California Society of Addiction Medicine

"The Voice for Treatment"

Minimum Insurance Benefits for Patients with Opioid Use Disorder

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THE OPIOID USE DISORDER EPIDEMIC:

Opioid use disorder has emerged as a worsening, and often deadly, epidemic in the United States. Recent surveys indicate that up to 1.9 million Americans met criteria for an opioid use disorder based on their use of prescription opioid medications alone in 2013, and that another 300,000 were regular users of heroin (SAMHSA 2013). The burgeoning number of ER visits, hospitalizations, and overdoses related to opioids have led several parts of the country to declare states of emergency in combating the epidemic through urgent public health measures.

THE EVIDENCE FOR OPIOID TREATMENT:

Robust studies have shown the effectiveness of methadone, buprenorphine, buprenorphine/naloxone (Suboxone®), and naltrexone in treating opioid use disorder when combined with the appropriate psychosocial approaches. Methadone is a full opioid agonist, which reduces opioid withdrawal symptoms and cravings (Amato et al, 2005), and buprenorphine/naloxone combination (Suboxone®) is a partial opioid agonist which acts similarly (Ling et al, 2005). Naltrexone, or its injected form, Vivitrol®, is an opioid antagonist, which blocks the reward from opioids and helps reduce the reinforcing nature of the substance (Comer et al, 2006). All three medications, when used in a long-term manner, can help a patient to avoid relapse, and experience the health and functional benefits of effective treatment for opioid use disorder.

The decision to start any of these medications, and the duration to continue them, is highly individual and requires close collaboration between patients and their providers (see appendix). Substance use disorders, like all chronic medical illnesses, require treatments that provide ongoing care throughout patients' lifespans with many having remissions and relapses. Outcomes from substance abuse treatment is similar to that of chronic diseases such as diabetes, asthma and hypertension (McLellan, A.T., et.al., 2000).

LACK OF ACCESS TO MEDICATION-ASSISTED TREATMENTS (MATS):

Despite the extensive evidence for their efficacy, less than 45% of addiction treatment programs prescribe any single substance use disorder (SUD) pharmacotherapy (Romana et al 2011). While a number of barriers contribute to low access to and utilization of medication-assisted treatments (MATs), insurance utilization management policies remain a major obstacle to evidence-based treatment. A recent New England Journal of Medicine article documents that, "…several policy-related obstacles that warrant closer scrutiny. These barriers include utilization-management techniques such as limits on dosages prescribed, annual or lifetime medication limits, initial authorization and reauthorization requirements, minimal counseling coverage, and "fail first" criteria requiring that other therapies be attempted first. Although these policies may be intended to ensure that MAT is the best course of treatment, they may hinder access and appropriate care. For example, "Maintenance MAT has been shown to prevent relapse and death but is strongly discouraged by lifetime limits." (Volkow et al 2014)

At this time, MediCal recipients who choose to enroll in an opioid treatment program (OTP) to receive methadone-buprenorphine must pay out-of-pocket.

In 2015 the California Society of Addiction Medicine published its survey of bronze-level plans offered by Covered California (CSAM 2015). CSAM's report indicated that, while coverage varied, NONE of the plans offered an acceptable level of coverage for the treatment of patients with opioid use disorders.

EVIDENCE-BASED BEST PRACTICES:

1. Limits on opioid maintenance dosages: Individuals vary greatly in their inborn capacity to metabolize opioid maintenance medications such as methadone. Arbitrary dosage limits are irrational and daily doses need to be clinically determined.

2. Annual or lifetime medication limits: Such limits are based on the ideology that all patients are best served by eventual detoxification and a drug-free lifestyle. However, research shows that the gold standard for treatment of recurrent heroin addiction is long term, often lifetime, maintenance on opioid agonist medications. Premature termination of supportive medications massively increases risks of relapse.
3. Authorization/Re-authorization: Chronic illnesses with long-term medication management should not be subject to overly frequent and burdensome re-authorizations.
4. Coverage for counseling: The scientific literature has established that support services and counseling are essential for effective treatment. Counseling services require insurance coverage for these DSM-V disorders.
5. "Fail First" Criteria: These criteria violate precepts of "first do no harm." Many opioid relapses, particularly to street drugs such as heroin, contain risks of infection with HIV or hepatitis C, overdoses, and overdose deaths. Eligibility for maintenance medications is best established by a relapsing clinical history, not by regulations that demand a high-risk event as a pre-condition for coverage.

MINIMUM BENEFITS FOR PATIENTS WITH OPIOID USE DISORDER:

Given the grave and increasing dangers related to opioid use disorders, patients should have full access to the effective treatments available. Minimum insurance coverage should include full coverage for:

1. Regular physician visits for evaluation and follow up of opioid use disorders.
2. Methadone at doses, frequency, and duration recommended by the provider.
3. Buprenorphine at doses, frequency, and duration recommended by the provider.
4. Naltrexone at doses, frequency, and duration recommended by the provider.
5. Naloxone at doses, frequency, and duration recommended by the provider.
6. Lab work and diagnostic tests necessary for safely and effectively treating opioid use disorders.
7. Counseling or other substance use programming as recommended for each patient.
8. All patients' insurance plans should cover both methadone and buprenorphine, including state funded and regulated opioid treatment programs.

REFERENCES:

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APPENDIX: EVIDENCE-BASED CONSENSUS TREATMENT RECOMMENDATIONS

The following recommendations are from:

Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, Treatment Improvement Protocol (TIP) Series, No. 43, Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005.

TIPS are best-practice guidelines for the treatment of substance use disorders prepared by a large consensus panel sponsored by the U.S. Department of Health and Human Services (HHS).

CHOICE OF MEDICATIONS

"The consensus panel recommends that OTPs offer a variety of treatment medications. Chapters 3 and 5 provide more details about the pharmacology and appropriate use of methadone, levoalpha-acetyl methadol [no longer available], buprenorphine, and naltrexone." (p. 91)

"The consensus panel for this TIP expects that the availability of buprenorphine in multiple settings will increase the number of patients in treatment and that its availability in physicians' offices and other medical and health care settings should help move medical maintenance treatment of opioid addiction into mainstream medical practice." (p. 26)

"In general, patient–treatment matching involves individualizing, to the extent possible, the choice and application of treatment resources to each patient's needs." (p. 87)

TREATMENT DURATION

"Decisions concerning treatment duration (time spent in each phase of treatment) should be made jointly by OTP physicians, other members of the treatment team, and patients. Decisions should be based on accumulated data and medical experience, as well as patient participation in treatment, rather than on regulatory or general administrative policy." (p. 106)

DOSAGE

"It is critical to successful patient management in MAT to determine a medication dosage that will minimize withdrawal symptoms and craving and decrease or eliminate opioid abuse. Dosage requirements for methadone, LAAM, and buprenorphine must be determined on an individual basis. There is no single recommended dosage or even a fixed range of dosages for all patients. For many patients, the therapeutic dosage range of methadone may be in the neighborhood of 80 to 120 mg per day (Joseph et al. 2000), but it can be much higher, and occasionally it is much lower." (p. 70)

REGULAR PHYSICIAN VISITS FOR EVALUATION AND FOLLOW UP OF OPIATE USE DISORDER

Patient–treatment matching begins with a thorough assessment to determine each patient's service needs (see chapter 4); then these needs are matched to appropriate levels of care and types of services. Assessment should include the extent, nature, and duration of patients' opioid and other substance use and their treatment histories, as well as their medical, psychiatric, and psychosocial needs and functional status. (p. 88)

[In the continuing care phase of treatment…] "the panel recommends that appointments with the OTP continue to be scheduled every 1 to 3 months, although many programs prefer that patients in continuing care maintain at least monthly contact." (p. 119)

COUNSELING OR OTHER SUBSTANCE USE PROGRAMMING AS RECOMMENDED FOR EACH PATIENT

A core group of basic- and extended-care services is essential to the effectiveness of medication-assisted treatment for opioid addiction (MAT) in opioid treatment programs (OTPs). Numerous studies support the belief that psychosocial interventions contribute to treatment retention and compliance by addressing the social and behavioral problems and co-occurring disorders affecting patients in MAT (e.g., Brooner and Kidorf 2002; Joe et al. 2001). The consensus panel agrees that a well-planned and well-supported comprehensive treatment program increases patient retention in MAT and the likelihood of positive treatment outcomes. (p.121)

LAB WORK AND DIAGNOSTIC TESTS NECESSARY FOR SAFELY AND EFFECTIVELY TREATING OPIATE USE DISORDER

Since the inception of medication-assisted treatment for opioid addiction (MAT), drug testing has provided both an objective measure of treatment efficacy and a tool to monitor patient progress. Important changes have occurred in current knowledge about and methods for drug testing in opioid treatment programs (OTPs) since the publication of TIP 1, State Methadone Treatment Guidelines (CSAT 1993b). Testing now is performed extensively to detect substance use and monitor treatment compliance. Analysis of test results provides guidance for OTP accreditation, as well as information for program planning and performance improvement. In addition, other agencies concerned with patient progress (e.g., child welfare and criminal justice agencies) routinely request and use drug test results with patients' informed consent (see CSAT 2004b). (p.143)

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