Research

The Legislative Response to the Nation's Opioid Crisis

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Introduction

Substance use disorder (SUD) rates and deaths from opioid overdoses have reached epidemic levels. For the past two years, policymakers, first responders, health care providers, and state and local officials have struggled to stop this crisis. Progress thus far has been slow and ineffective, largely because of legislative barriers to access to treatment or the lack of legislative authority to provide needed assistance, monitoring, and collaboration among care providers and government agencies.

Congress has recently put together a comprehensive package of legislative proposals aimed at solving or mitigating a broad range of known challenges and impediments to addressing the crisis. These solutions offer promising steps for stemming the crisis while providing much-needed support to the individuals, families, and communities suffering.

Background

Previous work by the American Action Forum (AAF) details the extent of the crisis, how it started and how it has evolved, initial response efforts, and the barriers to more effective solutions. Opioids accounted for more than 42,000 deaths in the United States in 2016, and that figure has only increased since.[1] In 2017, drug overdoses became the leading cause of death for Americans younger than 50 years old,[2] and the opioid epidemic, yet to reach its apex, has already claimed more lives than the AIDS epidemic did at its peak in the 1990s.[3] Researchers attribute the opioid crisis with the first decrease in life expectancy in the United States since 1993.[4] In addition to the tragic number of deaths, there are estimated to be more than 30 times as many nonfatal overdoses; that's roughly 3,000 people every day who overdose, are fortunate enough to survive, but need significant follow-up care in order to recover well.

Beyond the catastrophic loss of life, the crisis has also generated significant economic losses. AAF research found that in 2015, 919,400 prime-age individuals were not in the labor force due to opioids. Between 1999 and 2015, the cumulative decline in labor force participation cost the economy 12.1 billion work hours and $702.1 billion in real economic output.

Legislative Efforts

Congress is taking a multi-pronged approach to address this crisis and has been considering ways to fight the epidemic for several years. Congress passed two pieces of legislation in 2016 that provided some assistance for fighting the opioid crisis: the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act. While those laws provided some funding for grants, increased access to treatment options, and funding for drug abuse education and provider training, the epidemic has continued to worsen. Over the past several months, Congress has focused more attention on the crisis. In June, the House of Representatives passed more

than 50 bills that have since been combined into one large piece of legislation, H.R. 6, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. (This report will refer to most legislation with its original bill number and title and not in its consolidated form.)

The Senate Finance Committee has also passed a comprehensive piece of legislation: S. 3120, the Helping to End Addiction and Lessen (HEAL) Substance Use Disorders Act. The full Senate is expected to consider this legislation later this year. The House and Senate bills do not directly overlap much, however, so it is likely the two chambers will need to reconcile the differences in a conference committee; the end product may be less comprehensive than the various measures described here. The biggest hurdle to making into law many of the House-passed provisions will likely be finding ways to pay for them[5]; most of the Senate provisions have little to no cost.[6]

The following outlines the most recent proposals that Congress is considering and not the bills that Congress passed in 2016.

Treatment and Recovery

An important step for solving this crisis is to help those already suffering. Congress is considering several proposals that either provide new treatment opportunities or increase access to existing treatment options, helping people find a path to long-term recovery through a combination of various support services.

One of the more wholistic efforts aimed at increasing access to treatment and recovery services is H.R. 5327, the Comprehensive Opioid Recovery Centers Act. It would provide competitive grants for the establishment of at least 10 recovery centers across the country that provide access to the full range of medications approved by the Food and Drug Administration (FDA) and evidence-based treatments, as well as counseling services, community-based supports, recovery housing, and workforce re-entry support. These recovery centers would be required to submit annual reports on the outcomes and effectiveness of their interventions. Other bills that aim to expand access to treatment services include H.R. 5776, the MOST Act, which would provide Medicare beneficiaries with coverage of medication-assisted treatment (MAT) and other opioid use disorder treatment services. Another provision of H.R. 6 would expand access to addiction treatment for Medicare beneficiaries at federally qualified health centers and rural health clinics. H.R. 3692 would enable clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists to prescribe buprenorphine, which is one type of MAT used to treat opioid dependence; existing federal law limits the types of providers who may prescribe it.[7]

Another bill would roll back a decades-old policy that, while well-intentioned, has long been considered to be doing more harm than good. H.R. 5797, the IMD Care Act, would allow states to loosen temporarily the Institutions for Mental Diseases (IMD) exclusion that prohibits federal funding for care provided to Medicaid beneficiaries aged 21-64 in an IMD facility with more than 16 beds. This exclusion, intended to stop the mass institutionalization of people with mental disorders, makes it more difficult to provide behavioral health services to Medicaid beneficiaries. The IMD Care Act would allow states to receive federal funding from FY2019 through FY2023 for care provided to Medicaid beneficiaries with an opioid use disorder at an IMD facility with more than 16 beds for up to 30 days within a 12-month period. The HEAL Act authorizes federal funding for services provided outside IMDs to Medicaid beneficiaries who are pregnant or postpartum and receiving substance use disorder services at an IMD. The HEAL Act also codifies an existing rule that allows Medicaid to pay for managed care capitation payments that cover IMD services for beneficiaries up to 15 days per month.

Other pieces of legislation seek to improve patient care by reforming existing privacy laws and updating best practice guidelines. H.R. 5009, known as Jessie's Law, would require a patient's history of substance use disorder to be prominently displayed in a patient's medical records so that all of a patient's providers are aware and can make the most appropriate clinical decisions.

H.R. 5483 would require the administration to issue long-overdue federal regulations permitting the prescription of controlled substances via telemedicine; while Congress previously passed a law authorizing such waivers, no final rule was ever published. This permission would give patients who lack access to in-person specialists, particularly those in rural areas, the ability to receive medication-assisted therapy. S. 3120 would also require the Centers for Medicare and Medicaid Services (CMS) to publish guidance regarding state options for providing Medicaid beneficiaries telehealth services for substance use disorder.[8] H.R. 5789 would require HHS to issue guidance to improve care for both infants with neonatal abstinence syndrome and their mothers when Medicaid covers them.

Prevention

Another invaluable step alongside treatment is preventing addiction in the first place. Prevention efforts are largely focused on three angles: monitoring the prescribing of opioids, identifying at-risk individuals, and informing both providers and patients of the risks of opioid dependence along with alternative options for pain-management treatment.

One of the primary ways policymakers are working to prevent substance abuse is by requiring providers to use tools that monitor both prescriber behavior and patient use of controlled substances. Such tools include electronic prescribing and prescription drug monitoring programs (PDMPs). H.R. 3528 would require e-prescribing for controlled substances to be covered under the Medicare Part D program. E-prescribing makes it easier to track the use of controlled substances in a patient's medical history, and presumably makes doctor-shopping more difficult. H.R. 5801 would require each state to establish a PDMP and require providers to check the PDMP for a Medicaid patient's prescription drug history before prescribing a controlled substance for that individual. The Senate HEAL Act would also require states to assist providers and insurers in accessing PDMPs.[9] CMS has notified states of how PDMPs, especially when fully integrated with electronic health record systems and health information exchanges, can help improve appropriate prescribing. CMS has also notified states that enhanced federal matching funds are available to assist states in developing and implementing such systems.[10] H.R. 5799, the Medicaid DRUG Improvement Act, would require states to have protocols in place to monitor concurrent prescribing of opioids and certain other drugs along with the prescription of antipsychotic drugs to children. H.R. 5808 would require Medicaid beneficiaries identified as "at-risk" for substance use disorder to be assigned to a pharmaceutical home program, which would limit the number of prescribers and pharmacies the beneficiary may use.

Other efforts focus on educating providers and patients about the potential to become addicted to opioids, warning signs of addiction, best practices for treating pain and using opioids, and alternative non-opioid treatment options. H.R. 5716, the COMPASS Act, would require the CMS to identify outlier prescribers in Medicare and provide such individuals with information regarding proper prescribing methods. CMS has already begun gathering such data and has made a publicly available map showing opioid prescribing rates by state, county, and ZIP code.[11] The Department of Justice recently used such data to identify fraudulent activity and arrested 162 individuals involved in fraudulently prescribing or billing for more than $2 billion worth of opioids and narcotics.[12] H.R. 4275 would require the Drug Enforcement Administration to develop and disseminate training programs and materials on the circumstances under which a pharmacist may refuse to fill a controlled substance prescription; such circumstances currently permitted by law include suspicions that a

prescription is fraudulent, forged, or indicative of abuse or diversion (being given to someone other than the patient for whom it is prescribed). A recent congressional report detailed significant opioid-prescription fraud and abuse in the Medicaid program, and the same types of behavior are likely prevalent outside of the program as well.[13] H.R. 5261 would improve how health professionals are taught about substance use disorders and how to treat pain by supporting higher-learning institutions. H.R. 5176, the POWER Act, would help hospitals develop protocols on discharging patients who experienced an opioid overdose; such protocols would address the provision of naloxone upon discharge, connecting patients to peer-support specialists, and referral to treatment providers and other services that the patient may need. H.R. 5685 would require CMS to provide beneficiaries with educational resources regarding opioid use, pain management, and alternative pain treatment options, while H.R. 5686, the Medicare CHOICE Act, would require Part D plans to provide beneficiaries information on the adverse effects of opioid overuse and what other non-opioid pain management treatment options their plan covers. H.R. 5684 would expand Medicare coverage of medication therapy management to Part D beneficiaries at risk for prescription drug abuse. H.R. 5809, H.R. 5804, and H.R. 6110 would alter Medicare payments to encourage the development and use of non-opioid pain treatments.

Several pieces of legislation aim to prevent drugs from reaching individuals in the first place, whether by making it easier to dispose of unused prescription opioids safely, or by stopping the delivery of illicit synthetic opioids sent from other countries. H.R. 5041, the Safe Disposal of Unused Medication Act, would allow hospice workers to dispose of controlled substances found in the home of a deceased hospice patient, an effort to limit access to easily-acquired supply by family, friends, or others who might be prone to addiction. H.R. 5228, the SCREEN Act, and H.R. 5752, the Stop Illicit Drug Importation Act, would provide the FDA greater authority to seize counterfeit and illicit drugs that enter the United States through international mail facilities.

Longer-term prevention efforts under consideration include researching new treatment options. H.R. 5002, the ACE Research Act, would provide the National Institutes of Health with new authority to conduct research on the prevention, diagnosis, or treatment of diseases and disorders, or to respond quickly to a public health threat, such as the opioid epidemic. The SCREEN Act, previously mentioned, would also provide funding to the FDA to support the development of non-opioid, non-addictive options for pain treatment.

Conclusion

The number and breadth of the pieces of legislation considered above indicate that Congress is serious about stopping this epidemic. Expanding access to and coverage of existing and new treatment and recovery options, increasing educational materials to better inform patients and providers of the risk of dependence, and providing new authority to prevent illicit drugs from reaching individuals in the first place should all help to provide relief for those already suffering and prevent others from falling victim to this epidemic. Congressional action alone, however, will not solve the problem. Individuals, their families and communities, state and local government officials, first responders, and other health care providers must all work together to change behavior and currently accepted practices, provide support to individuals in need, and intervene when warning signs are present.

[1] https://www.cdc.gov/drugoverdose/epidemic/index.html

[2] https://www.cbsnews.com/news/overdoses-are-leading-cause-of-death-americans-under-50/

[3] https://www.economist.com/news/united-states/21730690-when-will-it-peak-and-how-many-will-it-kill-forecasting-opioid-epidemic

[4] https://jamanetwork.com/journals/jama/fullarticle/2654372

[5] https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr6amendedby11578.pdf

[6] https://www.finance.senate.gov/imo/media/doc/SFC%20Opioid%20Legislation%20preliminary%20estimate,%20June%

[7] https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

[8] https://www.kff.org/medicaid/issue-brief/federal-legislative-proposals-related-to-medicaid-and-opioids-what-to-watch/

[9] https://www.kff.org/medicaid/issue-brief/federal-legislative-proposals-related-to-medicaid-and-opioids-what-to-watch/

[10] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf

[11] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/Opioid_Methodology.pdf

[12] https://www.pbs.org/newshour/health/justice-department-announces-crackdown-on-fraudulent-opioid-prescriptions

[13] https://www.hsgac.senate.gov/media/majority-media/chairman-johnson-releases-report-on-how-medicaid-has-helped-to-fuel-the-opioid-epidemic-