national partnership for women & families
Because actions speak louder than words.

February 16, 2018

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

RE: Policy Solutions for the Ongoing Opioid Crises

Dear Chairman Hatch and Ranking Member Wyden:

The National Partnership for Women & Families appreciates the opportunity to offer comments in response to the Senate Finance Committee's request for information about potential policy solutions for the ongoing opioid crises. The National Partnership is a nonprofit, nonpartisan organization that has fought for decades to strengthen our health care system and advance the rights and wellbeing of women. We strongly support the Committee's view that it is necessary to take a broad view of the issue and pursue policy solutions along the continuum that spans roots causes that lead to, or fail to prevent, opioid use disorder (OUD) and other substance abuse disorders (SUDs) to improving access to and quality of treatment.

In response to the Committee's request, we offer overarching comments about the effective elements of policy proposals to effectively stem the opioid crisis. Effective policies should 1) include a specific focus on unique health care needs of women with OUD, 2) maintain and expand Medicaid coverage, and access to necessary services for treating OUDs, 3) rely on evidence-based practices for treating OUD during pregnancy, 4) address the complexity of women's lives and health care needs and 5) focus on providers women trust and the settings where they receive care.

Effective policy solutions include a specific focus on the health care needs of women with opioid use disorders.

Women are disproportionately affected by the opioid crisis and its underlying issues. For example, adolescent women are more likely than adolescent men to misuse prescription drugs, which puts them at higher risk for developing opioid use disorders.[1] In rural areas,

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where the opioid crisis has been especially severe, pregnant women and women experiencing partner violence are among populations with higher prevalence of misuse of prescription pain relievers.[2] Additionally, heroin use has also been increasing among women, and at rates faster than men; heroin use among women increased 100 percent from 2002 to 2013.[3] Hospitalization and opioid-related deaths are also increasing at a startling rate for women:

- Hospitalizations involving opioid pain relievers and heroin increased 75 percent for women between 2005 and 2014, a jump that significantly outpaced the 55-percent increase among men.[4]
- Between 1999 and 2015, the rate of deaths from prescription opioid overdoses increased 471 percent among women, compared to an increase of 218 percent among men, and heroin deaths among women increased at more than twice the rate than among men.[5]
- There has also been an alarming increase in the rates of synthetic opioid-related deaths; these deaths increased 850 percent in women between 1999 and 2015.[6]

Women are also affected by opioid use differently than men. Research finds that women progress from opioid use to opioid dependence more quickly than men, suffer more severe emotional and physical consequences of drug use as compared to men, yet women underutilize treatment.[7] Women are also more likely than men to have co-occurring mental and substance use disorders.[8] For women, anxiety disorders and major depression are associated with substance use disorders and are typically the most common co-occurring diagnoses, in addition to other diagnosis such as PTSD, eating disorders, and agoraphobia.[9]

Effective policies maintain and expand coverage of and access to necessary services for opioid use disorders.

Medicaid is a critical program for meeting the health needs of low-income women, including care related to behavioral health and OUDs. Medicaid covers 17 million adult women (ages 18-64), and women make up the majority of adult Medicaid enrollees.[10,11] Medicaid is the largest public payer of reproductive health care.[12] In fact, for nearly half of women giving birth, Medicaid is the source of coverage for essential health care, including prenatal and delivery care. Medicaid also plays a significant role in providing health coverage to women of color. Due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population; 30 percent of African-American women and 24 percent of Hispanic women are enrolled in Medicaid, compared to only 14 percent of white women.[13]

We strongly oppose proposals to end the Medicaid expansion created by the Affordable Care Act (ACA) and cap federal Medicaid funding to states. Such changes would create significant barriers to care for women, including those in need of treatment for OUDs. [14] Any changes to the Medicaid program should preserve Medicaid in its current structure, including federal funding for states to cover all low-income adults; and maintain administrative protections that facilitate Medicaid access, coverage and affordability.

To decrease OUD among women with low incomes, any response to the opioid crisis must improve, not reduce, access to high-quality health care for all women. We support Medicaid policies that enable integration of physical, including reproductive health, and behavioral health care needs – new policies should not continue the health care silos that have long plagued our health care system and stymied efforts to treat the whole person effectively. Innovation in Medicaid should prioritize universal screening and early evidence-based intervention of OUDs for women.

Medicaid and private insurance should provide ready access to the evidence-based care that women need to prevent and treat opioid use disorders. Policy solutions should include addressing barriers to accessing non-pharmacological pain relief including insurance coverage, as well as transportation and childcare options for women seeking non-opioid treatment for pain.

Effective policies rely on evidence-based practices for treating opioid use disorders during pregnancy.

As noted above, the rates of opioid use disorder are rising among women, this also means more women are opioid-dependent during their pregnancy. In an evaluation of over one million Medicaid enrollees, one out of five pregnant women filled a prescription for an opioid and 2.5 percent received a chronic opioid prescription for greater than 30 days.[15] Increases in prescription opioid use among pregnant women has led to a stark increase in the proportion of women needing treatment for opioid-related disorders.[16] Among pregnant women who are opioid-dependent, researchers have found a higher odds of inpatient mortality compared to non-opioid-using pregnant women.[17] Additionally, in a number of states, overdose and suicide are becoming the leading cause of pregnancy-related mortality.[18,19,20]

We are deeply concerned about policies that criminalize pregnant women who suffer from addiction, which are counterproductive and ineffective at fighting the opioid crisis. A number of states have pursued policy approaches that penalize pregnant women suffering including prosecuting women for assault and/or characterizing substance abuse during pregnancy as criminal child abuse.[21]

Penalizing pregnant women for disclosing substance use disorders discourages women from seeking prenatal care and/or substance use treatment, and can lead to women withholding important information from their providers that could affect their health.[22] The American College of Obstetricians and Gynecologists (ACOG) recommends a coordinated multidisplinary approach without criminal sanctions as the best chance of improving maternal and infant outcomes.[23] Indeed, pregnancy provides an important opportunity to identify and treat women with substance use disorders. ACOG recommends universal screening of pregnant women for substance use as part of comprehensive obstetric care, and should be done at the first prenatal visit in partnership with the pregnant woman.[24] Multidisciplinary long-term follow-up should include medical, developmental, and social support for women.[25]

Effective policies address the complexity of women's lives and health care needs.

According to the Department of Health and Human Services' Office of Women's Health, psychological and emotional distress are risk factors for prescription opioid nonmedical use among women, but not in men.[26] Victims of violence and/or sexual abuse are at an increased risk for adverse outcomes from substance use, and research indicates that opioid use disorders are associated with intimate partner violence victimization and that women may also be particularly susceptible to such violence when under the influence of opioids.[27]

A history of traumatic childhood events is also associated with the initiation of substance use among women.[28] Rates of both childhood and adult sexual abuse are higher among women than among men and that this abuse correlates with developing substance use disorders.[29] Adverse childhood experiences, however, may also include other forms of trauma including emotional abuse, neglect, substance use disorders among family members, mental illness in the home, an incarcerated household member, or having a mother who was treated violently.[30] Research shows a strong relationship between adverse childhood experiences and a variety of negative health outcomes including harmful drug use.

The Office of Women's Health recommends that health care and other service providers should be aware of and understand trauma theory, and how to provide or refer to trauma-informed services for their clients. The Office of Women's Health also recommends prevention strategies to eliminate exposure to trauma in childhood and adulthood as an important part of a comprehensive approach to substance use disorders.[31]

Policy options to address opioid use should also consider that women disproportionally shoulder caregiving responsibilities. The responsibilities of caregiving in addition to undergoing substance use treatment can become overwhelming for some women. Again, the Office of Women's health finds that many women who are in caregiving roles often will not seek treatment or do not complete treatment because they are unable to manage their caregiving responsibilities and participate in treatment programs at the same time.[32] Women who are allowed to stay with their children in treatment are more inclined not only to enter into treatment, but also to participate and stay in the program.[33] Successful policies and treatment programs need to consider providing increased social supports, including child care, to address this barrier for women seeking treatment.

Effective policies focus on providers women trust and the settings where they receive care.

To address the opioid crisis and related health disparities effectively, policymakers and payers must consider the unique needs of women, including how they utilize the health care system. Research shows that women of reproductive age place great trust in their OB/GYNs, and overwhelmingly (90 percent) say they want the option of seeing an OB/GYN as their main provider. [34]

Women rate their OB/GYNs higher than general practitioners (GPs) on a number of measures, such as listening, cultural understanding, and shared decision-making.[35] About two-thirds of women say they are more likely to be open and honest with their OB/GYN

providers than their GP.[36] Black women stand out as most likely to rate their OB/GYN providers favorably in contrast to their GPs.[37]

Reproductive health providers have already been at the forefront in developing solutions to the opioid crisis. As noted throughout, ACOG findings and recommendations emphasize the strong role OB/GYNs can play to address OUDs in pregnant women, with both prenatal and postpartum care.[38] ACOG recommends that family planning should be a routine part of OUD care among women of reproductive age.[39] Reproductive health providers not only provide preventive health screenings and family planning but are also uniquely situated to be able to identify behavioral health needs, early signs of OUD and make appropriate referrals for health care and resources addressing social determinants that promote wellness and recovery.

New federal initiatives and resources should prioritize flexibility in the settings where women may seek care, and specifically take account of women's need for and access to interventions and screenings. In particular, policies should build on strategies specifically developed for care of women with OUDs and include health care providers that women trust.

Thank you for this opportunity to offer comments on the Senate Finance Committee's request for policy solutions to combat the opioid epidemic. If you have any questions about our concerns and recommendations, please contact Katie Martin, vice president for health policy and programs at kmartin@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness, President

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