

## **Testimony of Richard G. Frank before the Joint Economic Committee Hearing: Economic Aspects of the Opioid Crisis**

### **I. Introduction**

Chairman Tiberi and Ranking Member Heinrich, thank you for inviting me to participate in this discussion of the opioid epidemic that is plaguing our nation. This epidemic is especially devastating to low-income communities as the prevalence of opioid use disorder is higher in low-income groups and financial access to treatment is more precarious. My focus today will be on the policy tools available to close the gap between the number of people suffering from an opioid use disorder and the number receiving treatment. New policy tools developed in the last decade, offer a unique opportunity to close what is a deadly treatment gap. I will touch on three main points about key policy instruments at the disposal of the Congress and the Administration for closing the gap. The first is that Medicaid is fundamental to promoting access to treatment of opioid use disorders. Medicaid has been especially instrumental in lowering barriers to effective treatment for high need low income groups. The second is that recent policies aimed at improved private insurance coverage for treatment of mental illnesses and substance use disorders such as subsidized private insurance, the Essential Health Benefit and Parity legislation have dramatically enhanced the ability to close the *treatment* gap. The third is that private investment has responded to the new funding sources by expanding treatment capacity and so new funding initiatives like the *21<sup>st</sup> Century Cures Act* offer an opportunity to make targeted public investments in treatment capacity that are designed to complement the private market.

### **II. The Opioid Epidemic**

Drug overdoses claimed 52,404 lives in 2015.<sup>1</sup> It is estimated that in 33,091 of those cases, or 63%, opioids were implicated. The growth in opioid related deaths grew 15.5% between 2014 and 2015. It is important to recognize that the epidemic is evolving. Since the late 1990s, most of the growth in opioid related mortality has been driven by the use of prescription opioids. In recent years, the rise in deaths stemming from prescription opioids has leveled off, and the actual number of opioid prescriptions has begun to decline, although it remains high. This is, in part, due to greater vigilance by insurers, pharmacists and clinicians. Changes in formulary design, prescription drug lists, and investments in prescription drug monitoring programs have been influential. The effectiveness of these programs is seen in the changes in opioid-related mortality trends. Recent increases in mortality, however, have been driven by illicit opioids, like heroin, Fentanyl and counterfeit Oxycontin. Heroin dependence has been growing at up to 11% per year across the country in recent years, and opioid related hospitalizations grew at an average of about 6% over the last 10 years.

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<sup>1</sup> Rudd RA, P Seth, F David, L Scholl; Increases in Drug Overdoses and Opioid-Involved Deaths—United States 2010-2015; *Morbidity and Mortality Weekly Report*, December 16, 2016

The number of heroin, Fentanyl and counterfeit Oxycontin users is growing and those drugs are more lethal than prescription opioids. This indicates an increasing urgency to engage more people suffering from Opioid Use Disorders (OUD) in treatment. Fortunately, important strides have been made to improve financial access to treatment for OUD.

While the rate of opioid use disorder among the population with incomes 200% of the Federal Poverty Line (FPL) is significant (11.4 per 1,000 people), Table 1 highlights the fact that the rate is substantially higher among low-income populations. The highest rates of opioid use disorder for Americans between 18 and 64 years of age is among those with incomes of less than 100% of the FPL (16.8 per 1,000 people). This rate is 47% higher than the rate for the non-poor (incomes > 200% of FPL). People with incomes between 100% and 199% of the FPL have a prevalence rate for OUDs that is roughly 32% higher than that of the group with incomes greater than 200% of the FPL. The implication is that 51.4% of all people in the U.S. with an opioid use disorder have incomes below 200% of the FPL even though they make up only 32% of the nation's population.<sup>2</sup>

Table 1 also indicates that people between 26 and 34 years of age also have elevated levels of OUD (17.0 per 1,000 people). The prevalence of OUD is generally higher among young, white non-Hispanic males compared to their older, female, minority counterparts.<sup>3</sup> Those most affected by OUD and SUD, more generally, have historically also been the least likely to have coverage for and access to adequate treatment options. For example, the uninsured rates for low income adults 18-64 years of age prior to ACA implementation of coverage expansions were 39.3% for those below the FPL and 38.5% for those between 100% and 200% of the FPL compared to 11.4% for people above 200% of the FPL.

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<sup>2</sup> The income distribution figure is based on the March 2016 Current Population Survey.

<sup>3</sup> The opioid epidemic has meant that even though the rates of disorder are relatively low for older adults (ages 50-64) there has been notable growth in the rate of disorder—this is consistent with recent results on mortality by cause. See Case A, A Deaton; Mortality and Morbidity in the 21<sup>st</sup> Century, *Brookings Papers on Economic Activity* (conference version), March 2017

Table 1: Prevalence of Opioid Use Disorder (OUD) and Substance Use Disorder (SUD) for Selected Demographic Characteristics, United States, 2015

	OUD prevalence (per 1,000)	SUD prevalence (per 1,000)
<b>Total Income</b>		
0 – 100% FPL	16.8	47.1
101 – 200% FPL	15.0	36.8
>200% FPL	11.4	28.4
<b>Age</b>		
18-25	14.7	52.8
26-34	17.0	34.0
35-49	10.9	19.7
50-64	7.2	12.4
<b>Gender</b>		
Male	16.5	43.3
Female	10.4	26.3
<b>Race</b>		
Non-Hispanic White	15.2	35.8
Non-Hispanic Black	8.1	32.6
Hispanic	10.7	28.5
<b>In Treatment</b>	3.4	4.8
<b>Overall Prevalence</b>	13.3	34.2

Source: Author’s Tabulations from NHSDUH, 2015

The shift to heroin and other illicit drugs also implies that there is a complicated interplay between public safety and public health. For example, in considering the shifting of the epidemic towards heroin, it is important to recognize that between 24% and 36% of people addicted to heroin pass through jails or prisons in a year.<sup>4</sup> People with histories of addiction that are re-entering their communities from jails and prisons are at especially high risk of mortality due to overdose. The mortality rate for re-entering prisoners is 1840 per 100,000 prisoner years compared to an overall mortality rate for the population of 747 per 100,000.<sup>5</sup> This is a rate that is about 2.5 times that for the rest of the population.<sup>6</sup> It is estimated that 80% to 90% of these people have incomes below 150% of the FPL and are thus eligible for Medicaid in expansion states and also subsidized private insurance (across the country). OUD is also linked to higher risks for HIV related illnesses, suicide and Hepatitis C. Finally, it is estimated that 1.5 million adults have a serious mental illness and also misuse opioids.<sup>7</sup>

In addition to its public health consequences, the opioid epidemic makes large claims on resources. One recent estimate puts the total treatment costs for the nation at \$28.9 billion

<sup>4</sup> Boutwell AE, A Nijhawan, N Zaller, J Rich; Arrested on heroin: a national opportunity, *Journal of Opioid Management* 3(6): 328-332, 2006

<sup>5</sup> Binswanger IA, MF Stern, RA Deyo et al, Release from prison—a high risk of death for former inmates; *New England Journal of Medicine* 356 (2): 157-165, 2007

<sup>6</sup> Note that most of the post release mortality occurs in the first month post release.

<sup>7</sup> SAMHSA, *The CBSQ Report*, January 25, 2017.

in 2013.<sup>8</sup> Adding in costs related to lost productivity, incarceration and other legal expenses yields an estimated total cost to society of \$78.5 billion.

### **III. Closing the Treatment Gap**

#### Untreated Opioid Use Disorder

According to the 2015 National Survey on Drug Use and Health (NSDUH), about 2.66 million individuals under the age of 65 met diagnostic criteria for an opioid use disorder (OUD). It is estimated that between 500,000 and 718,000 receive any treatment for those conditions.<sup>9</sup> The remaining 1.9 to 2.2 million people with an OUD did not receive treatment for that condition.

What are the reasons for this vexing gap between need and receipt of care? The predominant reasons include: inability to afford treatment and lack of readiness to seek treatment. For persons suffering with drug use disorders, 36 percent reported that they had no health insurance coverage and could not afford the cost of treatment. 29 percent reported that they were not ready to stop using substances. Other commonly cited barriers to receiving treatment include the stigma of addiction in the work place and the community (22%), the lack of availability of providers (16%) and the belief that they do not have a problem that needs care.

#### What treatments work for OUD?

Medication Assisted Treatment (MAT) is the gold standard of treatment for OUD. This is based on dozens of randomized clinical trials of the three medications used in MAT: methadone, buprenorphine and long acting naltrexone.<sup>10</sup> MAT combines medications with behavioral therapy (psychotherapy/counseling) and drug testing to track adherence with treatment. Methadone is an opioid that replaces other drugs and allows patients to function better. It is provided through a set of highly regulated clinics. Buprenorphine another opioid is also regulated but can be provided by trained physicians in their offices subject to limits on the number of patients treated. It too allows patient to function as they recover. Naltrexone is not an opioid and can be provided by any licensed physician. However, naltrexone is typically administered as a 30-day injection that requires that a patient be detoxified. These three approaches to MAT are recommended “first-line”

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<sup>8</sup> Florence CS, C Zhou, F Luo, L Xu, The Economic Burden of Opioid Overdose, Abuse and Deterrence in the United States, 2013; *Medical Care*, 54(10): 901-906, 2016. Note that these are social cost of illness estimates not spending estimates.

<sup>9</sup> This range is based on the author’s tabulations from the NHSDUH and recent literature such as Wu LT, M Swartz; Treatment utilization among persons with opioid use disorder in the United States; *Drug and Alcohol Dependence* 169: 117-127, 2016.

<sup>10</sup> See for example the Cochrane reviews of methadone and buprenorphine and PG Barnett, JH Rodgers, D Bloch, A meta-analysis comparing buprenorphine to methadone for treatment of opiate dependence, *Addiction*, 96:683-690, 2001

treatments in clinical guidelines. Note that only about 25% of people obtaining treatment (or about 2% of all people with an OUD) for an OUD get MAT.<sup>11</sup>

### Tools for addressing the treatment gap

The reasons highlighted for not obtaining treatment that are most amenable to being addressed through public policy are those related to **affordability** and **availability** of treatment. Recall 36% of those with an OUD not receiving treatment cited affordability as a key reason for not obtaining treatment. Important strides have been made recently to make treatment for OUD and other Substance Use Disorders for affordable.

Medicaid has always had a significant part in paying for treatment of OUDs. In 2014, the year the Affordable Care Act's (ACA) coverage expansion went into effect an estimated 21% of the health care costs from treating SUDs were paid by Medicaid. Since 2014, Medicaid has been playing an increasingly central role in paying for treatment of OUDs. There are three main reasons for this. First, the ACA coverage expansion including Medicaid expansion along with the creation of the health insurance Marketplaces has extended coverage to an estimated 220,000 people with an OUD or 8% of the population with an OUD.<sup>12</sup> Of these, we estimate that 45% or 99,000 were in the Medicaid expansion group. To put these figures into context there are a total of 1.37 million people with OUD with incomes below 200% of the Federal Poverty Line. The second is that the ACA applied the Essential Health Benefit to the Medicaid expansion and that included substance use disorder treatment coverage. The third reason that Medicaid's role has expanded is that the Mental Health Parity and Addictions Equity Act (MHPAEA) of 2008 requires Medicaid managed care plans to offer coverage for treatment of Substance Use Disorders (SUDs) that is no more restrictive than that for medical-surgical conditions. In addition the Affordable Care Act required that MHPAEA's provisions be extended to the Medicaid expansion population. This has meant a notable expansion of not only the number of people covered but also the extent of coverage. Thus, the Medicaid program, which covers about 34% of people with an OUD, has a central place in paying for their treatment. This is especially salient in considering the importance of Medicaid in paying for evidence based treatment in the U.S. generally and in the states hardest hit by the epidemic. Nationwide Medicaid paid for 24% of Buprenorphine prescriptions in 2016 and an average of 41% in the 5 states with the highest mortality rates (West Virginia 41.5 per 100,000), New Hampshire (34.3), Kentucky (29.9), Ohio (29.9) and Rhode Island (28.2).<sup>13</sup> The evidence to date suggests that the reduced financial

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<sup>11</sup> See Saloner, B, S Karthikeyan, Changes in Substance Abuse Treatment Use Among Individuals With Opioid Use Disorders in the United States, 2004-2013. JAMA 314(14): 1515-17; 2015

<sup>12</sup> Using Landscape File data from the Centers on Medicare and Medicaid Services for 2016 and estimates of the expansion population from the Council of Economic Advisors and applying prevalence rates by income classes from the National Household Survey on Drug Use and Health, we estimate that there are 220,000 people with an OUD that were covered by the Marketplaces and the Medicaid expansions in 2016. The Medicaid share is based on an estimate of the share of people with serious behavioral health problems in Medicaid in the estimated expansion populations.

<sup>13</sup> For the Medicaid shares see IMS Institute for Healthcare Informatics, *Use of Opioid Recovery Medications*, 2016 and for the mortality data see CDC, Drug Overdose Death Data, December 16, 2016.

barriers to treatment produced by Medicaid policy changes are resulting in more evidence based treatment. A recent study shows that between the fourth quarter of 2013 and the third quarter of 2016 use of buprenorphine per 1000 population increased by 41.2% in states that expanded Medicaid while the corresponding increase in non-expansion states was 17.2%. Furthermore the evidence suggests that the Medicaid utilization increases were net gains in treatment as only a small part of the increase was due to shifts in source of payment.<sup>14</sup> For these reasons proposals to scale back Medicaid coverage expansions and level of coverage requirements (by repeal of the Medicaid Essential Health Benefit provision) and to strictly limit spending growth based on 2016 spending patterns via per capita caps in the face of a rapidly growing epidemic would serve to widen not narrow the treatment gap.

Finally, an analysis by the State of Ohio's Department of Medicaid shows that people with an opioid use disorder that gained coverage under the state's Medicaid expansion reported the largest improvements in access to prescription drugs for treatment, mental health care and overall health care. Of particular note is the observation that people with SUDs saw important gains in access to care for other chronic conditions that frequently co-occur with an SUD.<sup>15</sup>

Private insurance is also an important source of payment for treatment of OUD and addressing the treatment gap. Private insurance covers about 42% of people with OUD and paid for nearly 20% of spending on SUD treatments in 2014.<sup>16</sup> Private insurance too has taken an expanded role in treatment of OUDs and as a mechanism for closing the treatment gap. This expanding role also emanates from three sources: MHPAEA that applied to private insurance coverage for employers with 50 or more employees, the Essential Health Benefit provision in the Affordable Care Act that names coverage for treatment of SUDs as an Essential Health Benefit, and the extension of MHPAEA to the small group and individual health insurance markets.

As in the case of Medicaid, recent policy changes served to cover many people for care of OUD that were previously uncovered due either to being uninsured or holding a policy that did not cover SUDs, and to expand the extent of coverage. Together the combination of policy initiatives that started with MHPAEA in 2008 has affected the SUD coverage for at least 173 million people.<sup>17</sup> It is important to recall that during the period prior to the implementation of the Affordable Care Act's Essential Health Benefit and underwriting provisions, based on a survey of insurance carriers, an estimated 34% of policies sold in the individual health insurance market did not cover care of SUDs.<sup>18</sup> As noted earlier, a large segment of the population of people with an OUD hold private health insurance and

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<sup>14</sup> Clemans-Cope L, V Lynch, M Epstein, JM Kenney; *Medicaid Coverage of Effective Treatment for Opioid Use Disorder*, Urban Institute, May 2017.

<sup>15</sup> Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the General Assembly, 2016*

<sup>16</sup> Author tabulations from the NHSDUH 2015; and SAMHSA, Behavioral Health Spending Accounts: 1986-2014.

<sup>17</sup> Executive Office of the President, *A Report of the President's Parity Task Force*, October 2016.

<sup>18</sup> Assistant Secretary for Planning and Evaluation, *Essential Health Benefits: Individual Market Coverage*, U.S. Department of Health and Human Services, December 16, 2011.

that coverage has recently improved notably thereby increasing the power of such coverage to be a tool for closing the treatment gap. History tells us that weakening the ACA's Essential Health Benefit and Parity provisions stands to substantially compromise the coverage for SUD care of about 48 million Americans in the individual (18 million) and small group markets (30 million).<sup>19</sup> Altering the subsidies for low-income participants in the individual health insurance market would most strongly affect the estimated 120,000 people with an OUD that are covered in the Marketplaces currently.

The third area of federal policy change aimed at addressing the treatment gap is federal grants to states. Direct grants to providers by and through states accounted for about 41% of SUD spending in 2014, yet only totaled \$13.9 billion.<sup>20</sup> States stretch these discretionary dollars to attempt to meet the needs created by all substance use disorders not only OUDs, and as a result frequently maintain waiting lists as demand for care outstrips treatment capacity. The *21<sup>st</sup> Century Cures Act* appropriated \$1 billion over two years for targeted grants to states aimed at addressing the treatment gap among other aspects of the opioid epidemic. Just under \$500 million was recently allocated by the U.S. Department of Health and Human Services to the states. This was an important step forward but as President Obama noted in his 2016 budget proposal such grants were meant to serve as a complement to the insurance-based tools and existing grant mechanisms. That is, the funds were targeted at building capacity and serving people with OUD that remained uninsured, an estimated 18%.<sup>21</sup> For example, substantial numbers of people that are not eligible for Medicaid with an OUD and incomes below the poverty line live in states that did not expand Medicaid.

#### Observations on Affordability and the Treatment Gap:

Earlier I highlighted the elevated prevalence of OUD in the population with incomes under 200% of the FPL. These populations have traditionally had the most significant financial barriers to treatment and affordability figures significantly in creating the treatment gap. The recent Congressional Budget Office score of the American Health Care Act highlights the large losses in coverage that would occur among people with incomes below 200% of the FPL.<sup>22</sup> Because the prevalence of OUD and the coverage expansions for this population are concentrated in the group of people with incomes 200% of FPL or less, the likelihood of an expanded treatment gap both in percentage terms and in absolute numbers is likely if proposals such as the Americans Health Care Act advance.

The magnitude of these changes can be put into perspective by considering a case in point. The Commonwealth of Kentucky recently received a \$10.5 million grant stemming from the *21<sup>st</sup> Century Cure Act*. The average spending in Medicaid for MAT for OUD is

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<sup>19</sup> These estimates are based on the CBO January 2017 baseline.

<sup>20</sup> See SAMHSA spending accounts Note 11.

<sup>21</sup> Author's tabulation from the NHSDUH 2015

<sup>22</sup> Congressional Budget Office, *HR 1628 Americans Health Care Act of 2017*, May 24, 2017; see Figure 2.

estimated at about \$5,500.<sup>23</sup> That means that the grant to Kentucky if it were only used to treat OUD would buy a little over 1900 full year treatments with MAT.<sup>24 25</sup> IMSHealth reports that 44% of prescriptions for buprenorphine in Kentucky or 4180 person years of treatment were paid for by Medicaid.<sup>26</sup> Thus, should the Medicaid expansion in Kentucky be eliminated, the *21<sup>st</sup> Century Cures* Act grant would not be able to help expand state treatment capacity—as it was intended to do—instead it would have to backfill cuts to Medicaid because roughly 73% of all Medicaid SUD care was for the expansion population. Yet even Kentucky’s share of the \$1 billion is far too small to fill that gap. Given current treatment patterns, its grant would pay for less than 2/3 of lost Medicaid spending on Buprenorphine not counting other forms of MAT, and the thousands of opioid related SUD admissions paid for by Medicaid.<sup>27</sup> This is especially troubling given the rapid increases in opioid misuse morbidity and mortality taking place nationally and in Kentucky. Finally, the costs of treatment reported here put treatment out of reach for most low-income people without insurance. This is because a year of OUD treatment would claim 44% of the income of an individual at the federal poverty line.

I recognize that the Americans Health Care Act sets aside funds for mental health, substance use disorder and maternity services and support for premiums to aid in paying for premium underwriting of pre-existing conditions. My analysis suggests that those funds will simply not be close to adequate to fund the services that would be lost as a result of the elimination of the Medicaid expansion, the restructured subsidies, the flexibility with respect to Essential Health Benefits and underwriting practices and the Medicaid measures recently articulated in President Trump’s budget.

The second barrier to access to OUD treatment is availability of treatment providers. SUD treatment capacity in the U.S grew about 3.9% between 2003 and 2013, whereas patient demand drew about 14.4% during that same period. Patient demand has continued to increase since. This is in part because spending on SUD treatments was so reliant on grant based funding programs supported by federal and state funds and because public and private insurance programs offered limited coverage. One important consequence of the new coverage and revenue sources is that new private investment in treatment capacity has been spurred.

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<sup>23</sup> Because Kentucky specific data were not available I make use of national data, data from Vermont and from the treatment system Recovery.org. See Stein BD, Pacula RL, Gordon AJ, et al. Where is buprenorphine dispensed to treat opioid use disorders? The role of private offices, opioid treatment programs, and substance abuse treatment facilities in urban and rural counties; *Milbank Quarterly* 93:561–583 2015; Note the estimates by Stein et al and by Recovery.org indicate yearly costs of \$6,000. Vermont estimates are lower at \$5,500.

<sup>24</sup> To put these figures into additional context, currently Medicaid in Kentucky pays for an estimated 11,000 SUD treatments for the Medicaid expansion population alone an increase of 700% since 2014. Medicaid also paid for an additional 4,000 treatments for people in traditional Medicaid.

<sup>25</sup> Foundation for a Health Kentucky, *Substance Abuse and the ACA in Kentucky*, December 2016. We obtain the person years of treatment by taking the reported doses and dividing by 365. We then apply the IMS spending share for buprenorphine by Medicaid in Kentucky.

<sup>26</sup> Kentucky’s KASPER monitoring system shows that in 2015 3.5 million doses of buprenorphine were dispensed. That amounts to a bit more than 9500 person years of MAT.

<sup>27</sup> This assumes the only Medicaid cuts would be those supporting the expansion. The President’s budget suggests substantially larger cuts to Medicaid.

Private equity deals that aim to purchase and scale existing treatment providers have multiplied. Between 2012 and 2015 there have been 170 private equity transactions in the behavioral health area. There were 40 deals in 2015 alone.<sup>28</sup> Of note is a \$100 million investment made by the private equity firm of Welsh-Carson. The industry attributes the impulse to invest directly to recent policy changes I have reviewed: MHPAEA, the creation of the subsidized private insurance Marketplaces and the Medicaid expansions under the Affordable Care Act. Thus, an important effect of the recent policy changes has been to promote private investment and scaling of provider systems in an industry that has been plagued by small scale and slow innovation. Thus, interrupting the coverage changes for OUDs risks halting the flow of investments and allowing demand to continue to outstrip supply. This would be further aggravated by the proposed reductions in support for behavioral health workforce training in President Trump's budget. It would also likely limit the impact of government efforts to seed capacity in high need low resource areas as was done with the \$100 million in grants to Federally Qualified Health Centers in 2015 and the new *21<sup>st</sup> Century Cures* funds. I estimate that the Medicaid expansion and the subsidized Marketplaces alone contribute about \$5.5 billion per year in treatment for behavioral health conditions (mental illnesses and SUDs). Withdrawing these funds that are well targeted to where the need sits—will dampen both our ability to close the treatment gap and our ability to expand and modernized the SUD treatment system.

#### **IV. Concluding Observations**

The last decade has seen a bipartisan consensus about the need to aggressively address the opioid epidemic and behavioral health issues more generally. Beginning with the Domenici-Wellstone Mental Health Parity and Addictions Equity Act and most recently the *21<sup>st</sup> Century Cures Act* those efforts have been aimed at putting more purchasing power into the hands of people that might suffer from an OUD and directing more attention to the capacity of the treatment system to supply treatments that work.

There is mounting evidence that MAT is growing and especially where insurance coverage has expanded such as in Medicaid expansion states. It is also the case that traditional Medicaid is also serves a critical function in reducing financial barriers to treatment access in a population that is at elevated risk of OUDs. The result is that the states that have been hit hardest by the opioid epidemic are using Medicaid to finance a response that aims to expand treatment using the gold standard for care MAT. These states rely more heavily on Medicaid than the national average.

The response to the opioid epidemic has been more sluggish than most would have hoped. This is in part due to the failure of treatment capacity to keep up with demand both in the aggregate and in specific geographic areas. Rural areas have lagged behind in the availability of treatment resources while experiencing relatively high rates of opioid misuse, abuse and overdose. In recent years we have seen both the public and private sector direct resources towards expanding capacity. The private market has done so in

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<sup>28</sup> Duff and Phelps, Industry Insights: Behavioral Health, 2015

response to the expansion in the number of Americans insured against the costs of treating SUDs and the improvement in the extent of coverage. This permits the public sector to direct resources to where market forces are not creating new capacity to meet the threat of OUD.

Reversing the policies that have created the new purchasing power for treatment and in turn new investments in treatment capacity will likely drive the nation towards a period where the treatment gap will grow that carries with it upward pressure on mortality, infectious disease morbidity, and public safety threats from the epidemic. This would all come at a time when we are claiming a bipartisan assault on the opioid epidemic. My reading of the evidence is that it is good public health and good economics to keep our promises by using all the tools we have to fight this scourge.

June 8, 2017