ACA Implementation—Monitoring and Tracking

Coverage of Substance-Use Disorder Treatments in Marketplace Plans in Six Cities

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

INTRODUCTION

A national survey conducted in 2014 indicated that approximately 21.5 million individuals in the United States over age 12—around 8.1 percent—had a substance-use disorder (SUD) within the last year, including 14.4 million with alcohol-use disorders and 4.5 million with opioid-use disorders.[1] Opioids include heroin and prescription pain relievers such as oxycodone, codeine, morphine, and others. Misuse of opioids and prescription drugs has increased in recent years, and this growth in misuse has been accompanied by a nearly fourfold increase in deaths caused by opioid overdose between 1999 and 2010.[2] Research shows that medication-assisted treatment (MAT) can be effective for individuals with substance-use disorders,[3] but considerable stigma and access issues continue to prevent widespread treatment.

With the passage of the Affordable Care Act (ACA) in 2010, mental health and substance use disorder services – which may include MAT– were listed as an essential health benefit (EHB) and became a component of all ACA-compliant individual and small-group health insurance policies.[4] Before the ACA, many health plans excluded MAT and other treatments for individuals with SUDs, so these benefits have expanded considerably over the last few years. Additionally, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires that health care plans offer mental health services (including addiction services) comparable in scope to services provided for physical illnesses.[5] Most recently, on May 26, 2016, the U.S. Food and Drug Administration (FDA) approved the first buprenorphine implant, which will deliver a constant low dose of medication for individuals with opioid dependence who are already stable on another form of buprenorphine.[6]

Together, these policies should represent a significant expansion of treatment for individuals with SUDs. However, as we and others have shown in other treatment areas (cancer,[7] depression,[8] etc.), coverage specifics and cost-sharing requirements vary considerably within and across states, even for covered services. This variation occurs because of differences in state benchmark plans and in the flexibility that regulators permit insurers around these benchmark plans.

In this study, we examine marketplace coverage and cost-sharing requirements for MAT for opioid and alcohol use as well as outpatient and inpatient care for individuals with SUDs to provide preliminary information on whether access is consistent and sufficient. We focus on coverage provided in six large cities—Albuquerque, NM; Chicago, IL; Kansas City, MO.; Los Angeles, CA; Manchester, NH; and Memphis, TN — as indicators of the extent of and variation in coverage.

BACKGROUND

The FDA has approved three medications for the treatment of alcohol addiction and three for the treatment of opioid addiction (one is prescribed for both alcohol and opioid addictions):

- *Disulfiram (trade name: Antabuse):* Disulfiram—approved by the FDA in 1981—works by inhibiting an enzyme critical to alcohol metabolization, thereby causing unpleasant reactions (e.g., headache, nausea, vomiting, sweating) if alcohol is consumed. It comes in tablet form and should be taken daily. Physicians do not require special training to prescribe disulfiram.
- *Acamprosate (trade name: Campral):* Acamprosate—approved by the FDA in 2004—works by reducing alcohol withdrawal symptoms and is typically delivered in conjunction with professional counseling.
- *Naltrexone (trade names: Vivitrol, Revia):* Naltrexone—approved by the FDA in 2006—is an antagonist[9] that is delivered through a monthly intramuscular injection or oral tablets and works by blocking opioid receptors, thereby preventing opioid cravings. It can only be delivered after complete detoxification from opioids, and as such, is a popular option for maintenance therapy. For treatment of alcohol addiction, naltrexone works by blocking the receptors that produce the pleasurable effects of consuming alcohol and reducing cravings. Physicians can prescribe it without any special training and it is not considered a controlled substance.
- *Methadone (trade names: Methadose, Diskets, Dolophine):* Methadone—approved by the FDA in 1947—is a long-acting agonist[10] that works by relieving withdrawal symptoms, minimizing cravings, and preventing euphoric effects if other opioids are ingested. Methadone can be used in detoxification. It is administered in an oral solution by physicians who are not required to undergo special training, but it is only available in specially licensed opioid-treatment programs. Methadone is classified as a Schedule II controlled substance.
- *Buprenorphine (trade names: Buprenex, Butrans, Suboxone [buprenorphine/naloxone]):* Buprenorphine—approved by the FDA in 2002—is a long-acting agonist that works by relieving withdrawal symptoms, minimizing cravings, and preventing euphoric effects if other opioids are ingested. It can be delivered in either an oral tablet or a sublingual film. Recently, the FDA approved a buprenorphine implant that would deliver the medication at a low dose over six months.[11] Buprenorphine also can be prescribed in combination with naloxone, which discourages drug abuse by producing withdrawal symptoms if it is injected intravenously. Buprenorphine is classified as a Schedule III controlled substance and can only be prescribed by physicians who have undergone special training and received a waiver to deliver it in office-based settings. Additionally, current regulations impose caps on the number of patients these specially trained providers can treat (a maximum of 100 patients after one year of certification), although there are efforts to raise these caps.[12] The stringent requirements to prescribe buprenorphine have led to a significant shortage of available providers. Recent analyses have calculated the number of physicians who could deliver buprenorphine at the county level. In 2011, 43 percent of U.S counties had no physicians who could deliver buprenorphine, while 7 percent had 20 or more.[13]

Despite the ACA's changes, which have increased insurers' inclusion of treatment for individuals with SUDs, the specifics of coverage and cost-sharing requirements vary considerably across plans. To date, not much is known about which marketplace insurers cover which MATs, the associated cost-sharing requirements on MATs and on general inpatient/outpatient treatment for SUDs, or what restrictions (e.g., prior authorization, quantity limits) are imposed on the coverage provided. To begin to address these questions, we investigated marketplace coverage for individuals with SUDs in six cities: Albuquerque, Chicago, Kansas City, Los Angeles, Manchester, and Memphis.

METHODS

In this paper we analyze prescription drug coverage and cost-sharing requirements for the treatment of SUDs in the largest cities in six states: California (Los Angeles), Illinois (Chicago), Missouri (Kansas City), New Hampshire (Manchester), New Mexico (Albuquerque), and Tennessee (Memphis). We selected these states for geographic dispersion, varying population size, and benchmark plan generosity. "Benchmark plan generosity" refers to how many medications each state's EHB benchmark plan requires insurers to cover, in addition to any quantitative limits or

restrictions that may have been imposed upon inpatient and outpatient SUD treatment services. All data were collected from the marketplace websites Healthcare.gov (four insurers in Tennessee, four in New Mexico, seven in Illinois, two in Missouri, and five in New Hampshire) and Covered California (seven insurers), as well as from each insurer's website. We analyzed the formulary for every silver-tier plan on the nongroup marketplace in each city. No calls were made to insurers for additional information not available on the websites. We determined our drug list for the analysis of opioid treatment using the list of active ingredients (i.e., the generic versions) from the SAMHSA/CSAT Treatment Improvement Protocols for medication-assisted treatment in opioid-treatment programs.[14] For the alcohol-treatment medications, we compiled our drug list from SAMHSA.[15] We do not count separate formulations of the same active ingredient in different form (e.g., liquid, tablet, or capsule). We included all FDA-approved treatment options for alcohol- and substance-use disorders. We did not include treatment for tobacco cessation.

We also collected the inpatient and outpatient service cost-sharing requirements for SUD treatment in all silver plans in our study cities. To compile this information we used the summaries of benefits and coverage (SBCs) available through Healthcare.gov and Covered California.

This study has one significant limitation. We do not analyze the network adequacy of these plans as it relates to SUD treatment. The number of physicians licensed to prescribe opioid addiction treatment medication (notably buprenorphine) is small relative to the need for such services, with many areas lacking even a single licensed provider.[16] The shortage of providers able to prescribe these medications has created a central barrier to access to care. However, we do not find similar restrictions on providers for dispensing medications used to treat alcohol addiction. As such, this study is primarily focused on the breadth of coverage available and the cost-sharing requirements associated with seeking treatment.

Coverage and exclusions of MAT therapies were identified by comparing our list of active ingredients to each plan's formulary list of covered drugs. A drug is not considered excluded from a plan unless it is not covered in its generic form.

RESULTS

Medication-Assisted Treatment

Access to prescription drug formularies is of paramount importance so individuals can make informed decisions when purchasing health insurance on the marketplace. As such, we analyzed not only the coverage of prescription drugs, but also the transparency and ease of use of the formularies on marketplace and insurer websites. In most cases, the formularies themselves were easy to locate and use; many websites contained search functions that expedited the search for a specific drug. Every formulary had a search function or at least a searchable document. However, discerning whether a plan covered methadone beyond its use as an opioid (painkiller) was consistently difficult. We have excluded methadone from our analysis on prescription drug benefits since it must be dispensed in a licensed facility. Methadone prescribed as a medication to treat SUDs is not included in formularies or as a prescription drug benefit. Individuals who want to know whether a given plan covers methadone treatment would need to contact each insurer individually.

The coverage of medications used to treat alcohol use, as opposed to those used to treat opioid-use disorders, differs considerably. Disulfiram, acamprosate, and naltrexone, the three FDA-approved treatments available for alcohol dependence, are covered more frequently and at lower cost-sharing tiers than their opioid-treatment counterparts. As seen in table 1, these three medications (disulfiram, 0 percent; acamprosate, 1 percent; and naltrexone, 6 percent) tend to be excluded from coverage less frequently than the opioid-use medications (buprenorphine, 3 percent, and naltrexone, 29 percent). Additionally, the alcohol-use MATs are placed in the lowest cost-sharing tier (Tier 1) in at least 70 percent of plans in our study cities. Disulfiram is covered exclusively at Tier 1 and Tier 2, and over 90 percent of plans covered naltrexone in one of the lowest two tiers of cost-sharing when used to treat alcohol-use disorders. Acamprosate is covered about 87 percent of the time in the two lowest tiers.

The opioid dependence medications are more frequently excluded from coverage, but when they are covered, they also are generally found in the lower prescription drug cost-sharing tiers. Naltrexone is excluded from coverage in 29 percent of silver marketplace plans. This drug is often found in plan formularies as both an opioid-treatment and an alcohol-treatment medication, but it is much less likely to be covered for opioid-use treatment than it is for alcohol-use treatment. Buprenorphine is excluded from coverage in 3 percent of the plans studied, and while it is most frequently

Table 1. Cost-Sharing Requirements for Medication-Assisted Treatment in Selected Cities, by Percentage of Plans, 2016

	Alcohol Use			Opioid Use	
	Disulfiram	Acamprosate	Naltrexone	Buprenorphine	Naltrexone
Exclusion rate	0%	1%	6%	3%	29%
Tier 1	88%	70%	78%	74%	54%
Tier 2	13%	17%	13%	12%	13%
Tier 3	0%	9%	4%	10%	4%
Tier 4	0%	3%	0%	0%	0%
Quantity limit	0%	9%	0%	66%	0%
Prior authorization	0%	8%	0%	42%	0%
Total plans					**90**

Source: Covered California and Healthcare.gov public use files.

Table Notes: Analysis comprised marketplace plans in six cities: Albuquerque, Chicago, Kansas City, Los Angeles, Manchester,and Memphis.

covered in cost-sharing Tiers 1 or 2, 10 percent of the plans covered it in Tier 3.

These findings vary somewhat across the study cities, as shown in table 2. Every plan in Manchester, Kansas City, Los Angeles, and Chicago offers coverage of every drug analyzed here, for both alcohol dependency and substance use. Memphis plans vary in which opioid-use MATs are covered (and most exclude naltrexone), although all plans there cover the three alcohol-dependency MATs. In contrast, the Albuquerque plans vary in coverage for acamprosate and naltrexone (most exclude the latter for alcohol use), but they all include the two opioid-use treatments studied.

Thus, the substantial coverage differential seen in table 1 for naltrexone as an opioid-use treatment is entirely attributable to the high exclusion rate among Memphis plans. And the alcohol-use treatment exclusions seen in table 1 are entirely attributable to plans in Albuquerque.

Cost-Sharing Requirements in MAT

The cost-sharing tier in which each drug is placed (if it is covered) varies considerably (table 2). Note that the percentages of plans covering a particular drug across the four cost-sharing tiers may sum to more than 100 percent because some insurers cover the medications in multiple tiers, depending upon the dosage prescribed. Most frequently, these plans cover our studied drugs at tier 1 or tier 2, but there are exceptions. In Albuquerque, for example, 50 percent of plans (four of the available eight silver plans) cover both acamprosate and buprenorphine in Tier 3; in Memphis, 10 percent of available silver plans cover acamprosate in Tier 4. Despite these drugs being available at a lower tier, they are not always available at a low cost. With the exception of California, which has standardized benefit designs, cost-sharing requirements vary significantly across plans, even among Tier 1 covered medications (table 3). Some plans in four of the six study cities (none in Kansas City or Los Angeles) apply co-insurance to Tier 1 drugs. Customers, therefore, do not know a priori the cost of purchasing their prescriptions, since they do not know the rate negotiated between their plans and their pharmacies. Additionally, three of our study cities include plans that do not provide prescription drug benefits until after enrollees pay the deductible.

Prior Authorization and Quantity Limits in MAT

Buprenorphine, in addition to the limited prescribing authority noted in the Background section, is the medication studied for which plans most frequently require prior authorization and impose quantity limits (table 1). About 42 percent of plans require prior authorization for patients to receive coverage for buprenorphine, while 66 percent of plans impose quantity limits on its use. These strategies are common across all cities studied (table 2). Unfortunately, determining prior authorization denial rates is not within the scope of our study. Further information on the limits and denial rates would provide insight into how extensively these provisions create significant barriers to treatment. Some plans also require prior authorization or quantity limits for acamprosate, but they

Table 2. Medication-Assisted Treatment Drug Coverage and Restrictions, by Percentage of Plans in Selected Cities, 2016

	Alcohol Use			Opioid Use	
	Disulfiram	Acamprosate	Naltrexone	Buprenorphine	Naltrexone
Los Angeles[a]					
Exclusion rate	0%	0%	0%	0%	0%
Tier 1	100%	86%	100%	100%	100%
Tier 2	14%	14%	14%	0%	14%
Tier 3	0%	0%	0%	0%	0%
Tier 4	0%	0%	0%	0%	0%
Quantity limit	0%	0%	0%	86%	0%
Prior authorization	0%	29%	0%	86%	0%
Total plans					**7**
Memphis					
Exclusion rate	0%	0%	0%	10%	87%
Tier 1	87%	77%	87%	77%	0%
Tier 2	13%	13%	13%	13%	13%
Tier 3	0%	0%	0%	0%	0%
Tier 4	0%	10%	0%	0%	0%
Quantity limit	0%	3%	1%	80%	0%
Prior authorization	0%	0%	0%	3%	0%
Total plans					**30**
Albuquerque					
Exclusion rate	0%	13%	63%	0%	0%
Tier 1	100%	38%	38%	50%	100%
Tier 2	0%	0%	0%	0%	0%
Tier 3	0%	50%	0%	50%	0%
Tier 4	0%	0%	0%	0%	0%
Quantity limit	0%	50%	0%	50%	0%
Prior authorization	0%	63%	0%	63%	0%
Total plans					**8**
Chicago					
Exclusion rate	0%	0%	0%	0%	0%
Tier 1	68%	59%	59%	59%	59%
Tier 2	32%	32%	32%	32%	32%
Tier 3	0%	9%	9%	9%	9%
Tier 4	0%	0%	0%	0%	0%
Quantity limit	0%	5%	0%	64%	0%
Prior authorization	0%	0%	0%	68%	0%
Total plans					**22**

Table 2 Continued

	Alcohol Use			Opioid Use	
	Disulfiram	Acamprosate	Naltrexone	Buprenorphine	Naltrexone
Kansas City					
Exclusion rate	0%	0%	0%	0%	0%
Tier 1	100%	71%	71%	71%	71%
Tier 2	0%	0%	0%	0%	0%
Tier 3	0%	29%	29%	29%	29%
Tier 4	0%	0%	0%	0%	0%
Quantity limit	0%	29%	0%	100%	0%
Prior authorization	0%	0%	0%	100%	0%
Total plans					**7**
Manchester					
Exclusion rate	0%	0%	0%	0%	0%
Tier 1	100%	81%	100%	94%	100%
Tier 2	0%	19%	0%	0%	0%
Tier 3	0%	0%	0%	6%	0%
Tier 4	0%	0%	0%	0%	0%
Quantity limit	0%	0%	0%	25%	0%
Prior authorization	0%	0%	0%	25%	0%
Total plans					**16**

Source: Covered California and Healthcare.gov public use files.

Table Notes: Sum may be greater than 100% because some insurers cover the above medications in multiple tiers depending on dosage level.City, Los Angeles, Manchester,and Memphis.

Table 3. Cost-Sharing Requirements for Medication-Assisted Treatment in Selected Cities, by Percentage of Plans, 2016

		Tier 1		Tier 2		Tier 3		Tier 4	
		Co-pay	Coinsurance	Co-pay	Coinsurance	Co-pay	Coinsurance	Co-pay	Coinsurance
Los Angeles	Low	$15	NA	$50[a]	NA	$70[a]	NA	NA	20% up to $250
	High								
Memphis	Low	$3	10%	$35	10%	$60	10%	$120	10%
	High	No charge after deductible	50% after deductible	No charge after deductible	50%	No charge after deductible	50%	No charge after deductible	50%
Albuquerque	Low	$4	30% after deductible	$40 before deductible	30% after deductible	$40 before deductible	30% after deductible	No charge after deductible	25% after deductible
	High	No charge after deductible		No charge after deductible		$125			50% after deductible
Chicago	Low	No charge	30% after deductible	$40	20% after deductible	$100	$120 + 20%	$500	$250 + 30%
	High	$10 after deductible		$40 after deductible	30% after deductible	$75 after deductible	35%	No charge after deductible	50%

Table 3 Continued

		Tier 1		Tier 2		Tier 3		Tier 4	
		Co-pay	Coinsurance	Co-pay	Coinsurance	Co-pay	Coinsurance	Co-pay	Coinsurance
Kansas City	Low	$4	NA	$40	NA	$60	$120 +20% after deductible	$80	$300+ 30% after deductible
	High	$15		$50 copay after deductible		$120	50%	$100 copay after deductible	50% after deductible
Manchester	Low	$10	10% coinsurance	$40	10% after deductible	$75	30% after deductible	$200	30% after deductible
	High	$15 after deductible		$50 copay after deductible	30% after deductible	$100 after deductible	40% after deductible	$100 after deductible	50% after deductible

Source: Covered California and Healthcare.gov public use files.

a. Price is after drug deductible is met. For an individual in 2016, the drug deductible is $500.
NA = No plans in the city require this form of cost-sharing.

do so at a significantly lower frequency than observed with buprenorphine (table 1). About 8 percent of plans studied require prior authorization for prescriptions of acamprosate and 9 percent impose quantity limits for it. However, quantity limits and prior authorization rates can be high depending upon the city, particularly in Albuquerque (table 2). None of the plans studied impose quantity limits or prior authorization requirements for prescriptions of disulfiram or naltrexone (for either alcohol or opioid use).

For a consumer looking for health insurance coverage based on their MAT needs, the ability to purchase appropriate coverage varies city by city. For example, in Los Angeles, no silver plan options cover buprenorphine without prior authorization or quantity limits. However, five plans offer the remaining four drugs in Tier 1 without prior authorization or quantity limits, providing an array of low out-of-pocket cost options for those needing one of these treatments. One plan in Memphis covers all of the study drugs. However, this particular plan covers all of these (both alcohol use and opioid use) in cost-sharing Tier 2, with quantity limits and prior authorization required for three of the drugs. In every study city, an individual can find a plan that covers each drug, generally at a low cost-sharing tier.

In our study cities, plans are available that cover all of our study medications. However, a distinction must be drawn between the two types of consumers with MAT needs shopping for health insurance coverage. The first type is the consumer already receiving treatment with a need to have that specific treatment covered. The formularies are currently constructed to enable a consumer to easily determine if his or her medication is covered or not, with the exception of methadone. The second type is the consumer who begins treatment during the plan year. In this case, having as broad prescription drug coverage as possible is important, given the restrictions placed on administration of these medications (particularly buprenorphine). In our study cities, only New Mexico Health Connections, in Albuquerque, offers plans that cover all of the study medications, providing all in cost-sharing tier 1. In Chicago, six plans are available (out of 22 offered) that cover every MAT studied with no quantity limits or prior authorization requirements. Another nine plans provide coverage for all five MATs, but all require prior authorization or have a quantity limit for at least one of the drugs. In Kansas City, every silver plan available (seven in total) covers all five MAT drugs, but again, all require prior authorization and impose quantity limits for buprenorphine (and some impose quantity limits on acamprosate). Finally, all 16 of the silver plans available in Manchester cover all five MATs, and 12 of these plans do not require either prior authorization or quantity limits.

Inpatient and Outpatient Care

Inpatient and Outpatient Counseling Services

Clinical evidence suggests counseling and behavioral therapy is an important component of treatment for individuals with SUDs. For all silver plans in each of our study cities, we investigated the SBC documents posted on marketplace websites to analyze the availability and cost-sharing requirements of inpatient and outpatient

services (including counseling) for individuals with SUDs. Since the ACA's EHBs require SUD services, each plan covers them; however, breadth of coverage and associated cost-sharing requirements vary considerably across cities and across the plans offered within each city (table 4).

Prior Authorization Requirements for SUD Inpatient Care

The majority of plans in all the study cities except Manchester require prior authorization for all inpatient services, including those for individuals with SUDs.[17] Seven out of the eight silver plans (88 percent) offered in Albuquerque in 2016 require prior authorization for SUD inpatient services, compared with only 40 percent in Manchester Prior authorization requirements in the other cities range from 68 percent of silver plans in Chicago to 86 percent of silver plans in Los Angeles. While emergency services for individuals requiring stabilization cannot be restricted,[18] prior authorization requirements for nonemergency inpatient services could represent a barrier to admission for some individuals seeking these services. We found that prior authorization policies were nearly identical for SUD inpatient and general inpatient care, though any barrier to care could be especially harmful for individuals with SUDs, some of whom risk relapse or overdose without prompt treatment. Rates of denials of prior authorization for SUD treatment are unknown at this time, however.

Table 4. Inpatient and Outpatient Cost-Sharing Requirements for Substance-Use Disorder Treatment in Selected Cities, 2016

		Los Angeles	Memphis	Albuquerque	Chicago	Kansas City	Manchester
	Out of pocket ($: min / max / median)	6,250 / 6,250 / 6,250	3,500 / 6,700 / 5,500	6,000 / 6,850 / 6,850	3,500 / 6,850 / 6,500	4,750 / 6,850 / 6,225	4,750 / 6,850 / 5,875
	Deductible ($: min / max / median)	2,250 / 2,250 / 2,250	0 / 5,500 / 2,500	750 / 5,000 / 2,500	2,000 / 6,500 / 3,500	2,000 / 5,100 / 3,625	2,000 / 4,200 / 3,200
Inpatient	% require prior authorization	86%	83%	88%	68%	75%	40%
	% require co-pay	0%	0%	38%	27%	31%	60%
	Low co-pay	NA	NA	$250	$400	$500	$300
	High co-pay	NA	NA	$2,500	$1,500	$1,000	$1,000
	% require coinsurance	100%	100%	63%	50%	63%	40%
	Low coinsurance	20%	10%	20%	20%	10%	10%
	High coinsurance	20%	50%	40%	30%	40%	30%
Outpatient	% require prior authorization	57%	80%	25%	50%	0%	10%
	% require co-pay	100%	33%	88%	68%	50%	70%
	Low co-pay	$45[a]	$10	$5	$10	$20	$10
	High co-pay	$45	$60	$50	$75	$40	$40
	% require coinsurance	0%	93%	13%	9%	50%	30%
	Low coinsurance	NA	10%	30%	20%	10%	10%
	High coinsurance	NA	50%	30%	30%	30%	15%

Source: Summaries of benefits covered from Covered California and Healthcare.gov

Table Notes: Some plans require both a co-pay and cinsurance for certain services and others do not have any cost-sharing requirements at all, so some percentages do not add up to 100 percent.

a. Several plans in Los Angeles stipulate that certain types of outpatient services (e.g., group therapy, non-office visits) are subject to lower co-pay requirements, but for the purposes of this table, we have included only the standardized $45 co-pay, which applies to the vast majority of SUD outpatient services.

Prior Authorization for Outpatient SUD Visits

The plans we studied require prior authorization for outpatient SUD visits less frequently than they do for inpatient SUD visits. This is consistent with prior authorization requirements for other types of general outpatient care. Fifty-seven percent of the silver plans in Los Angeles and 80 percent in Memphis require prior authorization for outpatient SUD services, but half or fewer of the silver plans in the remaining four study cities require it (including none in Kansas City). This finding indicates that, generally, outpatient SUD services are less restricted than inpatient SUD services, yet considerable variation exists between cities and between insurers within each city.

Inpatient Cost-Sharing Requirements

Out-of-pocket plan maximums and deductibles vary across and within study cities, ranging from a low out-of-pocket maximum of $3,500 (Chicago and Memphis) to a high of $6,850 (Albuquerque, Chicago, Kansas City, and Manchester). Median out-of-pocket maximums range from $5,500 (Memphis) to $6,850 (Albuquerque). Similarly, deductibles range across and within study cities, from one silver plan with a zero-dollar deductible in Memphis to a plan with a $6,500 deductible in Chicago. Median deductibles across the six cities range from $2,250 (Los Angeles) to $3,625 (Kansas City).

Some plans relying upon coinsurance or co-payments require that enrollees meet their deductibles first, while others reimburse enrollees before they meet their deductibles. Plan SBCs were inconsistent in noting whether cost-sharing would come into effect before or after the deductible has been met, but it is fair to say that this varies somewhat. Some individuals could be barred from services because they cannot meet a plan's deductible or because cost-sharing requirements are prohibitively high.

From our sample cities, we observed that after enrollees meet their deductibles, plans are more likely to require coinsurance for SUD inpatient services than co-payments. In all study cities except Manchester, a majority of silver plans require coinsurance while a minority require co-payments. Coinsurance is inherently less transparent than fixed co-payment amounts: before obtaining care, consumers do not have information on negotiated provider rates and so do not know the dollar amount to which coinsurance percentages will be applied. All plans in Los Angeles and Memphis require coinsurance for inpatient SUD services; the patient's contribution requirement ranges from 10 percent to 50 percent in Memphis and it is 20 percent for all plans in Los Angeles. Most, but not all, plans in the other study cities also require coinsurance for inpatient SUD services, with the patient's contribution ranging up to a maximum of 40 percent (Kansas City and Albuquerque). Some plans require both a co-pay and coinsurance for certain services and others do not have any cost-sharing requirements at all, which is why some percentages in table 4 do not add up to 100 percent.

Although coinsurance is more common among plans in our study cities, some plans require co-payments in addition to or instead of coinsurance for SUD inpatient services. The range of co-payments is broad, for example, from $250 to $2,500 in Albuquerque. However, no plan in Memphis or Los Angeles applies co-payments to SUD inpatient care. These patterns are consistent with other types of inpatient care, which is more likely to be subject to coinsurance (or to coinsurance and co-payment) than to only co-payment.

Cost-Sharing Requirements for Outpatient SUD Visits

We found that co-payments are more common for outpatient than for inpatient SUD services—in all study cities except Memphis, the majority of silver plans (including all plans in Los Angeles) apply co-payments to outpatient SUD services. The amounts of these co-payments vary significantly across and within study cities, although they are the same across plans in Los Angeles because the state standardizes qualified health plans. Silver plans with co-payment requirements in Chicago have the largest co-pay range, from a low of a $10 per outpatient appointment to a high of $75. The co-payment range was narrowest among plans that required co-payments in Kansas City, where the lowest was $20 and the highest $40. Several plans also vary co-payment requirements with the outpatient service. For example, several plans in Manchester explicitly state that individual SUD counseling is subject to higher co-payments than group therapy. However, not all SBCs provided explicit information about how co-payments might vary based on service.

At least one plan in each state does not require coinsurance, but at least one plan in each state does impose coinsurance for outpatient services; these rates range, from 15 percent in Manchester to 50 percent in Memphis. Last, some plans in some cities waive all cost-sharing requirements for the first several (usually three) outpatient appointments. Some plans differentiate between types of outpatient services and have different cost-sharing structures based on the service. For example, some plans require copays for office-based outpatient services and coinsurance for outpatient services in other settings.

In summary, variation in outpatient and inpatient cost-sharing is extensive, both across cities and across plans in a given city. Generally, coinsurance is more common for

inpatient care, while co-payments are more common for outpatient care. Prior authorization is more common for inpatient care compared to outpatient care, which reflects prior authorization requirements for general (non-SUD) care. It is difficult to conclude which study city had the most favorable cost-sharing conditions, since consumers have different needs (i.e., some have a good idea of what care they anticipate needing, while others have needs arise after purchasing coverage). Generally, however, at least one option in each of our study cities provides inpatient and outpatient care before the deductible and with low out-of-pocket requirements. Since each qualified health plan is required to offer services for individuals with SUDs, the breadth of coverage is wide; we found that variety in cost-sharing arrangements would present a consumer with considerable choice in plans.

Comparing plan details as we did here can be useful for those who know or expect that they will need services. Yet the wide variation across plans means that those whose needs arise unexpectedly may find the financial burden to obtain needed services to be high, which may well create a barrier to accessing care.

DISCUSSION

Coverage and cost-sharing requirements for MAT, as well as for inpatient and outpatient services for individuals with SUDs, vary significantly across marketplace plans. All marketplace plans must include at least some services for individuals with SUDs, consistent with the ACA's EHBs; yet plans vary in the specific medications they cover, and plans frequently require prior authorization or quantity limits. Of the MAT options we analyzed, prescription drug coverage was generally better for treatments targeted to individuals with alcohol-use disorders compared to treatment for those with opioid-use disorders, in that plans often imposed fewer restrictions. Exclusion rates were slightly higher for medications treating opioid dependency, but the rates were still rather low. Of the medications available for individuals with opioid-use disorders, naltrexone was more frequently excluded from coverage than was buprenorphine, but only one of our study cities, Memphis accounted for all the plan exclusions for naltrexone. With regard to MAT for alcohol-use disorders, Albuquerque accounted for all the plan exclusions for acamprosate.

Among plans that do cover MATs for opiod use, the cost-sharing tiers in which each drug is placed differ only modestly, although buprenorphine is often subject to quantity or prior authorization limits while naltrexone is not. Naltrexone can only be used as a maintenance therapy for individuals who have already detoxed from opioid use, so its availability does not replace the need for buprenorphine or methadone. No plan studied provides easily accessible and easily understood information about methadone coverage for SUD treatment, a significant issue.

While each study city has plans that cover all five of the MATs for SUDs, the limited number of physicians available to prescribe some of these drugs is likely a more significant barrier to accessing necessary care of this type.[19] This is particularly true for opioid-use dependency, given the restrictions on prescribing buprenorphine.

Inpatient and outpatient services beyond MATs frequently require prior authorization (especially for inpatient services) and frequently impose copays or co-insurance. The cost-sharing requirements vary considerably by plan and by city, and they can be substantial for some plans. Consumers may find it difficult to assess the differential financial burdens across plans because of the lack of transparency associated with coinsurance-based out-of-pocket costs, as opposed to the more-straightforward co-pays. But even for plans requiring co-payments, some are as high as $60 or $75 per outpatient visit and $2,500 per inpatient stay.

Overall, a variety of MAT, inpatient, and outpatient counseling options are available to individuals with SUDs through the marketplace plans, but cost-sharing requirements and other barriers (e.g., prior authorization) may present a hindrance, causing treatment delay or significant financial burden. Further information on prior authorization denial rates and specifics on how quantity limits are imposed would be valuable. Continued monitoring of marketplace coverage for substance-use disorder treatments will remain important as new approaches and practices are developed, to ensure adequate treatment options remain available. Those who recognize their need for these treatments before choosing an insurance plan would do well to carefully assess the drug formularies and cost-sharing requirements for the plan options in their area.

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