California Society of Addiction Medicine

"The Voice for Treatment"

Minimum Insurance Benefits for Patients with Alcohol Use Disorders

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PREVALENCE OF ALCOHOL USE DISORDERS:

Alcohol use disorders affect 10-15% of Americans, and alcohol-related morbidity and mortality affect a large percentage of the US population: 65,000 deaths a year are associated with complications of alcohol use.[1] Alcohol, despite its legality, remains one of our most toxic drugs.

LACK OF ACCESS TO ALCOHOL USE DISORDER TREATMENT:

Californians with substance use disorders are grossly underserved. According to the 2007 state estimates from the National Survey on Drug Use and Health, 764,000 Californians needed but didn't receive treatment for drug use and 2.3 million Californians needed but did not receive treatment for alcohol use.[2]

EFFICACY OF TREATMENT FOR ALCOHOL USE DISORDERS:

Treatment for alcohol use disorders is effective, with outcomes on par with treatment for other chronic illnesses, such as depression, diabetes, and heart disease.[3] Research demonstrates that when substance use disorder (SUD) treatment benefits are provided equal to other medical disorders (parity), lives are saved without increasing total costs.[4]

Effective treatment for alcohol use disorders consists of integrated services, from medical detoxification to rehabilitation to maintenance.

MEDICAL DETOXIFICATION:

People with substance use disorders often need detoxification prior to treatment. Detoxification is medically supervised withdrawal from the substance of choice. Detoxification from alcohol can be life threatening, including risk of seizures and delirium tremens (DTs), leading to a stay in the intensive care unit. Early treatment can prevent these dangerous (and costly) outcomes. Equally important, many individuals who might benefit from long-term addiction treatment cannot make an informed decision to enter treatment when they are actively experiencing the vicious cycle of intoxication and withdrawal. With the help of medical detoxification, they can withstand the physiologic drive to use substances and regain the ability to choose abstinence and treatment.

INPATIENT TREATMENT (REHABILITATION):

Outpatient treatment will be the mainstay for most patients. However, some patients will require inpatient treatment, particularly higher risk patients, such as those with cognitive or mental illness and co-occurring drug use, those not responsive to outpatient treatment, and those who live in high-risk environments such as the homeless.

MEDICATION ASSISTED TREATMENT (MAT) IN ALCOHOL USE DISORDERS:

There are four FDA-approved treatments for alcohol use disorders: disulfiram, acamprosate, oral naltrexone, and injectable naltrexone. Studies have shown the effectiveness of these medications in the treatment of alcohol use problems, both for improving rates of abstinence and decreasing the number of drinks on drinking days. They are especially helpful for the syndrome of protracted withdrawal that occurs after the first week of acute withdrawal and may persist for many months.

Disulfiram (Antabuse) blocks the metabolism of alcohol by inhibiting the enzyme aldehyde dehydrogenase, leading to a 'flushing' reaction if alcohol is ingested. Disulfiram thus works as a deterrent to alcohol use. Acamprosate (Campral) modulates brain neurotransmitters GABA and glutamate, modifying protracted withdrawal symptoms and mollifying the cravings that result from the alcohol-induced disturbance in the brain reward pathway. Naltrexone, in its oral or injectable form, is an opioid antagonist which blocks the reward from opioids and helps reduce the reinforcing nature of alcohol.

Off-label use of topiramate, gabapentin, and baclofen has also been shown to be helpful in the treatment of alcohol use disorders. Topiramate and gabapentin are both anti-seizure medications, and Baclofen is a muscle relaxant. All three medications modulate neurotransmitters GABA and glutamate, and dampen the neurotoxic storm that characterizes the protracted withdrawal and abstinence periods after quitting drinking.

All of these 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 alcohol use disorders. Anecdotal evidence suggests benefit when these medications are used in combination and/or on an as needed basis; for example using disulfiram and gabapentin in combination, or using naltrexone just prior to a drink-risky event, such as a wedding or a happy hour.

Despite the extensive evidence for the efficacy of MATs, 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." [5]

COUNSELING OR OTHER SUBSTANCE USE PROGRAMMING AS RECOMMENDED FOR EACH PATIENT:

All MAT for alcohol use disorders is optimized when used in combination with a psychosocial intervention, either individual or group. Cognitive behavioral therapy (CBT), Motivational Interviewing (MI), and 12-Step facilitation therapy (which facilitates transition from professional treatment to 12-Step peer recovery, such as Alcoholics Anonymous AA), have all been shown to help people with alcohol use disorders.[6] (AA, of note, is not treatment per se, since it does not involve a medically trained professional. AA nonetheless has been shown to provide benefit for those with alcohol use disorders, is readily accessible, and can be used as an adjuvant to addiction treatment.)

LAB WORK AND DIAGNOSTIC TESTS NECESSARY FOR SAFELY AND EFFECTIVELY TREATING ALCOHOL USE DISORDERS:

Laboratory testing is important in the diagnosis and monitoring of treatment response for alcohol use disorders. Laboratory testing is both sensitive and specific in detecting excessive alcohol use and alcohol use disorders.[7,8] The use of alcohol breathalyzer and biological fluid testing should be considered a minimum medical standard for the management of alcohol use disorders, including blood, urine, and/or oral fluid tests for alcohol, ethyl glucuronide, ethyl sulfate, % carbohydrate deficient transferrin, and/or phosphatidyl ethanol. Standard laboratory screening for alcohol use disorders and monitoring for progress in recovery should include liver function tests, at minimum.

TREATMENT DURATION:

The decision to start any of these treatments, and the duration to continue them, is highly individual and requires close collaboration between patients and their providers. Substance use disorders, like all chronic medical illnesses, require treatments that provide ongoing care throughout patients' lifespans with many having remissions and relapses.

EVIDENCE-BASED BEST PRACTICES:

1. Coverage for MAT without annual or lifetime medication limits: Alcohol use disorders are chronic relapsing and remitting illnesses. As with patients suffering from other chronic diseases, many addicted individuals need multiple episodes of treatment. The scientific literature has established effective treatment for alcohol use disorders. Research shows that the gold standard for treatment of recurrent addiction is long term. Premature termination of treatment may increase risks of relapse.

2. Minimizing the need for treatment authorization/re-authorization: Chronic illnesses with long-term medication management should not be subject to overly frequent and burdensome re-authorizations.

3. 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.

4. Elimination of "Fail First" criteria: These criteria violate precepts of "first do no harm." 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.

5. Entry to treatment should be readily accessible: Treatment benefits should permit referral options that facilitate entry for treatment through medical settings, as well as allowing self-referral. Systems barriers, such as out-of-network limitations, should not prevent patients from immediately accessing SUD treatment, particularly when the number of physicians trained in the treatment of SUDs is far short of the current need.

MINIMUM BENEFITS FOR PATIENTS WITH ALCOHOL USE DISORDERS:

Alcohol use disorder treatment should include a continuum of basic integrated services: medical detoxification, rehabilitation, and continuing care treatment. Patients should have full access to the effective treatments available. Minimum insurance coverage should include full coverage for:

1. Inpatient detoxification for severe alcohol withdrawal symptoms: Patients who require 24-hour medical and nursing care should receive the full resources of a licensed hospital and other medical benefits. Patients not requiring 24-hour medical and nursing care may be treated as outpatients.

2. Two-weeks of residential treatment for patients unable to achieve abstinence as outpatients (high risk patients)

3. Regular physician visits for evaluation and follow up of alcohol use disorders, allowing for out-of-network providers given the paucity of physicians trained in addiction medicine

4. FDA-approved medication for alcohol use disorders at doses, frequency, and duration recommended by the provider; and off-label usage of other medications shown to be effective for alcohol use disorders (e.g. topiramate, gabapentin, baclofen)

5. Lab work and diagnostic tests necessary for safely and effectively treating alcohol use disorders

6. Counseling or other substance use programming as recommended for each patient

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