Closing the Care-Continuity Gap in SUD

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An Actuarial View of $569M in ACA Marketplace SUD Spending

$569M
SUD-primary spend analyzed across ~150K ACA marketplace lives

3.64:1
Ratio of acute-stabilization vs. sustained-recovery spend

~$2K
Per-member opportunity if spend shifts toward recovery-sustaining services

EXECUTIVE SUMMARY

Across approximately **150,000 ACA marketplace lives**, members with a primary SUD diagnosis generated **$569 million in allowed costs in benefit year 2023**, averaging $2,700 PMPM and 5.4% of total cost of care for this segment.

When every dollar is classified along a recovery-value spectrum:

- **51.5%** flows to acute-stabilization and short-cycle services (emergency department, ambulance, detox, short-term residential, partial hospitalization)
- **14.1%** flows to sustained-recovery services (medically-assisted treatment, case management, psychotherapy, preventive primary care)

This imbalance is not a deliberate allocation. It is the predictable byproduct of fragmented continuity of care, regional workforce constraints, and benefit designs that pay reliably for crisis episodes and unevenly for what comes after. **Closing even part of the gap represents an estimated ~$2K per-member opportunity**, quantifiable but sensitive to local conditions.

Source: Wakely ACA Database (WACA), 2023 Benefit Year, primary SUD diagnosis ICD-10-CM F10–F19. Recovery-value classification developed jointly by Wakely actuaries and HMA SUD subject-matter experts.

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SUD at the Population Level

$2.7T[1]

Total economic burden of illicit opioids, 2023

48.5M[2]

Americans ages 12+ with a SUD in 2023 (14.1% of population)

$13.2B[3]

Annual SUD-attributable hospital costs (ED + inpatient)

WHERE SUD DOLLARS CONCENTRATE TODAY

- Medicaid covers SUD services for ~7.2% of enrollees,[4] with per-person spending ~2.1×[4,5] the average Medicaid beneficiary
- The ACA extended mental health and SUD parity to 62 million Americans,[6] yet treatment initiation and engagement rates remain well below those for other chronic conditions

WHAT THIS BRIEF EXAMINES

A claims-level look at **how SUD dollars actually distribute across the recovery continuum** in a commercial ACA population and what that distribution implies for payers building value-based contracts

Sources: [1]White House CEA (2025); [2]SAMHSA NSDUH (2024); [3]JAMA Netw Open (2021); [4]KFF (2020); [5]ASPE/HHS (2014); [6]SAMHSA (2023).

A RECOVERY-VALUE FRAMEWORK, NOT A CLINICAL-NECESSITY RANKING

How We Classified Every Dollar

Tier	% of $569.2M	Representative Services	Recovery-Value Rationale
Highest Value	3.4%	MAT (methadone, buprenorphine, naloxone), case mgmt, peer support, preventive primary care	Strongest evidence base; lowers mortality and downstream TCOC
High Value	10.7%	Psychotherapy, group therapy, structured outpatient, psychiatric evaluation	Builds recovery capital; effectiveness is dose- and continuity-dependent
Mid Value	34.4%	Office visits, lab, diagnostic imaging	Context-dependent; excluded from headline ratio
Low Value	29.7%	Detox, short-term residential, partial hospitalization, hospital observation	Often clinically necessary acutely; weaker evidence as standalone for sustained recovery
Lowest Value	21.7%	ED visits, ambulance transport	Life-saving in crisis; contributes little to long-term recovery stability when not connected to follow-on care

DATA SOURCE: WAKELY ACA DATABASE

Proprietary dataset maintained by Wakely Consulting Group containing detailed claim-line-level medical and pharmacy data for millions of individual and small group market lives across the ACA marketplace. Widely recognized as the most comprehensive commercially available ACA dataset. Analysis encompasses all 2023 benefit year claims with primary SUD diagnosis (ICD-10-CM F10-F19).

HOW TIERS WERE BUILT

Wakely actuaries and HMA SUD clinical SMEs jointly classified each HCPCS code based on four dimensions:

1. Strength of clinical evidence for SUD outcomes
2. Cost-effectiveness in peer-reviewed literature
3. Whether the service typically reflects upstream prevention or downstream consequence
4. Contribution to long-term recovery stability

CLINICAL DISCLAIMER

These tiers describe cost-effectiveness as a pathway to sustained recovery, not clinical necessity. An ED visit for an overdose, an ambulance transport for acute withdrawal, or a medically-supervised detox can be the most clinically appropriate and life-saving service in the moment. The framework asks a different question: what mix of services produces the strongest long-term recovery trajectory at the lowest total cost of care? No tier is a recommendation against a service when it is clinically indicated.

Source: Wakely ACA Database (WACA)

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THE 3.64:1 RATIO, IN CONTEXT

What $569M Actually Pays For

For every $1 of SUD-primary spend on sustained-recovery services,

$3.64 goes to acute-stabilization & short-cycle services

(Mid-value services ($195.8M, 34.4%) were excluded from the ratio due to context-dependent nature)

ACUTE-STABILIZATION & SHORT-CYCLE

$293.0M

51.5% of SUD Spending

52,526 members | $5,577 per person

SUSTAINED-RECOVERY

$80.4M

14.1% of SUD Spending

22,941 members | $3,506 per person

WHERE THE DOLLARS CONCENTRATE — TOP 6 OF 200 HCPCS CODES

#	Service	HCPCS	Allowed	Tier
1	ED visit, high severity	99285	**$48.0M**	Lowest
2	Short-term residential	H0018	**$44.3M**	Low
3	ED visit, moderate severity	99284	**$44.3M**	Lowest
4	Intensive outpatient	H0015	**$30.5M**	Mid
5	Treatment program, per diem	H2036	**$28.8M**	Low
6	ED visit, moderate complexity	99283	**$26.5M**	Lowest

First sustained-recovery service (psychotherapy) appears at rank 12 ($9.9M); first MAT service (methadone) at rank 18 ($5.9M).

THREE OBSERVATIONS

1. ED utilization is the largest single concentration of SUD-primary spend.
$127.9M across six HCPCS codes. ED care saves lives in these moments. The opportunity is in what happens next, most SUD ED encounters discharge without a connected follow-up appointment.

2. Behavioral-health spend is concentrated in residential & detox.
Of $187.4M in SUD behavioral-health services, 73.7% sits in detox, short-term residential, and partial hospitalization. Sustained-recovery services, psychotherapy, MAT, case management, receive 6.3%.

3. Outpatient psychiatric services are underutilized.
Psychotherapy, group therapy, and psychiatric evaluation together total $23.7M, roughly one-fifth of ED-only spend. Workforce shortages in psychiatry and behavioral-health prescribers contribute meaningfully to this pattern.

Source: Wakely ACA Database (WACA)

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STRONG EVIDENCE, MODEST REPRESENTATION IN CURRENT SPEND

The Treatments That Move Recovery Trajectories

HIGHEST-VALUE SERVICES: $19.5M ACROSS 12 HCPCS CODES (3.4% OF TOTAL)

- **Methadone administration (H0020): $5.9M** — Reduces opioid overdose risk; est. ~$100K lifetime savings/person[1]
- **Case management (H0006): $3.9M** — Coordinates sustained engagement; recovery-coaching trials report engagement uplifts[2]
- **Buprenorphine/naloxone (Q9991/Q9992): $3.2M** — Reduces overdose risk; est. ~$60K lifetime savings/person[1]
- **Naloxone injection (J2315): $2.6M** — Acute overdose reversal
- **Preventive + SUD assessment (various): $3.5M** — Earliest engagement point in the continuum

MAT: THE SINGLE MOST COST-EFFECTIVE OUD INTERVENTION

In this dataset, all MAT-related codes total **$9.2M or 1.6% of SUD-primary spend.** Underutilization—not under-reimbursement—is the dominant driver. Workforce capacity, X-waiver/DEA prescriber availability, stigma, and care handoff design all influence whether eligible members initiate MAT.

HIGH-VALUE SERVICES: $60.9M ACROSS 30 HCPCS CODES (10.7% OF TOTAL)

- Psychotherapy (individual + group + SUD-specific): **$18.3M**
- Drug testing: **$15.5M** | Therapeutic injections: **$8.0M**
- Psychiatric evaluation: **$4.1M** | Office visits (new patient): **$3.0M**

THE SPEND PATTERN

- MAT, case management, prevention (strongest evidence): **3.4%**
- Psychotherapy, psychiatric services, monitoring: **10.7%**
- Detox, residential, hospital-based: **29.7%**
- ED visits, ambulance: **21.7%**

Sources: [1]JAMA Psychiatry (2021), microsimulation model of MAT cost-effectiveness (lifetime estimates depend on adherence assumptions); [2]SAMHSA peer-support evidence brief (2023); PMC (2020). All HCPCS cost data: WACA 2023.

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ALIGNING SUD CARE WITH HOW OTHER CHRONIC DISEASES ARE MANAGED

Why Continuity Matters More Than Episodes

SUD AS CHRONIC DISEASE

SUD relapse rates (40–60%) are comparable to type 1 diabetes (30–50%), hypertension (50–70%), and asthma (50–70%).[1] For diabetes and hypertension, payers and providers organize around continuous management. SUD spending in this dataset is organized differently: episodic stabilization at high frequency, with comparatively thin connective tissue between episodes.

~23% vs. ~13%[2]

SUD all-cause 30-day readmission rate vs. non-SUD admissions

50–75%[3]

of detox episodes not followed by entry into ongoing treatment within 30 days

WHY THIS IS NOT SIMPLY AN INCENTIVE PROBLEM

- **Workforce capacity.** Behavioral-health and addiction-medicine prescribers are unevenly distributed, with significant rural and Medicaid access gaps.
- **Geographic and benefit variation.** Coverage of MAT, peer support, and recovery housing differs materially across states and lines of business.
- **Member-level dynamics.** Engagement, stigma, and social determinants influence which services members actually use after a stabilizing event.

THE MEDICAID IMPERATIVE

Medicaid is the largest payer for SUD services and likely sees a wider gap. HEDIS measures point to where continuity can be measured and contracted on:

- **IET** — % initiating SUD treatment within 14 days; % engaged within 34 days
- **FUA** — Follow-up within 7/30 days after SUD-related ED visit
- **FUI** — Follow-up after inpatient/residential SUD discharge
- **POD** — % of OUD members receiving pharmacotherapy

OPPORTUNITY: A subset of states are advancing value-based payment for SUD, creating openings for shared-savings, episode-bundled, and HEDIS-linked arrangements.

Sources: [1]NIDA Principles of Drug Addiction Treatment, 3rd ed.; [2]AHRQ HCUP readmission analyses; [3]SAMHSA TEDS analyses; Mark TL et al. MA Medicaid analysis (PMC); Georgetown CCF (2025); state Medicaid VBP inventories.

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The ~$2K Per-Member Opportunity

ACUTE-STABILIZATION
$5,577/yr
per unique member

SUSTAINED-RECOVERY
$3,506/yr
per unique member

OPPORTUNITY
~$2,071
per member redirected

SUPPORTING EVIDENCE FROM THE PUBLISHED LITERATURE

- **MAT lowers total medical spend.** Buprenorphine/methadone members show meaningfully lower monthly medical expenditures vs. behavioral-treatment-only cohorts. (Est. $153-$223 lower monthly expenditures)[1]
- **Outpatient follow-up reduces readmissions 21%:**[2] Structured follow-up after ED/hospitalization significantly reduces 30-day readmission rates.
- **Digital therapeutics extend the reach of clinical care.** reSET-O has reported higher 12-week opioid abstinence vs. treatment-as-usual in its FDA registrational data.[3]
- **Telehealth maintains comparable outcomes:** Telehealth buprenorphine: 48% 90-day retention vs. 44% in-person, no increase in overdose risk.[4]

FOUR COMPONENTS OF A GLIDEPATH

1
Identify
Members at inflection points (post-ED, post-detox, missed follow-up)

2
Engage
In the days when members are most receptive with peer support, digital tools, case

3
Sustain
With MAT, psychotherapy, community supports

4
Monitor
Check-ins, digital engagement to determine early disengagement detection

Sources: [1]RRI / MGH; Stanford/FSI (2021); [2]AHRQ managed-care follow-up literature; [3]Pear Therapeutics reSET-O FDA submission; PMC (2021); [4]NIH/PMC observational analyses (2022–2024).

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FOUR OPERATING COMPONENTS & WHERE DIGITAL PEER SUPPORT FITS

What Closing the Gap Looks Like in Practice

1 Interception at Crisis

ED visits, detox admissions, and residential discharges are inflection points. Members are at highest risk and highest receptivity. Operating models that route members into peer support, case management, and MAT initiation at the discharge boundary outperform member-initiated follow-up.

2 Medication as Foundation

MAT is the most cost-effective intervention for OUD in the published literature and represents 1.6% of SUD-primary spend in this dataset. Scaling MAT initiation and retention, including via telehealth, is the highest-leverage clinical move available.

3 Continuous Peer Connection

SAMHSA recognizes peer support as an evidence-based component of SUD treatment. Connection between clinical encounters is where the continuity gap is widest, and where digital platforms can extend reach beyond geography and scheduling.

4 Behavioral Signal Monitoring

The gap between monthly outpatient appointments is where recovery breaks down. Digital health tools that maintain daily connection to recovery community, monitor engagement patterns, and flag early signs of disengagement can fill this gap at a fraction of the cost of another residential admission.

SOBER SIDEKICK'S INDEPENDENT AND INTERNAL EVIDENCE ON DIGITAL PEER SUPPORT

VALIDATION INSTITUTE (2023)

In a cohort of **50,000+ Sober Sidekick users**, relapse declines as peer engagements increase. Users with **5+ peer interactions in their first day are ~2× more likely to remain enrolled at 12 months** (7.5% vs. 3.1%; $p < 0.00001$). At 12 months, Sober Sidekick's user abstinence rate (55%) sits within the range reported for graduates of formal residential programs (49–78%) at no member cost.

RELAPSE RESILIENCY (2024–2025)

80.4% of users who self-report a relapse return to the platform. Daily app sessions decline in the two weeks before relapse and spike on Day +1, a measurable "wake-up call" window. Peer engagement shows a secondary spike around Day +12, consistent with a mid-phase reconnection pattern that is actionable for outreach. n = 31,068 self-reported relapse events.

$569M of SUD-primary spend in the ACA marketplace flows predominantly to services that stabilize members in crisis. Those services save lives and are not the problem. **The opportunity is the continuity gap between them** and that gap is increasingly measurable, addressable, and contractable through HEDIS-linked arrangements, MAT scaling, and digital peer-support infrastructure.

Sources: Validation Institute, 2023 Validation Report — Sober Sidekick App, Validated for Outcomes (Feb 2023). Sober Sidekick, Measuring Relapse Resiliency in Digital Recovery (2025), n = 31,068 self-reported relapse events Oct 2024 – Oct 2025.

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APPENDIX

Partners, Methodology, and Limitations

About HMA

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With multidisciplinary consultants coast to coast, HMA's expertise, services, and team are always within client reach. Learn more at healthmanagement.com.

Wakely Consulting Group, an HMA Company

Wakely maintains the Wakely ACA Database (WACA), the most comprehensive claims-level ACA dataset commercially available. Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

Sober Sidekick

Digital recovery support platform with over **1.4 million downloads**. Provides 24/7 peer-to-peer support, community engagement, and recovery tracking. Users who form social connections show 93–244% increases in sustained engagement compared to baseline, including a validated **48% reduction in self-reported relapse** for users who engage with peers at least once. Designed to extend care beyond clinical settings and support longitudinal recovery.

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APPENDIX

Partners, Methodology, and Limitations (continued)

Methodology

- Population: ACA marketplace members with primary SUD diagnosis (ICD-10-CM F10–F19), benefit year 2023, ~150,000 lives in the WACA sample
- Cost measure: Allowed costs (plan-paid + member cost-sharing)
- Tier classification: Joint Wakely actuarial / HMA SUD clinical SME process across 200 HCPCS codes
- Headline ratio: (Low + Lowest allowed) / (High + Highest allowed); Mid tier excluded as context-dependent
- Unique-utilizer counts deduplicated within tier; members may appear in multiple tiers

Limitations

- ACA individual-market findings; not directly generalizable to Medicaid or employer-sponsored populations without adjustment
- Tiering reflects expert judgment at the service-category level; individual clinical scenarios may justify a different value designation
- The ~$2K per-member opportunity is a planning estimate sensitive to local conditions; not a guaranteed yield
- Sober Sidekick outcome data referenced on Slide 8 reflect a) an independent Validation Institute review of pre-2023 cohort data, and b) internal self-reported behavioral data from 2024–25; neither is a randomized

This brief was produced jointly by Sober Sidekick and Wakely Consulting Group, an HMA Company. Value classifications developed collaboratively by Wakely actuaries and HMA SUD subject matter experts.

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Modeling Disclosures

Data Source

Wakely relied upon the Wakely ACA Database (WACA) to perform the analysis. WACA is an aggregated database based on de-identified EDGE Server input and output files (including enrollment, claims, and pharmacy data) from the 2021–2023 benefit years submitted through April of the following year, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 2.5–3 million lives from the individual ACA markets.

Data Caveats

- Results will be affected by issuer-specific data management. Omitted claims, erroneously coded claims, erroneous enrollment records, and other data issues may not reflect actual ACA cost and diagnosis experience.
- A subset of issuers nationwide submitted data to the database. Wakely believes the database represents a fair cross-section of nationwide experience, but limitations in this regard will affect results.
- There may be irregularities in enrollment date reporting. Given that this analysis relies heavily on enrollment dates, systematic irregularities or errors in enrollment date reporting may impact results, potentially significantly.
- Nationwide observations in one year may differ significantly by state and by issuer, and may not hold in future years. Great care must be taken when applying nationwide observations to localized scenarios. Also note that experience from different benefit years may have a different mix of states and issuers, so great care must be taken when investigating longitudinal trends.
- Wakely excluded data for both enrollees in American Indian (limited/no-cost sharing) CSR plans and enrollees in Medicaid Private Option plans (these only occur in a few states).
- In cases where enrollees switched market, metal tier, or CSR tier, Wakely left the enrollment records as-is, rather than impute a single market, metal, and CSR tier for each unique member ID. Based on our understanding of the context of this analysis, Wakely believes that leaving the enrollment records unchanged will provide the most accurate and meaningful results. This decision is informed by general industry practice of resetting premiums, deductibles, and maximum out-of-pocket costs after such changes in plan type.
- Coding practices may impact results. Mental health diagnoses are particularly susceptible to discretionary coding. Overall prevalence, as well as comparative prevalence between stratifications, should be interpreted with care in light of this limitation.
- Benefit year 2020 was excluded from this analysis due to the impact of COVID-19 and the direction of Aetna. 2021 experience will still exhibit significant impacts from the COVID-19 pandemic, including but not limited to:
    - Deferred care from members and providers avoiding medically discretionary visits
    - Lower coding trend from deferred care and other disruptions
    - Significant claims related to COVID-19 including inpatient admissions, vaccine administration, and testing administration and materials.
    - Ongoing impacts to morbidity from post-COVID Complications
- Run out in each benefit year is limited to March of the following year (ex: benefit year 2018 has run out through March 2019). Therefore, Wakely does not have complete and ultimate run out. Claims incurred in later months are more affected by this limitation than those incurred in earlier months.
- Runout is limited to March instead of April of the following year due to data limitations as issuers cut off claim reports before 4/30 to meet submission deadlines, preventing April from being a complete month.

Methodology and Assumptions

- Members sometimes switch metal and CSR tier during the year. The member months will be bucketed by month based on the member's enrollment in that specific month. A member with multiple coverages in a month will be counted multiple times for that month in the specific metal and CSR tiers of his or her multiple enrollment spans.
- Categories of service are assigned using the Wakely Service Category Grouper. The "ER" category of service includes both facility and professional emergency services.
- Ancillary claims such as home health, ambulance, and DME are grouped with professional claims
- Around 1% of IP claims in our data our cross year claims starting in the previous year - those are excluded from this calculation
- Claims are classified as "outliers" if they are incurred by a member with more than $250,000 in allowed claims during a single month.
- A small amount of claims in each year are flagged as capitated claims, in which the submitter is required to estimate the costs of these services. These claims can be included or excluded with an input and are around ~$15 PMPM.
- Risk score represents the PLRS calculated using the 2023 HHS model.
- Description of inputs:
    - The "Silver 70%" input includes the 00 and 01 CSR variants.
    - For the "Fully Enrolled" input, a value of "Yes" filters the data to only include enrollees who were enrolled for all 12 months (January to December).
    - For the "HCC's" input, a value of "Yes" filters the data to only include enrollees who are diagnosed with at least one Hierarchical Condition Category in a calendar year.
    - For the "SEP" input, a value of "Yes" filters the data to only include enrollees who were enrolled during a special enrollment period. Wakely identified these members as those who began their coverage in March or later.
- The user should use judgement when considering results with low credibility (members months).
- All completion factors presented in this analysis indicate completion as of 15 months since inception.