LEGAL ACTION CENTER

August 7, 2017

Al Redmer, Jr.
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Dear Commissioner Redmer,

I am writing on behalf of the Legal Action Center, Community Behavioral Health Association of Maryland, Mental Health Association of Maryland, Maryland Psychiatric Society and National Council on Alcoholism and Drug Dependence – Maryland regarding the Maryland Insurance Administration's June 30, 2017 summary of its second market conduct survey regarding carrier compliance with the Mental Health Parity and Addiction Equity Act. We appreciate the MIA's efforts to investigate carrier compliance with the Parity Act and its use of CMS funds to hire a staff member to carry out the market conduct process required by the Senate Finance Committee in 2015. As described below, the survey summary raises a number of questions about the MIA's findings and factual and legal conclusions.

The MIA has concluded from its investigation of Aetna, Cigna and Kaiser's practices that no violations of federal or state parity laws exist with regard to the limited set of plan design questions covered in the October 2015 survey.[1] The brief summary of carrier data presented, however, reveal serious gaps in network adequacy for both substance use disorder and mental health providers. This is the second survey over a three-year period in which the MIA has made the same findings regarding inadequate networks for two of these three carriers. The MIA's rationale for not issuing orders to address these serious gaps – "no harm to consumers" – is not consistent with the Parity Act, which does not require proof of harm for a finding of a violation, and is a conclusion that is not supported factually. Additionally, we have a number of questions about (1) the basis on which the MIA concluded that one carrier's public document (identified as the MHPAEA summary) was erroneous on specific points as opposed to an accurate statement of a non-compliant practice; and (2) the trends revealed by the quantitative data summary MIA requested regarding denial of prior and concurrent authorization for inpatient services and authorization of lower levels of care.

[1] The MIA concluded that Freedom Life Insurance was not subject to the survey because it disclosed that "it did not offer *qualified health plans* in the individual or group markets in Maryland." MIA Survey Summary at 2. (emphasis added). We would appreciate clarification of whether Freedom offers plans in the large group market, which is also subject to the Parity Act.

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We appreciate the MIA's deliberative process in conducting this survey, but we are very concerned that this most recent survey has taken over eighteen (18) months and is not yet complete for the State's two predominant carriers, UnitedHealthcare and CareFirst. Fundamentally, reliance on market conduct surveys, which are useful for targeted investigations, is not an effective practice to fully assess or achieve Parity Act compliance. Parity Act compliance issues are inherently different from the financial auditing function of most market conduct actions. The limitations of relying primarily on this tool in the Parity Act context are apparent from: (1) the lengthy time required to conduct a survey, which carriers can extend through the submission of incomplete responses; (2) the inherently limited scope of each survey as compared with the comprehensive plan design standards, including numerous quantitative and non-quantitative limitations, subject to the Parity Act;[2] and (3) the lack of transparency regarding carrier practices, particularly if the MIA does not issue an order.

Federal law bars the sale of plans that do not comply with the Parity Act (29 C.F.R. § 2590.712(h); 45 C.F.R. § 146.136(h)), and a pre-market compliance review is the only way to achieve real-time compliance, ensuring that members are not harmed during the course of a lengthy market survey. This approach would also ensure the availability of relevant plan documents, which, based on our experience, carriers fail to disclose even in connection with member grievances. We urge the immediate implementation of a pre-market compliance tool, as adopted by the California Department of Managed Health Care.

Finally, the survey results themselves suggest several steps that the MIA should take to improve coverage and access to substance use disorder and mental health benefits in the commercial market. We urge the MIA to address these issues immediately, even as it launches its third market conduct survey.

I. Lack of Information Regarding Quantitative Data and Findings on Prescription Drug Coverage

While we recognize the confidential nature of a market conduct survey absent the issuance of an order, the MIA has not effectively summarized the results of its investigation for most data points. As a result, policy-makers and the public have no basis on which to assess whether a market conduct survey is a valuable compliance tool for the Parity Act evaluation and whether regulators are addressing all federal law requirements. Regulators in other states have identified significant disparities in the coverage of mental health and substance use disorder treatment based on some of the same metrics included in the second survey. *See* MIA Survey Summary at Letter at 5-6. The MIA's failure to describe its findings on several questions raise questions

[2] By way of example, the second survey, as drafted, investigated a handful of non-quantitative treatment limitations (NQTLs) for prescription drug coverage – fail first requirements for all medications and, for four health conditions, coverage, tiering and dosage limitations of medications used to treat those conditions (Survey Questions 2 and 6(f)). The survey excluded many other plan design features for prescription drugs, including authorization requirements, as well as questions about medications for **all** substance use and mental health disorders, not just the two covered – opioid use disorders and bipolar disorder. More importantly, for even the limited number of NQTLs addressed in the survey (Survey Questions 2-6), the questions investigated the carrier's standards "as written" but not "in operation." The MIA cannot conclude that carriers comply with federal law without conducting this second step of the NQTL analysis. 45 C.F.R. § 146.136(c)(4)(i). We urge MIA to obtain and review raw data from carriers in the third survey to assess compliance practices.

about the scope of investigations, the level of carrier disclosure and carrier understanding of how to analyze financial requirements for parity compliance.[3]

For example, the MIA has provided no information about it findings related to the use of fail first requirements for prescription medications or the coverage, tiering and dosage limits of prescription drugs for four health conditions – opioid use disorders, bipolar disorders, diabetes and stroke. Survey Questions 2 and 6(f). We know from data collected by the Drug Policy Clinic, University of Maryland Carey School of Law, in connection with the passage of H.R. 887 in the 2017 General Assembly,[4] which removes prior authorization requirements for medications used to treat opioid use disorders, that there are disparities in the scope and tiering of medications for substance use disorder treatment across the State's carriers. *See* Attachment A. We are very interested in learning the MIA's findings regarding fail first requirements and formulary coverage, tiering and dosage limitations for the full range of medications reviewed. This information is critical to evaluate whether the private insurance market is meeting its obligations to cover treatment that is so essential to address the State's opioid crisis.

Similarly, the MIA has provided no information about its findings related to access to inpatient and residential treatment for mental health and substance use disorders. Survey Questions 4,[5] 5 and 6(b) and (g). The survey should have provided valuable quantitative data that compared the level of authorization and denials for inpatient care across mental health, substance use disorder and medical/surgical conditions and any requirement to use lower levels of care prior to accessing residential treatment. The New York Attorney General evaluated similar data to determine that Excellus Health Plan, Inc. used more rigorous and frequent utilization review for inpatient substance use disorder treatment than for medical/surgical conditions, resulting in significantly higher rates of denial for inpatient substance use disorder treatment than for inpatient medical/surgical conditions. *See* MIA Survey Summary at 6, n. 13. It would be surprising if similar disparities do not exist for some of Maryland's carriers, particularly given the MIA's finding that many jurisdictions in Maryland do not have in-network inpatient facilities for the treatment of opioid use or bipolar disorders.[6]

We request that the MIA provide a summary of its findings on these data points and all others not addressed in its brief summary of findings.

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[3] As noted in your letter, California's desk audits revealed that "insurers did not understand how to analyze financial requirements for parity compliance." MIA Summary at 4.

[4] HB 887 removed prior authorization requirements for medications to treat opioid use disorders, but did not address the scope of coverage or tiering of those medications. An analysis of carrier prescription drug lists reflects significant disparities in scope of medication coverage across the State's carriers. Attachment A.

[5] We note that Survey Question 4 asks the carrier to *describe* its process for determining length of stay for inpatient/residential services, but does not ask for the raw data to support the carrier's description. While we do not know the scope of the MIA's data gathering during its investigations, the raw data is needed to confirm the carrier's representations. As your summary noted, the California Department of Managed Health Care "identified inaccuracies between what plans report to use for utilization management standards and what standards are actually in place." MIA Survey Summary at 5.

[6] The MIA has found that in-network inpatient hospitals, inpatient non-hospital facilities or intensive outpatient programs do not exist in 3 counties for the treatment of opioid use disorders and in 7 counties for the treatment of bipolar disorders. MIA Survey Summary at 4 n. 3.

II. Parity Act Violations Corrected During Investigation: Key Information Was Not Provided and the Threshold for Parity Act Violations Has Been Misconstrued.

The MIA has identified five issues for which it permitted carriers to correct practices that amount to Parity Act violations, without issuing an order, concluding that the carrier administered health benefits in compliance with the law or "no harm to consumers was identified." MIA Survey Summary at 2. As a preliminary matter, the MIA's failure to identify the carrier(s) that engaged in each specific violation undermines the public's ability to gain knowledge about individual carrier practices and monitor carrier activity. The MIA places great weight on consumer and provider complaints as the vehicle for Parity Act enforcement, but it has withheld key information that could facilitate closer consumer and provider oversight of specific carriers. We request that the MIA identify the carrier(s) associated with each practice.

Second, to evaluate the MIA's determination of plan compliance with the law, notwithstanding carrier violations, we request that the MIA identify how it confirmed the following findings:

- For the carrier that limited disclosure of medical necessity criteria to three guidelines at one time, what evidence did the MIA review that substantiated the carrier's assertion that no "requests for the guidelines had been denied or limited because of the internal policy"?
- For the carrier with the on-line directory that included no in-network inpatient facilities for mental illness, did the MIA evaluate why the carrier contained inaccurate information? Additionally, did the MIA review documents to verify that this carrier has contracts with and reimburses specific inpatient facilities and that those facilities accept patients?[7]
- For the carrier with incorrect information in its MHPAEA Summary related to credentialing standards, what documentation did the MIA use to verify that the carrier does not **implement** an "on-site visit" credentialing requirement more stringently for mental health and substance use disorder providers than medical/surgical providers?[8]
- For the carrier with incorrect information in its MHPAEA Summary related to prior authorization requirements for out-of-network inpatient services, what documents and raw data did the MIA rely on to verify that the carrier does not **implement** a more restrictive authorization requirement for mental health and substance use disorder services than for medical/surgical services and that the "as soon as possible" authorization time standard is implemented in a comparable and no more restrictive manner for mental health and substance use disorder benefits?

As the above questions reflect, the MIA's finding of "no violation" must be based on documented evidence, and its assessment is not complete unless it has determined that the carrier's NQTLs comply both in writing and in operation. Federal regulators have provided extensive guidance on the scope of information that a carrier must disclose to demonstrate

[7] It is important to assess the extent to which the carrier's on-line directory deterred individuals with histories of mental health or substance use disorders from selecting this plan because of the apparent lack in-network inpatient facilities.

[8] It is important to assess the extent to which the heightened credentialing standards, as represented, deterred providers from seeking admission to this carrier's network.

parity compliance. *See* Dept. of Labor FAQ 31, Q.9. We request verification that carriers have presented information for each of these elements in compliance with federal standards.

Finally, the MIA suggests that some of the violations, which were corrected in the course of the investigation, should be deemed a technical violation because a consumer suffered no harm. The MIA's finding of "no harm" is incorrect as a factual matter for some of these violations. For example, an inaccurate on-line provider directory clearly harms consumers who either (1) forgo care because in-network providers are not available or (2) pay for care from an out-of-network provider because no in-network providers has been listed. **The MIA has no way of identifying the number of consumers who experienced the very real "harm" of forgoing care.** Regulators could, however, evaluate the impact of accessing out-of-network care by examining the carrier's claims data for inpatient benefits to determine the level of use of out-of-network providers for mental health and substance use treatment and the increased cost of care to policyholders.

More importantly, the MIA's notion that consumer harm is needed to find a Parity Act violation is incorrect as a matter of law. The Parity Act applies a strict liability model by which a non-quantitative treatment limitation (NQTL) violation exists if plan design standard is not comparable, as written or in operation, across mental health, substance use disorder and medical/surgical benefits or is imposed more stringently, either as written or in operation, for mental health or substance use disorder benefits than for medical/surgical benefits. Proof of disparate standards alone results in a violation. We urge the MIA to correct its legal interpretation and issue an order regarding non-compliant practices in the areas in which "no harm to consumers" was found.

III. Network Adequacy Findings: Violations Exist and Carriers Should Be Sanctioned and Required to Take Remedial Actions.

The MIA has identified significant gaps in in-network coverage of outpatient and/or inpatient providers of opioid use disorders (8 counties) and bipolar disorder services (12 counties) (MIA Survey Summary at 4, notes 2 and 3), yet it ***summarily excuses*** these Parity Act violations.[9] The MIA offers four reasons for not pursuing these violations:

- No licensed non-hospital-based behavioral health inpatient facilities are willing to contract with managed care plans in many counties.
- Some carriers meet their in-network accessibility standards despite the lack of in-network facilities in certain counties.
- Some carriers address their shortages by allowing members to access out-of-network providers at their in-network cost-sharing rates.
- Some carriers authorize continued acute inpatient care until the patient may be transitioned to partial hospitalization or intensive outpatient care.

[9] The MIA identifies no lack of outpatient or inpatient network providers for diabetes or stroke. While the MIA's "mapping" of specific mental health and substance use disorders to specific medical conditions is not consistent with the Parity Act's analytical framework (i.e., the standards for all mental health and substance use disorder conditions must be compared with the standards for all medical/surgical conditions), its conclusions highlight the gaps in network standards that would likely be magnified by a complete analysis.

We have specific questions regarding each of the MIA's explanations, based on the limited information provided. Additionally, we do not believe that any of these reasons justify the MIA's decision to not issue an order that would, at a minimum, require corrective action, provide an incentive to improve compliance with federal law and allow the MIA to monitor corrective actions.

A. Carrier Contracting with Non-Hospital Behavioral Health Inpatient Facilities

We are pleased that the MIA's investigation has resulted in some carriers entering into contracts with providers in counties that lacked in-network services. This demonstrates that providers are available and interested in entering commercial contracts.[10] This outcome also raises questions regarding the provider's underlying reasons for not entering network contracts and, importantly, whether those reasons reflect a Parity Act violation. For example, inpatient programs may decline contracts based on the in-network reimbursement rate offered, credentialing standards that disallow facility credentialing consistent with the provider's service delivery model, and utilization management requirements. Each of these considerations implicates an NQTL.

The MIA's survey summary does not reflect whether it evaluated each of these NQTLs when considering the carrier's assertion that providers decline contracts with managed care plans. As noted above, the MIA should review not only the carrier's written standards for each of these NQTLs, but also the carrier's implementation of each when seeking to contract with mental health, substance use disorder and medical/surgical facilities. For example, the New Hampshire Department of Insurance evaluated claims data and determined that commercial carriers consistently reimbursed substance use disorder providers less than the Medicare rate. *See* MIA Survey Summary at 6.

B. Carrier Satisfaction of Network Accessibility Standards Without In-County Providers

The MIA's reliance on a carrier's attestation of satisfaction of its network accessibility standards raises several questions. First, it is unclear whether the MIA concluded that a carrier's compliance with its own accessibility standard is commensurate with Parity Act compliance. The two standards are related but different. While the carrier's accessibility standards constitute some part of its plan for achieving network adequacy and, thus, must comply with the Parity Act (Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013)), the fact that the carrier has met its internal network accessibility standards does not amount to Parity Act compliance. The access plan, itself, must comply with the Parity Act for it to be an adequate measure. [11]

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[10] In the context of the MIA's first market conduct survey and regulatory process for the development of quantitative network adequacy regulations, the University of Maryland Law School's Drug Policy and Public Health Strategies Clinic conducted a state-wide survey that found that opioid treatment programs (OTPs) across the state were interested in contracting with commercial carriers, and specifically CareFirst, if appropriately contacted by and connected with the carrier. Ellen Weber, Drug Policy Clinic, to Nancy Grodin, Deputy Commissioner, MIA (Oct. 18, 2016) (on file with the MIA).

[11] We are aware generally of providers that have asked to join a carrier's network only to be told that it has sufficient providers.

The carrier's accessibility standard could violate the Parity Act in a number of ways, including its written standards for relying on out-of-county providers to meet network adequacy and the manner by which it operationalizes that standard. The MIA's summary offers no information as to whether it evaluated each carrier's accessibility standard, as written and in operation, for Parity Act compliance.

C. Allowing Access to Out-of-Network Providers at the In-Network Cost Sharing Rate Does Not Satisfy the Parity Act

State law appropriately authorizes plan members to access out-of-network providers when an in-network provider is not available without unreasonable delay or travel and to pay cost-sharing based on the in-network deductible and cost-sharing amounts. MD INS. ART. § 15-830(d)(2)(ii)(2) and (e). The MIA interprets the reimbursement standard for the out-of-network provider as allowing for balance billing. *See* Fiscal and Policy Note, HB 800, Maryland General Assembly, 2016 Session, at 2.[12] [available at http://mgaleg.maryland.gov/2016RS/fnotes/bil_0000/hb0800.pdf]. This policy, as operationalized, violates the spirit of state law and cannot serve as an adequate justification for network adequacy violations under the Parity Act.[13]

A carrier that relies on this strategy to make network services available would have to demonstrate that the strategy is applied no more stringently for mental health or substance use services than for medical/surgical services. A carrier could not do so here: a person obtaining a mental health or substance use disorder service would be forced to pay more in total for that service than a patient seeking a medical service that is available through an in-network provider. A carrier would have to assume the expense of the non-contracting provider if it relies on this strategy to achieve parity compliance. The MIA's summary does not indicate that it considered this analysis.

D. Authorization of Continued Care in an Acute Setting to Allow for Safe Transition to a Lower Level of Care

The MIA offers no information by which one can evaluate the frequency with which a carrier authorizes continued care in acute care facilities to address network gaps or whether the carrier's implementation of this strategy for meeting network adequacy complies with the Parity Act. As with other conclusions identified in Point II, we urge the MIA to identify the information that the carrier disclosed to demonstrate that it, in fact, implements this strategy and does so in a parity compliant manner. We are concerned that this strategy may impose a higher cost on enrollees with substance use disorders because care in an in-patient setting generally has higher cost sharing than care in an outpatient setting, including partial hospitalization and intensive outpatient programs.

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[12] HB 800 was introduced by the MIA specifically to address concerns raised by the Lt. Governor's Heroin and Opioid Task Force regarding the limited number of substance use disorder providers in carrier networks. The bill would have required carriers to pay non-contracting providers no less than 140% of the allowed Medicare amount, if the provider network was inadequate, with the goal of incentivizing carriers to contract with providers and ensuring that members have a reasonable benefit when a network provider is not readily available. *See* Fiscal Note at 2-3.

[13] A separate question exists as to whether carriers notify their members that they can seek out-of-network care when in-network providers are not available. If carriers rely on this strategy, they should, at a minimum, demonstrate that members are fully informed of their right to under § 15-830(d)(2)(ii)(2).

IV. Technical Assistance To Improve Network Adequacy

The MIA's findings regarding network adequacy call for either a more complete explanation of its review or a deeper investigation of carrier practices, as set out above. The MIA is also uniquely positioned to go beyond compliance review and affirmatively assist substance use disorder and mental health providers to become network providers. The MIA's implementation of quantitative standards for network adequacy will begin to establish benchmark standards that should result in carriers contracting with more mental health and substance use disorder providers. In this context, some providers will need technical assistance to navigate the credentialing and contracting process and reimbursement rate negotiation. The MIA can play a critical role in translating carrier practices and standards and equipping providers to enter this market.

We understand that the MIA has convened groups of substance use disorder providers to encourage them to file complaints related to denials of care and could do the same to better understand the problems that providers have in these processes, provide technical assistance and bridge carrier-provider differences. Affirmative efforts are necessary to ensure that the private market is playing its role in addressing the state's opioid crisis.

Thank you for considering our request of additional information. We look forward to discussing these issues with you and will contact your office to arrange a convenient time to meet.

Sincerely,

Ellen M. Weber
Vice President for Health Initiatives

Cc: Honorable Thomas McLain Middleton
Honorable Shane Pendergrass
Patrick Carlson, Committee Counsel
Linda Stahr, Committee Counsel
Nancy Grodin, Deputy Commissioner
Robert Morrow, Jr., Associate Commissioner, Life & Health
John Van Lear Dorsey, Principal Counsel
Darci Smith, Special Assistant - MHPAEA

ATTACHMENT A

Maryland Commercial Carriers – Prescription Drug Lists January 2017
Access to Medications for the Treatment of Substance Use Disorders

The U.S. Food and Drug Administration (FDA) has approved three medications for the treatment of alcohol use disorders – disulfiram, naltrexone and acamprosate – and three medications for the treatment of opioid use disorders – methadone, buprenorphine, and extended-release injectable naltrexone. These medications are available as generic and brand drugs and, for opioid use disorder medications, in different formulations (liquid, tablet, film, implant and injectable).

Fourteen (14) generic and brand medications may be covered on plan formularies (prescription drug list) for medication assisted treatment (MAT).

- **Alcohol Use Disorder Medications**
  - Disulfiram/Anatbuse®; Naltrexone/ Revia®; Acamprosate/Campral®
- **Opioid Use Disorders**
  - Buprenorphine/Subutex®, Probuphine® (buprenorphine implant); Buprenorphine-Naloxone/Suboxone® (table and film), Zubsolv® (tablet), Bunavail (buccal film)
  - Vivitrol® (injectable Naltrexone)

Methadone (also available as Methadose and Dolophine) can only be prescribed and dispensed for the treatment of an opioid use disorder by a licensed program and, therefore, is not available on a carrier's formulary for addiction treatment.

Maryland's commercial insurance plans offer different coverage for medications and some impose prior authorization requirements:

- **Coverage of Substance Use Disorder Medications**
  - Two carriers – CareFirst and Aetna – offer the most comprehensive coverage of medications for both alcohol and opioid use disorders. CareFirst covers 11 of 14 medications, and Aetna covers 9 of 14. (*See* attached chart).
  - Evergreen's formulary covers 7 of 14 medications.
  - United Healthcare's small employer plan formulary covers 6 of 14 medications, while other United formularies, which may apply to large employer plans, cover only 3 medications – all for opioid use disorders.
  - Two carriers – Cigna and Kaiser – provide coverage for 5 of 14 medications, all of which are generic drugs.
  - Vivitrol is covered by 4 carriers as either a medical or pharmacy benefit – Aetna, CareFirst, Evergreen and Kaiser.

- **Prior Authorization – Opioid Use Disorder Medications**
  - Aetna, United and Evergreen impose prior authorization for **all** covered opioid use disorder medications.
  - CareFirst imposes prior authorization on **1 of 6** covered opioid use disorder medications.
  - Kaiser does not impose prior authorization on any of 3 covered opioid use disorder medications.

- **Other Utilization Management**
  - Aetna, Kaiser and Evergreen impose supply or quantity limits on opioid use disorder medications.

Prepared by Ellen Weber, Professor of Law, Drug Policy and Public Health Strategies Clinic, University of Maryland Carey School of Law (Feb. 2017). Contact 410-706-0590
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Maryland Commercial Carriers – Prescription Drug Lists January 2017
Access to Medications for the Treatment of Substance Use Disorders

	Aetna – Value Plus Small/Large Group[1]	CareFirst ACA Plans[2]	CareFirst Large Group – 3/4 Tier[3]	Cigna[4]	Kaiser[5]
Tier 1	Acamprosate (QL) Buprenorphine (PA, QL)# Buprenorphine/Naloxone(PA, QL) Disulfiram Naltrexone	Acamprosate Buprenorphine Buprenorphine/Naloxone Disulfiram Naltrexone	Acamprosate Buprenorphine Buprenorphine/Naloxone Disulfiram Naltrexone	None	Acamprosate (T 1/3) Buprenorphine(QL) (T 1/3) Buprenorphine/Naloxone (QL) (T 1/3) Disulfiram (T1/ 3) Naltrexone
Tier 2	None	Antabuse® Revia® Suboxone®	Antabuse® Revia® Suboxone®	Acamprosate Buprenorphine Buprenorphine/Naloxone Disulfiram Naltrexone	None
Tier 3	Bunavail® (PA, QL, ST) Suboxone® Film (PA, QL) Suboxone® Tablet (PA) Vivitrol® (SP) Zubsolv (PA, QL, ST)	Bunavail® Zubsolv® (PA)	Bunavail® Zubsolv® (PA)	None	See Tier 1 for medications also on Tier 3
Tier 4	None	NA	None	NA	None
Other		Vivitrol® (Medical Benefit)	Vivitrol® (Medical Benefit)		Vivitrol (Medical Service Drug not available through pharmacy)
Not on Formulary	Antabuse® Campral® Probuphine® Revia® Subutex®	Campral® Probuphine® Subutex®	Campral® Probuphine® Subutex®	Antabuse® Bunavail® Campral® Probuphine® Revia® Suboxone® Subutex® Vivitrol Zubsolv	Antabuse® Bunavail® Campral® Probuphine® Revia® Suboxone® Subutex® Zubsolv®

Key
PA – Prior Authorization
QL – Quantity Limit
SP – Specialty Pharmacy (may pay higher out-of-pocket costs and may be required to get product at an Aetna Specialty Pharmacy)
ST – Step Therapy
- Limitations may differ based on dosage

Maryland Commercial Carriers – Prescription Drug Lists January 2017
Access to Medications for the Treatment of Substance Use Disorders

	United Healthcare SHOP 3 Tier Advantage[6]	United Healthcare 3 Tier Traditional[7]	United Healthcare 4 Tier Advantage[8]	USHealth Group[9]
Tier 1	Buprenorphine (PA,SL) Disulfiram Naltrexone	Buprenorphine/naloxone (E, PA,SL) Zubsolv® (PA, SL)		PRESCRIPTION DRUG LIST NOT AVAILABLE ON CARRIER'S WEBSITE
Tier 2	Zubsolv® (PA, SL)#	None	Zubsolv® (PA, SL)	
Tier 3	Antabuse® Revia®	Suboxone® Film (E, PA, SL)		
Tier 4	NA	NA	Buprenorphine/naloxone (E, PA, SL) Suboxone® Film (E, PA, SL)	
Not on Formulary	Acamprosate Bunavail® Buprenorphine/naloxone Campral® Probuphine® Suboxone® Subutex® Vivitrol®	Acamprosate Antabuse Bunavail® Buprenorphine Campral® Disulfiram Probuphine® Naltrexone Revia® Subutex® Vivitrol®	Acamprosate Antabuse® Bunavail® Buprenorphine Campral® Disulfiram Naltrexone Probuphine® Revia® Subutex® Vivitrol®	

Key

E – May be excluded from coverage
PA – Prior Authorization
SL – Supply Limit
ST – Step Therapy·
- Limitations may differ based on dosage

Maryland Commercial Carriers – Prescription Drug Lists January 2017
Access to Medications for the Treatment of Substance Use Disorders

	Evergreen – Optum Rx[10]
Low Cost Generic	None
Generic	Acamprosate Buprenorphine (PA, QL) Buprenorphine/Naloxone (PA,QL) Disulfiram Naltrexone
Preferred Brand	Suboxone (PA,QL)
Non-Preferred Brand	None
Specialty Drug – Generic and Preferred Brand	None
Specialty Drug – Non-Preferred Brand	Vivitrol (PA)
Non-Formulary	Antabuse Bunavail Campral Probuphine Revia Subutex Zubsolv

Key

PA – Prior Authorization (Additional information is required to determine coverage)
QL – Quantity Limits (Amount of Medication covered per copayment or in a specific time period is limited)

[1] Aetna Value Plus Formulary for Maryland Small and Larger Employer Plans. *Available at* https://client.formularynavigator.com/Search.aspx?siteCode=6428343782; Referenced at http://www.aetna.com/employer-plans/document-library/states/md-1-50-benefit-grid.pdf (small employer); and http://www.aetna.com/employer-plans/document-library/states/md-51-100-benefit-grid.pdf (larger employer).

[2] CareFirst ACA Plans. *Available at* https://member.carefirst.com/carefirst-resources/pdf/aca-2017-formulary-2.pdf. Specialty drugs are available at https://member.carefirst.com/carefirst-resources/pdf/specialty-pharmacy-drug-list-sum2654.pdf.
[3] CareFirst Large Employer Plans – 3 and 4 Tier Plans. *Available at* https://member.carefirst.com/carefirst-resources/pdf/non-aca-2017-formulary-2-3-tier.pdf (3 Tier); and https://member.carefirst.com/carefirst-resources/pdf/non-aca-2017-formulary-2-4-tier.pdf (4 Tier).
[4] Cigna Health and Life Insurance Co. – Maryland. *Available at* https://www.cigna.com/individuals-families/prescription-drug-list?consumerID=cigna&indicator=IFP&pdlYearType=CD
[5] Kaiser Foundation Health Plan of Mid-Atlantic States, Inc. Commercial Plan Formulary. *Available at* https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_exchange_formulary.pdf
[6] United Healthcare Maryland SHOP Plans – 3 Tier Advantage identified as formulary *at* https://chp.optumrx.com/RxSolWeb/mvc/rxExternalFormularySearch/displaySearch.do?type=StaticPDFFormulary&id=P17A3MDSS&st=P17A3MDSS&State=Maryland&Plan=3%20Tier%20Advantage%20PDL&Phone=1-877-856-2430&Welcome=Guest. 3 Tier Advantage *available at* https://www.uhc.com/content/dam/uhcdotcom/en/Pharmacy/PDFs/Advantage3TierPlans.pdf. All United Healthcare formularies *available at* https://www.uhc.com/employer/pharmacy/total-cost-management/prescription-drug-list.
[7] United Healthcare Traditional Formulary. *Available at* https://www.uhc.com/content/dam/uhcdotcom/en/Pharmacy/PDFs/Traditional3TierPlans.pdf.
[8] United Healthcare Advantage 4 Tier Formulary *available at* https://www.uhc.com/content/dam/uhcdotcom/en/Pharmacy/PDFs/Advantage4TierPlans.pdf.
[9] Freedom Life Insurance Co. of America (individual ACA market). *See* http://www.ushealthgroup.com/sbc.aspx.
[10] Evergreen Small Employer Formulary. *Available at* http://www.evergreenmd.org/everwp/wp-content/uploads/2016/11/010117-Evergreen-EHB-Formulary.pdf.