DATE: February 15, 2018

TO: Committee on Education and the Workforce: Joint Subcommittees on Health, Employment, Labor and Pensions and Workforce Protections

FROM: Dr. Christina M. Andrews, University of South Carolina

RE: Testimony: "Opioids Epidemic: Implications for America's Workplaces"

Chairwoman Foxx, Ranking Member Scott, Subcommittee Chairmen Walberg and Byrne, Ranking Members Sablan and Takano, and Distinguished Members of the Committee:

Thank you for the opportunity to speak with you today. I am a professor of social policy at the University of South Carolina and have spent the past decade researching how we can improve access to substance use disorder treatment in the United States, with a particularly focus on opioid addiction.

Without question, the opioid epidemic is having a profound impact on our nation. We are now losing more people to opioid overdose than to AIDS at the height of that epidemic, and will have lost 10 Americans to a fatal opioid overdose by the conclusion of this hearing today.[1] The human cost of addiction and overdose is accompanied by a substantial financial price: In 2013 alone, expenses related to opioid use, overdose, death were estimated to be $79 billion.[2] More recent estimates from 2016 put these expenses at over $95 billion.[3]

The epidemic presents new challenges for our economy. Reports from employers across the country tell a similar tale: Opioid misuse is impairing their ability to hire and retain qualified workers. The Fed recently identified the epidemic as an emerging threat to economic growth. In its Beige Book, a summary of regional economic conditions, officials point to a concerning number of employers who are reporting difficulty finding qualified employees who are drug free.[4]

The research indicates a strong link between opioids and labor force participation.[5] More prescriptions, more unemployment. The proportion of prime-age men in the workforce has reached a historic low. Among those 25-54 who are unemployed, a staggering 50% report taking pain medication on a regular basis — in most cases, prescription drugs. The National Safety Council reports that 70% of employers report witnessing negative consequences of opioid use in

the workplace, including absenteeism and drug use on the job.[6] The total cost to employers annually: An estimated $26 billion resulting from no shows, turnover, and reduced productivity.[7]

The most effective strategy to address these challenges is expansion of opioid use disorder treatment. Decades of research have established that opioid addiction is a chronic disease that can be treated effectively with a combination of medication and psychosocial intervention.[8-10] Recovery is possible.

Employees struggling with addiction must be connected to treatment so that they can achieve recovery and remain employed. Those who have dropped out of the workforce due to addiction must also receive treatment so that that can get back to work. This is the only realistic way to increase the supply of qualified workers. Drug testing is not an effective deterrent for people who have the disease of addiction.[11-13] Treatment is the most sensible and evidence-based approach to reduce opioid misuse in the workplace.

How can we increase access to treatment? Let me share with you several excellent recommendations, many of which come from the Surgeon General's *Report on Alcohol, Drugs, and Health*,[14] and the Final Report of the Opioid Commission[15] appointed by President Trump:

First, protect the Medicaid expansion and the health insurance exchanges. The Affordable Care Act (ACA) has extended health insurance coverage to nearly one million people with opioid use disorders.[1] Many are in the workforce. If the law were repealed, nearly one-third of all Americans with an opioid use disorder would suddenly lose access to treatment. Lifesaving drugs, such as buprenorphine and extended-release naltrexone, are costly and financially out of reach for many uninsured people. The uninsured must seek care from overburdened safety-net providers, which often have long waiting lists to enter treatment. People with opioid use disorder risk a fatal overdose each day that they must wait for treatment to begin. With an increase in the use of deadly drugs as fentanyl in the heroin purchased in the United States, the stakes of not receiving treatment on demand are high.

Moreover, Medicaid waivers that impose work requirements could force beneficiaries to quit treatment in order to maintain their coverage, with negative effects for the workplace and the epidemic. This poses a particular hardship for Medicaid beneficiaries who have severe substance

use disorder that requires medically-managed inpatient or residential treatment in order to achieve detoxification and stabilization.

Second, actively enforce parity regulations established under the Mental Health Parity and Addiction Equity Act (MHAEA) of 2008 and extended under the ACA. These regulations, which have benefited approximately 60 million Americans, have been critically important in reducing utilization controls have historically limited patients' ability to access to opioid use disorder treatment.[16] Research findings from the National Drug Abuse Treatment System Survey have revealed substantial decreases in use of preauthorization and annual service limits for life-saving treatment for opioid use disorder after implementation of MHPAEA parity regulations. For employers to help their workers get the treatment they need, we must ensure that their health plans provide equitable access to opioid use disorder treatment benefits.

Third, uphold existing regulations on Association Health Plans. The Trump Administration recently directed the federal government to expand access to association health plans and other types of insurance products, such as short-term limited duration insurance.[17] The proposed rule issued by the Department of Labor last month would allow for a proliferation of poorly-regulated health plans subject to few consumer protections. We must not allow Americans to spend their money on health plans that may not provide coverage for opioid use disorder treatment should they need it.

Fourth, rapidly expand distribution of naloxone, the opioid-agonist designed to counteract the effects opioid overdose. We must get naloxone into every hospital, school, and local police station in the country. While the price of naloxone has increased substantially in recent years, the Federal government is in a strong position to purchase naloxone in bulk at a reduced rate. According to the Centers on Disease Control, naloxone has saved over 27,000 lives between 1996 and 2014.[18] Thousands of additional lives can be saved by taking this step alone.

Finally, increase prevention efforts. This includes better regulation and monitoring of opioid prescribing. expanded options for safe disposal, greater support for effective non-opioid approaches to pain management, and expansion of injury prevention programs to reduce the need for pain medications.

I applaud Congress for including an additional $6 billion over two years for opioid use disorder treatment in the recent budget agreement. However, given the magnitude of this crisis, more funding is needed to meet the need. It is critical that these funds be directed towards purchase of naloxone and evidence-based treatments such as buprenorphine and extended-release naltrexone. Greater resources are absolutely crucial to enable our states and local communities to mount an effective response to this deadly epidemic.

I express my sincere gratitude for the opportunity to share my thoughts with the Committee. I look forward to your comments and questions.

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