Key Findings

Analysis of California Assembly Bill 1288
Medication-Assisted Treatment

Summary to the 2023–2024 California State Legislature, April 16, 2023

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

Assembly Bill (AB) 1288 would prohibit prior authorization requirements for several medications related to the treatment of opioid use disorder (OUD) and alcohol use disorder (AUD).

Benefit Coverage: Approximately 95.6% of commercial/CalPERS enrollees have a pharmacy benefit that would be subject to AB 1288. CHBRP estimates that 1% to 5% of these enrollees (the figure varies by medication) have a prior authorization requirement that would be prohibited by AB 1288. Postmandate, none would.

Medical Effectiveness: There is *limited evidence* that removal of prior authorization requirements for buprenorphine products is associated with increased prescriptions and higher treatment retention for OUD. There is *insufficient evidence* on the impact of prior authorization on methadone use for OUD. There is i*nsufficient evidence* on the impact of prior authorization on long-acting injectable naltrexone use for either OUD or AUD.

Cost and Health Impacts[1]: As benefit coverage would change for so few enrollees (5% or less, depending on the medication), and as few of that group both have AUD or OUD and are likely users of medication-assisted treatment, no measurable change in utilization, expenditures, or public health is expected at the state level. However, it is possible that there could be person-level effects. If some persons begin and continue treatment, there could be better health outcomes, possibly including the avoidance of a premature death.

BILL SUMMARY

For these medications:

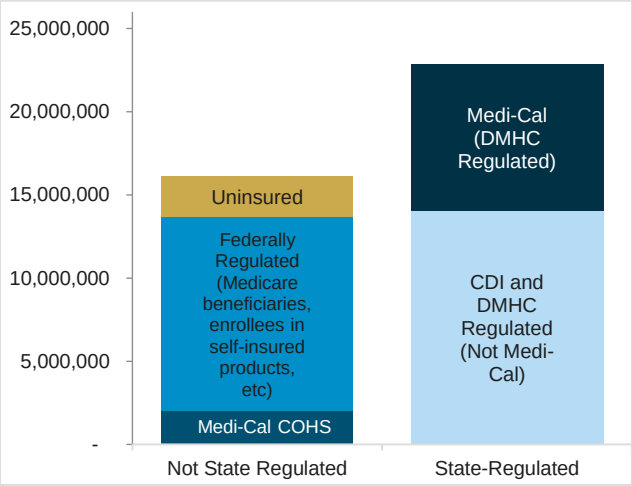
- buprenorphine products
- methadone
- long-acting injectable naltrexone

AB 1288 would not require coverage but would prohibit plans and policies regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) from applying prior authorization requirements to their coverage of these prescription medications when the medications are used for detoxification or as treatment for substance use disorders (SUDs). All of these medications can be used for treatment of opioid use disorder and long-acting injectable naltrexone can be used for treatment of alcohol use disorder.

Although there are Medi-Cal beneficiaries enrolled in DMHC-regulated plans, their prescription medication benefit and benefits for some medication treatments are through centralized systems that are not subject to DMHC. Therefore, the impacts of AB 1288 would be on the health insurance of commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI.

[1] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

Figure A. Health Insurance in CA



Source: California Health Benefits Review Program, 2023.

ANALYTIC APPROACH AND KEY ASSUMPTIONS

For this analysis, CHBRP has assumed that AB 1288 would not prohibit other forms of utilization management, such as formularies or step therapy, from being applicable.

CONTEXT

The prevalence of opioid use disorder is estimated to be 1.58% among Californians aged 12 years and older. The prevalence of alcohol use disorder is estimated to be 11% among Californians aged 12 years and older.

Chronic diseases of all types often involve cycles of relapse and remission, can vary in severity, and often require ongoing professional treatment, lifestyle changes, and case management. SUDs are chronic conditions that may go into remission and are characterized by relapses requiring longitudinal, long-term care. Patients typically require long-term treatment consisting of multiple episodes of treatment or continued treatment over several years. Many patients are never able to achieve long-term recovery. Therefore, treatment goals not only focus on abstinence, but also on reducing harm from the negative consequences of substance use.

Treatments for SUD include prescription medication as well as counseling, residential facilities, and mutual help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous).

There are many reasons persons with opioid use disorder and alcohol use disorder may not receive or seek treatment, including the medications addressed by AB 1288.

- Patient-level barriers may include lack of health insurance; patient-experienced stigma related to having opioid use disorder or alcohol use disorder or taking medications for these conditions; past treatment experiences and beliefs (positive or negative); readiness; logistical or financial issues; knowledge and role of medications used in treatment.
- Provider-level barriers may include general provider supply limits; some providers' unwillingness to prescribe.
- System- or policy-level barriers may include federal and/or state regulatory restrictions on the medications; for persons with health insurance, any applicable cost sharing requirements or utilization management requirements (which may include prior authorization).

IMPACTS

Medical Effectiveness

There is *limited evidence* that removal of prior authorization requirements for buprenorphine products is associated with increased use and higher treatment retention for opioid use disorder.

There is *insufficient evidence* on the impact of prior authorization on methadone use for opioid use disorder.

There is *insufficient evidence* on the impact of prior authorization on long-acting injectable naltrexone use for either opioid use disorder or alcohol use disorder.

For treatment of opioid use disorder, there is *clear and convincing evidence* that buprenorphine products and methadone are more effective with regard to treatment retention, reduction in use of illicit opioids, relapse, and improved health outcomes, compared to a placebo or no treatment. There is a *preponderance of evidence* that long-acting injectable naltrexone is effective with regard to treatment retention and abstinence, but not for overdose prevention, compared to a placebo or oral naltrexone.

For treatment of alcohol use disorder, there is a *preponderance of evidence* that long-acting injectable naltrexone is more effective with regard to reducing

return to drinking compared to a placebo or oral naltrexone.

Benefit Coverage, Utilization, and Cost

Benefit Coverage

The medications addressed by AB 1288 are most commonly covered through a pharmacy benefit.

For Medi-Cal beneficiaries in DMHC-regulated managed care plans, the pharmacy benefit is separate and is administered by the Department of Health Care Services (DHCS). Therefore, these beneficiaries have a pharmacy benefit that is not subject to DMHC regulation. Among commercial/CalPERS enrollees, 1.2% do not have a pharmacy benefit and 3.2% have a pharmacy benefit that is not regulated by DMHC or CDI. Because AB 1288 does not require coverage of the medications it addresses, baseline benefit coverage for enrollees without a pharmacy benefit or whose pharmacy benefit is not regulated by DMHC or CDI is compliant and would not change.

Approximately 95.6% of commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI have a pharmacy benefit regulated by DMHC or CDI that would be subject to AB 1288. CHBRP estimates that 1% to 5% of these enrollees (the figure varies by medication) have a prior authorization requirement that would be prohibited by AB 1288. Postmandate, none of these enrollees would have a prior authorization requirement applicable to these medications when they are on formulary.

Utilization and Expenditures

No measurable change in utilization or expenditures at the state level is expected because benefit coverage would change for very few commercial/CalPERS enrollees (1% to 5% of depending on the medication) and few in that group would both have one of the disorders and be a likely user of one of the medications. However, it is possible that a few enrollees might increase utilization of the medications addressed by AB 1288, postmandate.

Public Health

CHBRP projects no measurable public health impact at the population level because AB 1288 is not expected to create measurable changes in benefit coverage for or utilization at the state level. However, it is possible that AB 1288 could yield some person-level health improvements if some enrollees increase utilization of the medications the bill addresses.

Long-Term Impacts

Because the change in benefit coverage is so limited, no state-level long-term impacts of AB 1288 on health outcomes — including premature death associated with opioid use disorder and alcohol use disorder — can be projected. However, if some enrollees increase utilization of the medications addressed by AB 1288, it is possible that there could be some reduction in premature deaths at the person level.