The Affordable Care Act Transformation of Substance Use Disorder Treatment

Any historical assessment of the public health legacy of the Obama administration will have to look favorably at the impact of the Affordable Care Act (ACA; Pub L No. 111–148) on the US response to the opioid epidemic, and its ability to incentivize and assist states in taking action to fight against the epidemic.

Substance use disorder (SUD) is a major public health issue in the United States, particularly in light of the nation's growing opioid epidemic. In 2015, more than 12 million Americans reported misusing opioid pain relievers, and nearly one million Americans reported using heroin.[1] The rate of opioid-related overdose deaths has increased more than 200% over the past 15 years, and overdose deaths related to heroin more than tripled from 2011 to 2014.[2] The costs associated with prescription opioid use, abuse, and overdose are high, estimated at $78.5 billion in 2013 alone.[3]

SUD TREATMENT SERVICES

To meet the needs of patients with opioid use disorder (OUD), it is critically important for insurers to cover the full range of SUD treatment services including outpatient treatment, intensive outpatient treatment, residential treatment, detoxification, recovery support services, and medications.[4] Used in conjunction with psychosocial treatment, OUD medications—methadone, buprenorphine, and naltrexone—are considered the gold standard for OUD treatment. Key federal stakeholders have identified improving access to these medications as a key strategy to address the opioid epidemic.

Historically, SUD treatment services have either not been covered at all under private and public insurance plans or have been limited through the use of higher copayments, annual visit limits, and placing medications on higher tiers.[5] As a result, many Americans in need were unable to access affordable SUD treatment.

AFFORDABLE CARE ACT

The ACA has dramatically changed that picture. The ACA provides greater access to SUD treatment through major coverage expansions, regulatory changes requiring coverage of SUD treatments in existing insurance plans, and requirements for SUD treatments to be offered on par with medical and surgical procedures. As such, the ACA allows an arsenal of tools for states to not only address use disorders for all substances, but the opioid epidemic in particular. Many states have taken full advantage of this arsenal, and although the epidemic continues, it would arguably be worse without these reforms.

The ACA enables states to address the opioid epidemic through four primary mechanisms: insurance coverage expansions, regulatory insurance reforms that require inclusion of SUD treatments, enhanced parity, and opportunities to integrate SUD treatment and mainstream health care.

Insurance Coverage

First, the ACA extends insurance coverage to millions of previously uninsured Americans through Medicaid expansion and state health insurance exchanges. An estimated 1.6 million Americans with SUD have gained insurance coverage in Medicaid expansion states.[6] The ACA also extends coverage to adult children up to the age of 26 years through their parent's insurance, a population with high rates of OUD,[1] and bans insurers from refusing to sell insurance to individuals with preexisting conditions. Specifically, those with a prior treatment admission for OUD can no longer be denied insurance.

Regulatory Insurance Reforms

Second, the ACA requires coverage of SUD screening and brief intervention for all insurance plans and requires coverage of the Essential Health Benefits package, which includes SUD treatment services under Medicaid expansion programs and qualified health plans offered on state health insurance exchanges. While federal guidance on the Essential Health Benefits requires coverage of SUD treatment, it does not specify which services must be included. Thus, states have wide latitude in determining the optimal range of treatment services to cover for patients with OUD. For the first time in history, there are coverage requirements for SUD treatment. Given these requirements, which are largely funded by the federal government, states have the opportunity to address critical gaps in treatment services for Americans with OUD.

Enhanced Parity

Third, the ACA extends the 2008 Mental Health Parity and Addiction Equity Act, which requires that insurers cover SUD treatment in a no more restrictive way than medical and surgical services. Federal parity rules now apply to all private plans including those offered on state exchanges and Medicaid expansion programs.

Opportunities to Integrate Treatment

Fourth, the ACA offers new opportunities to improve care for

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Americans with OUD by promoting integration of SUD treatment and mainstream health care. Innovations such as Medicaid Health Homes, Coordinated Care Entities, Accountable Care Organizations and Patient Centered Medical Homes, allow a broad range of services to be reimbursed under a unified budget, thus creating incentives to increase integration and coordination of care across SUD, mental health, and medical care needs. Given the complex needs of most SUD patients, especially those with OUD, integrating services with primary care and other specialty services, as well as community-based social supports, is considered crucially important.

A TREMENDOUS OPPORTUNITY FOR STATES

States that have expanded Medicaid are better positioned to address the opioid epidemic. However, many of the states that have been hardest hit by the opioid epidemic have not expanded Medicaid (i.e., Maine, Missouri, Oklahoma, Tennessee, and Utah). While extending coverage is extremely important, 10 states that accepted Medicaid expansion limit access to OUD medications. Most concerning, however, are the nine states that have not expanded Medicaid and do not cover methadone, the best studied and most effective treatment of OUD.[7]

The ACA represents a tremendous opportunity for states to address the opioid epidemic. Of course, the ACA raises many implementation challenges. States are still learning how to use these numerous and varied tools, and how to determine which tools are most effective. That said, most of the ACA reforms are optional and allow significant state discretion. As a result, despite crucially important reforms that have enabled some states to mount comprehensive responses to the opioid epidemic, other states continue to lag behind. Nonetheless, the Obama administration will have made a difference. AJPH

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This editorial was written prior to the November 2016 election, the results of which are likely to produce changes to the ACA. Whatever those are, they would not minimize the positive impact the law has already had on the lives of people with substance use disorder as described in this editorial.

Note. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

REFERENCES

1. *Key Substance Use and Mental Health Indicators in the United States: Results From the 2015 National Survey on Drug Use and Health*. Bethesda, MD: Substance Abuse and Mental Health Services Administration; 2016.

2. Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in drug and opioid overdose deaths - United States, 2000-2014. *MMWR Morb Mortal Wkly Rep*. 2016;64(50-51):1378–1382.

3. Florence CS, Zhou C, Luo F, Xu L. The economic burden of prescription opioid overdose, abuse, and dependence in the United States, 2013. *Med Care*. 2016;54(10):901–906.

4. American Society of Addiction Medicine. *The ASAM Criteria*. 2016. Available at: http://www.asam.org/publications/the-asamcriteria/about. Accessed February 13, 2016.

5. Barry CL, Huskamp HA, Goldman HH. A political history of federal mental health and addiction insurance parity. *Milbank Q*. 2010;88(3):404–433.

6. Humphreys K, Frank RG. The Affordable Care Act will revolutionize care for substance use disorders in the United States. *Addiction*. 2014;109(12):1957–1958.

7. Grogan CM, Andrews C, Abraham A, et al. Survey highlights differences in Medicaid coverage for substance use treatment and opioid use disorder medications. *Health Aff (Millwood)*. In press.

Population Health During the Obama Administration: An Ambitious Strategy With an Uncertain Future

No innovations in health policy of the Obama Administration have attracted as little attention from Democratic and Republican office holders, journalists, and researchers as its efforts to improve population health. Considerable research over many years has found that the most effective and efficient policies and professional practices for improving the health of populations and the individuals who constitute them address making access to health care and social services more equitable; raising the quality of education, diet, and housing, and encouraging individual physical activity; increasing the availability of jobs that offer a living wage and security; reducing and remediating drug and domestic abuse; and eliminating toxins from the environment.[1] The effectiveness of the Obama Administration's prioritization of population health has, however, not yet been evaluated rigorously; and as we write this commentary, its political future is uncertain.

TRIPLE AIM STRATEGY

Explicit attention to population health in the Obama Administration began with the appointment of Donald Berwick as Administrator of the Centers for Medicare and Medicaid Services

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