The Effects of MHPAEA on Access to Medication-Assisted Treatment for Opioid Use Disorders

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Research Questions & Objectives

Could insurance parity lead to an increase in access to buprenorphine for opioid use disorder treatment?

• Does the federal parity law, MHPAEA, mean more access to MAT, particularly during a time period when the opioid epidemic was getting out of control?
• What effects did MHPAEA have on purchased quantities of buprenorphine?
• What are the costs for MAT in outpatient settings and how are these costs distributed among payers?

Background

• Drug overdoses: leading cause of injury deaths since 2009. These surpass gun-related deaths, motor vehicle accidents (Barry et al., 2015).
• The expansion of treatment and treatment capacities, especially medication-assisted treatment, have not expanded to meet the challenge of the opioid use disorder epidemic in America.
• Buprenorphine, one of three MAT that are FDA approved, can be prescribed or dispensed in physician offices, significantly increasing treatment access (unlike methadone treatment, which must be performed in a highly structured clinic).
• Insurance parity makes sure that if mental health or substance use disorder benefits are being offered, they are being offered equal to medical/surgical benefits.
• Medication costs and insurance coverage are two of the identified barriers for medication-assisted treatment that state and federal parity laws have sought to address.
• It is not well understood just how much parity affects access and uptake of MAT for opioid use disorders.

Data

Symphony Health Solutions Integrated Dataverse
• Prescription data originating from a random sample of 5,000 physicians from any specialty
• Covers the years 2010-2014
• States include California, New York, Pennsylvania, Florida, Massachusetts, Michigan, and Texas.

Methods

Source of Identification:
• Three phases of MHPAEA implementation: statutory provisions, interim final regulations, and final regulations.
• Focus on implementation after the Interim Final Rules (IFR) took effect on January 1st, 2011.
• Crucially, MA and NY had strong parity laws in effect before MHPAEA. In turn, MHPAEA applied only to some insured groups.

Descriptive Statistics

• 93,265 unique patients over the entire study period
• 52% of sample had 3 prescriptions or less during the study period
• 75% of sample had 10 prescriptions or less during the study period

Total number of buprenorphine prescriptions for select states, 2010-2014

<table>
<thead>
<tr>
<th>State</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>23,754</td>
<td>14,644</td>
<td>13,872</td>
<td>41,286</td>
<td>24,397</td>
<td>50,453</td>
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<td>Florida</td>
<td>57,941</td>
<td>61,452</td>
<td>63,093</td>
<td>74,475</td>
<td>82,418</td>
<td>270,375</td>
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<tr>
<td>Massachusetts</td>
<td>5,007</td>
<td>9,074</td>
<td>11,513</td>
<td>14,425</td>
<td>7,511</td>
<td>48,590</td>
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<tr>
<td>Michigan</td>
<td>1,528</td>
<td>2,941</td>
<td>2,792</td>
<td>14,930</td>
<td>10,113</td>
<td>46,050</td>
</tr>
<tr>
<td>New York</td>
<td>6,968</td>
<td>11,683</td>
<td>14,002</td>
<td>21,925</td>
<td>12,291</td>
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<tr>
<td>Pennsylvania</td>
<td>12,508</td>
<td>10,132</td>
<td>45,278</td>
<td>54,474</td>
<td>28,095</td>
<td>170,913</td>
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<tr>
<td>Texas</td>
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<td>13,093</td>
<td>26,712</td>
<td>15,543</td>
<td>89,058</td>
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<tr>
<td>Total</td>
<td>103,541</td>
<td>70,200</td>
<td>202,453</td>
<td>248,331</td>
<td>141,782</td>
<td>854,207</td>
</tr>
</tbody>
</table>

Descriptive Statistics, continued

Commercial insurance comprised approximately 58.5% of all buprenorphine prescriptions in the sample. All forms of insurance coverage (public and private) grew in absolute terms over the period.

Preliminary Results

• Difference-in-differences-in-differences (DDD) approach to estimate the effects of MHPAEA on purchased quantities of buprenorphine.
• MA and NY had previous parity laws serving as "control" states.

Discussion & Conclusions

The medicalization of OUD treatment means that MAT usage could be greatly expanded under the ACA, which adopted MHPAEA parity rules and mandates that individuals obtain insurance (Buck, 2011).

Preliminary evidence suggests MHPAEA implementation could have expanded buprenorphine access in states with no previous parity laws. Further evidence is needed to conclude whether the effect is not confounded by supply-side policies or other unobservable characteristics in the data.

While assuring insurance parity for those with substance use disorders may reduce one of the structural barriers to treatment (Mojtabai et al., 2011), this may not be enough to reduce the current gap in treatment. Mandating MAT’s may be a simple and cost-effective way to reduce opioid-related harms.

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