

FACT SHEET

Medical Costs and Unrecognized/Untreated Substance Use Disorders: A Case for Health Reform

BACKGROUND

Substance use disorders are a chronic disease identified in about 9.5% of the general population (about 24 million Americans over the age of 12):

- Of those, 3% or 7 million people are current users of prescription drugs taken non-medically
- Among the elderly, about 8% have been identified as heavy drinkers
- Substance use disorders are associated with over 110,000 deaths annually and are the 2nd leading cause of disability (WHO, 2003)
- Pre-deployment data indicates that approximately 8% of military service members are heavy weekly drinkers, 45% engage in binge drinking, and 11% report at least one alcohol-related problem (Jacobson et al., 2008) with substance dependence and PTSD a significant clinical problem in returning veterans (Eggleston et al., 2009)
- Public funding constitutes the vast majority of addiction treatment expenditures – over 80% of all expenditures for treatment
- Federal, state, and local governments pay twice for this care---in the 20-40% rates of uncompensated healthcare (particularly in hospitals and ERs) and the 50-75% rates of jail and prison costs for untreated addicted offenders
- Yet, only about 10% of those identified are treated in the specialty treatment system and over 40% of those who try to get help are denied treatment because of cost or insurance barriers (NSDUH, 2005)

THE PROBLEM

I. Substance use disorders are prevalent throughout the healthcare system.

- While 9.5% of the general population (about the same as Type II Diabetes) and 2.5 million adolescents suffer from substance dependence, **SUBSTANCE DEPENDENCE AFFECTS 22% OF THOSE IN MEDICAL SETTINGS;**
- Among young adults between 18 and 34 between 10% and 20% have substance use disorders, **AND AGAIN 90% RECEIVE NO CARE.**

II. Health care costs increase for people with treated and untreated substance use, alcohol and other drug disorders; costs in 2008 were about \$62 billion in healthcare alone (more in crime and welfare costs) (Harwood, 2000 updated and adjusted for 2008).

- Individuals with untreated substance use disorders have higher medical costs than those without such disorders (Clark et al. 2009) especially for emergency department visits and hospitalizations;
 - Individuals with substance use disorders use about 8 times more healthcare services;
 - Families of untreated individuals with substance use disorders have significantly higher medical costs than other families (Ray et al. 2000);
 - ◊ In fact, families of such individuals use about 5 times more health care driven by hospitalizations, pharmacy costs, and primary care visits;
 - Drug or alcohol use disorders are identified in about 3% of all hospital stays in the U.S., totaling about \$12 billion in hospital costs (AHRQ, 2006 and 2007);
 - ◊ For the uninsured, the emergency department is the entry point for hospital stays for more than 50% of individuals with drug use disorders and over 75% of those with alcohol use disorders;
 - Among both the uninsured and Medicaid patients, about 25% of hospital stays are the result of alcohol use disorders;
 - Almost 20% of Medicaid hospital costs and nearly \$1 of every \$4 spent on inpatient care by Medicare is associated with substance use.
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III. Care for Veterans

- Although substance use disorders, with and without PTSD, have been increasingly diagnosed among veterans (and are expected to continue to increase), specialty treatment programs have decreased significantly;
- One in eight (about 13%) of non-elderly veterans are uninsured and about half of those are not eligible for VA healthcare (Kaiser Family Foundation, 2008).

IV. Health care costs for businesses are significant due to premature death and illness.

- In 2005, among the 52.6 million adult binge or heavy drinkers, about 80 percent were employed either full or part time. Of the 17.2 million illicit drug users aged 18 or older, nearly 75 percent were employed either full or part time (NSDUH, 2005);
- Yet, while about 70% of individuals with substance use disorders are employed, more than 35% are NOT insured;
- Compared to the insured, uninsured workers are about twice as likely to be heavy alcohol users or to report illicit drug use in the past month and less than 25% report access to EAPs (Spicer, 2006).

SOME SOLUTIONS

A. Treatment Penetration for Substance Use Disorders

- In the public sector, States that have increased *treatment* penetration rates have reduced Medicaid costs by over 10% in two years and about 18% within 4 years - *this is the best case for how health reform can control costs.*
 - In one state study, treatment led to a decrease in Medicaid costs of about 5% over a five-year period (Luchansky et al. 1997);
 - In a separate study, treatment for Medicaid patients in a comprehensive health maintenance organization reduced medical costs by 30% per treatment member; reductions were in all major areas of health care use (Walter et al., 2005).
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B. Early and Economical Screening and Brief Interventions (SBI) in Healthcare Settings Has Reduced Substance Use and Saved Dollars

- Inpatient and ER costs decline by about 39% and 35% respectively following treatment (Parthasarathy et al. 2001);
- Total medical costs per patient per month decline from \$431 to \$200 following treatment (Parthasarathy et al. 2003).

C. Use of Medications in Treatment

- Use of medications in the treatment of substance use disorders has led to significant reductions in healthcare costs in Medicaid populations, primarily related to reductions in hospitalizations;
- For alcohol dependent patients, use of medications in treatment in the private sector again shows a significant reduction in hospital costs and ER costs, while increasing costs for outpatient psychiatric visits, which may be considered a positive finding (Aetna Behavioral Health, 2008).

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The Treatment Research Institute (TRI) is an independent, non-profit research and development organization specializing in science-driven reform of policy and practice in addiction and substance use. TRI was founded in 1992 by A. Thomas McLellan, Ph.D. and colleagues from the University of Pennsylvania's Center for the Studies of Addiction. To learn more, visit the TRI website at www.tresearch.org or contact Bonnie Catone, Director of Communications, at bcatone@tresearch.org.

SUMMARY OF PARITY ACT OF 2008 WITH COMMENTARY

Scope of the Parity Act:

The 2008 Parity Act applies to employer-sponsored group health insurance for companies with 50 or more employees and managed care plans under Medicaid and SCHIP (State Children's Health Insurance Programs). The Parity Act also applies to self-funded employer plans for individuals not covered under State parity laws. In another piece of legislation earlier in FY2008, language was inserted into Medicare that equalizes co-pays and deductibles for mental health (including substance abuse) and medical care. The Parity Act will apply to plans beginning on January 1, 2010. Regulations to carry out changes under the Parity Act must be issued one year after the enactment date.

Self-insured state and local government plans may elect to be exempt from parity. The Parity Act does not apply to small employers with less than 50 employees though such firms are not exempt from State parity laws.

- **It is critical that we understand that the Parity Act applies ONLY when insurance plans already contain benefits for mental health and substance use disorders. There is NO requirement in the Parity Act that insurance plans cover mental health and substance abuse treatment services. In other words, the Parity Act does not mandate benefits.**

Requirements of the Parity Act:

- Mental health and substance abuse coverage applies to ALL financial requirements including deductibles, copayments, coinsurance, and out-of-pocket payments; benefits may NOT be more limited than medical/surgical benefits with regard to number of days or visits and annual or lifetime dollar limits.
Comment: In Kaiser's 2006 survey of employer-sponsored health plans, over half of large firms had annual inpatient hospital limits and about 60% had annual outpatient visit limits.
- If a plan has more than one benefit package, the requirements of the Parity Act require that parity be applied to each one separately.
- If a plan has out-of-network coverage for medical/surgical benefits, it must also apply that coverage, AT PARITY, for mental health and substance use disorders

Benefit Management:

- Plans may manage benefits. However, plans are required to make medical necessity criteria for mental health and substance use disorders available to current and potential participants, beneficiaries and providers upon request. Plans must also make available reasons for denial of payment on request.

Comment: While the Act requires that medical necessity criteria be made available upon request (a major advance from previous parity legislation), such criteria have been very difficult to identify. A few plans have identified “clinical necessity criteria” that must be applied before approving services e.g., one plan states, “to be considered clinically necessary, treatment must address a MH/SA disorder as defined by DSM-IV qualified by all five axes” and “services must be expected to improve and/or maintain an individual’s condition or level of functioning” to be considered clinically necessary.

Cost Exemptions:

- If a health plan incurs an increase in real total costs with respect to medical/surgical benefits and mental health/substance use disorder benefits of 1% (2% in the first year after the Act is implemented), the plan can be exempted from the Parity Law.
 - ◊ Employers may elect to continue parity coverage;
 - ◊ Employers can apply for exemption for one plan year at a time;
 - ◊ A qualified actuary must determine and report on a plan’s cost increase and the plan must have complied with all coverage requirements for the first six months of the year involved;
 - ◊ If self-funded the plan must notify the Department of Labor (DOL) or, if fully-insured, a plan must notify the Department of Health and Human Services (DHHS), the appropriate State agencies, participants and beneficiaries if it elects exemption;
 - ◊ DOL and DHHS may audit any plan to determine compliance when a plan chooses to become exempt.

Reports and Studies:

- The Secretary of DOL will report on compliance with the Parity Act in 2012 and every two years thereafter. The report will include results of audits or surveys and underlying reasons for compliance failures.
 - Within three years, the GAO will conduct a study and analyze specific patterns, rates, and trends in coverage; exclusions of specific mental health or substance use diagnoses from coverage; and the impact of the Parity Act on coverage and benefit costs to employers, participants, and beneficiaries.
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Consumer Assistance:

- The Secretary of DOL (with the Secretaries of HHS and Treasury) will publish and disseminate guidance and information for plans, participants, beneficiaries, State agencies, and the National Association of Insurance Commissioners concerning the requirements of the Parity Act; and how beneficiaries can obtain assistance from State agencies.

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SCIENCE-BASED PRODUCTS AND SERVICES: THE TREATMENT RESEARCH SOLUTIONS GROUP

The Treatment Research Institute is known for *do novo* and applied research spanning a wide array of treatment and prevention issues – long-term management and monitoring protocols, contingency management adaptations, strategies for parents in recovery, and criminal justice solutions for drug-involved offenders.

At the Section on Treatment Research Solutions, TRI also puts science to work for policy makers and practitioners through science-derived products and services:

- ◆ *A Parent's Guide to the Teen Brain*, developed with the Partnership for a Drug Free America (Partnership), is an interactive, multi-media tool to help parents understand teen brain processes and establish the parent-teen talking connection. *Act Now!* contains science-based guidance when parents know or suspect their children are drinking or taking drugs.
- ◆ The *Risk and Needs Triage* is a web-based decision support tool to help judges and other court officials assign drug-involved offenders to the community-based program where they stand the best chance for recovery.
- ◆ *TRI-CEP*, or TRI Court Evaluation Program, is a web-based tool to evaluate drug and other problem solving courts and adaptively manage substance abusing offenders.
- ◆ The automated *DENS* patient assessment system, incorporating the Addiction Severity Index (ASI), was developed with partial funding from the White House Office of National Drug Control Policy and is now widely used in numerous state, local and private treatment systems.
- ◆ ASI-based *treatment planning software* facilitates empirically suggested level of care decisions.
- ◆ *CASPAR* is an electronic tool to help counselors find and refer patients to essential wrap-around services.
- ◆ Under development is *Recovery Track*, an electronic patient monitoring and management system to promote long-term recovery.

The Addiction Severity Index: Developed in the 1980s by TRI co-founder A. Thomas McLellan, Ph.D. and others from the University of Pennsylvania, the instrument has spawned an extensive network of TRI development and training specialties:

- ◆ ASI training protocols, manuals and competency assessments created by TRI have become the gold standard in the field of addiction.
- ◆ TRI specialists, extensively trained by the creators of the ASI, have conducted substantial numbers of trainings for substance abuse treatment programs, individual counselors, researchers, and government agencies.
- ◆ All ASI applications developed by TRI, including the automated DENS software suite and Treatment Planning software, include training protocols designed and delivered by ASI specialists.
- ◆ Since its inception, TRI has hosted an ASI “Help Line” and is a repository for the instruments, manuals, and coding tools that help practitioners incorporate the instrument into clinical practice.

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MUTUAL ASSISTANCE FOR THE STATES (MAPS)



MAPS is a small, member-supported and member-directed, collaborative project to design and empirically evaluate strategies for reforming administrative, regulatory, purchasing and/or organizational practices that are impeding quality improvement within systems of care. Currently, four state partners are working with TRI. MAPS is supported by the partnering states through a membership fee, with TRI playing host to the group and providing technical expertise, as well as design, evaluation and analytical support for projects identified by the States.

It was apparent from the outset of MAPS that states wanted at least four things from TRI:

- A safe environment within which to be able to discuss strategic issues;
- The most recent information and scientific findings about specific financing, purchasing, and organizational issues and strategies; including those that involve healthcare and/or the criminal justice system.
- Assistance with planning, implementing, and evaluating policy initiatives, including legislative briefings and cost-offset studies and,
- Validation/justification (formative evaluation) for their approaches.

The basic MAPS membership consists of three components. In the first component, MAPS members participate in two, one-day policy forums per year convened by TRI on specific issues of mutual interest. The forums join the state participants in MAPS with TRI scientific staff, along with other relevant experts, to foster discussion of a specific issue and to develop consensus strategies for moving the issue forward. Policy papers and other relevant materials are used as a springboard for discussion at these forums. In addition to the policy forums, MAPS members are invited to participate in an invitation-only conference convened by TRI and the Wharton School that applies knowledge gained from other industries to issues that are emerging in the treatment industry.

