

Private Coverage of Methadone in Outpatient Treatment Programs

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Among the three medications approved for the treatment of opioid use disorder, methadone has been in use for the longest period and has the most extensive evidence base of effectiveness. Yet it remains underutilized as new insurance policies favor access to buprenorphine and neglect to dismantle barriers to obtaining methadone. In the absence of wholesale regulatory change, private insurance carriers

should take the lead in expanding access to this medication. We offer several solutions for private payers, including expanding coverage, removing prior authorization, addressing out-of-pocket costs, increasing provider reimbursement, and incentivizing system integration.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.201900373)

The current opioid epidemic in the United States has brought much-needed attention to the shortcomings of the addiction treatment system. Although opioid addiction, also known as opioid use disorder, can be treated as effectively as other chronic diseases, its effective treatments, which include the use of medication, are not sufficiently accessible. During the past 10 years, opioid overdose deaths increased by 157%, but the number of facilities treating addiction remained roughly unchanged, and the majority (about 60%) still do not use medication to treat (1). During this same time frame, much has changed to expand access to medications, with a doubling of the number of facilities offering buprenorphine. Yet, the number of facilities offering methadone has lagged, increasing by only 19%.

One reason methadone utilization has seen little growth is that use of the medication for addiction treatment, but not for pain, has been restricted to administration at opioid treatment programs (2). These programs have been stringently regulated by both state and federal agencies since the 1970s. Thus, for a facility to offer methadone, it must meet specific requirements and obtain approval from the state, the Substance Abuse and Mental Health Services Administration, and the Drug Enforcement Administration. These regulations were established to reduce diversion in treatment and to ensure that treatment is delivered with fidelity. However, expansion in access to methadone has lagged behind the more recently approved medications for opioid use disorder because those medications do not require the same level of oversight. Naltrexone, typically administered with a monthly injection, can be accessed in a doctor's office. Buprenorphine can be prescribed by a waived health care

professional, such as a physician or nurse practitioner, picked up in a local pharmacy, and taken at home.

Patients using methadone to manage their opioid use disorder cannot access the medication through their local pharmacy. They must visit an outpatient treatment provider (OTP) daily (or nearly daily if they are qualified for take-home doses) to receive the medication, and in some facilities patients are forced to wait outside in long lines regardless of weather conditions. The costs and travel time can be prohibitive to many patients who would benefit from the medication.

Many experts have already argued for the transformation of the methadone maintenance system to better align it with other health care services (3, 4). Yet there remains a high level of stigma against methadone maintenance, which has made it difficult to generate the cooperation among many stakeholders necessary to produce the regulatory reforms that are needed to trigger transformation. We too believe these reforms are needed in addition to measures that directly address the issue of stigma. We also believe private

HIGHLIGHTS

- Private insurance companies have an important role to play in addressing the underutilization of methadone for the treatment of opioid use disorder.
- Commercial health plans should expand coverage of methadone, remove prior authorization, reduce out-of-pocket costs, increase provider reimbursement, and incentivize system integration.

payers can strategically address immediate barriers to methadone access and simultaneously create incentives for expanding the medication's availability and use. Private insurance companies can act more quickly than legislative and regulatory reform. Financial systems can begin to drive overdue changes to the methadone maintenance system in order to improve access. This column presents options for commercial insurance companies to expand access to methadone treatment. Quick action could save the lives of their own insurance beneficiaries at little cost and ultimately trigger the long-needed transformation of the methadone maintenance system.

Options for Private Insurance Carriers to Address Barriers to Methadone Access

In response to the opioid epidemic, many health insurers have worked to expand access to effective treatments. Expanding access to methadone, however, has been difficult because private insurance has historically covered methadone only through a laborious prior-authorization process. From the perspective of the methadone provider, private insurance plays a negligible role as a revenue source (5). We interviewed three large health insurers about treatment for opioid use disorder and identified steps that private insurance companies can take to lead efforts that address access barriers.

Expanding coverage of methadone. The first step is to ensure that methadone treatment is a covered service in commercial health plans. Although some commercial insurance carriers have expanded coverage of methadone in some areas or plans, we encourage even more to follow suit, particularly those insurers who serve the communities hardest hit by the opioid epidemic. Given that methadone is one of the most frequently excluded or not explicitly covered treatment benefits for substance use disorder, insurance plans providing coverage for this medication should clearly state that methadone is a covered medical benefit in the plan's evidence of coverage. Furthermore, an insurer directive to cover methadone is not sufficient; employer clients can dictate coverage policies managed by insurers. Insurance companies should educate their employer clients to help them overcome reticence to covering methadone.

Employer clients are an important constituency if coverage policies are to include methadone because most beneficiaries of private insurance receive employer-sponsored insurance. Most employer-sponsored coverage comes from employers who are self-insured, meaning the insurance company acts as the administrator of the health plan. In these cases, the employer has wide latitude in determining what services are covered in the plans that are offered to employees. Even if an insurance company sets internal policy to cover methadone or if the federal government sets parity policies that support treatment for mental and substance use disorders, employers are not required to cover

these services, and many do not. Many employers may believe that covering methadone exposes them to conflict or controversy. Although this effective treatment can help employees live healthier, more functional lives and can reduce additional medical costs, stigma around addiction in general and methadone use specifically may prevent employers from viewing methadone as an appropriate treatment option, especially in job settings that involve driving or use of heavy machinery. These attitudes have inhibited changes to methadone coverage by self-insured employers. In addition, unlike state or federal policy changes, changes to employer coverage would likely occur one employer at a time, if at all. Although this transition would take some time, employers must embrace methadone coverage if expansions in coverage are ever to take hold.

Eliminating prior authorization. In some cases, plans that cover methadone require prior authorization to ensure the treatment is medically necessary before it is approved (6). This requirement can delay access to the first dose, in some cases by more than a day—critical time that could result in relapse or even death for those suffering from opioid use disorder (7). The payers we interviewed described efforts to reduce prior authorization for medications, especially in trusted high-quality programs, but these efforts did not appear to be universal, indicating room for improvement.

Reducing patients' out-of-pocket costs. When methadone treatment is covered by insurance and an individual has access to an OTP that accepts the insurance, there still may be other cost factors prohibitive to methadone access. Specifically, coverage for methadone maintenance typically sits within a traditional medical or behavioral health benefit whereby each specialist visit is subject to a copay. If the copay for each visit ranges from \$10 to \$35 or more, for the 20 visits needed for a month of treatment, copays alone could run over \$700. This cost may be an insurmountable barrier for those trying to access treatment or may deter patients from using their insurance. Instead, patients may choose to pay out of pocket and incur a total monthly cost (about \$126 per week) that is likely to be less than the cumulative copays. If methadone were instead available as a prescription, similar to buprenorphine-based medications, and covered under the pharmaceutical benefit, there could be a single copay for each prescription, usually spanning multiple days or weeks, resulting in lower out-of-pocket costs. Alternatively, a single bundled payment for a weekly or monthly course of methadone treatment could reduce out-of-pocket costs for patients while encouraging high-quality, comprehensive care.

Increasing and aligning reimbursement. Even if an individual's health insurance covers methadone, the treatment may be hard or impossible to access in his or her geographic area. Although commercial payers reported covering methadone, they suspected treatments rates to be very low. This is, in

part, due to scarcity of in-network methadone providers in many areas. In these cases, a candidate for methadone treatment would have to decide whether it would be worth the cost of out-of-network care or a long daily drive for treatment (8). These barriers may prevent patients from using methadone treatment at all, even when it may be the best option. Increasing provider reimbursement can create incentives for providers to offer methadone treatment and to participate in the insurer's provider network (9).

Managing provider networks. Payers should examine their beneficiaries' access to methadone treatment and leverage findings to inform creative solutions. For example, if a payer finds that there are several OTPs in a given geographic area, but these programs do not accept insurance, it may be because the reimbursement rates are not adequate or the contracting process introduces administrative complexities for the treatment programs that can be avoided by billing out of pocket. In these cases, payers may be able to create solutions in partnership with the OTPs. If no OTPs are in the area, payers may choose to work with state and community partners to identify reasons behind the shortage of providers and to implement solutions.

Limitations for Private Insurance Carriers to Address Barriers to Methadone Access

Even if methadone is a covered and accessible treatment option, the fact that OTPs are separated from standard medical facilities and are typically located in unwelcoming or less safe areas deters those with commercial insurance from seeking care there. As one insurer asked, "Why would someone choose to trek long and far or to a shady area when they are being lured to a rehab facility through 'plane tickets and palm trees,' even when the former is a more effective treatment?" A reversal in attitudes toward methadone is needed. The willingness of private insurance companies to cover methadone and pay for it in a similar fashion as treatment for other chronic illnesses can also help reduce stigma towards methadone as a treatment option. Similarly, modifying methadone coverage to align with other supportive services can better integrate methadone treatment with the management of other medical conditions.

Treatment for behavioral health, particularly treatment for substance use disorders, has long been separated from the management of other medical conditions (10). This fractured delivery is reinforced by a fractured payment structure in which behavioral health is often "carved-out" of the medical benefit and managed separately. The separated system incentivizes acute, intensive episodes of care rather than long-term treatment, and relegating this treatment to separate and distinct facilities does not foster coordination between providers. Additionally, this system limits insurers' ability to use health care data to analyze trends and quality because information may be stored in nonintegrated claims

systems. Because methadone is restricted to heavily regulated OTPs, few avenues for health care delivery integration remain. Strategies to address regulatory restrictions or expand access to methadone in other health care settings, such as emergency rooms and primary care, are needed but are outside the scope of this column.

Conclusions

People with opioid use disorder should have options for evidence-based treatments so that every individual's needs can be met. For many, methadone would be the best option if barriers to treatment access could be addressed. Changing payment mechanisms for methadone treatment represents a valuable short-term lever for directly increasing patient access to the medication. Over the long term, however, all stakeholders must work together to reverse societal stigma, promote system integration, and support regulatory reform in order to catalyze a long-overdue transformation of methadone treatment specifically, and addiction treatment more broadly.

Modifying coverage, benefit design, and utilization management for methadone to align with the medical management for other chronic illnesses, such as asthma or diabetes, can reduce stigma toward both users of the medication and those with opioid use disorder by allowing treatment to be viewed on par with other chronic illnesses. Increased access to methadone through commercial insurance reform and by streamlining both public and private payment would create incentives for new providers and investors to participate in and expand access to methadone treatment.

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This study was supported by Arnold Ventures (formerly the Laura and John Arnold Foundation). The authors acknowledge Brendan Saloner, Ph.D., for his critical advice, Caroline Davidson, M.P.H., for her excellent management, and Jamey Holloway for her editorial assistance.

Dr. Azocar is an employee of Optum-UnitedHealth Group. The other authors report no financial relationships with commercial interests.

Received July 25, 2019; revision received September 16, 2019; accepted October 17, 2019; published online December 11, 2019.

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