Characteristics of Adults With Substance Use Disorders Expected to Be Eligible for Medicaid Under the ACA

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Objectives: **Provisions in the Affordable Care Act (ACA) are likely to expand access to substance use disorder treatment for low-income individuals. The aim of the study was to provide information on the need for substance use disorder treatment among individuals who may be eligible for Medicaid under the ACA.** ***Methods:*** **The 2008 and 2009 National Survey on Drug Use and Health provided data on demographic characteristics, health status, and substance use disorders for comparison of current low-income Medicaid enrollees (N=3,809) with currently uninsured individuals with household incomes that may qualify them for Medicaid coverage beginning in 2014 (N=5,049). The incomes of the groups compared were 138% of the federal poverty level (133% provided in the ACA plus a 5% income "disregard" allowed by the law).** ***Results:*** **The rate of substance use disorders among currently uninsured income-eligible individuals was slightly higher than the rate among current Medicaid enrollees (14.6% versus 11.5%, p=.03). Although both groups had significant unmet need for substance use disorder treatment, the treatment rate among those who needed treatment was significantly lower in the income-eligible group than in the currently enrolled group (31.3% versus 46.8%, p<.01). When the analysis excluded informal care received outside the medical sector, treatment rates among those with treatment needs were much lower in both groups (12.8% in the income-eligible group and 30.7% among current enrollees).** ***Conclusions:*** **Findings suggest that Medicaid insurance expansions under the ACA will reduce unmet need for substance use disorder treatment. (*Psychiatric Services* 64:520–526, 2013; doi: 10.1176/appi.ps.201200011)**

Provisions in the Patient Protection and Affordable Care Act (ACA) of 2010 are likely to significantly expand access to substance use disorder treatment for low-income individuals. The ACA gave states the option of extending Medicaid coverage beginning in 2014 to all uninsured adults under age 65 with incomes up to 133% of the federal poverty level (FPL). In July 2012, the U.S. Supreme Court ruled that states will not face the penalty of losing federal funding from their traditional Medicaid programs if they choose not to expand eligibility, and some states are now likely to forgo Medicaid expansion. The Congressional Budget Office estimates that given the Supreme Court decision, the ACA's Medicaid expansion will result in an additional seven million individuals covered by Medicaid by 2014 (1). The expansion of Medicaid coverage is expected to increase use of substance use disorder treatment, alter the types and settings of services received, and change how treatments are financed (2).

Although data on the population expected to be newly eligible for Medicaid as a result of the ACA are scarce, these individuals may have significant demand for substance use disorder treatment. Unlike other disabling conditions, substance use disorders are not a qualifying disability category under Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). This has made it difficult for individuals with a substance use disorder to gain public coverage, even if the condition results in absence from the labor market. Reports from states that have previously expanded Medicaid coverage to low-income childless adults suggest high rates of substance use disorders (as well as mental illness) in this population (3). At least two studies

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have examined current use of health care by the newly eligible Medicaid population, although neither examined the population with substance use disorders specifically. One study found significant problems with access to general medical care; about 60% of those expected to be newly eligible had no usual source of care and 50% had received no medical care during the past year (4). A second study estimated that the proportion of individuals with probable depression or serious psychological distress who will be covered by Medicaid when reform is fully implemented in 2019 will increase from 12.8% to 24.5% (5).

The goal of this study was to gather data on the need for substance use disorder treatment among persons with low incomes who are anticipated to be newly eligible for Medicaid in 2014 and to compare current rates of substance use disorder treatment in this population with rates among persons with similar incomes who are currently enrolled in Medicaid. Because it is unknown at this time which states will choose to expand their Medicaid programs, for simplicity we assumed that uninsured individuals in any state who meet the income threshold will become eligible. Understanding the characteristics of these individuals will be helpful to states designing benefit packages, making funding and resource determinations, addressing workforce issues, and developing enrollment strategies as they prepare for implementation in 2014.

Methods

Data

We used the 2008 and 2009 data from the National Survey on Drug Use and Health (NSDUH), a nationally representative survey of noninstitutionalized adolescents and adults in the United States conducted annually by the Substance Abuse and Mental Health Services Administration. The NSDUH collects information on use of alcohol and illicit drugs and consequences of use, which allowed us to estimate rates of treated and untreated substance use disorders. Rates of substance use disorders found in the NSDUH are consistent with rates found in other national surveys (6,7), although the National Comorbidity Survey Replication reported lower rates (8,9). Because Medicaid expansion will primarily affect nonelderly adults and Medicaid programs are required to cover poor children up to age 19, we restricted our analysis to individuals age 20 through 64.

Measures

The NSDUH defines alcohol and illicit drug dependence and abuse on the basis of criteria in the *DSM-IV*. To be considered alcohol dependent, a respondent must report three or more of the following during the past 12 months: spent a great deal of time over a period of a month using or getting over the effects of alcohol, used alcohol more often than intended, needed to use alcohol more than before to get desired effects, was unable to cut down or stop using alcohol, continued to use alcohol even though it was causing problems with mental health or physical problems, reduced involvement in important activities due to alcohol, or experienced two or more alcohol withdrawal symptoms after alcohol use was cut back or stopped (10,11).

For individuals with no alcohol or drug dependence, we considered whether the individual had alcohol or illicit drug abuse. To be considered to have alcohol abuse, an individual must report one or more of the following during the past 12 months: had serious problems at home, work, or school due to alcohol use; used alcohol regularly and engaged in an activity in which being drunk may have put the individual in physical danger; got into trouble with the law repeatedly due to actions resulting from alcohol use; or experienced problems with family or friends due to alcohol use and continued to use alcohol. Similar measures were used to identify illicit drug dependence and illicit drug abuse.

To create a variable indicating whether household income would qualify the individual for Medicaid in 2014, we used the midpoint of the income ranges reported in the NSDUH, household size, and the FPL during the relevant year. We performed sensitivity analysis using the lower and upper bound in each income range and found that results did not change in a qualitatively meaningful way. Although the ACA requires Medicaid eligibility at 133% of the FPL, the law allows for a 5% income "disregard," and thus we considered individuals with incomes up to and including 138% of the FPL to be income eligible (12). Individuals age 20 to 22 living in a college dormitory were not included because information on family income was unavailable.

We created a measure of serious psychological distress based on the K6 scale, with a K6 score $\geq$13 indicating serious psychological distress (13,14).

We constructed six mutually exclusive insurance coverage variables in the following hierarchical order: Medicare, Medicaid, private coverage, military health care, other coverage, and uninsured. For example, if an individual had both Medicare and Medicaid, he or she was coded as insured under Medicare. Individuals covered by the State Children's Health Insurance Program were included under Medicaid.

We categorized substance use disorder treatment on the basis of self-reported services received during the past 12 months. Outpatient treatment included outpatient treatment in a residential drug or alcohol rehabilitation facility, treatment in a mental health center or facility, or treatment in a private physician's office. Inpatient treatment included treatment in a hospital overnight as an inpatient, treatment in a residential drug or alcohol rehabilitation facility overnight, or treatment in an emergency room. Informal treatment included services received through a self-help group, religious organization, or alcohol or drug education program.

We created an indicator variable, "substance use disorder treatment need," to identify individuals who met the dependence or abuse criteria described above as well as individuals with no current disorder who reported being currently in treatment (either formal or informal). Consistent with prior research (15), we chose to categorize the latter group as having treatment need because, like patients with other chronic recurring illnesses, individuals with substance use disorders experience

Table 1

Individuals with household incomes ≤138% of the federal poverty level with and without a substance use disorder, by current insurance status, 2008–2009[a]

	Total (N=13,937)		No substance use disorder (N=11,695)		Substance use disorder					
					Any (N=2,242)		Alcohol or illicit drug dependence (N=1,375)[c]		Alcohol or illicit drug abuse (N=867)[c]	
Insurance[b]	N	%	N	%	N	%	N	%	N	%
Medicare	622	8.1	539	8.3	83	6.2	58	6.8	25	5.2
Medicaid	3,824	24.5	3,326	24.9	498	21.8	350	24.4	148	17.0
Private	3,639	23.8	2,982	24.2	657	21.6	340	18.9	317	26.3
Military health care[d]	180	1.3	151	1.2	29	1.6	20	1.8	9	1.3
Other insurance	591	3.1	458	2.9	133	4.3	84	3.9	49	5.1
Uninsured[e]	5,081	39.3	4,239	38.5	842	44.6	523	44.2	319	45.1

[a] Source: National Survey on Drug Use and Health, 2008–2009. Ns are unweighted and percentages are weighted to make estimates representative of the noninstitutionalized population. The income eligibility threshold reflects 133% of the federal poverty level provided in the Affordable Care Act plus a 5% income "disregard" allowed by the law.

[b] Insurance categories are defined to be mutually exclusive and exhaustive. Therefore, columns sum to 100%.

[c] Individuals with symptoms of both dependence and abuse were coded as dependent.

[d] Includes individuals currently reporting coverage by TRICARE, CHAMPUS, CHAMPVA, the Department of Veterans Affairs, or military health care

[e] $p<.01$ for the difference in insurance distribution between individuals with and without a substance use disorder; $p=.08$ for the difference in insurance distribution between individuals with alcohol or illicit drug dependence and individuals with alcohol or illicit drug abuse

periods of reduced or no symptoms, but symptoms can and do recur over time.

Data analysis

First, we compared individuals with incomes below 138% FPL with and without a need for substance use disorder treatment by current insurance status. Next, we compared current Medicaid enrollees with incomes below 138% FPL (N=3,809) with currently uninsured individuals with incomes below 138% FPL (N=5,049), the threshold that would qualify them for Medicaid expansion coverage as of 2014 (hereafter referred to as "future income eligible"). We included only individuals with a household income less than 138% FPL because Medicaid beneficiaries with higher income are likely to have qualified under the medically needy eligibility category. Note that the future income-eligible group included individuals who met current categorical eligibility criteria for Medicaid but had not taken up coverage. Given substantial uncertainty about implementation of the ACA, we did not model behavioral responses to the law (for example, changes in labor market participation) or account for individuals who might switch from private coverage to Medicaid or insurance take-up. Because immigration status is not available in the NSDUH, it was also not considered. We excluded current Medicaid enrollees who were dually enrolled in Medicare because Medicare is their primary payer.

For current and future income-eligible Medicaid enrollees, we calculated pooled national estimates of demographic, health, and substance use disorder characteristics and compared substance use disorder treatment rates and treatment type for individuals with a need for substance use disorder treatment. Finally, we compared the characteristics of future income-eligible individuals with and without a substance use disorder. In all cases, differences were tested by using chi square tests. All estimates were weighted to make estimates representative of the noninstitutionalized population, and variance estimates were adjusted for the complex sampling design of the survey.

Results

We examined the insurance status of all individuals meeting the income threshold of 138% FPL under the Medicaid expansion and compared individuals with and without a substance use disorder (Table 1). We found significant differences in the distribution of insurance status ($p<.01$). Individuals at this income level with a substance use disorder were more likely to be uninsured than those without a substance use disorder (44.6% versus 38.5%). In addition, those with a substance use disorder were slightly less likely to be enrolled in Medicaid (21.8% versus 24.9%).

We compared characteristics of future income-eligible individuals with individuals currently covered by Medicaid (Table 2). Future income-eligible individuals were less likely than current enrollees to be female and to have children but more likely to be employed and married. The future income-eligible group was also less likely to report being in fair or poor health (19.7% versus 27.2%, $p<.01$) and more likely to have a substance use disorder (14.6% versus 11.5%, $p=.03$). Future income-eligible individuals were significantly more likely than current enrollees to meet criteria for substance abuse ($p<.01$) but not more likely to meet criteria for substance dependence. In contrast, future income-eligible individuals were significantly less likely to have serious psychological distress (14.1 % versus 24.1%, $p<.01$).

We compared the percentage of respondents who received treatment for a substance use disorder in the past 12 months, conditional on having a need for substance use disorder treatment, among future income-eligible individuals who were uninsured and current Medicaid enrollees (Table 3). The rates of receipt of substance use disorder treatment were low in both groups. In the future income-eligible group only 31.3% of individuals with a need for substance use disorder treatment had received any treatment. The rate was approximately 50% higher among current Medicaid enrollees, 46.8% of whom had received treatment ($p<.01$). When the

analysis excluded informal care received outside the medical sector, treatment rates were much lower: 12.8% in the future income-eligible group and 30.7% in the currently enrolled group ($p<.01$).

We limited our sample to individuals who met criteria for substance dependence (Table 3). We expected that rates of substance use disorder treatment would be lower in this group, because this subsample excluded individuals who had no current substance use disorder but who were currently receiving treatment (inclusion of individuals currently in treatment would mechanically increase treatment rates). For this subgroup, the treatment rate among the currently uninsured income-eligible group was significantly lower than the rate among current Medicaid enrollees (19.0% versus 38.7%, $p<.01$). When informal care received outside the medical sector was excluded, only 12.6% of the future income-eligible group and 30.2% of the current Medicaid group received any outpatient or inpatient care ($p<.01$). In Table 3, we also present treatment rates for individuals who met criteria for substance abuse (other comparisons are not shown because of the small cell size); no differences in treatment rates were detected.

We compared characteristics of uninsured future income-eligible individuals and current Medicaid enrollees with and without a substance use disorder (Table 4). We found that in both groups, those with a substance use disorder were less likely than those without a substance use disorder to be female or married and more likely to be childless and use tobacco. Among those with a substance use disorder, individuals in the future income-eligible group were less likely than those in the current Medicaid group to have concurrent serious psychological distress (28.8% versus 41.1%, $p<.01$). Among those with a substance use disorder, individuals in the current Medicaid group had higher overall emergency room use (56.3% versus 42.2%, $p<.01$) and higher inpatient use (20.8% versus 10.8%, $p<.01$) than those in the future income-eligible group.

Table 2

Characteristics of currently uninsured individuals expected to be income eligible for Medicaid and current Medicaid enrollees, both with household incomes ≤138% of the federal poverty level[a]

	Uninsured and future income eligible (N=5,049)		Currently enrolled in Medicaid (N=3,809)[b]		
Characteristic	N	%	N	%	p
Age					<.13
20–25	2,877	21.0	2,060	20.8	
26–34	946	25.3	827	29.4	
35–49	979	35.7	728	34.3	
50–64	247	18.0	194	15.5	
Female	2,714	52.2	3,004	72.3	<.01
Childless	2,769	52.3	1,059	34.5	<.01
Employed	2,913	55.8	1,570	37.7	<.01
Married	1,495	40.1	914	28.9	<.01
Education					<.20
Less than high school	1,987	41.8	1,377	40.6	
High school	1,727	34.1	1,580	36.7	
Some college	1,335	24.1	852	22.7	
Fair or poor health status	750	19.7	720	27.2	<.01
Any current substance use disorder[c]	837	14.6	496	11.5	.03
Substance dependence	520	9.3	348	8.2	.38
Substance abuse	317	5.4	148	3.3	<.01
Substance use treatment need[d]	964	17.8	597	14.7	.04
Serious psychological distress	906	14.1	892	24.1	<.01
Co-occurring disorders (current substance use disorder and serious psychological distress)	291	4.2	217	4.7	.47

[a] Source: National Survey on Drug Use and Health, 2008–2009. Ns are unweighted and percentages are weighted to make estimates representative of the noninstitutionalized population. The income eligibility threshold reflects 133% of the federal poverty level provided in the Affordable Care Act plus a 5% income "disregard" allowed by the law.

[b] Individuals reporting both Medicare and Medicaid coverage were not included as current Medicaid enrollees.

[c] Includes both alcohol or illicit drug abuse or dependence. Individuals with symptoms of both dependence and abuse were coded as dependent.

[d] Includes individuals with a current substance use disorder as well as those with no current substance use disorder who received substance use disorder treatment in the past 12 months. Thus this group includes some individuals with no current dependence or abuse.

Discussion

We found slightly higher rates of substance use disorders among individuals who would be income eligible for Medicaid in 2014 (household income less than 138% FPL) than among current Medicaid enrollees at the same income level. Measures of health status also suggested that Medicaid enrollees are less healthy than their currently uninsured counterparts. For example, rates of serious psychological distress were significantly higher among current Medicaid enrollees, and current enrollees were also significantly more likely to report fair or poor health status. These differences likely reflect the difficulty that individuals with a substance use disorder (in the absence of other health conditions) have obtaining Medicaid by qualifying for SSI or SSDI. Given the availability of effective and cost-effective substance use disorder treatments (16,17), providing insurance to these individuals may be appropriate, with the goal of increasing treatment rates.

Both the income-eligible group and the current enrollee group had significant unmet need for substance use disorder treatment, although treatment rates were about 50% higher among current Medicaid enrollees. We found that all of the difference in treatment rates was accounted for by the more severe category of substance use dependence. This finding

Table 3

Receipt of substance use disorder treatment among currently uninsured individuals expected to be income eligible for Medicaid and current Medicaid enrollees, both with household incomes less than 138% of the federal poverty level[a]

Variable	Uninsured and future income eligible		Currently enrolled in Medicaid[b]		
	N	%	N	%	p
With substance use disorder treatment need[c]	964	100.0	597	100.0	
Any treatment receipt	272	31.3	234	46.8	<.01
Substance use disorder treatment type					
Formal[d]	143	12.8	159	30.7	<.01
Outpatient	118	11.3	145	29.5	<.01
Inpatient	78	7.2	74	15.2	<.01
Informal	218	27.3	175	38.5	<.01
With current substance dependence	520	100.0	348	100.0	
Any treatment receipt	103	19.0	111	38.7	<.01
Substance use disorder treatment type					
Formal[d]	67	12.6	83	30.2	<.01
Outpatient	54	11.3	74	28.7	<.01
Inpatient	41	7.1	53	20.8	<.01
Informal	82	15.7	86	32.1	<.01
With current abuse	317	100.0	148	100.0	
Any treatment receipt	42	11.9	22	13.8	.62

[a] Source: National Survey on Drug Use and Health, 2008–2009. Ns are unweighted and percentages are weighted to make estimates representative of the noninstitutionalized population. The income eligibility threshold reflects 133% of the federal poverty level provided in the Affordable Care Act plus a 5% income "disregard" allowed by the law.

[b] Individuals reporting both Medicare and Medicaid coverage were not included as current Medicaid enrollees.

[c] Includes individuals with a current substance use disorder as well as those with no current substance use disorder who received substance use disorder treatment in the past 12 months. Thus this group includes some individuals with no current dependence or abuse.

[d] Includes both outpatient and inpatient treatment

suggests that without other changes, many individuals with a substance use disorder will remain untreated, even if they gain insurance coverage.

Beyond expansion in eligibility for Medicaid coverage, a number of provisions in the ACA are expected to improve the scope of substance use disorder treatment benefits under Medicaid. Under the new Medicaid "health home" option for people with multiple chronic conditions (including individuals with substance use disorders), Medicaid will pay for services that traditionally have not been reimbursable; the reimbursement will be at a 90% federal matching rate for the first two years after a health home is established (18). Eligible services include care management, health promotion, postinpatient transition care, referral to social support services, and information technology to link services. The ACA also provides additional funding to improve the capacity of Federally Qualified Health Centers to provide behavioral health care, including substance use disorder treatment. These and other changes under the ACA may improve access to medication-assisted treatments, such as buprenorphine for opioid dependence and acamprosate for alcohol dependence, because these treatments are often used in an office-based setting. Yet access to insurance alone is insufficient to ensure that individuals who need substance use disorder treatment receive services. Undertreatment is also a problem in private insurance. NSDUH data suggest that the treatment rate among the privately insured—9%—was even lower than in the populations studied here (authors' calculation, results not shown).

Although these ACA provisions suggest that treatment rates may improve for both current Medicaid enrollees and newly eligible enrollees, states will face significant challenges related to coverage of substance use disorder treatment when they implement Medicaid expansions. First, the current primary care workforce may not be adequate to treat the new influx of patients, and available primary care providers may be inexperienced with substance use disorder treatment. Second, some providers of substance use disorder treatment may find it difficult to make the transition from direct service provision financed by state funds to insurance reimbursement. Issues related to provider credentialing, consolidation of the industry, and the movement toward a person-centered integrated care model (2) will put pressure on providers of substance use disorder treatment to transform how care is delivered. Finally, without additional state enrollment provisions, Medicaid take-up rates for the population with substance use disorders may be low (19).

When considering the state resources currently used to treat Medicaid beneficiaries with a substance use disorder, it may be useful for states to compare demographic characteristics of the future income-eligible population with those of current Medicaid beneficiaries. As indicated in Table 4, future income-eligible individuals with a substance use disorder were more likely than current beneficiaries with a substance use disorder to be male, employed, and married. Both groups had similar rates of self-reported fair or poor health status, but income-eligible individuals were less likely than current Medicaid enrollees to have comorbid serious psychological distress. In addition, income-eligible individuals were not significantly more likely than current enrollees to have substance dependence, a more severe disorder.

A rich literature confirms that the pathways into treatment and the success of treatments vary by gender, and different approaches are required (20). Time constraints in an employed population, especially when jobs are unlikely to be highly flexible, may affect strategies to reduce barriers and to make treatment more accessible (21). Spouses of newly enrolled

Table 4

Characteristics of currently uninsured individuals expected to be income eligible for Medicaid and current Medicaid enrollees, both with household incomes less than 138% of the federal poverty level, by substance use disorder status[a]

Characteristic	Uninsured and future income eligible					Currently enrolled in Medicaid[b]					p for comparison of those with substance use disorders
	Substance use disorder[c]		No substance use disorder			Substance use disorder[c]		No substance use disorder			
	N (N=837)	%	N (N=4,212)	%	p	N (N=496)	%	N (N=3,313)	%	p	
Age					<.01					.17	.12
20–25	568	29.1	2,309	19.6		268	23.5	1,792	20.4		
26–34	139	27.6	807	24.9		123	33.5	704	28.9		
35–49	112	32.3	867	36.3		89	32.5	639	34.6		
50–64	18	11.0	229	19.2		16	10.5	178	16.2		
Female	299	28.2	2,415	56.3	<.01	328	57.1	2,676	74.2	<.01	<.01
Childless	564	60.1	2,205	51.8	.03	189	45.7	870	33.0	<.01	<.01
Employed	501	65.4	2,412	54.2	<.01	188	35.7	1,382	37.9	.49	<.01
Married	145	29.9	1,350	41.9	<.01	78	16.6	836	30.5	<.01	.01
Education					.15					.97	.32
Less than high school	366	47.5	1,621	40.8		205	40.7	1,172	40.5		
High school	251	29.4	1,476	34.9		175	36.1	1,405	36.8		
Some college	220	23.1	1,115	24.3		116	23.2	736	22.6		
Fair or poor health status	154	24.2	596	18.9	.09	106	24.7	614	27.5	.40	.91
Tobacco use in past month	650	76.0	1,712	39.1	<.01	378	72.1	1,451	42.1	<.01	.50
Substance dependence[d]	520	63.4	0	—		348	71.6	0	—		.08
Substance abuse	317	36.6	0	—		148	28.4	0	—		
Serious psychological distress	291	28.8	615	11.5	<.01	217	41.1	675	21.9	<.01	<.01
Any emergency room use in past year	369	42.2	1,481	33.6	<.01	279	56.3	1,679	50.8	.18	<.01
Any inpatient use in past year	96	10.8	408	9.4	.44	105	20.8	703	19.6	.76	<.01

[a] Source: National Survey on Drug Use and Health, 2008–2009. Ns are unweighted and percentages are weighted to make estimates representative of the noninstitutionalized population. The income eligibility threshold reflects 133% of the federal poverty level provided in the ACA plus a 5% income "disregard" allowed by the law.

[b] Individuals reporting both Medicare and Medicaid coverage were not included as current Medicaid enrollees.

[c] Includes both alcohol and illicit drug abuse or dependence

[d] Individuals with symptoms of both dependence and abuse were coded as dependent.

Medicaid beneficiaries with substance use disorders will also present both opportunities and challenges, depending on whether they provide support or additional triggers for substance abuse. Tailoring available treatment options to patient characteristics may improve treatment rates and treatment effectiveness.

This study had several limitations. Data limitations include the self-reporting of substance use and mental health symptoms and the absence of information on exact income, immigrant status, or the institutionalized population. The Kaiser Family Foundation has estimated that noncitizens (lawfully present and undocumented) account for 20% of the uninsured U.S. population and that 57% of the noncitizen uninsured group have incomes <134% of the FPL (22), which suggests that the absence of this information did not drive our results. An advantage of the NSDUH is that the data allow us to look at general prevalence rather than treated prevalence, which is important given that the expansion of insurance coverage may lead to earlier and increased identification of substance use disorders. We considered only whether individuals received any treatments and not the quantity or quality of treatment received.

Conclusions

The Centers for Medicare and Medicaid Services has estimated that if all states expand Medicaid, approximately 15 million nonelderly individuals will gain Medicaid coverage by 2014 (23). A back-of-the-envelope calculation using our estimates suggests that 14.6% of this group, or 2.2 million individuals, will have a substance use disorder. We found a large gap between the need for substance use disorder treatment and treatment receipt among both current Medicaid enrollees and those who may be newly income eligible for Medicaid beginning in 2014. It is estimated that the cost of substance use disorders in the United States is $600 billion annually (24,25). Better addressing the human and financial costs through an expanded Medicaid benefit could have far-reaching societal effects. The ACA has the potential to transform addiction treatment, but it will be important to create incentives to provide evidence-based care. More generally, implementation will be critical to the success of health care reform in meeting the treatment needs of individuals with substance use disorders.

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References

1. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. Washington, DC, Congressional Budget Office, July 2012. Available at www.cbo.gov/publication/43472
2. Buck JA: The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. Health Affairs 30:1402–1410, 2011
3. Somers SA, Hamblin A, Verdier JM: Covering Low Income Childless Adults in Medicaid: Experiences From Selected States. Hamilton, NJ, Center for Health Care Strategies, Inc, 2010
4. Expanding Medicaid Under Health Reform: A Look at Adults at or Below 133% of Poverty. Menlo Park, Calif, Kaiser Family Foundation, April 2010. Available at www.kff.org/healthreform/upload/8052-02.pdf
5. Garfield RL, Zuvekas SH, Lave JR, et al: The impact of national health care reform on adults with severe mental disorders. American Journal of Psychiatry 168:486–494, 2011
6. Grucza RA, Abbacchi AM, Przybeck TR, et al: Discrepancies in estimates of prevalence and correlates of substance use and disorders between two national surveys. Addiction 102:623–629, 2007
7. Miller JW, Gfroerer JC, Brewer RD, et al: Prevalence of adult binge drinking: a comparison of two national surveys. American Journal of Preventive Medicine 27:197–204, 2004
8. Kessler RC, Barker PR, Colpe LJ, et al: Screening for serious mental illness in the general population. Archives of General Psychiatry 60:184–189, 2003
9. Kessler RC, Berglund P, Demler O, et al: The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA 289:3095–3105, 2003
10. National Survey on Drug Use and Health, 2008 Codebook. Rockville, Md, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2009
11. National Survey on Drug Use and Health, 2009 Codebook. Rockville, Md, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2010
12. Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014. Washington, DC, Kaiser Commission on Medicaid and the Uninsured, June 2011. Available at www.kff.org/healthreform/8194.cfm
13. Kessler RC, Andrews G, Colpe LJ, et al: Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine 32:959–976, 2002
14. Colpe LJ, Epstein JF, Barker PR, et al: Screening for serious mental illness in the National Survey on Drug Use and Health (NSDUH). Annals of Epidemiology 19: 210–211, 2009
15. Pollack HA, Reuter P: Welfare receipt and substance-abuse treatment among low-income mothers: the impact of welfare reform. American Journal of Public Health 96:2024–2031, 2006
16. Polsky D, Glick HA, Yang J, et al: Cost-effectiveness of extended buprenorphine-naloxone treatment for opioid-dependent youth: data from a randomized trial. Addiction 105:1616–1624, 2010
17. Ettner SL, Huang D, Evans E, et al: Benefit-cost in the California Treatment Outcome Project: does substance abuse treatment "pay for itself"? Health Services Research 41:192–213, 2006
18. Re: Health Homes for Enrollees with Chronic Conditions. Letter SMDL#10-024 ACA #12. Baltimore, Md, Centers for Medicare and Medicaid Services, 2010. Available at downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf
19. Capoccia VA, Grazier KL, Toal C, et al: Massachusetts's experience suggests coverage alone is insufficient to increase addiction disorders treatment. Health Affairs 31:1000–1008, 2012
20. Greenfield SF, Brooks AJ, Gordon SM, et al: Substance abuse treatment entry, retention, and outcome in women: a review of the literature. Drug and Alcohol Dependence 86:1–21, 2007
21. Rapp RC, Xu J, Carr CA, et al: Treatment barriers identified by substance abusers assessed at a centralized intake unit. Journal of Substance Abuse Treatment 30: 227–235, 2006
22. Key Facts on Health Coverage for Low Income Immigrants Today and Under Health Reform. Washington, DC, Kaiser Commission on Medicaid and the Uninsured, Feb 2012. Available at www.kff.org/uninsured/upload/8279.pdf
23. 2011 Actuarial Report on the Financial Outlook for Medicaid. Baltimore, Md, Centers for Medicare and Medicaid Services, Office of the Actuary, March 16, 2012
24. The Economic Costs of Drug Abuse in the United States, 1992–2002. Pub no 207303. Washington, DC, Office of National Drug Control Policy, 2004. Available at www.ncjrs.gov/ondcppubs/publications/pdf/economic_costs.pdf
25. Rehm J, Mathers C, Popova S, et al: Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet 373:2223–2233, 2009