The Affordable Care Act and Medication-Assisted Treatment Accessibility: A Context-Inclusive Review of Research

Jacob Blevins

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University of Kentucky
Martin School of Public Policy & Administration
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Abstract

This paper provides a contextual review of research investigating associations between the health insurance reforms implemented by the Affordable Care Act and the accessibility and utilization of medication-assisted treatment for opioid use disorder. Research indicates that relative to 2008, the year of initial Medicaid expansions in 2014 is nationally associated with increased rates of insurance coverage, increased rates of treatment, and reduced rates of individuals with opioid use disorder forgoing treatment due to financial concerns (McKenna 2017). Between the year prior to state Medicaid expansion and the third year after it, the number of specialty treatment admissions related to the medication-assisted treatment of opioid use disorder increased across all payers by a significantly larger amount than in nonexpansion states (Saloner, Levin, et al. 2018). The proportion of outpatient admissions who received methadone or buprenorphine for opioid use disorder increased across all payers by over eleven percentage points in expansion states and by under one percentage point in nonexpansion states between the 2010-2013 period and 2014-2016 (Mojtabai, et al. 2019). In addition, provisions within the Affordable Care Act support an opportunity to integrate medication-assisted treatment with the mainstream healthcare system which could result in improved outcomes for individuals receiving treatment (Substance Abuse and Mental Health Services Administration 2018b). While evidence shows improvements in the access and utilization of treatment, some states have not expanded Medicaid while others do not cover or impose restrictions on methadone (KFF 2018d). Other existing concerns include questionable compliance with parity law in private providers (Tovino 2019), nonexpansion low-income populations in the “coverage gap” (KFF 2020c), and a Supreme Court case challenging the Affordable Care Act’s constitutionality (Musumeci 2020).

Executive Summary

The American opioid epidemic has grown increasingly deadly due to the rising prevalence of synthetic opioids such as fentanyl. Overdose statistics have risen over time, in part due to the use of synthetic opioids as additives in heroin and counterfeit prescription opioids to increase their potency. The presence of unpredictably strong and potentially adulterated opioids highlights the importance of effective opioid use disorder treatments that support cessation of use and sustained abstinence. Medication-assisted treatment (MAT) has been shown to increase the likelihood of abstinence, adherence to treatment, and ultimately survival, however research suggests that the cost of treatment limits its accessibility (Leshner and Mancher 2019). Contributing to this barrier, a large portion of individuals with opioid use disorder (OUD) are uninsured (Orgera and Tolbert 2019a). Medicaid expansion and regulatory reforms created by the Affordable Care Act of 2010 (ACA) provided a potential avenue to improve medication-assisted treatment accessibility.
Past research has identified positive associations between Medicaid expansion and access to medication-assisted treatment. In years following initial state expansions of Medicaid eligibility up to 138% of the federal poverty line (FPL), uninsured populations shrunk significantly (U.S. Census Bureau n.d.). In addition, the portion of individuals with opioid use disorder forgoing treatment due to financial concerns nationally declined following initial expansions in 2014 (McKenna 2017). Outpatient admissions for patients receiving medication-assisted treatment increased in expansion states by 11.1% (Mojtabai, et al. 2019). Medicaid expansion was associated with a 70% increase in Medicaid-covered prescriptions of one form of medication-assisted treatment compared to a three-year period prior to expansion (Wen, et al. 2017). Moving forward, the ACA also provides an opportunity to increase the accessibility and utilization by supporting the integration of medication-assisted treatment into the mainstream health care system.

Despite evidence of the Affordable Care Act having positive effects on medication-assisted treatment accessibility and utilization, concerns remain. To date, 35 states have implemented Medicaid expansion. In nonexpansion states, 2.3 million nonelderly uninsured adults fall into the “coverage gap”, a term describing populations with incomes below 100% of the federal poverty line who are often ineligible for both Medicaid coverage and federal aid for insurance premiums (KFF 2020c). In 2018, ten states did not include methadone in Medicaid coverage, and 15 states restrict Medicaid coverage of methadone through mechanisms such as prior authorization requirements (KFF 2018d). The largest concern is an ongoing lawsuit challenging the ACA’s constitutionality that recently reached the United States Supreme Court. The outcome of the case could result in the ACA being dismantled in its entirety (Musumeci 2020).
**Introduction**

The modern state of the American opioid epidemic has grown increasingly more dangerous due to the prevalence of heroin and fentanyl. In contrast to the pharmaceutically produced and federally regulated medications that were commonly abused in the early 2000s, users consume substances that vary unpredictably in strength and content (Joyce 2018). Determining the potency of illicit opioids prior to use is often impossible and is further impeded by potential adulterants such as fentanyl (Drug Enforcement Agency 2018). Research indicates that individuals with opioid use disorder (OUD) who successfully detoxify from drug use and establish abstinence are likely to relapse. Due to the presence of synthetic opioids such as fentanyl, continued opioid use or a relapse could be imminently fatal. A research-informed efficacious approach involves the administration of medications to treat OUD. While various formulations and additional drug combinations are used, the three medications approved by the FDA for OUD treatment are methadone, buprenorphine, and extended-release naltrexone. Methadone and buprenorphine both act on opioid receptors in the brain to reduce or eliminate withdrawal symptoms and cravings without providing the intoxicating effects of traditionally abused opioids. Naltrexone prevents a user from being able to experience a high when using illicit opioids but does not alleviate withdrawal symptoms (National Institute on Drug Abuse n.d.). Medication Assisted Therapy\(^1\) (MAT) has been demonstrated to increase rates of treatment retention, reduce illicit opioid use, and ultimately lower mortality risks (Connery 2015). While there is substantial evidence supporting its efficacy, research suggests that treatment costs are often a barrier preventing individuals with OUD from receiving treatment (Ali, Teich and Mutter 2017).

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\(^1\) Arguments have been made to use alternative terminology to describe medication-assisted treatment due to the potential connotation that the medications are supplementary instead of central to treatment (Chou, et al. 2016). In the interest of consistency with source material, the term medication-assisted treatment will be used in this paper.
This paper serves to provide a context-inclusive review of research investigating associations between the modern accessibility and utilization of medication-assisted treatment and the implementation of the Affordable Care Act of 2010. The Affordable Care Act (ACA) was designed to promote insurance accessibility, improve the quality of healthcare, and reduce costs. While its focus was to increase American access to healthcare coverage overall, it also had the potential to improve the accessibility and utilization of OUD treatments such as MAT. In states that chose to do so, Medicaid benefits were expanded to low-income households and individuals earning below 138% of the federal poverty line. The ACA extended provisions of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) that require qualifying insurance plans to provide equal benefits for mental health and addiction treatment services relative to standard medical services. By requiring plans to provide ten essential health benefits (EHB), one of which includes substance use disorder (SUD) treatment, MHPAEA protections were expanded to a larger portion of health insurance plans (KFF 2013). The strongest evidence for the ACA improving access to MAT is associated with state Medicaid expansions that fully began in 2014. Research has identified an associated decrease in the proportion of individuals with OUD who are uninsured. In addition, there is evidence of reduced financial barriers for the treatment of OUD and increased likelihood of individuals with OUD receiving treatment (McKenna 2017). Research also suggests that there has been an associated increase in the utilization of the MAT drugs buprenorphine and methadone (Mojtabai, et al. 2019).

**Fentanyl and Fentanyl Analogues**

The modern opioid epidemic began in the late 1990’s and early 2000’s with the excessive prescribing of opioid pain medications that lead to a growing presence of prescription opioids on the black market (Joyce 2018). One of the defining features of this period was the presence of pain clinics, now labeled “pill mills”, that dispensed high quantities of opioid pain medications (Kennedy-Hendricks,
et al. 2016). Prescription opioid use began to stabilize in 2010, likely due to new regulations and medication formulas developed to reduce illicit supply and use. The reduction in black-market supply contributed to an increase in street price. Demand for a cheaper and more accessible alternative to prescription opioids developed. Heroin represented a better value to users and began its resurgence in the U.S. (Cicero and Ellis 2017). Overdose deaths continued to rise as heroin use became more common (Figure 1). Perceived strength of product became a driving factor in the black-market economy leading to fentanyl’s rise to prevalence around 2013. Fentanyl and its analogues are synthetic opioids with incredibly high potency to weight ratios leading to their use as an additive in other opioids to increase strength of effect. Overdose numbers increased as fentanyl became more common in autopsy toxicology reports (Mars, Ondocsin and Ciccarone 2018). As of 2017, deaths per 100,000 had increased every year since 2004 (Centers for Disease Control and Prevention n.d.). In 2017 opioids were associated with over 70,000 overdose deaths in America (CDC WONDER Online Database 1999-2018).

Deaths involving synthetic opioids increased from 3,105 in 2013 to an estimated 20,000 in 2016. The most common synthetic opioid associated with overdose deaths was illegally produced fentanyl; a substance that is 50 – 100 times stronger than morphine. Its analogues include acetylfentanyl, carfentanil, and furanylfentanyl all of which were increasingly involved in opioid deaths over the same time period. The strongest of this group is carfentanil which is estimated to be 10,000 times the potency of morphine.
Figure 1

Fentanyl and fentanyl analogues are not only deadly due to their high potency, but also due to their rapid onset of effects. Routes of administration differ in speed of onset and bioavailability. Injection accounts for the most deaths, however other routes such as insufflation, oral consumption, or smoking account for roughly 20% of deaths related to fentanyl and its analogues. It is not known to what extent users are aware that they are consuming a synthetic opioid. Reports of counterfeit prescription opioids containing substances such as fentanyl suggest that deaths associated with only synthetic opioids are not direct evidence of the user being aware of its presence. In 2017 the Centers for Disease Control and Prevention published a report discussing the current severity of synthetic opioid death statistics in ten states between July and December of 2016. The report indicates that 56.3% of the 5,152
individuals who died due to an opioid overdose had fentanyl in their system and over half of them also involved other drugs such as cocaine, methamphetamine, or most commonly heroin (O'Donnell, et al. 2017).

The Drug Enforcement Agency (DEA) suggests that fentanyl and its analogues are being marketed to current opioid users. The agency found a state level correlation between law enforcement seizures of items containing fentanyl and seizures of prescription opioids or heroin. In 2016, Ohio led the nation in law enforcement procurances of fentanyl, heroin, and the prescription opioids hydrocodone and oxycodone. Out of the top ten states for fentanyl overdose cause of death, three of the states are also in the top ten for heroin overdose deaths. Data suggests that highly tolerant heroin users might seek out stronger product whether they know of synthetic opioid involvement or not. Further complicating the issue, dealers may be unaware of the contents of their product. According to the DEA, many dealers likely do not know if the heroin or pills they are selling have been adulterated with fentanyl. Users may prefer fentanyl due to its rapid onset resulting in a “rush”, however its short duration can be considered a negative by the user in comparison to heroin. Users wishing to avoid fentanyl due to preference for other opioids or fear of overdose are still at-risk for consuming a product laced with fentanyl (Drug Enforcement Agency 2018).

An Overview of Medication-Assisted Treatment

Medication-assisted treatment commonly involves methadone, buprenorphine, or naltrexone that each act in pharmacologically unique ways. Current evidence suggests that MAT can be an effective method for reducing the use of opioids and keeping patients in treatment. It also indicates a decreased chance of death for those engaged in long term treatment involving methadone or buprenorphine relative to those not receiving treatments (Leshner and Mancher 2019). MAT has grown in popularity over time, with the percentage of SUD treatment facilities operating opioid specific treatment programs
that offer all three MAT drugs increasing from 12% in 2012 to 28% in 2018. The percentage of programs offering extended-release naltrexone increased from 10% to 28% in the same period, and those offering buprenorphine increased from 15% to 32% between 2008 and 2018 (Substance Abuse and Mental Health Services Administration 2018a).

Methadone is an opioid agonist that mimics the effects of illicit opioids in a medically controlled and monitored manner. It is the oldest and most studied OUD treatment medication and has been utilized worldwide for roughly 50 years. It can be used to ease withdrawal symptoms and to serve as a bridge between illicit use and sobriety through a medically supervised taper schedule while reducing the euphoric effect of other opioids if consumed during treatment. Federal law dictates that methadone treatment can only be administered by state and federally certified opioid treatment programs (OTP) or in a hospital setting. Most methadone patients must physically go to a facility operating an OTP to receive their daily dose, while individuals deemed “stable” may be allowed to take the medication home and self-administer. Methadone appears to have the strongest association with treatment retention and patient satisfaction, but it is also the most similar to standard opioids and can share similar risks (Leshner and Mancher 2019).

Buprenorphine is a newer option than methadone that was first approved for OUD treatment in 2002 (Substance Abuse and Mental Health Services Administration 2018). It is a partial opioid agonist and is not as direct of an opioid substitute for drugs such as heroin and oxycodone. Buprenorphine is similar to methadone due to its ability to reduce withdrawal symptoms and bridge patients to sobriety, however its risk profile is slightly lower because it is not a full agonist. It is commonly administered alongside the opioid antagonist naloxone that disincentivizes potential abuse of the medication or other opioids by blocking their euphoric effects. Unlike methadone, it is most often provided at a primary care clinic and prescribed for self-administration. Prescribers are required to receive training and to pursue a waiver from the DEA to legally provide the drug. Nationally, between two and three percent of
physicians have completed the requirements to prescribe buprenorphine, however in 2017 nurse practitioners and physician assistants were deemed eligible to complete the requirements to become an authorized prescriber.

Methadone and buprenorphine have been the subjects of extensive research using a spectrum of measures to determine efficacy. In the fentanyl era, risk of mortality is often a focus of such research. Treatment including agonists such as methadone and buprenorphine have been linked to reduced risk of mortality in individuals with OUD, with estimates suggesting a decrease of 50% (Leshner and Mancher 2019). Research also indicates that average overdose death rates for individuals with OUD may be 25 deaths per 1000 persons lower in those that have received methadone treatment (Sordo, et al. 2017). Adherence to treatment is also an area where MAT is associated with positive outcomes. Individuals treated with methadone are associated with a 400% increase in likelihood of staying in treatment while also demonstrating significantly lower heroin use rates. Methadone is the oldest and most studied medication out of the three. Buprenorphine treatment has not been studied to the degree methadone has, however there is evidence that it has a similar, albeit slightly less pronounced, negative association with risk of mortality. Available evidence also suggests buprenorphine is similarly effective in decreasing illicit opioid use, however with slightly lower associated rates of retention. Further outcome measures for methadone or buprenorphine treatment indicate associations ranging from improvement in quality of life to reduced risk of HIV and hepatitis C transmission. Methadone has been linked to a reduction in criminality for those with OUD. Buprenorphine administered to pregnant women is associated with better maternal outcomes as well as reduced neonatal abstinence syndrome in infants (Leshner and Mancher 2019).

Naltrexone is unlike methadone and buprenorphine because it is a full antagonist of the mu-opioid receptor which enables it to prevent any high from opioid use. It is commonly administered in an extended-release injection formula that works for up to a month. By blocking the opioid high, it can
cause severe withdrawal symptoms in patients upon initial administration. Naltrexone may be most appropriate for patients who have successfully detoxified and may be at risk of relapse or for those who have successfully completed a methadone or buprenorphine taper to ensure adherence to sobriety. Extended-release naltrexone is the newest of the three MAT drugs and was first approved for OUD treatment in 2010 (Substance Abuse and Mental Health Services Administration 2018). Extended-release naltrexone may have promising associations with decreased opioid use however it is the least studied of the three MAT drugs and research is limited (Leshner and Mancher 2019).

**Barriers to Medication-Assisted Treatment Accessibility and Utilization**

Prior research supports MAT efficacy claims however concerns surrounding underutilization and accessibility limitations remain. Under 35% of adults with OUD have received such treatments in the last year according to 2019 estimates. In addition, there is an estimated average delay of four to seven years between an individual developing OUD and the time they receive treatment. Studies indicate that cost of treatment may be a barrier for those seeking any form of it (Leshner and Mancher 2019). In a survey using data from the pre-ACA period that analyzed a sample of 1,300 18 to 64-year-old individuals who felt the need for treatment but did not get it, 25% cited financial reasons for their lack of treatment. Roughly 36 percent of this sample was uninsured, and a similar percentage (38%) reported an income less than 138% of the FPL (Ali, Teich and Mutter 2017). Another study estimated that the rate of individuals with OUD not receiving SUD treatment because of financial concerns was 51%, and that the uninsured rate of Americans with OUD was 36% in 2008 (McKenna 2017). For this reason, increased attention is being paid to insurance coverage of SUD treatment and MAT. Research shows that uninsured populations and those with OUD overlap. In 2016 and 2017 an estimated 373,000 nonelderly adult Americans with OUD were uninsured (18%). 25% of uninsured nonelderly adults with OUD had a yearly income under 100% of the FPL, while 35% had a yearly income between 100% and 200% of the
FPL (Orgera and Tolbert 2019a). Insurance coverage has been linked to MAT utilization and efficacy. Research shows that states who include MAT in Medicaid coverage see a significant increase in the use of this method. A 2011 study suggests that Medicaid enrollees that receive MAT are 50% less likely to return to illicit opioid use in comparison to other treatments. Private insurance coverage of MAT is also an important factor in MAT accessibility, although historically it may not have been covered in many plans. In the past, private insurance coverage of SUD treatments involved higher patient costs and annual benefit caps in comparison to mainstream medical treatments (Leshner and Mancher 2019).

**The Role of the Affordable Care Act**

The Affordable Care Act of 2010 was designed to promote insurance accessibility, improve the quality of healthcare, and reduce costs. In states that chose to do so, Medicaid benefits were expanded to low-income households and individuals earning below 138% of the federal poverty line. The ACA extended provisions of the Mental Health Parity and Addiction Equity Act that require qualifying insurance plans to provide equal benefits for mental health and addiction treatment services relative to standard medical services. By requiring insurance plans provide ten essential health benefits (EHB), one of which includes SUD treatments, MHPAEA protections were expanded to a much larger portion of plans than before (KFF 2013). There is evidence that the expansion of healthcare coverage decreased the likelihood of Americans with OUD being uninsured and increased the likelihood of receiving treatment (McKenna 2017). There is also evidence of an associated increase in the use of MAT that involves buprenorphine and methadone (Mojtabai, et al. 2019).

**A Brief Description of Medicaid Expansion**

The ACA included Medicaid expansions that would cover nonelderly Americans, with or without dependent children, with incomes under 138% of the federal poverty line. A controversial facet of the ACA would require states to adopt Medicaid expansion or lose federal Medicaid funding. A U.S. Supreme
Court ruling in 2012 struck down the requirement of states to expand Medicaid, stating that the penalty was coercive and therefore unconstitutional (KFF 2013).

Figure 2: Year of Implementation as of July, 2020

As of 2020, 35 states and the District of Columbia have implemented Medicaid expansion however Nebraska and Oklahoma plan to do so in the next year. There is significant variance among expansion states for year of implementation (Figure 2), with Idaho being the most recent (KFF 2020b). Eligibility factors also differ between expansion states ranging from additional work requirements and income-based eligibility. As of July 2020 Utah, Ohio, Indiana, and Arizona have included work requirements in eligibility considerations for the expansion population. Two require at least 80 hours a month, one requires demonstration of searching or training for a job unless working 30 hours a week, and one will phase in a requirement of 20 hours a week. Nine states have work requirement legislation

Figure 2: Data sourced from Status of State Action on the Medicaid Expansion Decision, KFF, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Lo
pending or involved in ongoing legal consideration. Other pending or implemented modifications include ending coverage if premiums go unpaid, delaying enrollment until initial premiums are paid, and offering reduced co-pay for healthy behaviors (KFF 2020a). Nonexpansion states continue to have large populations of uninsured individuals that would be eligible for Medicaid if residing in an expansion state (Figure 3).

![Figure 3: Nonexpansion States: 2020 Share of Nonelderly Uninsured Adult Population Eligible if Expanded](https://www.kff.org/medicaid/fact-sheet/uninsured-adults-in-states-that-did-not-expand-who-would-become-eligible-for-medicaid-under-expansion/)

Figure 3: Data sourced from *Who Could Get Covered Under Medicaid Expansion*, CDC.
In addition, federal tax credits for insurance premiums were made nationally available to households between 100% and 400% of the federal poverty line if they are unable to obtain affordable coverage elsewhere (KFF 2013). In expansion states, low-income individuals could either be eligible for Medicaid or qualify for a tax credit. In nonexpansion states, individuals who are not eligible for traditional Medicaid with an income under 100% of the FPL are in what has been labeled the “coverage gap” (Figure 4). Traditional Medicaid in these states restrict eligibility to specific groups such as low-income children, pregnant women, the disabled, parents under specific conditions. Adults who are not caretakers of a family member, do not have a disability themselves, or are not parents are typically ineligible for Medicaid benefits in many of the nonexpansion states. Ineligible adults may have no option for public assistance if their income is under 100% of the FPL (KFF 2020c). The 2020 FPL marking eligibility for federal premium tax credits is $21,720 for a household of three and $12,760 for individuals (HHS 2020). In 2018, 2.3 million nonelderly uninsured adults would have been eligible for Medicaid if their state chose to expand (KFF 2020c).

Figure 4: Nonexpansion States: 2020 Uninsured Adults in the Coverage Gap

*Wisconsin used a Medicaid waiver to cover adults up to 100% of the FPL effectively eliminating their coverage gap*
A Brief Overview of Regulatory Provisions

In addition to Medicaid expansion and private insurance subsidies, the ACA includes regulatory provisions designed to increase coverage for certain populations, promote comprehensive benefits offered by plans, and to simplify the procurement of health insurance. Unlike Medicaid expansion, these provisions apply to all states regardless of expansion status. One significant change requires health insurance providers to offer equitable benefits for mental health and addiction treatment services as they do for standard medical treatment. While the MHPAEA is a central cause of this progress, the law did not originally require that providers cover mental health and addiction services, instead requiring parity in some plans that choose to offer such benefits. The ACA expanded MHPAEA regulations to more plans through provisions that required plans to provide coverage of both types (CMS n.d.). The ACA required non-grandfathered plans in the small group and individual markets to cover “essential health benefits”, an umbrella term for a list of services and treatments that a “typical employer plan” would cover. The EHBs were developed to promote a minimum standard for what services plans must provide coverage for.

In 2014, states chose from a list of ten plan options that would then become the “benchmark” for applicable providers within the state. On January 1st of 2014, individual plans, small group market plans, and plans sold on state exchange markets had to comply with the established benchmark plans and provide “substantially equal” coverage levels of each of the ten EHB categories. It should be noted that the ACA gave states the discretion to select the specific benefits they prioritize, granting flexibility to states to interpret the broad categories individually (NCSL 2018). The private insurance benchmark plan chosen by expansion states would serve as the benchmark for the protections the state chooses to provide for the expansion Medicaid population (Baumrucker 2018).

Several provisions of the ACA provided new coverage protections for vulnerable populations. The ACA allowed dependent young adults to remain on their parents plan until they turn 26, an age
group that may be at risk for OUD (Leshner and Mancher 2019, 125). In 2015 and 2016, 7.8% of surveyed individuals aged 18 to 25 reported misusing prescription opioids in the past year (Hudgins, et al. 2019). In addition, the act included protections for individuals with pre-existing conditions by mandating that insurers cannot deny coverage to those with pre-existing conditions or raise premiums for those with pre-existing conditions (Figure 5) including past treatment for OUD (Abraham, et al. 2017). Financial lifetime limits on coverage became illegal and annual caps were limited to protect Americans with chronic conditions (KFF 2013).

Figure 5: Estimated Percentage of Nonelderly Adults with Previously Declinable Pre-Existing Conditions in 2018

Health insurance exchanges for each state and the District of Columbia were mandated by the ACA, with the primary purpose of simplify the way consumers shop for and compare insurance plans. ACA exchanges are marketplace resources that facilitate individuals and small businesses to compare and purchase qualified private health insurance plans that include state benchmark defined EHBs.
Exchanges are designed to help consumers identify if they are eligible for federal financial assistance such as subsidies and out-of-pocket limits or Medicaid (Forsberg 2018).

The Impact of the 2008 Economic Downturn

The economic downturn of 2008 was followed by growing uninsured rates. Between 2008 and 2010, the number of uninsured Americans increased from 44.2 million (17.1% of nonelderly population) in 2008 to 46.5 million (17.8% of the nonelderly population) in 2010 (KFF 2018d). In 2010, some provisions of the ACA were enacted which were followed by reductions in uninsured rates. The provisions included prohibiting lifetime monetary or annual benefit caps, denying coverage for children with pre-existing conditions, and the cancellation of coverage outside of instances of fraud. They also established state review systems for premium increases, the office of health insurance consumer assistance, and minimum medical loss ratios that required a minimum amount of provider revenues be allotted to healthcare claims and quality improvement expenses (NCSL 2011). By 2013, the uninsured nonelderly population dropped to 44.4 million (16.8% of the nonelderly population) (Garfield and Orgera 2019).

Coverage Trends Following 2014

The years immediately following 2014 coincided with a decrease in uninsured Americans (U.S. Census Bureau n.d.). According to census data (Figure 6), between 2013 and 2016 the number of Americans who were:

- Uninsured dropped from 44.7 million to 26.9 million (16.7% to 10.0%)
- Covered by private insurance increased from 180.7 million to 186.9 million (65.4% to 69.1%)
- Enrolled in Medicaid increased from 49.7 million to 59.7 million (18.5% to 22.1%)
In years following the implementation of the ACA in 2014, significant reductions occurred in the uninsured rate of Americans with low incomes (KFF 2018b). For the nonelderly population in family units with an income below 200% of the federal poverty line, between 2013 and 2016 the number of individuals who were (Figure 7):

- Uninsured dropped from 26.1 million to 14.7 million (28.0% to 17.0%)
- Covered by a non-group plan increased from 4.6 million to 6.2 million (4.9% to 7.2%)
- Enrolled in Medicaid increased from 37.8 million to 42.3 million (40.5% to 49.0%)
Figure 7: Insurance status of Nonelderly Americans with Incomes Below 200% of the FPL

Figure 7: 2013 n = 93.3 million, 2016 n = 86.3 million
Data sourced from Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 200% Federal Poverty Level (FPL), KFF. https://www.kff.org/other/state-indicator/nonelderly-up-to-200-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

For the nonelderly population in family units with income below 100% of the federal poverty line (Figure 8), between 2013 and 2016 the number of Americans who were (KFF 2018a):

- Uninsured dropped from 12.4 million to 6.9 million (27.9% to 17.4%)
- Covered by a non-group plan increased from 2.1 million to 2.6 million (4.8% to 6.5%)
- Enrolled in Medicaid increased from 22.6 million to 23.2 million (50.7% to 58.4%)
Figure 2: 2013 n = 44.5 million, 2016 n = 39.8 million
Data sourced from Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL), KFF. https://www.kff.org/other/state-indicator/nonelderly-up-to-100-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Trends in Coverage and Treatment following the ACA

The expansion of insurance coverage and coverage for substance abuse treatment through Medicaid expansion, private insurance subsidies, and parity requirements has been studied for its potential to increase the accessibility and the utilization of OUD treatment. Research indicates that nationwide trends in treatment and coverage after 2014 have been positive in many ways. A study found significant evidence that between 2010 and 2015 the odds of being uninsured decreased by 40% for heroin users. The study found that the portion of heroin users covered by Medicaid and the portion who reported receiving care in the last year that was paid for through insurance increased substantially (Feder, et al. 2017). There is also evidence that national uninsured rate of nonelderly adult Americans with OUD decreased from an estimated 36% in 2008 to 27% in 2014 following the implementation of the ACA. The same study found a rise in SUD treatment from 22% to 33% and a drop in the percentage of individuals with OUD foregoing SUD treatment due to financial reasons (51% to 38%) (McKenna 2017).
Another study utilized a difference-in-difference model and found that in expansion states the mean percentage of patients covered by Medicaid per SUD outpatient treatment program increased by 17.5 percentage points (from 25.9% to 43.4%) between 2014 and 2017. The percentage of uninsured patients dropped from 35.3% to 16%. States that did not expand Medicaid had no significant change regarding these measures over the same time period (Andrews, et al. 2019). There is evidence that four years after expansion states broadened Medicaid eligibility the number of admissions with Medicaid increased by 27 percentage points relative to the year before expansion. In the same time frame uninsured admissions dropped by 26 percentage points. In the third year following expansion, the estimated number of admissions related to medications for opioid use disorder across all payers increased by 109.4 per 100,000 nonelderly adults (an increase of 166.3%) relative to the year before expansion (Saloner and Maclean 2020).

There is evidence that the use of MAT increased by a larger percentage in expansion states than nonexpansion states. The proportion of outpatient admissions for treatment of OUD who received opioid agonist therapy (methadone or buprenorphine) increased across all payers from 39.1% to 50.2% in expansion states compared to 39.9% to 40.5% in nonexpansion states between the 2010-2013 period and 2014-2016. The study’s model estimated that approximately 90% of difference could be explained by Medicaid expansion. In addition, patient Medicaid coverage was positively associated with both methadone and buprenorphine treatment regardless of whether the state expanded Medicaid. (Mojtabai, et al. 2019).

In 2014, Medicaid-covered buprenorphine prescriptions increased amongst expansion states in comparison to the years 2011-2013. Medicaid expansion was associated with a 70% increase in prescriptions per 1000 residents, and a 50% increase in Medicaid spending on buprenorphine (Wen, et al. 2017). Another study found that between 2010 and 2015 the rate of individuals filling Medicaid-covered buprenorphine-naloxone prescriptions increased from 10.6 to 25.4 per 100,000 in expansion
counties in California, Maryland, and Washington. The rate in nonexpansion counties in Florida and Georgia increased from 5.2 to 8.5 in comparison. Across all payers in the same period, the rate of individuals filling buprenorphine-naloxone prescriptions rose from 68.8 to 77.1 per 100,000 residents in expansion counties, while in nonexpansion counties it rose from 98.8 to 99.2 (Saloner, Levin, et al. 2018). Buprenorphine prescriptions amongst Medicaid enrollees ages 12 and older increased into 2018. Medicaid-covered prescription rates rose disproportionately in early 2014 expansion states (Figure 9), with an increase from 40 per 1,000 enrollees in 2011 to an estimated 138 in 2018, and 16 to 41 in nonexpansion states. Between 2011 and 2018 annual nationwide Medicaid-covered prescriptions of buprenorphine increased from 1.3 to million to 6.2 million. 77.2% of such prescriptions in 2018 occurred in states that expanded Medicaid in early 2014 (Clemans-Cope, et al. 2019).

Figure 3

![Graph showing annual buprenorphine maintenance treatment prescriptions per 1,000 Medicaid enrollees ages 12 and older, by state Medicaid expansion status, 2011 to 2018 (Estimated).](https://www.urban.org/sites/default/files/publication/100817/2019.08.19_av_state_medicaid_rx_oud_final_v3_1.pdf)
Remaining Coverage Concerns

Despite the utilization of MAT sharing positive associations with Medicaid expansion, there is still significant variation between the types of treatments and services states require insurers and Medicaid to cover and the extent to which they do. In 2018, ten states did not include Methadone in Medicaid coverage (Figure 10). Eight states required a copayment upon receiving methadone prescriptions. Limitations vary significantly with 15 states having some form of restriction. Some states require prior authorization, or proof of medical necessity, while other restrict the prescribing entity to OTP or certified programs (KFF 2018d). As of 2017 all states covered buprenorphine and naltrexone (KFF 2019).

The private insurance benchmarks established by states have been questioned by academics, as compliance with parity protections is not always apparent. In 2017, 14% of state marketplace private health plans would not cover buprenorphine in combination with naloxone, and only 26.1% of plans covered injectable naltrexone (Leshner and Mancher 2019). Alabama and Mississippi’s benchmark plans
impose “quantitative treatment limitations” for inpatient and outpatient SUD care that are not equally applied to standard care. According to a national study, “More than half of all states impose some type of prior authorization requirement on individuals seeking some form of substance use disorder care in at least one inpatient or outpatient context” (Tovino 2019). The stigmatization of individuals with OUD could be partially responsible for varying coverage. Stigma toward individuals with OUD is associated with higher support of policies promoting legally punitive measures for drug use and lower support of policies promoting healthcare-based solutions such as expanding Medicaid to cover OUD treatments (Leshner and Mancher 2019, 110-113).

**Opportunities for Integration Under the ACA**

SUD treatment has commonly taken place outside of the mainstream healthcare system in America. Treatment and harm reduction services are classically offered through specialty treatment programs that are segregated from the traditional medical services offered by hospitals and primary care providers. There are far reaching consequences, such as medical professionals not receiving extensive education training them to recognize, prevent, or treat SUD within their field. Research suggests that individuals with SUD may have twice the chance of developing other chronic conditions, and that there is a disproportionately high prevalence of individuals with SUD in the standard health system. There are still many misconceptions within the medical community about SUD treatment. MAT may be considered an exchange of addictions despite evidence of improved outcomes. In addition, the historical administration of MAT in specialty treatment programs has coincided with unique doctor authorization requirements that limit the number of dispensing physicians and the number of patients they are authorized to treat (Madras, et al. 2020).

There are several arguments that have been made for the integration of SUD with mainstream healthcare. There is research linking SUD and other conditions such as mental health disorders and
chronic illness. Prompt identification of SUD among those being treated for other conditions may improve health outcomes due to increased risk of negative interactions between the two medical issues. Mental health conditions and SUD are known to be interconnected and treatments often incorporate behavioral therapies with MAT. An estimated 40% of people receiving treatment for SUD may have some form of mental disorder and an estimated 29% of people with OUD have experienced a past depressive episode. A study found that heroin users experienced an improvement in depression symptoms during the first three months of methadone treatment (Leshner and Mancher 2019, 71-73). If brought into the mainstream, physicians not yet licensed to dispense MAT drugs may be incentivized to do so due to increased exposure and demand in their immediate work. In addition, SUD treatment could improve in cost-effectiveness if integrated into the mainstream system, which is supported by growing evidence that SUD is associated with a higher prevalence of costly chronic conditions. Individuals with publicly funded insurance make up a large portion of people seeking SUD treatment which contributes to interest in maximizing public funding outcomes. There is evidence that the economic benefits outweigh the costs of substance use treatment further supporting calls to integrate and provide comprehensive care.

The ACA and MHPAEA could increase the likelihood of increased integration for several reasons. Currently, many public and private insurance plans are required to include SUD treatment and prevention in their coverage suggesting that the population of those able to seek treatment has grown. Parity itself may support integration by providing financial incentive to hospitals and primary care providers to offer treatment as well as preventative and harm reduction services. The ACA included provisions that provided an optional Medicaid benefit allowing states to implement “Health Homes” that facilitate care for beneficiaries with chronic conditions. Health homes are designed to provide holistic services for individuals who have or are at risk of having two chronic conditions, one of which can be OUD. The ACA also established integrated healthcare networks between a range of medical
specialties including substance abuse treatment with the purpose of establishing shared responsibility of the patient’s well-being. Accountable Care Organizations (ACOs) are intended to promote collaborative care and therefore increase communication and ability to best serve Medicaid enrollees. Funding for Federally Qualified Health Centers (FQHS) was ensured by the ACA. FQHS are public health services that promote a combination of “primary and preventative” care to populations that are low-income or otherwise underserved. Their ability to provide both primary care and MAT approaches such as the utilization of buprenorphine to economically disadvantaged populations provides an opportunity to study the merits of integrated care (Substance Abuse and Mental Health Services Administration 2016, 6.1-6.45).

**The Current Legal Challenge to the ACA**

The ACA included a provision labeled the “individual mandate” that requires most people maintain a minimal level of health insurance or pay a penalty called the “shared responsibility payment.” It was first challenged in the United States Supreme Court in the National Federation of Independent Business v. Sebelius (2012). The constitutionality of the individual mandate was upheld because the payment was legally labeled an extension of Congress’s power to “tax” instead of a penalty while the requirement of states to expand Medicaid or lose Medicaid funding was struck down. The 2017 Tax Cuts and Jobs Act lowered the shared responsibility payment to $0.

In early 2018 20 states sued the Federal Government to challenge the ACA (**Figure 11**). Two months later two self-employed Texans joined the lawsuit arguing that the individual mandate required them to buy insurance they did not want despite there being no penalty. The Federal Government did not argue against the unconstitutionality of the individual mandate, instead choosing to argue that protections surrounding pre-existing conditions were irrevocably tied to the individual mandate. Once the case reached the U.S. Court of Appeals for the 5th circuit, the Federal Government took the position
that the entire ACA is tied to the individual mandate. The court subsequently determined that the
individual mandate was unconstitutional because the financial penalty no longer produced any revenue
and therefore could no longer be considered a tax but instead was a mandate to purchase insurance.
The future of the rest of the ACA was referred to the Supreme Court who will begin hearing the case as
early as October 2020. The Supreme Court will be reviewing whether Texas and the individual plaintiffs
have the standing to legally challenge the individual mandate, whether elimination of the shared
responsibility payment renders the individual mandate unconstitutional, and to what extent the
individual mandate is severable from the rest of the ACA.

**Figure 11**

**States’ positions in* Texas v. U.S.***


Outcomes could be vastly different depending on the ultimate decision. The ACA could continue
its existence without requiring minimal coverage if the individual mandate is struck down. If the
individual mandate and pre-existing condition protections are struck down, federal subsidies and
Medicaid expansion will continue, however states would decide their own insurance protections such as
those for pre-existing conditions. If the Supreme Court determines Texas and the associated individuals do not have standing, the ACA will continue in its current form. If the ACA is struck down in its entirety, a complicated process to undo the changes made to the health care system will begin. Medicaid expansion populations could lose coverage and the extension of the Mental Health Parity and Addiction Equity Act could cease to exist (Musumeci 2020). In 2017 an estimated 38% of nonelderly adults with OUD were covered by Medicaid roughly totaling to 750,000. A large percentage of this population could lose coverage for treatment if the ACA is dismantled (Orgera and Tolbert 2019b).

Conclusion

The modern American opioid epidemic is now over two decades old and has evolved to include increasingly deadly opioids. The epidemic began with pharmaceutically produced pain medications and has slowly shifted toward heroin and deadly synthetic opioids such as fentanyl. As overdose death rates have increased along with national concern, treatment methods such as MAT have been studied and employed (Centers for Disease Control and Prevention n.d.). There is significant evidence of the efficacy of MAT, especially methadone and buprenorphine, including a lowered risk of mortality and an increased chance of adhering to treatment protocols (Leshner and Mancher 2019). Studies suggest that cost may be a leading obstacle blocking individuals with OUD from receiving treatment and that the uninsured rate for individuals with OUD was 36% in 2013 (McKenna 2017).

In 2010 President Obama signed the Affordable Care Act into law, a milestone that had the potential to reduce uninsured populations including those with OUD. In 2014, states were given the option to expand Medicaid eligibility to low-income households and individuals up to 138% of the poverty line (KFF 2020b). The ACA also expanded parity requirements enacted by the Mental Health Parity and Addiction Equity Act. It required more plans to cover ten essential health benefits, one of which included behavioral health and substance abuse treatment services, in an equitable manner to
which they cover other medical services. Further protections were introduced that prevent plans from refusing to cover or raising premiums for individuals with pre-existing conditions such as OUD (KFF 2013). Coverage of some forms of MAT were expanded to state Medicaid plans and private individual or small group market plans (NCSL 2018). Federal tax credits for private insurance premiums were also made nationally available for those with incomes between 100% and 400% of the FPL. In expansion states low-income individuals with OUD may be eligible for either Medicaid benefits or federal assistance to purchase private insurance sold on state exchanges, both of which provide substance abuse treatment as a part of the ten EHBs (KFF 2020c).

The expected rise in the percentage of individuals covered for OUD treatment supported the possibility of improved access to MAT amongst individuals with OUD and research has provided evidence that this may be the case (Mojtabai, et al. 2019). Medicaid expansion has the most evidence of associated increases in coverage and MAT treatment. Research estimates that the mean percentage of patients covered by Medicaid per SUD outpatient treatment program increased from 25.9% to 43.4% in expansion states while uninsured patients dropped from 35.3% to 16%. The same study did not identify similar associations in states that did not expand (Andrews, et al. 2019). In expansion states, there is evidence of increased rates of individuals receiving MAT in comparison to nonexpansion states. The estimated percentage of outpatient admissions for OUD treatment that received opioid agonists such as methadone and buprenorphine increased from 39.1% to 50.2% in expansion states between the 2010-2013 period and 2014-2016. States that did not expand experienced an increase of less than one percentage point, a difference that the authors suggest is primarily explainable by proportionately higher Medicaid-covered admissions in expansion states (Mojtabai, et al. 2019). Between the period of 2011-2013 and 2014, Medicaid-covered buprenorphine prescriptions in expansion states increased by 70% (Wen, et al. 2017). Between 2011 and 2018 annual prescriptions of Medicaid-covered buprenorphine increased from 1.3 million to 6.2 million nationally (Clemans-Cope, et al. 2019). In
addition, the estimated percentage of Americans with OUD that did not receive treatment due to financial reasons decreased from 51% in 2008 to 38% in 2014 (McKenna 2017).

While evidence is available to suggest that the ACA is tied to increased access to health care and OUD treatment, there are several factors that may limit the scope of its effects or even dismantle the ACA as a whole. To date, 35 states have implemented Medicaid expansions and two are planning to do so (KFF 2020b). In nonexpansion states, demographics not eligible for traditional Medicaid with incomes less than 100% of the federal poverty line may fall into the “coverage gap” where they both cannot enroll in Medicaid and are not eligible to receive federal aid to purchase private insurance. In 2018 an estimated 2.3 million nonelderly uninsured adults would have been eligible for Medicaid if their state chose to expand it (KFF 2020c). In addition, ten states do not include methadone in Medicaid coverage while other states impose restrictions such as previous authorization or proof of medical necessity for Medicaid to cover MAT medications (KFF 2018d). There are also disparities amongst which MAT drugs exchange plans cover and what restrictions are applied (Tovino 2019). An ongoing lawsuit stemming from challenges to the individual mandate recently reached the Supreme Court and could result in the ACA being struck down in its entirety (Musumeci 2020).

This study reviewed research investigating the relationship between the implementation of the ACA and the accessibility and utilization of MAT. Evidence suggests that expansion is associated with decreases in uninsured individuals with OUD and increased access to MAT. While these associations are a sign that accessibility has been improved by past policy, there are several areas of concern such as the restrictive regulation of MAT prescribing, questionable parity amongst public and private insurers in some states, and the potential dismantling of the ACA by Supreme Court decision. The evidence provided in this paper ultimately supports the argument that access to comprehensive health insurance coverage is an important factor in improving the accessibility and utilization of an effective treatment for opioid use disorder.
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