD services in employer-sponsored health plans was significant. In 2018, enrollees on average paid $728 in cost sharing per year, while the median coinsurance was 20 percent per visit. Such high out-of-pocket costs have been identified by providers as a **barrier in accessing treatment**. In addition to cost sharing, some private health plans **leverage utilization management strategies**, such as prior authorization (by which health plans must approve treatment) or step therapy (by which patients must first try a lower-priced treatment). Both approaches may limit patients' access to MOUD.

MEDICARE

In 2019, some 264,000 individuals with OUD were covered by Medicare.[3] In the same year, Medicare spending for MOUD was approximately $568.8 million.[4]

Part B of the Medicare program covers OUD services delivered in an outpatient clinic, including payment for physician-administered drugs, as well as inpatient and partial hospitalization for mental health services. Medicare defines "medication-assisted treatment" as behavioral therapy and methadone maintenance treatment or other MOUD. The SUPPORT Act significantly expanded coverage for MOUD and other opioid treatment services. As a result, Part B now covers OUD treatment in opioid treatment programs (OTPs) and services including medication, counseling, drug testing, and individual and group therapy (including in-person and virtual counseling). Prior to the SUPPORT Act, MOUD was not covered for Medicare beneficiaries seeking care at federally registered OTPs and patients faced disruptions in care when they moved between care settings. Generally, Medicare beneficiaries are subject to 20 percent coinsurance after meeting an annual deductible ($203 in 2021) in Part B. As of January 1, 2020, Medicare waived cost-sharing (after the deductible) for services provided at an OTP, including MOUD.

Medicare Part D covers outpatient, retail prescription drugs through private health plans. The SUPPORT Act expanded Part D coverage for MOUD. Part D plans now must cover buprenorphine and other self-administered drugs used for OUD, either on their formularies or via a beneficiary coverage exception process. Part D plans are required to include MOUD on lower cost-sharing tiers, although beneficiaries' cost sharing may vary depending on their plan. Based on **Part D plan data from 2018**, most brand-name MOUD and the generic patch are assigned to the highest cost-sharing tiers and generic film and tablets for buprenorphine to lower tiers. Fewer Part D plans in recent years used prior authorization for MOUD as a result of guidance from CMS, however, more than **58 percent of plans** continue to require prior authorization for generic buprenorphine tablets. Removing **utilization management strategies** in Medicare, such as prior authorization, has been shown to increase access to MOUD and improve health outcomes, such as decreasing the likelihood of relapse.

In 2021, the standard benefit design for Medicare Part D plans includes:

$445
deductible

and

25%
coinsurance after the deductible is met

until reaching the

$6,550
out-of-pocket threshold

After that, the beneficiary pays:

5%
coinsurance

MEDICAID

Nearly 615,000 individuals with OUD were covered by Medicaid in 2019.[5] In the same year, Medicaid spending for MOUD was approximately $1.5 billion.[6]

Medicaid programs in all states and the District of Columbia cover some form of buprenorphine and naltrexone to treat OUD, though injectable and implantable buprenorphine are **not covered** by all state Medicaid programs. This may start to change: the SUPPORT Act required Medicaid programs to cover all FDA-approved MOUD and counseling as a mandatory benefit starting October 1, 2020, through September 30, 2025, unless a state certifies to the satisfaction of the Health and Human Services Secretary that it would not be feasible due to provider or facility shortages.

As of 2018, some states had adopted **prior authorization requirements or other utilization management tools** that limit access to MOUD. California and Illinois covered all forms of buprenorphine without benefit limitations. At the time of the analysis, most states covered all forms of naltrexone without limitations, though 13 states (Arkansas, Colorado, Hawaii, Indiana, Kansas, Maine, Mississippi, Montana, Nevada, New Jersey, Rhode Island, and Texas) and the District of Columbia did not. Oklahoma was the first state to receive CMS approval to amend its state plan under the SUPPORT Act to cover all FDA-approved MOUD. Previously, the state covered Probuphine (subdermal-implant buprenorphine) but applied prior utilization, quantity limits, and step therapy requirements, and did not cover Sublocade (extended-release, injectable buprenorphine).

Cost-sharing in Medicaid varies by eligibility and program type (i.e., Medicaid expansion, fee-for-service, managed care). For people whose annual incomes exceed 150 percent of the federal poverty level, or more than $39,700 for a family of four, copayments for non-preferred drugs may be as high as 20 percent. For people with income at or below 150 percent of the federal poverty level, copayments are nominal (e.g., $4 for preferred drugs, $8 for non-preferred drugs).

MOUD Coverage by Insurance Type

Type of Coverage	Coverage for MOUD Required	Cost-sharing Allowed	Utilization Management Permitted
Private insurance	• Partial, at least one per drug class[7]	• Yes. The mean cost sharing for MOUD treatment was $728 per year with a median coinsurance of 20% per visit in 2018 among employer-sponsored insurance plans.	• Yes
Medicare	• Part B covers OUD treatment in opioid treatment programs (OTPs) and services, including medication. • Part D plans must cover buprenorphine and other self-administered drugs used for opioid use disorder, either on their formularies (list of covered drugs) or via a beneficiary coverage exception process.	• No cost-sharing permitted under Part B for patients seeking treatment at an OTP and up to 20% coinsurance in other settings • Cost-sharing is permitted under Part D	• No utilization management under Part B • Utilization management is permitted under Part D
Medicaid	• Programs are required to cover all FDA-approved drugs for MOUD services.[8]	• For people with incomes above 150% of the federal poverty level (FPL), copayments for non-preferred drugs may be as high as 20% of the cost of the drug. • For people with income at or below 150% FPL, copayments are limited to no more than nominal amounts (e.g., $4 for preferred drugs, $8 for non-preferred drugs).	• Yes. Most impose utilization management techniques (e.g., prior authorization, quantity limits, or step therapy requirements).

Source: Author's analysis of regulations and laws for MOUD coverage.

POLICY IMPLICATIONS

While federal policy changes have increased the accessibility and affordability of MOUD for those with public or private health insurance, coverage continues to be a patchwork and some people struggle to get and maintain treatment. As noted above, recovery chances increase when MOUD treatment duration is longer than 15 months. Clinical guidelines recommend all FDA-approved forms of MOUD should be offered to a patient and treatment should be a shared decision between a patient and provider reflecting a patient's priorities, prior experience with treatment, psychosocial needs, and preference. Evidence-based treatment that meets patients' needs and preferences could prevent overdose deaths, relapses and increase their chance of long-term recovery.

The following policy changes could make MOUD treatment more affordable.

Require coverage for all FDA-approved MOUD. While all insured patients have access to MOUD, there are gaps related to access, coverage, and costs. Policymakers should require private health insurance, Medicare Part D, and Medicaid to cover all FDA-approved forms of MOUD consistent with **guidelines** from the American Society of Addiction Medicine.

Eliminate cost-sharing for MOUD services. Cost-sharing is **often cited as a significant barrier** to treatment and can **impede an individual's ability to access** MOUD services. Policymakers should eliminate cost-sharing — including deductibles and copayments — for MOUD services in private health insurance, Medicare, and Medicaid for people seeking care from a provider who has authority to prescribe medication and follows clinical guidelines.

Prohibit utilization management if it impedes access. Private insurance, Medicare Part D, and Medicaid allow some form of utilization management for MOUD, which may hinder people from getting timely treatment. **Studies** suggest that prohibiting prior authorization for MOUD services would increase utilization and reduce hospitalizations as well as emergency department visits. Policymakers should prohibit the use of utilization management strategies that are inconsistent with clinical guidelines for MOUD services.

Make sure treatment is affordable for providers, too. Federal agencies, such as the Department of Health and Human Services or the Government Accountability Office, could survey providers on their acquisition and storage costs for MOUD to understand how these costs affect access to treatment.

In addition, removing the need from providers to purchase some drugs upfront may encourage more providers to offer MOUD.

Costs to Providers of Delivering MOUD to Insured Patients

In addition to posing challenges to some insured patients, the costs associated with providing MOUD may be a significant hurdle for some providers.

MOUD are available as provider-administered or retail drugs. Provider-administered MOUD, such as buprenorphine injectables and implants, are purchased through a "buy and bill" system in which providers purchase the drugs and then bill the payer when they are administered to a patient. In this system, providers assume the upfront financial responsibility of purchasing and storing the drugs. This differs from retail MOUD, including tablets, films, patches, and some auto injectables, which are dispensed by pharmacies and do not require prescribers to shoulder upfront costs.

Provider-administered drugs are typically reimbursed by public and private payers based on their average sales price (ASP) plus a fee to compensate for the handling and storage of the drug. The costs of provider-administered drugs used for MOUD have gone up in recent years, and payers may **not adequately reimburse** providers for their costs.

Update studies by federal agencies or undertake new studies to inform policy. More research is needed to understand whether MOUD is affordable for all those with public or private health insurance coverage. In 2019, the Office of the Assistant Secretary for Policy and Evaluation published **a study** on patients' out-of-pocket costs for MOUD in employer-sponsored private health insurance. This could be updated and expanded to consider costs in the individual and small-group insurance markets as well as in Medicare Part D. In 2018, the Substance Abuse and Mental Health Services Administration published **a report** profiling the scope of Medicaid coverage for medicated-assisted treatment for alcohol and substance use disorder. Given changes in Medicaid policy at the state and federal levels, it would be an opportune time to update this report.

In addition to updating prior studies, the U.S. Government Accountability Office could review and assess the implementation status of policies intended to expand accessibility and affordability of MOUD services. For example, it could review whether state Medicaid programs and Medicare plans are in compliance with the SUPPORT Act.

ENDNOTES

1 Based on the author's analysis of the National Survey of Drug Use and Health, 2019. Available at: **https://nsduhweb.rti.org/respweb/homepage.cfm**.
2 Ibid.
3 Ibid.
4 Based on author's analysis of the CMS Medicare Part B and Part D Drug Spending Dashboards, 2019. Available at: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs**.
5 Based on author's analysis of the National Survey of Drug Use and Health, 2019. Available at: **https://nsduhweb.rti.org/respweb/homepage.cfm**.
6 Based on author's analysis of the CMS Medicaid Drug Spending Dashboard, 2019. Available at: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs**.
7 An analysis by CMS in 2020 found that most but not all qualified health plans on the ACA exchanges provided comprehensive coverage for MOUD services. For plan year 2018, 95 percent of plans covered all MOUD, 4 percent of plans covered three forms, and about 1 percent of plans covered only two forms.
8 The SUPPORT Act included a provision to require Medicaid programs to cover all FDA-approved MOUD and counseling as a mandatory benefit from October 1, 2020, to September 30, 2025, unless a state certifies to the satisfaction of the Secretary of the U.S. Department of Health and Human Services that statewide implementation for all Medicaid-eligible individuals would not be feasible due to provider or facility shortages.

Author

Kristi Martin, M.P.A., is a policy strategist focused on health care, drawing on her decades of experience working in the public sector, with private-sector clients, and in philanthropy. She is now the senior advisor to the Centers for Medicare and Medicaid Services deputy administrator for Medicare. She was previously the vice president for health care at Arnold Ventures where she led the philanthropy's prescription drug pricing portfolio and was the managing director of Waxman Strategies' health practice where she worked alongside Congressman Henry Waxman driving toward progressive outcomes in health policy. Martin served several years in the U.S. Department of Health and Human Services, Office of Personnel Management, and Government Accountability Office. As a senior advisor in the Obama administration's Office of Health Reform, she had primary oversight responsibility for the coordinated and timely implementation of cross-cutting departmental public health and prevention initiatives under the Affordable Care Act, including addressing the rising cost of drugs and setting up the women's preventive services initiative. Martin received her bachelor's and master's in health communication from the University of Kentucky and a master's of public administration from George Washington University.

This brief was prepared while Kristi Martin was employed at Highway 136 Consulting. The findings and recommendations expressed are the author's own and do not reflect the view of the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, or the United States government.