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Short communication

Treatment use, sources of payment, and financial barriers to treatment among individuals with opioid use disorder following the national implementation of the ACA

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ABSTRACT

Introduction: Despite increasing rates of opioid misuse and hospitalizations, rates of treatment for those with opioid use disorder (OUD) are very low. This study examined the impact of the Patient Protection and Affordable Care Act's (ACA) insurance expansion on improving rates of insurance, health care access, and treatment for those with OUD.

Methods: Data on individuals ages 18–64 with OUD come from the 2008–2014 National Survey on Drug Use and Health (N = 4100). Multivariable logistic regression analyses were performed to estimate the trends of health care insurance, treatment and barriers to care across the stages of ACA implementation: pre-ACA (2008–2009), partial-ACA (2010–2013), and national implementation (2014). All models were adjusted for predisposing, enabling, and need factors.

Results: In both adjusted and unadjusted comparisons, national implementation of the ACA was associated with significant improvements in outcome measures for those with OUD. Multivariable analyses indicate that, after national implementation, those with OUD were significantly less likely to be uninsured and were less likely to report financial barriers as a reason for not receiving substance use treatment, relative to the pre-ACA period. Individuals were also more likely to receive substance use treatment and were more likely to report that insurance paid for treatment after national implementation of the ACA relative to the pre-ACA period. These results persisted when national implementation was compared relative to partial-implementation.

Conclusions: National implementation of the ACA has helped to reduce rates of uninsurance, barriers to care, and improve rates of substance use treatment for those with OUD.

1. Introduction

The enactment of the 2010 Patient Protection and Affordable Care Act represented a milestone in US health care policy. While some aspects of the ACA, such as the young adult mandate, went into effect in 2010, the most substantial changes were nationally implemented in 2014. These changes included the creation of state insurance exchanges and the option for states to expand Medicaid to those with family incomes below 138% of the federal poverty level. Since national implementation of the Act, approximately 17 million individuals between the ages of 18–64 have gained health insurance coverage in the United States (Carman et al., 2015). Recent studies have demonstrated that the expansion of coverage resulting from the implementation of the ACA has translated into significant improvements in access to primary care, medications, and health outcomes (Chen et al., 2016; Cutler, 2015; Sommers et al., 2015).

In estimating the impact of this increased health insurance coverage, a population of interest is those with a prescription pain reliever misuse and/or heroin use disorder. However, limited research exists that has estimated the impact of the national implementation of the ACA on this population. According to the 2015 National Survey on Drug Use and Health (NSDUH), an estimated 12.5 million Americans used prescription pain relievers non-medically in the past year, and among them approximately 2 million had a prescription drug use disorder (Hughes et al., 2016). This is especially concerning, given that heroin use is 19 times higher among those who report prior nonmedical use of prescription drugs compared to those who do not (Muhuri et al., 2013). In fact, a significant portion of heroin users (78%) also report misusing prescription drugs (Hughes et al., 2016).

As a population, people with opioid use disorder (OUD; i.e., heroin or prescription pain reliever use disorder) are at greater risk than those without such conditions for inadequate care for several reasons. First,

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opioid use has been attributed to increasing numbers of emergency department visits, treatment admissions for opioid misuse, and fatal overdoses (Cai et al., 2010; CDC, 2016; Ling et al., 2011). Estimates indicate that deaths involving opioids accounted for 61% percent of all drug related overdose deaths in 2014–a rate that has nearly quadrupled from what it was in 2000 (Compton et al., 2016; Rudd et al., 2016). Second, opioid-related hospitalizations increased 150% between 1993 and 2012; however, less than a quarter of the patients had any post-discharge treatment engagement within 30 days, and only 17% of them received any U.S. Food and Drug Administration (FDA) approved opioid dependence medication within 30 days of an opioid-related hospitalization (Ali and Mutter, 2016; Naeger et al. (in press) 2016a; Naeger et al., 2016b; Owens et al., 2014). In addition, only a quarter of individuals with opioid use disorder reports receiving any substance use disorder treatment (Wu et al., 2016). Finally, people with substance use disorder − particularly those that involve disorders related to prescription drug misuse and heroin − may have a diminished ability to navigate the health care system, and, as a result, may receive more fragmented care (Buck, 2011). Therefore, it is important to examine how the national implementation of the ACA may affect health insurance coverage and barriers to health care access among adults with OUD.

This study examines the impact of the national implementation of the ACA on insurance coverage and barriers to health care access among individuals with OUD. Studies using data prior to national implementation the ACA have found limited impacts of the ACA on substance use disorder (SUD) treatment access (Creedon and Lê Cook, 2016; Saloner et al., 2016). However, these results likely understate the gains of national implementation. Although studies of Massachusetts health care reform and the Oregon Medicaid lottery experiment showed significant increases in health insurance coverage and services utilization with insurance expansion, to the author's knowledge, no studies have estimated the impact of the national implementation of ACA on individuals with OUD (Baicker and Finkelstein, 2011; Long et al., 2012).

2. Materials and methods

This study utilizes publically available data from the 2008–2014 NSDUH, a nationally representative survey of the non-institutionalized population in the United States, conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA). The NSDUH collects detailed information on use of alcohol and illicit drugs, mental illness, substance use disorders, utilization of a variety of behavioral health treatments, and treatment barriers for behavioral health conditions. Given the sensitive nature of the information reported, NSDUH collects data using both computer-assisted personal interviewing (CAPI) and audio computer-assisted self-interviewing (ACASI) in order to increase honest reporting (SAMHSA, 2015).

The NSDUH asks respondents questions to assess symptoms of OUD during the past year, using the criteria specified within the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) during the year prior to the survey interview (American Psychiatric Association, 1994). It includes such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school, or home during the past year. The variable for OUD in this study reflects whether the respondent had a prescription pain reliever misuse disorder or heroin use disorder.

Given that the focus of the study is on health insurance, source of payment and barriers to treatment among individuals with a OUD and because the ACA's insurance expansions primarily affect the nonelderly adult population, the sample is restricted to individuals aged 18 through 64 with OUD (unadjusted pooled N = 4100). All estimates are weighted to account for NSDUH's complex survey design and to make the estimates nationally representative (weighted pooled N ≈ 2

Table 1
Descriptive Statistics by ACA Implementation Period, NSDUH 2008–2014.

	Pre-ACA (2008–2009)	Partial-ACA (2010–2013)	ACA (2014)	Total	P-Val
Outcomes					
Being Uninsured	37.14	33.60	27.72	33.62	0.0399
SUD Treatment	24.77	30.65	32.28	29.35	0.0452
Insurance Paid for SUD Treatment	3.63	5.09	4.31	4.57	0.7011
Financial Barrier	5.85	8.54	4.95	7.28	0.0569
Predisposing					
Age					
18–25	36.57	34.28	26.60	33.69	< 0.01
26–34	25.89	33.41	33.43	31.43	
35–44	21.49	13.81	16.31	16.22	
45–54	11.95	14.9	15.96	14.31	
55–64	4.09	3.56	7.77	4.34	
Female	40.62	37.57	40.37	38.81	0.4186
Race/Ethnicity					
Non-Latino White	79.01	73.31	69.12	74.16	0.0119
Non-Latino Black	6.67	8.79	14.13	9.06	
Latino	11.39	12.86	10.08	12.04	
Non-Latino Other	2.93	5.04	6.68	4.74	
Married	24.65	22.02	23.80	22.90	0.5630
Enabling					
FPL					
> 200% FPL	50.33	51.63	53.55	51.59	0.7099
≤ 200% FPL	49.67	48.37	46.45	48.41	
Education					
Less than High School	26.91	24.69	20.69	24.66	0.0118
High School	38.00	36.06	30.06	35.64	
Some College	26.63	29.20	34.38	29.32	
College Graduate and Above	8.46	10.05	14.87	10.38	
Occupation					
White Collar	11.51	8.97	13.57	10.35	0.2640
Clerical/ Services	29.49	30.43	24.34	29.24	
Blue Collar	14.49	14.55	14.93	14.59	
Unemployed/ Other	44.50	46.05	47.15	45.81	
Metropolitan Statistical Area	95.29	94.10	96.74	94.83	0.1292
US Census Region					
Northeast	21.24	20.43	25.23	21.39	0.5485
Midwest	20.23	20.03	20.87	20.22	
South	37.37	23.82	19.58	22.46	
West	21.16	23.82	19.58	22.46	
Need					
Self-Rated Health Status					
Fair/Poor	19.31	23.00	22.56	21.95	0.2219
Good	39.44	34.64	35.14	35.98	
Very Good	31.74	30.94	34.51	31.70	
Excellent	9.50	11.43	7.79	10.36	
K6 Score[a]	12.80	12.83	12.79	12.81	0.7896
Alcohol or Other Illicit Drug Use Disorder	44.80	38.35	32.96	39.21	< 0.01
Parole/Probation	23.59	21.05	26.10	28.31	< 0.01
Arrested for DUI or Drunkenness	58.71	59.45	49.43	57.70	0.0152

Notes: [a] Indicates comparison conducted by Analysis of Variance (ANOVA). P-Values denote significance for tests across ACA implementation period. Unless otherwise indicated, comparisons are conducted via chi-squared analysis. All values are reported as column percentages.