TESTIMONY ON UNINTENDED CONSEQUENCES: MEDICAID AND THE OPIOID EPIDEMIC

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Chairman Johnson, Ranking Member McCaskill, and members of the committee, thank you for the privilege of testifying. I am Sam Adolphsen, a Senior Fellow at the Foundation for Government Accountability (FGA). FGA works at the state and federal level on healthcare and welfare policy issues.

Prior to joining FGA in 2017, I served for three years as the Chief Operating Officer of the Maine Department of Health and Human Services. In that role, I oversaw operations for Maine's welfare programs, including Medicaid. My duties included direct responsibility for the state's welfare fraud department and the Medicaid audit division. Our department also worked directly with the Attorney General's Medicaid Fraud Control Unit.

As your committee explores this important area, I'd like to draw to your attention to three specific areas in the Medicaid program related to the opioid crisis in America:

First, the Medicaid program has expanded dramatically to able-bodied adults. This is not exclusively positive, with no potential for harmful side effects. Like a doctor prescribing a drug, it is important that lawmakers ask the right questions and prescribe policy with a careful eye towards mitigating harmful unintended consequences.

Second, there is a robust black market of welfare funds being traded underground around the country. This includes people accessing Medicaid services who are not eligible. This fraud not only robs funds meant for the truly needy, but it is also helping to fuel the drug crisis in alarming ways.

Third, Medicaid's structure provides concerning levels of unfettered access to opioids. It also creates barriers to work, the very thing that is proven to help people move away from addiction, into a productive life, and even long-term recovery from substance abuse.

The Opioid Problem

For several years, our country has faced a massive drug crisis that continues to decimate our families and communities.

We know that legal opioids—prescription painkillers—play an outsized role in contributing to this epidemic. By now, you have heard the facts and figures:

- There were more than 33,000 opioid overdose deaths in 2015
- About half of those deaths were the result of prescription painkiller overdoses[1]
- On an average day in 2016, there were 650,000 opioid prescriptions written[2]
- Four out of five new heroin users started by misusing prescription painkillers, meaning that legal prescription abuse is the gateway to illegal drug addiction and death[3]

Unfortunately, the battle ground of addiction is not confined to dark alleys. It exists in the sterile rooms of our doctors' offices and hospitals.

Appropriate use of painkillers is life-changing to the recovery of so many. But misuse is life-ending.

We understand the potential dangers of prescription opioids are now more widely understood thanks to recent explorations by diverse groups like state governments, addiction specialists, and pharmacy experts.

Medicaid Expansion Was Supposed to Help—Are We Sure It is Not Hurting?

The solution to the opioid problem, however, is less clear. One of the most widely touted solutions has been to increase immediate access to the Medicaid program. This approach has been held up as a panacea by some lawmakers, government officials, and advocates who suggest that the expansion of Medicaid under the Affordable Care Act is the key to solving the crisis in their states.[4]

This promotion of Medicaid expansion as a solution to the opioid epidemic often centers on the presumed benefit of treatment to addicts. For example, Rhode Island Governor Gina Raimondo recently said that in Rhode Island they are, "very effectively using Medicaid coverage to allow people to seek treatment for their opioid addiction."[5]

What we do know for sure is that Rhode Island expanded Medicaid right after the passage of Obamacare and has since seen their Medicaid program grow by 66 percent (from 190,000 people to more than 315,000).[6]

It does not appear that Medicaid coverage has done anything at all to mitigate the opioid crisis. According to the CDC, Rhode Island was in the top ten in the country in 2016 for opioid related overdose deaths.[7] The Rhode Island Department of Health reported 183 overdose deaths in 2012 before expansion and 336 last year that were mostly opioid related.[8]

Has adding more than 100,000 people to Medicaid cured the drug crisis in Rhode Island? So far, no.

Early data shows similar results in other states around the country. West Virginia added 160,000 people to Medicaid through Medicaid expansion and continues to lead the nation in drug overdose deaths with 52 deaths per 100,000 residents.[9]

Similarly, Ohio added 725,000 people to Medicaid and has the second highest rate of overdose deaths in the country.

Pennsylvania added more than half-a-million adults to Medicaid and has the third highest rate of overdose deaths in the country.[10]

In fact, of the states with the highest age-adjusted rates of opioid overdose deaths:

- Five of the top five are Medicaid expansion states
- Nine of the top 10 are Medicaid expansion states
- 13 of the top 15 are Medicaid expansion states[11]

This correlation is deeply concerning. Is the addition of tens of millions of able-bodied adults to Medicaid partly responsible for the opioid crisis?

That question of causation begs for more inquiry.

There are limited recent studies of this question, but a CDC report from the Obama administration in 2009 sheds some light on Medicaid's connection to opioids. The report overviews findings from a study of Washington state Medicaid enrollees between 2004-2007. It found that Medicaid enrollees were 5.7 times more likely to die from a prescription opioid overdose than someone not on Medicaid.[12]

There are complex factors at work here. But this complexity does not mean Medicaid played no role in the damage. Medicaid provides very low, or no-cost, access to drugs for patients with loose prescriber controls. What is also very clear is that people on Medicaid funds a large share of prescriptions overall. Medicaid is a factor in a large share of the negative effects of legal and illegal opioids.

Most people who become addicted to heroin start by abusing prescription painkillers and Medicaid dispenses those opioids at a staggering rate.

I saw this personally as the COO at the Maine Department of Health and Human Services. Pharmacy was one of the fastest growing Medicaid budget lines. Opioids were at the top of the drug list, almost any way the data was viewed. Although Maine has not expanded Medicaid under the ACA, Maine expanded Medicaid back in the early 2000s and still covers more able-bodied adults than the federal baseline.

A recent study by Express Scripts of three million Medicaid members highlights that between 20-25 percent of Medicaid individuals received an opioid prescription in 2015.[13] The same report indicates this rate of opioid prescription is highest among able-bodied adults ages 18-64, which is the Medicaid expansion population.

The study also notes that Medicaid recipients eligible for Temporary Assistance for Needy Families (TANF) are receiving opioids at the highest rate of any group. Since TANF households almost always include a child at home, it means that the most opioid-dependent Medicaid population is parents caring for children, often young children. Teens in these homes have access to these drugs as well. That is a concern as we see the abuse of opioids is increasing among young people.

In the current Medicaid expansion environment, 20 percent of the population is on Medicaid.[14] While Medicaid covers one out of five people, it is the payer for 36.5 percent of all Emergency Department visits for Opioid poisonings.[15] Forty percent of all heroin poisonings that present at the ED are Medicaid recipients and just under half (or 47 percent) of all methadone poisonings in the ED are experienced by individuals on Medicaid.

These opioid related ED visits have spiked since 2014, when Medicaid expansion began. In Rhode Island for example, ED visits paid for by Medicaid for opioid-related reasons more than tripled, from 500 in 2011 to 1,850 in 2015. Nationally, Medicaid funded about 120,000 opioid related ED trips in 2011 and funded about 280,000 in 2015.[16]

Illegal Trafficking and Fraud in Medicaid Has Played a Role in the Opioid Crisis

These numbers show there is clearly a challenge with Medicaid and Medicaid expansion funding legal prescriptions for opioids that results in abuse, overdoses, and addiction. The flood of opioids into the market in the form of painkillers and other opioids like suboxone have made the drugs more available than ever.

The massive supply of opioids that Medicaid has made readily available has helped to create an underground market that is helping to fuel the epidemic. Again, during my time in Maine as COO of Maine DHHS, we regularly saw the intersection between the criminal drug world and welfare benefits, including Medicaid.

Too often, individuals we saw in newspaper accounts of drug arrests matched up with our enrollment information for Medicaid and other welfare programs. I saw unfortunate instances of people utilizing their welfare benefits and subsequently showing up in drug arrests, or worse, tragic accidents including death.

There is no shortage of examples of these benefits funding the drug trade in cases ranging from billions dollar national cases to local drug dealings in rural Maine:

- In 2017, in just once instance, the United States Attorney General arrested more than 400 people committing more than a billion-dollars' worth of fraud in Medicaid and Medicare for illegal prescription of opioids and other charges.[17]
- In 2016, in Maine, a couple was arrested and charged with trafficking oxycodone. When they were arrested, drug agents found dozens of pills, along with $9,000 in cash and eight welfare cards, including a medical card that did not belong to the couple.[18]

A Maine Drug Enforcement Agent also highlighted how often welfare cards are being used in the illegal drug trade, testifying that "it is common practice for drug dealers to take custody of a drug users EBT (welfare) card either as direct payment or in lieu of immediate payment."[19]

These cases raise a lot of important questions that should be asked. When arrests happen and thousands of prescription pain pills are seized, where did they come from? When someone is arrested dealing prescription meds, do we check if they are on Medicaid and receiving prescriptions pain killers? Are those cases followed up to determine the source? States have the data to answer these questions—I have seen it.

A 73-year old grandmother was killed last year in Maine by a driver who had methadone, benzodiazepine, other opiates, and cocaine in his blood when he caused the crash.[20] Where did he get these drugs? Did Medicaid pay for them?

Another way that drugs are being accessed illegally through Medicaid is by people scamming the system to become eligible for Medicaid in the first place. They then use their benefit to gain access to prescription drugs, funded by Medicaid.

This fraud is happening because states are not carefully checking the income of people applying for Medicaid. The tidal wave of enrollment created by Medicaid expansion exacerbated this problem.

Recently, the state of Arkansas cleaned up its Medicaid rolls and found inaccuracies that led to 80,000 people being on the program that should not have been.[21] Arkansas removed:

- 16,500 individuals for unreported income
- 25,700 individuals with connections to other states, including living in, or receiving benefits in another state
- 4,100 inmates that were not eligible for Medicaid

Arkansas is not alone. Oregon found that it may have spent more than $37 million each month on ineligible Medicaid members[22]and two different Minnesota Medicaid audits found errors in 20 and 38 percent of all cases, respectively.[23]

We know that Medicaid is funding a huge portion of the painkiller prescriptions and other opioids in this country. We can all agree that this spending should be limited to eligible individuals, not hundreds of thousands, or millions, of people who aren't truly eligible for Medicaid.

The Structure of Medicaid Facilitates Drug Abuse

The research is clear that someone on Medicaid is more likely to be addicted to, or die, from opioids. There are many aspects to this dynamic, but let me just discuss the three key areas of work, access, and incentives.

Work is Key

While many view Medicaid as the solution to the drug problem, a better solution may be the very thing that Medicaid so often undermines—work. We know that for most people, the best answer to so many of the problems they face is employment. That is where Medicaid has created a very real problem because it fosters dependency.

Fortunately, the Centers for Medicare and Medicaid Services is now allowing states to improve health by promoting work.

A recent study by the Foundation for Government Accountability found that 52 percent of able-bodied adults on Medicaid do not work at all. Only 16 percent work full time. In the Medicaid expansion population, the problem is even worse. In Ohio, 57 percent of able-bodied adults enrolled in Medicaid expansion are not working. In Nevada, 60 percent report zero income.[24]

How is this connected to the opioid crisis? Because for people struggling with addiction, work is a key to recovery. The addiction help website addiction.com even calls work, "a pillar of recovery" and lists 14 advantages to work for those in recovery.[25]

In Maine, we heard from people in recovery programs that they felt that the Medicaid-funded treatment they were in was too burdensome. This was not because they did not want to get treatment. They struggled because they said they wanted to work, yet the requirements of the treatment program made it difficult to do so. They recognized how important work was to their own recovery. Shouldn't our policies do the same?

Medicaid pays people not to work, so they do not. And instead of being out in the community, participating in the workforce, people are stuck at home, too often remaining isolated and idle. These are some of the very lifestyle circumstances that lead to addiction.

Medicaid policy changes that promote work would do more than just get people back into a job—they could save lives, keep people in recovery, and help solve the drug crisis.

Access and Incentives

Medicaid also provides access to prescription drugs that is unparalleled and too easy. The day you become eligible for Medicaid, you get a plastic card that turns on immediately, and at little or zero cost you get access to health care, including prescription painkillers.

This dynamic manifest itself in many ways, including people going to multiple doctors and pharmacies to get prescriptions for painkillers. We saw this often at Maine DHHS. With very limited co-pays, no premiums, and few restrictions on providers, prescription painkillers flowed unfettered to Medicaid recipients. I saw personally that every month opioids were found at or near the top of the list of most utilized prescriptions. Federal policy limits how many guardrails state can use to prevent such practices.

At the same time that opioid abuse and addiction increased, there was a dramatic shift in who was paying for these drugs. According to a 2016 Health Affairs study, opioid pain reliever overdose deaths quadrupled from 1999 to 2013, while consumer out-of-pocket spending for 100 milligrams of opioids dropped from $4.40 to $.90.[26] The cost was shifted to public and private insurers, including Medicaid.

Is it surprising that a drug that costs less to the person is being abused more? Nowhere is that dynamic more obvious than in Medicaid, where the member typically bears none of the out-of-pocket cost. Medicaid-funded opioids are entirely cost free to the recipient.

At the Maine Department of Health and Human Services we also saw our Medicaid members receiving large doses of painkiller mixes and receiving them from multiple doctors and filling them at multiple locations. This is happening across the country as well. According to Express Scripts, nine percent of Medicaid recipients were prescribed opioids by more than four doctors, and one out of every four got a prescription from more than one doctor. Similarly, members often used multiple pharmacies, with one member using 24 different pharmacies to fill opioid prescriptions.[27]

In my home state of Maine, we have made moves to address all of these areas. Maine has requested work requirements in the Medicaid program to help get people back to work through community engagement. Maine has limited and tracked prescriptions of opioids in Medicaid and uses a Medicaid program called "lock-in[28]" to help control opioid abuse.[29]

Other states are exploring these areas as well to help deal with Medicaid's role in the opioid epidemic, with many states requesting work requirements in Medicaid and moving to place limits on opioid prescriptions. These are important steps to explore.

Conclusion

The drug crisis impacts us all and there are many questions about how to solve the problem. Though many voices continue to stress that Medicaid expansion is the key to fixing this problem, the early data demonstrates that Medicaid may actually be causing some of the damage.

It is important that we ask the right questions to make sure that Medicaid is not funding the drug problem and instead is structured to promote work and health for our neighbors.

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