

MENTAL HEALTH AND SUBSTANCE ABUSE

Background

- ▶ Estimates put the annual economic cost to society of mental illness and substance abuse at \$273 billion including direct care, lost productivity, social welfare and the criminal justice system.
- ▶ In the health care system, mental and addictive disorders account for \$80.7 billion of the total cost, or 12 percent.
- ▶ Subtracting research and education costs, that amounts to an overall cost of about \$300 per person per year in current system.
- ▶ Approximately 5.9 percent of U.S. population — 10.9 million people -- use mental health and substance abuse services.

PRINCIPLES GUIDING MENTAL HEALTH AND SUBSTANCE ABUSE PLAN DEVELOPMENT

- ▶ Each of the options that will be described founded on set of critical principles. They are:
 - o The need to recognize that mental health and substance abuse problems fundamentally resemble all other health problems.
 - o Treatments are available that are as effective as treatments for other forms of illness.
 - o Treatment produces important effects, including:
 - Improvement to overall health
 - Increased productivity
 - Reduced health care costs
 - Potential savings in social welfare spending
 - Potential reductions in crime and criminal justice expenditures
- ▶ To reap those benefits, health care reform must end fragmentation, integrate services and remove barriers to care.

Needed change involves:

- o Altering financing mechanisms to create incentives for the development of integrated delivery systems, consistent with health care reform.

- o Providing a comprehensive benefit for both short-term acute care and extended care.**
 - o Assuring adequate access to care for low-income, under-insured and underserved populations.**
- Health care reform also must allow flexibility to assure the delivery of appropriate care. Including:**
 - o Encouraging the development and use of lower-cost alternatives to hospitalization**
 - o Making available a broad array of community and home-based services**
 - o Removing financial barriers to early intervention**
- In sum, it must include coverage for mental health and substance abuse in the comprehensive national benefits package on same basis as other illnesses.**

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT: OVERVIEW**I. BACKGROUND**

Mental health and substance abuse services currently are an integral part of health care delivery and will continue to be a fundamental element of the new health care system. The benefit structure for the treatment of individuals with mental and substance abuse disorders under health care reform departs significantly from past approaches. This departure is appropriate as scientific evidence and societal attitudes have coalesced toward an understanding of these disorders as major health problems which, when untreated, generate considerable social and economic costs. There is ample research evidence indicating that mental and substance abuse disorders can be diagnosed reliably and treated effectively. Further, it is increasingly recognized that treatment for mental illness and substance abuse problems yields important benefits such as improvement to overall health, reduced health care costs, increased productivity, potential savings in social welfare expenditures, and potential reductions in crime and criminal justice expenditures.

While the vast majority of private insurance policies include mental health coverage, benefits have been extremely restricted with respect to the scope, volume, and duration of covered services. Typical insurance benefit packages include only inpatient and outpatient services and discriminate between mental health care and general medical care by arbitrarily limiting the number of visits or days of treatment, by establishing lifetime limits for mental health benefits, and by excluding preexisting conditions. The structure of current mental health benefit packages has resulted in a two-tiered system of care consisting of the private sector for the insured population and public sector services for the poor, the uninsured, and for those whose insurance coverage is limited and/or exhausted. Additionally, the structure of mental health benefits has resulted in an overutilization of inpatient care; approximately 70 percent of current mental health care costs are from inpatient services. Excessive and inappropriate hospitalization, particularly for children and adolescents and for substance abuse, has been a major factor in driving up the total cost of mental health care.

A consequence of the current benefit structure has been the creation of excess inpatient capacity in many areas of the country, although shortages in the array of alternative service options exist almost everywhere. Further, the limited benefits have resulted in shifting both the responsibility and cost of care into the public sector mental health and substance abuse systems ("dumping"). For children and adolescents, the burden and cost of care also have been shifted to the child welfare, education, and juvenile justice systems.

Scientific evidence and experience have led to the recognition that a comprehensive array of services, along with the flexibility to provide such services to individuals based upon medical and psychological necessity, produces better outcomes than those experienced with traditional benefits. There is also scientific evidence that capitated approaches result in more efficient use of health care services. Thus, the trend in both the public and private sectors has been toward the development of a comprehensive range of services, many under capitated arrangements, along with management mechanisms to ensure appropriate service delivery.

II. PRINCIPLES GUIDING BENEFIT STRUCTURE

The development of the mental health and substance abuse (MH/SA) benefit was guided by the following principles:

- o The benefit structure should ensure that persons of all ages with mental and substance abuse disorders and their families participate fully in the health care system and that mental health and substance abuse services are available on the same terms and conditions as other medical and health services.
- o The benefit structure should ensure that persons with mental and substance abuse disorders have access to a comprehensive array of services for both acute and extended care, with the flexibility to provide the appropriate types, mix, level, and duration of services based upon medical and psychological necessity for each individual consumer.
- o The benefit structure should encourage the development and use of alternatives to hospitalization, maximize the use of home and community-based treatment approaches, and ensure that services are delivered in the least restrictive environment appropriate to the needs of the individual.
- o The benefit structure should minimize the current two-class, two-tiered service delivery system, shifting of costs and responsibilities, and fragmentation of service delivery by integrating the public and private delivery systems.
- o The benefit structure should encourage early intervention, incorporate incentives to overcome reluctance to initiate mental health and substance abuse treatment, and remove financial barriers to early intervention.
- o The benefit structure should ensure the availability and provision of comprehensive and appropriate services within organized systems of care for individuals with serious and persistent mental and substance abuse disorders.

There is considerable consensus among multiple and diverse constituencies including policy makers, providers, researchers, educators, advocates, families, and members of the business community regarding these principles.

III. ELIGIBILITY

Mental and substance abuse disorders occur at yearly rates comparable to other diseases, and service use rates also are analogous to those for other disorders, with approximately 5.9 percent of the U.S. population using specialty mental health services. Despite comparability to other health services, continuing concerns raised with respect to mental health and substance abuse benefits are related to ensuring appropriate utilization of resources. Once such concern is that, without the imposition of special limits, services may potentially be overused or inappropriately used. In fact, there is evidence to support the countervailing view that individuals who should be receiving treatment often avoid it, costing themselves, their families, and society "unnecessary" expense in the long run. Another

concern is the potential for undertreatment of mental health and substance abuse disorders because that has largely been the history of managed care. In the new health care system, financial incentives, along with appropriate standards and monitoring activities, are required to ensure that necessary and appropriate mental health and substance abuse treatment is provided.

To protect against inappropriate use of services and to better target resources, the following eligibility criteria are suggested: All persons are eligible for screening and assessment and 24-hour crisis services. Persons are eligible for mental health and substance abuse services other than screening and assessment and crisis services if they have, or have had in the past year, a diagnosable mental or substance abuse disorder that resulted in or poses a serious risk for functional impairment in family, work, school, or community activities. Further, family members of an eligible enrollee may receive necessary and appropriately related services (so-called collateral treatment).

IV. STRUCTURE OF BENEFIT

The benefit provides access to a broad array of services for persons of all ages with mental health and substance abuse disorders. It covers acute, extended, and rehabilitative care and eliminates arbitrary limits, thereby making mental health benefits consistent with other health benefits. AHPs have the flexibility to determine the most appropriate mix, volume, and duration of services for each individual based upon medical and psychological necessity. The approach creates a capitated budget for the treatment of persons with MH/SA disorders and relies upon a variety of management approaches to ensure that appropriate and cost-effective services are delivered. Cost sharing for mental health and substance abuse services is based upon the same principles as cost sharing requirements for other health services. By covering both acute and extended care services, the approach creates an integrated system of MH/SA services, eliminating the historically two-tiered system. Further, the approach shifts incentives from expensive hospital and institutional care by providing coverage for a wide range of cost-effective, community-based service options.

The array of the services included in the benefit is comprised of:

- o Screening and Assessment
- o 24 - Hour Crisis Services - Telephone Crisis Services, Walk-in Crisis Services, Mobile Outreach Crisis Services, Crisis Residential Services
- o Nonresidential Treatment Services - Medical Management, Prescription Drugs, Somatic Treatments, Ambulatory Detoxification, Outpatient Therapy (Individual, Family, and Group Therapy; Family Education/Support; Substance Abuse Counseling; Substance Abuse Relapse Prevention), Home and Community Services (Assertive Community Treatment; Home-Based Services; Therapeutic Respite Services; Behavioral Aide Services), Day Services (Partial Hospitalization; Day Treatment; Psychosocial Rehabilitation)
- o Residential Treatment and Inpatient Services - Residential Treatment Services (Therapeutic Family Homes; Therapeutic Group Homes; Residential Treatment Centers; Community Residential Treatment - Adults; Community Residential Treatment and Recovery - Substance Abuse; Residential Detoxification Services; Other Residential Treatment), Inpatient Hospital Services
- o Case Management Services - Service Coordination, Clinical Case Management Services

The services included in the MH/SA benefit can be provided in a wide range of settings and environments including offices, clinics, community mental health centers, homes, schools, hospitals, residential treatment facilities and other locations appropriate to the needs of consumers. In addition, all services will be provided by qualified MH/SA professionals, certified paraprofessionals, and staff under the supervision of licensed or certified MH/SA providers. States will continue to be responsible for licensing and certifying professionals and treatment facilities.

AHPs must ensure appropriate access to MH/SA services by having available multiple MH/SA specialists. For persons with serious and persistent MH/SA disorders, it is expected that AHPs will use multidisciplinary teams to develop individualized treatment plans and will have organized systems of care that provide an array of services, intensive case management, frequent case review, and close coordination with other agencies providing related services such as education and housing. It is recognized that other related and supportive services are required by persons with serious MH/SA disorders. AHPs must ensure that MH/SA providers establish linkages with agencies providing these services (e.g. education, child welfare, housing, vocational rehabilitation, transportation, legal, etc.) and that, at the client level, case managers are available to access and coordinate related and supportive services. A federal "enabling fund" is recommended to facilitate linkages at the HIPC, AHP, and client levels with other systems and agencies providing related services.

VI. MANAGEMENT APPROACHES

As noted, the MH/SA benefit makes available a wide range of diagnostic, treatment, and rehabilitative services to AHP enrollees, with service delivery based upon medical and psychological necessity rather than arbitrary constraints established by benefit design. Universal access to such coverage, however, does not mean that all people, at their own discretion, receive unlimited services. Rather, the approach is capitated, which establishes budgetary parameters for MH/SA service delivery (consistent with the overall reformed health care system), and is dependent upon specific management approaches to ensure that services and resources are utilized appropriately. Some previous attempts at managed care functioned with severely limited mental health benefits along with the ability to shift costs to the public sector, resulting in a tendency to focus more on managing costs than on managing care. The MH/SA benefit structure under health care reform emphasizes mechanisms to manage care and to ensure that individuals receive the appropriate scope, volume, and duration of services commensurate with need and severity of illness. Management strategies may include screeners with MH/SA expertise, case management, multidisciplinary teams to develop and monitor individualized treatment plans for persons with complex disorders, precertification, concurrent review, various provider arrangements, and organized systems of care for persons with severe and persistent MH/SA disorders.

While some degree of choice may be forfeited under this approach, consumers gain access to a broad array of treatment and rehabilitative services and are protected from financial risk resulting from MH/SA disorders -- neither of which consumers currently enjoy. Further, consumers receiving services from the public sector rarely have the opportunity to select either the agencies or providers from whom they will receive services. Demonstration research has shown that not only does this type of flexible, managed benefit structure result in more appropriate care, but it does so at reasonable cost. In fact, capitation coupled with management mechanisms have been shown to be more effective in controlling utilization and costs than the often-used limits on benefits and high cost sharing requirements. Examples of such approaches in both public and private sector environments have

resulted in reductions in utilization of inpatient and residential treatment, expanded use of an array of alternative home and community-based services, cost savings, and high levels of consumer satisfaction.

Within this framework, strategies are necessary to address possible incentives for risk selection and undertreatment. The approach incorporates the use of risk adjustment along with standards, quality measures, and monitoring mechanisms to reverse any such incentives. A combined prospective and retrospective risk adjustment approach is recommended, and specific standards and measures are recommended in order to monitor service access, quality, and outcomes, with particular attention to populations with severe and persistent MH/SA disorders and typically underserved populations.

VII. PUBLIC SECTOR ROLE

The MH/SA benefit integrates the public and private sectors, placing responsibility for MH/SA care within the new health care system. This approach requires that the current state and local investment in MH/SA services be retained and incorporated in the new system in order to ensure financial viability. The approach also necessitates a shift in the role of state-supported public mental health and substance abuse systems which, unlike general health care, have historically played a major service delivery role. Under the new system, state mental health delivery systems will continue to provide forensic beds and retain responsibility for this population and will also retain some number of state psychiatric beds which can be purchased by AHPs based on customary costs per bed day. Beyond these basic service delivery functions, states will have considerable latitude to determine the role of its existing public sector delivery system.

There are compelling reasons to retain publicly funded programs that would contribute to the new MH/SA system both during a transition period and thereafter. Publicly funded providers with MH/SA service capacity may be, at state discretion, designated as "preferred providers" to be part of the MH/SA service networks provided by AHPs for a specified period of time (five years is recommended) after which they would be viewed as competitors. State MH/SA agencies will retain primary responsibility for planning, regulating, monitoring, capacity development, outreach, and prevention activities.

VIII. MAJOR ADVANTAGES AND CHALLENGES

The MH/SA benefit presents an unprecedented opportunity to create an integrated MH/SA service delivery system which provides a continuum of services and in which service delivery is based upon need. The approach has many clear advantages including:

- o Expands coverage for MH/SA services to persons who are currently uninsured and those with limited coverage and eliminates patient financial risk.
- o Creates a unitary, integrated MH/SA treatment system, eliminating the current two-tiered, two-class system and minimizing the potential for cost shifting to the public sector, fragmentation, and gaming.
- o Encourages the development and use of more cost-effective home and community-based services and discourages the use of more costly, more restrictive service options.
- o Incorporates the flexibility to provide services based upon need rather than on arbitrary limits or a narrow range of covered services established by benefit design, relying upon management

- o approaches to ensure appropriate service utilization.
- o Creates organized systems of care for persons with severe and persistent disorders.
- o Distributes the risk pool fairly by spreading risk across the broadest population group.
- o Is consistent with the benefit plan created for other health services.

The effective implementation of the MH/SA benefit within the new health care system involves successfully addressing several inherent challenges. First, the system must incorporate safeguards to counter potential incentives of capitation for undertreatment, particularly for persons with severe disorders. Risk adjustment of AHP premiums, standards, and monitoring mechanisms are among the strategies proposed to minimize potential undertreatment and to ensure that persons with severe disorders receive appropriate services.

A second major challenge stems from the recognition that allowable services are not uniformly available or accessible and that many providers have little experience in providing services beyond traditional inpatient and outpatient care. The approach requires an investment in the development of both the service capacities and human resources needed to provide the services included in the benefit package. It is recommended that service capacity and human resource development be a responsibility shared by federal and state governments and that a specific funding stream be created to develop needed MH/SA service capacities and train MH/SA providers.

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MODEL LEGISLATION MANDATING NATIONAL HEALTH INSURANCE BENEFIT FOR PREVENTION AND TREATMENT FOR ALCOHOLISM AND DRUG ADDICTION Revised 2/12/93

I. INTRODUCTION AND PURPOSE

Alcoholism and drug dependencies can be prevented and treated effectively at low cost but, if they are left untreated, society will very quickly pay a much higher price. Though various national health care reform bills provide health benefits for the illnesses caused by alcoholism and drug dependencies, few cover drug and alcohol prevention and treatment itself.

The adverse social consequences of alcohol and other drug problems are associated with considerable economic costs. In the most recent comprehensive economic analysis, conducted in 1983, the cost of alcohol problems in America were estimated to exceed \$70 billion per year, with the majority of these costs attributed to reduced productivity. An additional \$44 billion in economic costs were attributed to drug problems. Prevention, early intervention and treatment will save billions of dollars each year.

The purpose of this proposal is to ensure that coverage of alcoholism and drug addictions prevention and treatment will be included in all proposals mandating private and/or public health insurance coverage for individuals and families. If coverage is not provided, our society will pay far more for the health care, social and economic problems that result from alcohol and drug problems.

This model outlines the necessary components for a comprehensive continuum of care. Individuals will be assessed for the severity of their addiction, and enter treatment at the level appropriate for their medical and psychosocial needs. This continuum of care is necessary for effective prevention and treatment whether it is provided through private or public sector programs.

All individuals should have access to the appropriate level of care for treatment of their addiction whether their payment source is private insurance, Medicaid, Medicare or federal and state dollars dedicated to treatment. Federal, state and local financing will continue to be needed to address larger issues related to poverty such as housing, unemployment and education.

It may become necessary to have substantial co-payments in order to limit excessive use of health care services. In that event, wealthier individuals should pay a higher proportion of their health care costs themselves. This could be achieved by having the co-payment percentage rise with income. The poor should not be deprived of health care because of their inability to pay. The lowest income members in society could be protected through an exemption from co-payment requirements for those below a certain income level. No co-payment should be required for preventive services.

II. SPECIFICATIONS OF PREVENTION AND TREATMENT FOR ALCOHOL AND DRUG ABUSE AND DEPENDENCE

Coverage for the prevention and treatment of alcohol and drug abuse and dependence shall be comprehensive and allow for services in the setting most appropriate for each individual. Individualized assessments should be based on clinical necessity and govern the intensity and duration of treatment.

The system of care must take into account that individuals entering treatment have diverse needs, some requiring prevention, some rehabilitation and others requiring more intensive habilitation efforts. While most individuals will not require all the services outlined in the model, the model should be flexible enough to accomodate individuals with diverse needs. In cases where the primary caretaker of children is residing in a program, drug and alcohol treatment services, including room and board where appropriate, will be provided for children.

At the minimum, benefits should allow for the following services, with appropriate applications of individualized services through case management:

- (1) prevention - clinical screening, health promotion and education on risks of drug and alcohol use;
- (2) intervention - including assessment, diagnosis, and referral;
- (3) detoxification - 10 days of treatment in a hospital, non-hospital, or ambulatory detoxification program as medically necessary in any calendar year, unless medical complications require additional days;

- (4) outpatient treatment - a full continuum of outpatient services should be provided including:
 - a. intensive day and evening treatment: 40 days in any calendar year;
 - b. outpatient - 60 visits in any calendar year;
 - c. continuing care - 60 visits in any calendar year;
 - d. family outpatient care, including preventive services for children irrespective of treatment status of parent: 60 visits in any calendar year;
- (5) residential treatment -
 - a. short-term: 30 days of treatment in a hospital or free-standing program in any calendar year;
 - b. long-term: up to 18 months of treatment in a residential program (halfway and quarterway houses, therapeutic communities);
- (6) case management - unlimited and determined as clinically appropriate; and
- (7) pharmacotherapeutic intervention - unlimited and determined as clinically appropriate.

III. RATIONALE

Alcoholism and drug addiction are among the leading health problems in our nation; therefore, any legislation mandating reform for the private and public health care financing systems should include comprehensive coverage for prevention and treatment of alcoholism and drug addictions.

Alcoholism and drug addictions are responsible for staggering economic loss, the deterioration of families, the spread of HIV/AIDS, and increased crime. These chronic illnesses cost billions of dollars each year and result in thousands of deaths.

Economic loss: Accidents at home and on the road resulting from drug and alcohol abuse cause a tremendous financial loss. Substance abuse results in huge economic losses in the workplace as well: employee productivity is greatly reduced, while absenteeism, health-related expenses, accidents and thefts all increase.

Social costs: Beyond the economic costs are the human costs. Individual lives are disrupted and entire families suffer when one member has an untreated alcohol or drug problem. Many families are destroyed as divorce rates increase and children are placed in foster care.

Increased crime: The proportion of offenders with alcohol or drug problems is overwhelming. By some estimates between 75% and 80% of offenders are substance abusers. Many offenses are directly alcohol and drug related, crimes committed to support continued drug use; other offenses are committed under the influence of alcohol or drugs. Numerous studies have established that treatment is far less expensive and far more effective in reducing crime than locking people up.

HIV/AIDS: Alcohol and drug abuse increase the spread of HIV/AIDS. Today, drug abusers account for 32% of those with AIDS, nationwide. Treatment for alcohol and drug abuse is one of the few ways we know works to prevent the spread of HIV/AIDS.

Many individuals who need alcohol or drug treatment cannot get it because they cannot afford private treatment and publicly funded programs are full. The importance of mandating coverage is clear: Treatment is the best answer we have to decreasing the economic losses, social costs, crime rates, and health-care costs (including birth defects and the spread of HIV/AIDS) caused by alcohol and drug abuse.

A comprehensive alcoholism and drug dependencies prevention and treatment benefit will help reduce the stigma associated with these diseases; individuals and families will be encouraged to seek preventive services and early treatment; early treatment increases the likelihood of successful recovery.

Forty (40) states currently require private health insurers to make available some reimbursement for alcohol and drug treatment. Many states provide Medicaid support for detoxification, outpatient and case management services.

National leadership is needed now to address our nation's drug and alcohol crisis. Stable financing for the prevention and treatment network is crucial if we are to conquer this tragic problem.

IV. QUALIFIED SERVICE PROVIDERS

Alcoholism and drug dependencies treatment may be provided by any of the following licensed or certified professionals with a specialty in addictions: alcoholism and drug addictions counselor, physician, nurse, psychologist, social worker, mental health worker, marriage and family therapist, acupuncturist, professional counselor or prevention specialist and will include treatment provided in programs licensed by the single state alcohol and drug agency.

Alcoholism and Drug Dependencies Prevention and Treatment Benefit Definitions*

- (1) Prevention - patient education about the risks associated with alcohol and drug use.
- (2) Intervention (including assessment, diagnosis and referral) -a structured review and evaluation of the individual's disease course, stage and prognosis including, when appropriate, consultations with family, employers and significant others to assist in the assessment, diagnosis and proper referral of the individual.
- (3) Detoxification - the medical and psychological management of an individual while he/she withdraws from alcohol and/or drugs.
- (4) Outpatient services -
 - (a) Intensive outpatient/day treatment - an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of treatment consisting of regularly scheduled sessions of a minimum of nine (9) treatment hours per week within a structured program. Services are tailored to meet the individual's needs, and include detoxification, medical management and psychological support.
 - (b) Outpatient services - an organized non-residential service or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, treatment and recovery services to addicted patients. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.
 - (c) Continuing care - a structured therapeutic involvement designed to enhance, facilitate, and promote the transition from primary care to ongoing recovery. The principle criterion for admission to continuing care is participation and satisfactory completion of a primary care treatment and intent to remain abstinent of alcohol and/or other nonmedical psychoactive substances.

* Some of these definitions were taken directly from the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders, American Society of Addiction Medicine, March 1991.

(d) Family outpatient services - an organized, non-residential services or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, prevention, treatment and recovery services to the families of addicted individuals. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.

(5) Residential treatment -

(a) short-term -- an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care, and treatment for addicted patients in a residential setting. Clinical services includes: medical; educational; and individual, group and family therapy.

(b) long-term --

Halfway house care - an organized, long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual including educational and vocational rehabilitation and locating permanent housing.

Three-quarter-way house care - a semi-structured long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides ongoing support and supervision for individuals who are resuming activity in the community.

Therapeutic community - an organized long-term residential service (up to 18 months) with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual, including educational and vocational rehabilitation and locating permanent housing.

- (6) Case management - supervision and management of a patient's progress through the continuum of prevention and treatment services for alcoholism and drug dependencies' treatment, including assistance with gaining access to ancillary services such as health care, housing, education, job placement and training.
- (7) Pharmacotherapeutic intervention - an organized medical intervention with a patient under the supervision of a licensed physician that utilizes approved medications such as methadone or Antabuse in conjunction with comprehensive medical, casework and counseling services.



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**The Need for Specific Coverage for Drug and Alcohol Treatment
in National Health Care Reform**

March 5, 1993

The Need for Specific Coverage for Drug and Alcohol Treatment in National Health Care Reform

EXECUTIVE SUMMARY

Coverage for the continuum of drug and alcohol services should and must be included (most preferably without a capitation rate) in any national health care benefit package. As we outline in this document:

- 1. Quality drug and alcohol treatment and prevention services save tens of thousands of lives every year**
- 2. Extensive research shows that treatment and prevention save this nation tens of millions of dollars by avoiding:**
 - * far more expensive medical care for HIV disease and other complications that arise from untreated drug and alcohol dependence**
 - * criminal justice, foster care, lost productivity and other social and economic costs**

I. A Comprehensive Continuum of Services

National health care reform should include coverage for the prevention and treatment of alcohol and drug abuse and dependence that is comprehensive and includes services in a continuum of care in the least restrictive and most appropriate setting for the individual.

To the extent possible, treatment should be provided in community based non-profit programs, which tend to be far less costly than hospital-based and free-standing for-profit programs. Treatment effectiveness studies have demonstrated that the most critical determinant for positive treatment outcome is the length of time an individual is in treatment. Therefore, the reformed health care delivery system and the benefit should not be structured in a manner to rely heavily on short-term intensive interventions in acute care settings but include an array of acute, rehabilitative and continuing care services.

Alcohol and Drug Prevention and Treatment Services for which coverage must be included in national health care reform include (these services are described in greater detail in the body of the document):

1. Prevention
2. Assessment and Diagnostic Services
3. Methadone Maintenance and other Medication Management Services
4. Withdrawal Services (medical and psychological management of an individual during alcohol and drug detoxification)
5. Outpatient/Ambulatory Services
 - * Short-Term Individual, Group or Family Addictions Counseling
 - * Extended Addictions Counseling and Continuing Care (for individuals who are seriously impaired and require ongoing supportive services in order to resume functioning)
 - * Partial Hospitalization (for individuals who need intensive, structured and ongoing services)
6. Residential Services
7. Casemanagement
8. Specialized Services for Children and Adolescents

Assessments for patient placement should be standardized nationally and use patient placement criteria such as the Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders developed by the American Society of Addiction Medicine (ASAM). Treatment should be provided by licensed or certified professionals with a specialty in addictions and in programs licensed by the single state drug and alcohol agency.

Utilization Review/Managed Care

Utilization review/managed care designed to assess the level of care an individual needs and to assist him/her in obtaining that care -- **not** channel everyone into the least costly level of care regardless of the care needed -- should be a component of health care reform. Our recommendations for the standards that should be used are outlined on page six of this document.

II. Cost-Effectiveness of Treatment

A wealth of research now exists that demonstrates that treatment works **and** that it saves enormous amounts of money that would otherwise be spent on much more expensive health care as well as criminal justice, foster care and other costs.

The cost savings generated by preventing and treating alcohol and drug dependence are enormous. A cost-benefit analysis conducted by the University of California estimated that every \$1 spent on treatment and prevention saved \$11.54 in social costs.

1. Health Care Savings

a. **Emergency Rooms and Other Medical Treatment**

- * People with alcohol disorders account for between 15% and 30% of all hospitalized patients.¹ Many of these are undiagnosed alcoholics being treated for the consequences of their drinking.
- * Emergency room and other hospital care typically costs between \$400 and \$600 per day, **far more** than the cost of drug and alcohol prevention and treatment.
- * A California study found that providing alcohol treatment reduces not only the alcoholic's medical expenses, but those of the **whole family**.

b. **Health Care for Children**

- * The total annual cost of health care for babies born with fetal alcohol syndrome (FAS) is \$1.6 billion. Treatment and prevention can prevent all FAS cases.
- * Over 4.5 million women of child bearing age are estimated to have used an illegal drug in the past month. Neo-natal hospital costs can range between \$3,500 and \$10,000, and the costs of long term care will mirror that for FAS. Treatment and prevention can also eliminate these costs.

c. **Treatment for HIV Disease and AIDS**

- * The average person diagnosed with AIDS requires \$32,000 worth of medical treatment each year, and IV drug users often require even more medical care.

¹ A. Umbrecht-Schneider, et al., "The Impact of Alcohol-Associated Morbidity in Hospitalized Patients," Substance Abuse 12((3), 145-55, 1991.

- * The average lifetime medical cost of HIV-related illness for each Medicaid eligible IV drug user in New York was estimated to be \$90,188 (based on 1988 data).

2. Foster Care, Criminal Justice and Other Savings

Drug and alcohol dependence are major causes of our nation's escalating foster care and criminal justice costs, as well as a host of other social problems. Treatment and prevention are far more cost-effective than filling our jails and prisons with offenders who have drug problems and overwhelming our foster care rolls with children of drug and alcohol dependent parents.

Conclusion

Untreated drug and alcohol problems impose heavy costs on society, far more than the cost of effective treatment. Because treatment constitutes primary prevention for AIDS and so many other costly health and social problems, we cannot afford not to include a comprehensive drug and alcohol treatment and prevention benefit in national health care reform.

The Need for Specific Coverage for Drug and Alcohol Treatment in National Health Care Reform

Introduction

Drug dependence and alcoholism are among our nation's leading health problems. Approximately 6.5 million individuals require treatment for a drug problem and as many as 22 million Americans are alcoholic or suffer from alcohol-related problems. These diseases cause great human suffering and impose substantial costs in terms of criminal activity, foster care and lost productivity. Moreover, they are directly linked to many costly health problems including HIV disease, fetal alcohol syndrome, cardio-pulmonary disease, cirrhosis, and injuries resulting from vehicular accidents and other alcohol and drug related incidents. The Bush Administration estimated that drug use alone cost our nation over \$300 billion each year.

We need not shoulder these staggering costs. Drug dependence and alcoholism are highly treatable diseases if comprehensive services are tailored to an individual's needs and are provided at the time an individual seeks services. Providing treatment is far less costly than the price being paid now for treating drug- and alcohol-related problems in emergency rooms and other hospital beds, incarcerating individuals with drug and alcohol problems, caring for children affected by maternal drug and alcohol use and treating individuals with HIV disease and other health problems. Our nation will lose a golden opportunity to trim health and other social costs if a comprehensive drug and alcohol treatment and prevention benefit is not included in national health care reform.

The purpose of this document is to identify the types of services that constitute drug and alcohol treatment and to summarize research on the effectiveness of treatment and the cost-offsets that can be realized if comprehensive treatment is available.

Section one identifies the goals of drug and alcohol treatment and the services that constitute such treatment. Section two discusses general medical, psychosocial and economic factors that govern patient placement. Section three outlines the components of a quality utilization review procedure. Section four summarizes the evidence on the cost effectiveness of treatment.

I. A Comprehensive Continuum of Services

National health care reform should include coverage for the prevention and treatment of alcohol and drug abuse and dependence that is comprehensive and includes services in a continuum of care in the least restrictive and most appropriate setting for the individual. Services should be available to adults and youth and special attention should be given to accommodating women with young children. Access to treatment for women and children has been seriously impeded because the treatment system is structured to serve individuals, not families. A reformed system must enable women to enter and remain in treatment with their children.

To the extent possible, treatment should be provided in community based non-profit programs, which tend to be far less costly than hospital-based and free-standing for-profit programs. Treatment effectiveness studies have demonstrated that the most critical determinant for positive treatment outcome is the length of time an individual is in treatment. Therefore, the reformed health care delivery system and the benefit should not be structured in a manner to rely heavily on short-term intensive interventions in acute care settings but include an array of acute, rehabilitative and continuing care services.

Co-payments and deductibles for drug and alcohol services should be set at the same rate as for other health care services. Co-payment percentage should rise with income. The poor should not be deprived of health care because of their inability to pay. Individuals below a certain income level should be protected through an exemption from co-payment requirements. No co-payment should be required for preventive services.

Utilization review should be a central feature of health care reform and should be applied universally to all health care services. The goal of utilization review should be to assist individuals in getting the proper level of services in the appropriate settings. Guidelines for quality utilization review are provided in Section III.

A specific drug and alcohol treatment benefit is described below. Assessments for patient placement should be standardized nationally and use patient placement criteria such as the Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders developed by the American Society of Addiction Medicine (ASAM).² Treatment should be provided by licensed or certified professionals with a specialty in addictions and in programs licensed by the single state drug and alcohol agency.

The goals of alcoholism and drug dependencies treatment are:

1. to safely withdraw the individual from alcohol and other drugs;

² American Society of Addiction Medicine, Patient Placement Criteria for the Treatment of Substance Abuse Disorders. March 1991.

2. to assess the physical, psychological, emotional and familial problems that have been caused and/or exacerbated by chronic alcohol and drug use and develop a structured individualized treatment plan to address these problems;
3. to assist the individual in identifying and accepting their addiction, the consequences of continued alcohol and drug use, and the need to take personal responsibility for ongoing recovery;
4. to provide information on alcoholism and drug addictions as chronic, bio-psychosocial disorders;
5. to assist individuals in restructuring their lives to maintain abstinence;
6. to assist the individual in becoming a part of sober communities for ongoing assistance in staying alcohol and drug free (such as A.A., N.A.);
7. to improve the individual's level of functioning in society — in relationships, in families, in work and, if necessary, assist individuals in acquiring basic educational, employment and living skills; and
8. to reduce illegal activities.

Alcohol and Drug Prevention and Treatment Services include the following services:

1. Prevention — patient education about the risks associated with alcohol and drug use. This typically takes place in a doctor or nurse's office or community health center. Prevention can include the following types of activities: identifying the risks associated with drinking or drug use during pregnancy; discussing the risks of using alcohol and other drugs in combination with prescription drugs; and screening adolescents and youth for alcohol and drug use and counseling on the risks of this use.
2. Assessment and Diagnostic Services — a structured review and evaluation of the individual's disease course, stage and prognosis including, when appropriate, consultations with family, employers and significant others to assist in the assessment, diagnosis and proper referral and treatment of the individual.
3. Medication Management Services — brief office or clinic visits supervised by licensed physicians that utilize FDA approved medications such as methadone or Antabuse. Medication management services are most

successful when provided in conjunction with comprehensive medical, casework and counseling services.

4. Withdrawal Services — the medical and psychological management of an individual while he/she detoxifies from alcohol and/or other drugs. The goals in this phase of treatment are to safely detoxify the individual from alcohol and drugs and to facilitate their timely entry into continuing treatment. Withdrawal services have been successfully provided in both a medical and a social model (emphasizes non-pharmaceutical methods for detoxification in a community-based setting) setting when appropriate individual assessment is conducted.
5. Outpatient/Ambulatory Services — **Short-Term Individual, Group or Family Addictions Counseling** when furnished by a licensed or certified alcoholism and drug dependencies health professional. The goal of the service is to assist individuals with making major lifestyle, attitudinal and behavioral changes that will help them to remain alcohol and drug free and able to cope with major life tasks without the use of alcohol and drugs.

Extended Addictions Counseling and Continuing Care for individuals who are seriously impaired and require ongoing supportive services in order to resume functioning. These services may include assistance with maintaining abstinence, psychosocial counseling for impaired family functioning and support in obtaining employment, housing and other basis services. Services are provided by a licensed or certified alcoholism and drug dependencies health professional and based.

Partial Hospitalization for individuals who need intensive, structured and ongoing services. The nature of services are correlated with the individual's needs and include counseling and medical management as appropriate.

6. Residential Services — **Short-term and long-term** based on a clinical evaluation of the need for inpatient/residential care and development of a treatment plan and subject to periodic utilization review. An organized service with designated addiction personnel or addiction-credentialed clinicians that provide a planned regimen of 24-hour professionally-directed evaluation, care and treatment for addicted patients in a residential setting. Clinical services include: medical; educational; and individual, group and family therapy. This level of care is required when a clinical evaluation indicates that the individual's level of impairment is so severe that outpatient services are counter-indicated.

7. Casemanagement Services – supervision and management of a patient's progress through the continuum of prevention and treatment services for alcoholism and drug dependencies' treatment, including assistance with gaining access to ancillary services such as health care, housing, education, job placement and training.

Services for Children and Adolescents

Children and adolescents will need specialized services to address the problems arising from growing up in a family where alcoholism and drug dependence are problems and adolescents will need specialized services to address their addictions. Therefore, in addition to the specific services outlined above, children and adolescents should have coverage for:

- The current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid for screening of their physical, psychological and developmental factors;
- Access to specialists for medical, psychological and developmental services based on the EPSDT screen;
- Health education programs for families that include developing and improving parenting skills and other risk reduction activities;
- The full range of services offered to adults but in settings where personnel are trained to work with adolescents. Again, standardized patient placement criteria should be used to determine the appropriate level of care using guides like the ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders.

II. General Medical, Psychosocial and Economic Factors that Govern Patient Placement

The American Society on Addiction Medicine has developed Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. ASAM identifies six primary problem areas for evaluation when making placement decisions: acute intoxication and/or withdrawal potential; biomedical conditions and complications (such as psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, transient neuropsychiatric conditions); emotional/behavioral conditions or complications; treatment acceptance or resistance; relapse potential; and recovery environment. Assessment of the individual's medical status and functioning in each of

these areas will determine the appropriate level of care and length of time needed in treatment.

In addition to these problem areas, it is important to assess the individual's economic situation including housing, employment and health insurance coverage. Many individuals entering treatment have long-term chronic drug and alcohol addictions. They require services that are habilitative and that will enable them to eventually function independently. The process of habilitation is often lengthy (up to two years) and requires ongoing psychological and lifeskills support. Finally, many individuals live in environments where drugs, alcohol, violence and crime are inextricably linked. They may need to leave these neighborhoods and assistance with establishing themselves in new and safer environments.

III. Utilization Review/Managed Care

Utilization review/managed care should be a component of health care reform. The purpose of utilization review is to assess the level of care an individual needs and to assist him/her in obtaining the appropriate care. Utilization review should not be used to channel all people into the least costly level of care. Standards should govern how utilization review operates. A good utilization review plan should include at least the following:

1. a process for certifying or licensing the bodies conducting utilization review;
2. a disclosed description of the specific admission and treatment criteria used in determining the justification for any form of hospital, inpatient, residential or outpatient services;
3. a description of an emergency preauthorization procedure that will include the process for allowing a smooth admission process for detoxification;
4. a description of the procedures the review agent will follow when making decisions — including confidentiality protections, process for making admissions decisions within 24 hours, a process for obtaining a second opinion within 24 hours in the case of any adverse determination;
5. a description of an independent appeals process;
6. the names, addresses, telephone numbers and qualifications of the personnel who will be performing utilization review for alcohol and drug treatment services — with minimum qualifications;

7. procedures to ensure that the review agent will be readily accessible by telephone to the insured and providers at least 40 hours per week during normal business hours, assurances that a toll-free telephone line will be provided for insureds, hospitals, and physicians to contact the review agent;
8. procedures to ensure that the review agent will respond by telephone to insureds and/or providers within four business hours;
9. procedures by which the review agent shall notify the insured and the providers when payment for alcohol or drug treatment is denied or limited, including a written statement for the denial or limitation;
10. policies and procedures to ensure that all applicable state and federal laws that protect the confidentiality of individual medical records are followed; and
11. procedures to ensure that no review agent shall enter a hospital or other treatment facility of a provider to interview an insured unless such activity has been approved in advance by such insured's attending physician and such attending physician or designee shall be able to attend such activity which shall occur only during regular business hours.

IV. Cost-Effectiveness of Treatment

A. Effectiveness of Treatment Numerous studies have concluded treatment substantially reduces drug and alcohol use and the serious social and health consequences related to such use. The Treatment Outcome Prospective Study (TOPS), sponsored by the National Institute on Drug Abuse (NIDA) tracked the progress over a five-year period of 10,000 clients who obtained treatment in 37 residential, methadone maintenance or out-patient drug free programs.³ According to TOPS:

- * After a year in treatment, 75% of the clients in out-patient drug free programs and 56% of the clients in residential therapeutic community treatment had stopped using heroin or cocaine.
- * Heroin use by clients in methadone maintenance declined by 70%.

³ The results of the study are reported in R. Hubbard, Drug Abuse Treatment, A National Study of Effectiveness, (1989).

In addition to substantial reductions in drug use, treatment had a significant effect on criminal activity and employment status.

- * 70% of the outpatient and 97% of the residential therapeutic community clients who admitted to having committed a predatory crime in the year prior to treatment had no criminal activity during or in the first six months after participating in treatment.
- * The portion of clients in all three treatment modalities who committed predatory crimes in the three to five-year post-treatment period was one-third to one-half the pretreatment proportion.
- * The employment rate of clients in residential treatment doubled, from 12.4% to 24.8%, and the employment of clients in outpatient treatment rose from 24.7% to 38.7%.

TOPS also concluded that the level of post-treatment criminal activity for criminal justice clients also declined substantially and that these individuals do as well or better than other clients in treatment. Criminal justice clients tended to stay in treatment longer than other clients, resulting in more positive outcomes.

A subsequent NIDA-sponsored study reported that methadone maintenance treatment effectively reduced IV drug use by 71%.⁴ With over 32% of AIDS cases being linked to IV drug use and 70% of all pediatric AIDS cases being linked to maternal exposure to HIV through drug use or sex with a drug user,⁵ treatment is clearly the most effective primary prevention tool for HIV disease. For this reason, the National Commission on AIDS recommended that accessible treatment be made available to all who need and request it.⁶

B. Cost of Treatment The 1990 Drug Services Research Survey (DSRS), sponsored by NIDA, provides the most recent information on treatment cost. DSRS reported the treatment charges billed to clients in 118 non-correctional treatment facilities

⁴ J. Ball et al., "Reducing the Risk of AIDS Through Methadone Maintenance Treatment, Journal of Health and Social Behavior, 1988.

⁵ Centers for Disease Control, HIV/AIDS Surveillance, January 1993.

⁶ National Commission on Acquired Immune Deficiency Syndrome, "The Twin Epidemics of Substance Use and HIV," 1991.

during the 12 months between September 1, 1989 and August 31, 1990.⁷ The types of treatment programs surveyed included inpatient hospital, residential, outpatient drug free and methadone maintenance.

According to the DSRS data, the treatment charges varied dramatically depending upon the setting of treatment. The mean per diem charge for clients who completed treatment and were billed for their care (but not the full amount) was:

hospital inpatient	— \$449
residential	— \$ 85
methadone	— \$96 ⁸
outpatient drug free	— not available because the number of days in treatment was unknown.

The mean per diem charge for clients who completed treatment and were billed the total charge for their care was slightly higher:

hospital inpatient	— \$486
residential	— \$139
methadone	— \$116
outpatient	— not available.

In addition, a recent survey conducted by the Therapeutic Communities of America on the cost of care in long-term therapeutic communities averages \$80 per day for adolescents and \$60 per day for adults.

These charges are instructive when determining the range of drug and alcohol services that should be included in a health care benefit. Clearly, inpatient hospital care, which is the type of service most frequently covered in private health insurance plans,⁹ is far more expensive than residential treatment services. Moreover, research sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) that compared patient

⁷ While the data presented reflects the charges billed to clients, not the actual cost of treatment, this data is a proxy for cost of treatment.

⁸ The final DSRS report emphasized that the per diem estimate for methadone treatment is highly questionable because the charge data was gathered from a very small client sample. Indeed, the American Methadone Treatment Association estimates that the weekly charge for methadone treatment care ranges from \$70 to \$80 per week. This charge covers medication, counseling, nursing services and an annual physical examination.

⁹ The DSRS data confirms that individuals who pay for their treatment with private insurance most frequently obtain inpatient hospital care: 38.2% obtain hospital care and 22.9% obtain outpatient drug free care.

health care expenditures and recurrent treatment of Medicare clients who received alcohol treatment in hospital inpatient programs versus freestanding treatment programs concluded that (a) clients served in freestanding programs had lower average health care expenditures than those treated in hospitals and (b) clients in freestanding programs has less recurrent treatment than those in hospital-based programs.¹⁰ Accordingly, a drug and alcohol benefit should include a broad range of treatment settings and modalities to ensure the most cost-effective care.

C. Cost-Offsets and Economic Benefits of Drug and Alcohol Treatment

The above treatment costs pale in comparison to the cost of providing health care to people with untreated alcohol or drug dependence, providing health care to children affected by maternal drug and alcohol use and those with HIV disease and alcohol and drug problems, placing children in foster care, and incarcerating individuals with drug and alcohol problems.

1. Health Care Savings

a. **Emergency Rooms and Other Medical Treatment**

- * People with alcohol disorders account for between 15% and 30% of all hospitalized patients.¹¹ Many of these are undiagnosed alcoholics being treated for the consequences of their drinking.
- * Hospital care typically costs between \$400 and \$600 per day, and an average hospitalization costs \$5,500.

The health care cost savings resulting from drug and alcohol treatment are enormous. Several studies have examined these savings. A California study found that prior to entering treatment, monthly medical bills for alcoholics and their families averaged \$135, while the average medical costs for non-alcoholics and their families were \$20 per month. Five years later, the monthly medical costs for families in which the alcoholic member had completed treatment had dropped to \$22 while inflation had

¹⁰ A. Lo and A. Woodward, "An Evaluation of Freestanding Alcoholism Treatment for Medicare Recipients, 88 Addiction 53-68 (1993).

¹¹ A. Umbricht-Schneider, et al., "The Impact of Alcohol-Associated Morbidity in Hospitalized Patients," Substance Abuse 12((3), 145-55, 1991.

brought the non-alcoholic families' medical expenses to \$50 per month.¹² Thus, providing alcohol treatment reduces not only the alcoholic's medical expenses, but those of the whole family.

Several other studies confirm that the health care expenditures of alcoholics decline substantially after treatment relative to non-alcoholics or to untreated alcoholics. For example, a 1992 study which examined the health records for a 14-year period of over 3,000 alcoholics who had received treatment revealed that health care costs of treated alcoholics were 24% lower than the health care costs for a control group of untreated alcoholics.¹³

Two other studies have examined the health care expenditures of alcoholics six-months prior to entering treatment, one-year after treatment and three to six years after treatment. Both reveal that health care expenditures in the six months prior to treatment increased steadily, but declined one-year after treatment and remained at or below the one-year level three to six years after treatment.

In the first study, health care expenditures for alcoholics under 44 years increased to up to \$350 per month in the six months prior to treatment, but then dropped to \$100 per month one year following treatment and remained at or below \$100 per month three years later.¹⁴ In the second study, health care expenditures for alcoholics under 50 years increased to up to \$600 per month six-months prior to treatment, but then dropped to below \$200 per month one-year post-treatment and \$100 per month six-years post-treatment.¹⁵

b. Health Care for Children

¹² Blue Cross/Blue Shield of California, "Medical Care and Alcoholism Treatment Costs and Utilization: A Five-Year Analysis of the California Pilot Project to Provide Health Insurance Coverage for Alcoholism," 1973-1979.

¹³ H.D. Holder and J.O. Blose, "The Reduction of Health Care Costs Associated With Alcoholism Treatment: A 14-Year Longitudinal Study," Journal of Studies on Alcohol 53(4), 293-302, 1992.

¹⁴ H.D. Holder and J.O. Blose, "Alcoholism Treatment and Total Health Care Utilization and Costs: A Four-Year Longitudinal Analysis of Federal Employees," Journal of the American Medical Association, 256(11), 1456-1460, 1986.

¹⁵ J.O. Blose and H.D. Holder, "The Utilization of Medical Care by Treated Alcoholics: Longitudinal Patterns by Age, Gender, and Type of Care," Journal of Substance Abuse, 3(1), 13-27, 1991.

- * Assuming an incidence rate of 1.9 children per 1,000 births are born with fetal alcohol syndrome (FAS), the total annual cost of care is \$1.6 billion, of which \$1.3 billion is for residential care and support services for mentally retarded persons over 21 years, \$118 million for neonatal intensive care services and \$118 million for full-time residential care for severely mentally retarded persons under 21 years.¹⁶ Treatment can prevent all FAS cases.
- * Over 4.5 million women of child bearing age are estimated to have used an illegal drug in the past month. Neo-natal hospital costs can range between \$3,500 and \$10,000, depending upon the level of care and length of stay required for each infant.¹⁷ The costs of long term care for persons with FAS sheds light on the potential future costs of caring for individuals affected by maternal cocaine and crack use. These costs can be eliminated with treatment.

c. **Treatment for HIV Disease and AIDS**

- * The average person diagnosed with AIDS requires \$32,000 worth of medical treatment each year. IV drug users often require more medical care than other persons with the disease because of their generally poorer state of health and inability to obtain outpatient and preventive care.¹⁸
- * The average lifetime medical cost of HIV-related illness for each Medicaid eligible IV drug user in New York was estimated to be \$90,188 (based on 1988 data).

3. **Foster Care Savings**

- * Approximately one-third (1/3) of the children placed in foster care are children of persons with drug problems. The annual cost of foster care for a child ranges from \$13,000 to \$36,000.¹⁹ Treatment is far less costly

¹⁶ D.P. Rice, et al., The Economic Costs of Alcohol and Drug Abuse and Mental Illness, 1990 at 153.

¹⁷ Phibbs et al., "The Neonatal Costs of Maternal Cocaine Use," The Journal of the American Medical Association, September 18, 1991.

¹⁸ National Commission on Acquired Immune Deficiency Syndrome, Americans Living With AIDS: Report of the National Commission on Acquired Immune Deficiency Syndrome 1991, p. 70 (1991).

¹⁹ Packard Foundation, 1991.

than placing one or more children in foster care for an indefinite period of time.

4. Criminal Justice Savings

- * Up to 75% of all federal and state prison and local jail inmates, probationers and parolees need comprehensive drug treatment and aftercare services. The annual cost of incarcerating an individual is \$30,000 a prison bed and the cost of building a new prison is \$100,000 per bed. Treatment is far less costly than repeated incarceration of drug dependent offenders.

TOPS examined the cost-effectiveness of treatment when measured against crime-related costs. The study examined two general measures of crime-related costs:

- * costs to society which include (a) the costs to victims such as medical treatment, loss of property and reduced productivity resulting for the crime, (b) criminal justice costs such as police, adjudication and incarceration costs, and (c) crime career/productivity costs which include the cost of removing the offender from the productive economy; and
- * costs to law-abiding citizens which include the costs to victims, criminal justice costs and theft costs.

TOPS found substantial economic benefits resulting both during and one year after treatment for each client served in residential, out-patient drug free and methadone maintenance programs.

Savings in the costs to law-abiding citizens

	<u>During Treatment</u>	<u>One-Year Post-Treatment</u>
Residential	\$12,206	\$13,731
Methadone	4,854	4,000
Out-patient	2,792	5,986

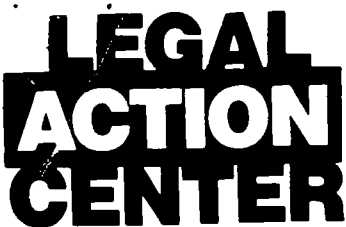
Savings in the costs to society

	<u>During Treatment</u>	<u>One-year Post-Treatment</u>
Residential	\$ 5,756	\$ 7,811
Methadone	2,022	3,362
Out-patient	2,785	6,789

Indeed, the savings realized during treatment offset the cost of the treatment provided. The greater savings after treatment is linked in large part to the reduction in criminal activity because the individual has been rehabilitated.

Conclusion

Untreated drug and alcohol problems impose heavy costs on society, far more than the cost of effective treatment. Because treatment constitutes primary prevention for AIDS and so many other costly health and social problems, we cannot afford not to include a comprehensive drug and alcohol benefit in national health care reform.



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**BLUEPRINT FOR
A NEW AND EFFECTIVE
NATIONAL DRUG AND ALCOHOL STRATEGY**

**Revised Version
February, 1993**

SUMMARY

I. Provide Treatment on Demand and Effective Prevention Programs in Every Community and School.

A. Allocate Resources to Ensure that at Least 50% of the Federal Drug Budget is Devoted to Prevention, Treatment and Services-Related Research.

Recommendation:

The Federal Government should add about \$2.5 billion to current treatment, prevention and services research initiatives and better utilize existing resources, as follows:

- * Implement the Institute of Medicine's "intermediate" option for expanding treatment and evaluation:**
 - (1) Expand Treatment Capacity: \$800 million in one time investments and \$1 billion in annual costs to provide treatment on demand;**
 - (2) Remedy Deficiencies in Existing Treatment Systems: \$425 million to restore funding lost by programs over the past 12 years that is desperately needed to remedy deficiencies in quality of treatment services and management and prevent many programs from collapsing; and**
 - (3) Expand Research on What Treatment and Prevention Strategies Work: \$100 million to evaluate treatment performance and ensure that at least \$150 million of current research funding is used to conduct research and evaluation studies to identify the most effective treatment and prevention strategies.**
- * Expand Effective Prevention and Early Intervention Efforts: \$100 million to expand effective prevention and early intervention services for community-based prevention in order to reach more youth in schools and adults in the workplace.**

- * Better target the approximately \$500 million now allocated under the Drug Free Schools Act to expand early prevention and intervention programs, such as student assistance programs, and enhance the ability of schools and communities to work with children at high risk for drug or alcohol abuse and/or who have alcohol and drug-related birth defects.**

B. Sources of Funds to Expand Prevention and Treatment Activities

Recommendation:

1. The Federal Government should redirect to treatment, prevention and services research activities all or a substantial portion of the approximately \$3 billion now spent annually on interdiction efforts that are not effective in reducing the supply of drugs in the United States. This would include:

- * The \$1.140 billion currently allocated to the Department of Defense interdiction and counter-drug activities;**
- * The approximately \$700 million remaining in the Andean Drug Initiative; and**
- * The \$1.1 billion currently allocated to the Coast Guard and Custom Service.**

2. The Federal Government should allocate at least 25% of the asset forfeiture funds expended each year on anti-drug abuse efforts to treatment, prevention and research activities. Last year, such a policy would have sent approximately \$125 million of the Justice Forfeiture Fund and \$7 million of the Customs Service forfeiture money to those highly effective programs.

II. Fight Crime By Providing Treatment and Prevention Services to All Individuals Involved in the Criminal Justice System Who Have Drug or Alcohol Problems.

Recommendation:

The Federal Government should:

- * Allocate a portion of criminal justice and law enforcement funds to pay for comprehensive drug and alcohol treatment in community-based and prison/jail settings;**
- * Expand programs that sentence non-violent drug and alcohol dependent individuals to drug and alcohol treatment and other less costly intermediate sanctions programs; and**
- * Provide funding for juvenile justice programs to develop alternative sentencing and early intervention programs.**

III. Include Coverage for Comprehensive Drug and Alcohol Treatment Services in National Health Care Reform.

Recommendation:

The Federal Government and the states must include a comprehensive drug and alcohol treatment benefit in national health care reform proposals. Prevention must be included in this health care discussion.

IV. Address the Economic and Social Factors that Contribute to Drug and Alcohol Problems.

Recommendation:

Increase government spending to create jobs, adequate and safe housing, better schools and youth programs and community support systems, particularly in poor and inner-city communities.

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BLUEPRINT FOR A NEW AND EFFECTIVE NATIONAL DRUG AND ALCOHOL STRATEGY

It is time to implement an effective national drug and alcohol policy — one that makes public health approaches, including treatment and prevention, an equal partner with law enforcement and interdiction. Our country's failure to even come close to realizing the vast potential of our most effective anti-drug weapons — prevention and treatment — has doomed too many of our citizens and their families to the ravages of addiction and alcoholism, and cost our society tens of billions of dollars.

It is time — long past time — for a change. President Clinton has wisely emphasized the need for a new drug strategy, including treatment on demand. The new Administration will have a tremendous opportunity to dramatically improve the nation's efforts to combat drug and alcohol abuse. We offer our recommendations here on how best to do that.

Support for a new and better drug strategy is widespread. Indeed, just a few months ago, the United States Senate passed by voice vote a "sense of the Congress" amendment directing the President to provide equal funding for demand reduction activities — including prevention, education and treatment — and supply reduction activities — including law enforcement, border control and customs efforts, prison construction and maintenance and international eradication efforts — in his FY 1995 budget.¹

The Senate's call for equalizing funding for demand reduction and supply reduction activities must be implemented now. Continuing the current strategy of investing 70% of federal funds in supply reduction activities and grossly underfunding more effective treatment, prevention and research initiatives will perpetuate policies that have not reduced either drug addiction or crime² and will waste precious funds.

Treatment and prevention work:³

- **Treatment and prevention save money.** A University of California study found that every \$1 spent on drug and alcohol treatment saves society \$11.54 in health care and criminal justice costs, and lost productivity for business.⁴

- **Treatment and prevention stop drug use.** Long-term studies sponsored by the federal government have proven that treatment reduces drug and alcohol use by as much as 71%; employment rates for clients participating in treatment double.⁵ Twenty-four controlled experiments, plus replications with high risk youth, have shown the efficacy of prevention programs in reducing the use of alcohol, tobacco and marijuana by 50 percent.⁶ These results have been replicated with youth in high risk environments and in community-wide interventions.⁷
- **Treatment and prevention reduce crime and recidivism.** One typical study reported a 74% drop in arrest rates for clients in all types of treatment.⁸ A recent study found that public housing areas that implemented community-based prevention programs experienced a 13 percent reduction in juvenile justice referrals, compared to projects that had not implemented an alcohol and drug prevention program.⁹
- **Treatment prevents HIV/AIDS.** A study found that HIV seroprevalence rates for former IV drug users in treatment was 1/2 the rate of untreated addicts.¹⁰

In contrast, the current strategy of emphasizing a "war on drugs" and giving treatment and prevention the back of the hand has not addressed our nation's drug and alcohol problem effectively. While overwhelming and record numbers of individuals have been arrested and incarcerated, drug use among all but the most casual users has increased recently. In 1991, weekly cocaine use rose sharply — by 29%.¹¹ We have failed on both fronts: the need of many thousands for treatment has not been met, the opportunity to prevent drug and alcohol problems has been lost and interdiction efforts have not reduced drug supplies in our country.¹²

In addition, the current strategy has ignored alcohol and prescription drugs, which are abused more than illegal drugs. Alcohol is responsible for more than 100,000 deaths each year¹³ and is the leading cause of death for persons under 21.¹⁴ An alcohol-related problem strikes one of every four families.¹⁵ Fetal Alcohol Syndrome is one of the major preventable causes of birth defects.¹⁶

As a result of flawed policies, our nation loses, according to Bush Administration statistics, an estimated \$300 billion each year, and millions of individuals and their families suffer the devastating effects of drug and alcohol dependence and HIV disease.

- Every year at least 2 to 3 million individuals with drug and alcohol problems need but cannot obtain treatment.¹⁷
- 32% of all AIDS cases are related to IV drug use, and 70% of all pediatric AIDS cases are related to maternal exposure to HIV through drug use or sex with a drug user.¹⁸
- More than 1 million people are currently incarcerated in the U.S., twice as many as in 1980, an increase largely due to incarceration of non-violent drug addicts.¹⁹

The following four-point plan is a blueprint for change — one that will effectively reduce drug and alcohol problems in our nation.

I. Provide Treatment On Demand and Effective Prevention Programs in Every Community and School

No one can deny that comprehensive drug and alcohol treatment and prevention programs reduce the demand for drugs and alcohol and stem the transmission of HIV among drug users, their partners and children. Treatment and prevention also save billions of dollars in health care, criminal justice and productivity costs.

Yet, annually our treatment system must turn away many thousands of men, women and young people who want and need treatment and prevention programs are unable to reach millions of people at high risk for alcohol and drug problems. The demand for treatment continues to far exceed the investment in and expansion of our treatment system. Many programs, particularly publicly-funded programs, have stretched scarce resources to provide treatment to more individuals. This has placed a tremendous strain on staff and facilities and, in some cases, endangered their ability to provide the highest quality care.

This disastrous situation cannot continue. The human and societal costs of continued drug and alcohol abuse are too high, while the cost of good, comprehensive treatment and prevention are very low in comparison. The cost of good treatment tailored to meet the needs of the individual is far lower than the astronomical costs that we incur from allowing addiction to go untreated. Preventing people from beginning to abuse alcohol and drugs saves even more money. **Appropriate treatment must be made available at the time an individual requests services. Prevention programs must be targeted at the general population, especially those at significant risk for developing alcohol and drug problems.**

A. Reallocate Resources to Ensure that at Least 50% of the Federal Drug Budget is Devoted to Prevention, Treatment and Services Related Research.

Recommendation:

The Federal Government should add about \$2.5 billion to current treatment, prevention and services research initiatives and better utilize existing resources, as follows:

- * Implement the Institute of Medicine's "intermediate" option for expanding treatment and evaluation (IOM recommended much greater increases in its "comprehensive" option, but current fiscal realities probably mitigate against enacting that more complete approach):²⁰**
 - (1) Expand Treatment Capacity: \$800 million in one time investments and \$1 billion in annual costs to provide treatment on demand by expanding services to women, adolescents, individuals with or at high risk for HIV disease, the homeless, and others in need of treatment;**
 - (2) Remedy Deficiencies in Existing Treatment Systems: \$425 million to restore funding lost by programs over the past 12 years that is desperately needed to remedy deficiencies in quality of treatment services and management and prevent many programs from collapsing; and**
 - (3) Expand Research on What Treatment and Prevention Strategies Work: \$100 million to evaluate treatment performance and ensure that at least \$150 million of current research funding is used to conduct research and evaluation studies to identify the most effective treatment and prevention strategies.**
- * Expand Effective Prevention and Early Intervention Efforts: \$100 million to expand effective prevention and early intervention services for community based prevention in order to reach more youth in schools and adults in the workplace;**
- * Better target the approximately \$500 million now allocated under the Drug Free Schools Act to expand early prevention and intervention programs, such as student assistance programs, and enhance the ability of schools and communities to work with children at high risk for drug or alcohol abuse and/or who have alcohol and drug-related birth defects.**

Discussion:

Federal funding for all of these desperately needed services has been woefully inadequate since the mid-1970's. Now is the time to change our nation's priorities and invest in our most effective anti-addiction and anti-alcoholism strategies.

1. Expand Treatment Capacity: Appropriate treatment services must be available so that individuals can receive treatment at the time they request it. The moment when someone finally seeks help for his or her addiction is our best opportunity to successfully treat the addiction, and that opportunity must not be wasted. The following populations are especially in need of expanded treatment services:

a. Individuals at Risk for HIV disease: Treatment is one of the most effective prevention tools we have for HIV disease and numerous other costly health care problems. HIV outreach services have effectively reduced high-risk injection and sexual practices by drug users and their partners and will serve as an effective bridge to treatment if services are available.

b. Women's Services: New services must also be established for women of all ages, including pregnant women and women with children who may need care in a residential setting with their children. The framework for providing expanded services to pregnant women who are addicted to drugs and alcohol has been established in P.L. 102-321, but on-going funding must be available to ensure that such programs are in fact established and sustained.

c. Individuals in the Criminal Justice System: Treatment services for individuals involved in the criminal justice system must be expanded dramatically. See discussion *infra* point 2.

Several funding vehicles are available to expand treatment capacity:

- The Substance Abuse Block Grant, the primary source of federal funding for alcohol and drug treatment and prevention services, should be increased substantially above the FY '93 level, and at the very least by \$900 million, for a total of \$2 billion.
- Medicaid should be expanded to reimburse alcohol and drug treatment in non-hospital residential settings, which is currently precluded under the "institution for mental disease" exclusion. Significant numbers of youth and adults who need alcohol and drug treatment are eligible for Medicaid, and Medicaid is already paying for the treatment of the many costly secondary conditions caused by alcoholism and drug dependence. At a minimum, legislation considered in the 102nd Congress to provide Medicaid reimbursement for comprehensive, non-hospital residential treatment services for pregnant women and their children should be enacted.

2. Remedy Deficiencies in the Existing Treatment and Prevention System: Inadequate resources over the past 12 years, including funding cuts, have endangered the ability of many programs to continue providing quality services. Many are even in danger of collapse. To ensure the highest treatment quality, funds must be devoted to (a) increasing reimbursement per client by 25%, as recommended by the Institute of Medicine; (b) repairing and renovating

treatment facilities; and (c) expanding the number of staff, enhancing training, increasing salaries currently stuck at very low levels, and improving benefit packages in order to attract and retain staff.²¹

In addition, treatment programs need increased resources to provide ancillary services to clients, including vocational training, education programs, and other health and social services. The 102nd Congress imposed new requirements on programs that receive Substance Abuse Block Grant funds — the primary source of federal funding for drug and alcohol treatment — that will require substantial funds to implement. Under P.L. 102-321, programs are now required to provide primary health care services, including tuberculosis screening, counseling and treatment, to all clients, and prenatal care and childcare services to pregnant women treated with funds from the Women's Set-Aside. Nearly half the states must also provide HIV testing, counseling and early intervention therapeutics to some clients.

Congress is relying on treatment and prevention programs to respond to more and more of the primary health care needs of their increasingly sicker patients and to fill in the gaps in the health care delivery system. Programs obviously cannot provide basic treatment services as well as these essential ancillary services without increased resources.

3. Expand Services-Related Research on What Treatment Works: The federal priorities for drug and alcohol treatment and prevention research must be reexamined. While bio-medical research is important, a larger percentage of resources must be spent on services-related research in order to demonstrate what works in preventing and treating drug and alcohol problems and the cost-effectiveness of intervention and treatment. This type of research was virtually eliminated in the late 1970's and is only now being resumed with the requirement in P.L. 102-321 that 15% of the research budgets of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) be spent on health services research.

Additional funds are necessary to monitor and evaluate the performance of treatment and prevention programs. Furthermore, a larger portion of federal research funds — at least 25% of the nearly \$600 million in research money now at the disposal of NIDA and NIAAA — should be devoted to research targeted on such issues as why and when people seek treatment, what makes them stay in treatment, what makes it work and why they relapse. Specifically, such research should include (a) studies to determine the client and program factors that influence treatment-seeking behavior, treatment retention and efficacy and relapse; (b) studies that determine the relationship between treatment outcome and the content, organization and cost of treatment; (c) the standards and criteria for measuring treatment outcome for all modalities; and (d) evaluation of prevention to determine what activities are effective, including the efficacy of alcohol beverage labeling and advertising and alcohol excise taxes. Funds must also be devoted to disseminating research findings to the field.

4. Expand Prevention and Early Intervention Efforts in Communities Including Schools and Workplaces:

a. Community/School Prevention Efforts: Effective education and outcome focused prevention efforts will reduce the use of alcohol and drugs, just as they have cut tobacco use. Research indicates that teaching children practical strategies to resist drug use — social influence programs and life skills training — are effective prevention tools, particularly if reinforced by family and community involvement.²² Student Assistance Programs (SAPs) and other school-based early intervention counseling programs are also extremely effective in assisting high-risk youth who come from families with alcohol or drug problems or are using drugs and alcohol themselves especially when they are used within a comprehensive community based program. Prevention programs for young people in high risk environments including -- public housing, juvenile detention runaway and homeless shelters, and neighborhoods with high drug trafficking -- must also be intensified.

Many schools have not targeted prevention funding — particularly the substantial funding provided under the Drug-Free Schools and Communities Act — to effective programs. For example, schools invest substantial funds in the DARE (Drug Abuse Resistance Education) program, and each state is required to spend a portion of the Governor's discretionary fund on this program, even though studies have shown that DARE does not reduce alcohol or drug use.²³

Drug Free Schools Act funding should be closely monitored to ensure that resources are not expended for activities that have not been evaluated or, upon evaluation, have proven ineffective in reducing drug and alcohol use. In addition, resources should be targeted to expanding early intervention programs, such as SAPs, and enhancing the ability of schools to work with children who have alcohol and drug-related birth defects.

Reducing alcohol use among youth presents a more difficult problem because of the mixed messages that come from alcohol advertisements, family and community. Accordingly, a broader effort to modify public attitudes about alcohol will be required to reduce alcohol use among youth. Restrictions on alcohol advertising, tighter controls on alcohol sales and enforcement of drinking-age laws are necessary.²⁴ Including health messages regarding the risks of alcohol consumption in all alcoholic beverage advertisements will also educate adults.

b. Workplace Prevention and Intervention Efforts: Employee Assistance Programs (EAPs) — labor/management programs that educate employees about the risks of drug and alcohol use, train supervisors to identify employees with work-related problems, refer individuals to appropriate treatment and monitor their rehabilitation — are the best and most cost-effective means of combatting alcohol and drug problems in the workplace. While approximately 80% of the large employers (250 employees or more) that existed in 1988 had an EAP in 1990, only 9% of the small businesses (1 to 49 employees) had one.²⁵ The federal government should provide \$10-15 million to help small businesses provide EAP services to employees.

B. Sources of Funds to Expand Prevention and Treatment Activities

Reordering of priorities is needed to expand prevention and treatment activities, not additional federal funds. "We do not need a bigger drug war which pours even more resources into trying to seal the nation's borders, eradicate foreign drug crops, and lock up addicts. We need an entirely different approach built on what we have learned about reducing drug abuse and drug crime."²⁶

Recommendation:

1. The Federal Government should redirect to treatment, prevention and services research activities all or a substantial portion of the approximately \$3 billion now spent annually on interdiction efforts that are not effective in reducing the supply of drugs in the United States. This would include:

- * The \$1.140 billion currently allocated to the Department of Defense interdiction and counter-drug activities;**
- * The approximately \$700 million remaining in the Andean Drug Initiative; and**
- * The \$1.1 billion currently allocated to the Coast Guard and Custom Service.**

Numerous government studies have documented the failure of interdiction efforts to stem the supply of drugs in the United States²⁷ and the ability of traffickers to rapidly adjust to and circumvent detection, monitoring and interdiction operations.²⁸ **Even if interdiction efforts and source-country programs — including crop eradication, crop substitution and refinery destruction — were tremendously successful, supplies would not be reduced enough to increase the market price of drugs sufficiently to affect demand and consumption in the United States.**²⁹

The following international and interdiction programs are among those that have received the largest appropriations, but have not and will not effectively reduce drug supply or demand in the United States. **Redirecting even a portion of these funds to prevention and treatment activities would move substantially toward a 50/50 split in funds and dramatically expand demand reduction services.**

a. **Department of Defense Interdiction and Counter-Drug Activities:** The Department of Defense was given substantial new authority in 1989 to coordinate drug detection and monitoring efforts — despite its initial reluctance to become involved in such activities — and has received increased appropriations for these activities since that time.³⁰

The Department of Defense will receive approximately \$1.140 billion in FY 1993 for interdiction activities. **While this amount constitutes less than 0.5% of the DODs total budget, it is almost equal to the entire FY 1993 appropriation for treatment.** Transferring these funds to treatment would almost double the treatment budget.

Eliminating the Defense Department's failed interdiction efforts will not have a detrimental effect on drug supplies in the United States. The General Accounting Office has concluded that DOD's efforts have not reduced cocaine flow into the United States, and, even more important, will not do so regardless of how well DOD does its job, because there is "little likelihood that any significant proportion of smugglers will be intercepted and arrested or their drugs and equipment confiscated."³¹

b. Andean Drug Initiative: This 5-year, \$2.2-billion program initiated in 1989 supports interdiction, crop eradication and substitution and military aid activities in Peru, Colombia and Bolivia. Approximately \$1.5 billion has been spent or appropriated for ADI through FY 1993, yet the results have been dismal. During the FY 1993 appropriations process, the Senate Foreign Operations and Export Financing Appropriations Subcommittee expressed its continuing concern about the management and effectiveness of ADI, citing reports of the GAO and State Department Inspector General. The subcommittee noted that coca production has increased and spread to new areas, not decreased, and that official profiteering from the drug trade and human rights abuses by security forces have persisted.³²

The roughly \$700 million remaining in the initiative should be redirected to prevention and treatment activities in the United States, because the initiative has not reduced supplies and is unlikely to do so.

c. United States Coast Guard and Customs Service Activities: The United States Coast Guard and Customs Service are primarily responsible for disrupting drug trafficking into the United States and seizing supplies at the borders. Since FY 1991, the combined budgets of the two entities for these activities has been approximately \$1.1 billion each year.

Notwithstanding this investment, traffickers have been relatively untouched by interdiction efforts, according to the GAO, because they ship drugs in containers or aboard large vessels or fly into Mexico where drugs are moved across the land border in cars, trucks and containers.³³ The Customs Service, itself, set an extremely modest goal for 1992 of examining for illicit drugs only 4% of all containers and 20% of containers from source countries entering the United States.³⁴

The cost-effectiveness of this investment must be seriously examined since only a small amount of cocaine and heroin need evade detection to satisfy the yearly consumption of users in the United States: four Boeing 747 cargo planes or thirteen trailer trucks can supply cocaine consumption for a year, and a twenty-square mile field of opium poppies produces enough heroin to meet annual demand.³⁵

Recommendation:

2. The Federal Government should allocate at least 25% of the asset forfeiture funds expended each year on anti-drug abuse efforts to treatment, prevention and research activities. Last year, such a policy would have sent approximately \$125 million of the Justice Forfeiture Fund and \$7 million of the Customs Service forfeiture money to those highly effective programs.

The federal government and many states authorize the seizure of assets (cash and property) from individuals who commit drug-related or other crimes or are associated with those who do. The Department of Justice and U.S. Customs Service maintain separate forfeiture funds. Both agencies share assets with state and local law enforcement entities when the entity participates in a seizure. While seventeen states allow these assets to be used for alcohol and drug prevention and treatment as well as law enforcement,³⁶ the federal law only permits the funds to be used for law enforcement activities even when assets are turned over to the state and local entities. The Justice Forfeiture Fund distributes approximately \$500 million (of its total fund of \$1.4 billion) each year for law enforcement purposes. The Customs funds included approximately \$205 million in FY 1991, the great majority of which was used for law enforcement activities. Any remaining unobligated Customs forfeiture funds, which totaled over \$50 million in FY 1991 and have averaged over \$27 million annually since 1986, in excess of \$15 million are returned to the Treasury.³⁷

The federal forfeiture law should be amended to allocate a substantial portion — at least 25% — of seized assets to treatment and prevention activities. Last year, such a policy change would have sent over \$130 million to these far more effective approaches. Moreover, the excess unobligated assets from the Customs forfeiture funds that are otherwise returned to the Treasury should be devoted to treatment and prevention activities.

The federal forfeiture laws also often have undercut the state forfeiture laws that require some portion of the assets seized to be spent on treatment and prevention. This occurs because local law enforcement officials sometimes turn over the forfeiture to federal officials, since the federal officials can then give most of the money back to the local law enforcement agency without any part of the money having to be used for treatment and prevention. Thus, at a minimum, the law should be amended to require distribution of assets by states and localities in the same manner as state law provides so that the federal law does not undercut State rules.

II. Fight Crime By Providing Treatment and Prevention Services To All Individuals Involved in the Criminal Justice System Who Have Drug or Alcohol Problems

Recommendation:

The Federal Government should:

- * Allocate a portion of criminal justice and law enforcement funds to pay for comprehensive drug and alcohol treatment in community-based and prison/jail settings;**
- * Expand programs that sentence non-violent drug and alcohol dependent individuals to drug and alcohol treatment and other less costly intermediate sanctions programs; and**
- * Provide funding for juvenile justice programs to develop alternative sentencing and early intervention programs**

Discussion:

The link between drug and alcohol use and crime is irrefutable. Up to 80% of persons arrested in many cities have used drugs within 24 hours prior to arrest,³⁸ and up to 75% of all inmates, probationers and parolees of federal and state prisons and local jails need comprehensive drug treatment and aftercare services.³⁹ Because of the national trend to impose harsher sentences on drug offenders and mandatory minimum sentences on repeat drug offenders, an overwhelming number of individuals who are clogging our courts, jails and prisons are non-violent, drug- or alcohol-dependent persons.

Treatment for individuals involved in the criminal justice system is cost-effective⁴⁰ and dramatically reduces recidivism.⁴¹ Yet, treatment services for incarcerated individuals — many of whom are non-violent offenders who could and should be in treatment programs — are woefully inadequate. According to 1991 government statistics, only 1% of federal inmates, 20% of state inmates and fewer than 10% of jail inmates currently receive adequate services.⁴² Moreover, community-based treatment programs in many states are spending between 30% and 85% of their treatment dollars to serve individuals who are diverted into treatment from the criminal justice system.⁴³ While such diversion programs are essential and cost-effective, they also consume the majority of resources. Additional resources are needed to treat individuals so that they never become involved in the criminal justice system in the first place.

Health dollars alone cannot cover the cost of treating this population. A portion of criminal justice and law enforcement funds must be used to pay for comprehensive treatment in community-based and prison/jail settings, because treatment is effective crime control. To save

money, non-violent drug and alcohol dependent individuals could be sentenced to less costly intermediate/alternative sentencing programs in their communities. The current Administration's policy has not been either cost-effective or crime-effective.

III. Include Coverage for Comprehensive Drug and Alcohol Treatment Services in National Health Care Reform

Recommendation:

The Federal Government and the states must include a comprehensive drug and alcohol treatment benefit in national health care reform proposals. Prevention must be included in this health care discussion.

Discussion:

It is time for the publicly and privately funded drug and alcohol treatment system, which has developed largely outside the primary health care network, to be considered an integral part of our mainstream health system. This will lead to earlier intervention for drug and alcohol problems and will result in substantial cost savings throughout the health care system.

Drug dependence and alcoholism are illnesses for which treatment is cost-effective, saving large amounts of money in emergency room and other far more expensive medical care that will inevitably result if an addict goes untreated. Comprehensive drug and alcohol treatment prevents many diseases, including HIV disease, hepatitis, cirrhosis, cancer, cardiopulmonary and respiratory diseases, and serious physical injuries, including those suffered in auto crashes. Drug and alcohol treatment therefore prevents many other costly treatments any health care system will have to cover.

While the savings generated by alcohol and drug treatment are substantial, the General Accounting Office has concluded that coverage for drug and alcohol treatment does not add substantial costs to a benefit package.⁴⁴

A drug and alcohol treatment benefit must embody the principles of cost and service equity, efficiency, care management, non-discrimination, comprehensiveness and consumer choice. The benefit must cover a wide range of services provided by qualified drug and alcohol counselors and other qualified professionals in the treatment setting that is most appropriate for the individual. In addition, lengths of stay must be determined by qualified providers based on individual treatment plans. To be effective, treatment must be provided over a period of months — in cases where individuals require habilitation, even a year or more — and relapse and resumption of treatment are often a natural part of the recovery process for which reimbursement must be available.⁴⁵ Utilization review procedures must be regulated to ensure that necessary and appropriate treatment is not denied in a misguided effort to save costs in the very short term.

IV. Address the Economic and Social Factors that Contribute to Drug and Alcohol Problems

Recommendation:

Increase government spending to create jobs, adequate and safe housing, better schools and youth programs and community support systems, particularly in poor and inner-city communities.

Discussion:

Steps must be taken to address the environmental factors that contribute to drug and alcohol problems. Unemployment and homelessness are closely linked with increased alcohol and drug use. The disintegration of communities and families leads to despair and violence that make drug and alcohol use an attractive escape. In many drug-infested communities, the drug trade is a major part of the local economy, offering children the most attractive — and too often the only available — employment opportunities.⁴⁶

Increased government spending must be devoted to create jobs, adequate and safe housing, better schools and youth programs and community support systems, particularly in poor and inner-city communities. The development of community based prevention programs can play a central role in community development strategies that address social problems resulting from or linked to alcohol and drug abuse. These steps will not only prevent drug and alcohol problems and prevent relapse among recovering individuals, but will also make our nation more competitive in the global economy.

* * *

New, strong leadership is needed to carry out this strategy. The Office for National Drug Control Policy (ONDCP) should be directed by an individual who acknowledges that drug abuse is driven primarily by demand, not supply,⁴⁷ and that alcohol problems are a major part of our Nation's drug problem and is committed to adequately funding public health approaches that will successfully reduce the demand for drugs and alcohol.

The Director's position should be a cabinet position so that he or she can effectively implement this new strategy. ONDCP should coordinate federal drug and alcohol efforts, without duplicating federal agency activities, and must be staffed by individuals who have expertise in drug and alcohol issues.

ENDNOTES

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13. Centers for Disease Control, **Morbidity and Mortality Weekly Report**, Vol. 39, No. 11, March 23, 1990, p. 174.
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21. See **Treating Drug Problems**, supra at pp. 214-219, 232-33, for an analysis of the sharp reduction in federal treatment funds, adjusted for inflation, from 1975 through 1989, the effect on treatment services, and recommendations for creating a more resource-intensive treatment system.
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MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT: OVERVIEW**I. BACKGROUND**

Mental health and substance abuse services currently are an integral part of health care delivery and will continue to be a fundamental element of the new health care system. The benefit structure for the treatment of individuals with mental and substance abuse disorders under health care reform departs significantly from past approaches. This departure is appropriate as scientific evidence and societal attitudes have coalesced toward an understanding of these disorders as major health problems which, when untreated, generate considerable social and economic costs. There is ample research evidence indicating that mental and substance abuse disorders can be diagnosed reliably and treated effectively. Further, it is increasingly recognized that treatment for mental illness and substance abuse problems yields important benefits such as improvement to overall health, reduced health care costs, increased productivity, potential savings in social welfare expenditures, and potential reductions in crime and criminal justice expenditures.

While the vast majority of private insurance policies include mental health coverage, benefits have been extremely restricted with respect to the scope, volume, and duration of covered services. Typical insurance benefit packages include only inpatient and outpatient services and discriminate between mental health care and general medical care by arbitrarily limiting the number of visits or days of treatment, by establishing lifetime limits for mental health benefits, and by excluding preexisting conditions. The structure of current mental health benefit packages has resulted in a two-tiered system of care consisting of the private sector for the insured population and public sector services for the poor, the uninsured, and for those whose insurance coverage is limited and/or exhausted. Additionally, the structure of mental health benefits has resulted in an overutilization of inpatient care; approximately 70 percent of current mental health care costs are from inpatient services. Excessive and inappropriate hospitalization, particularly for children and adolescents and for substance abuse, has been a major factor in driving up the total cost of mental health care.

A consequence of the current benefit structure has been the creation of excess inpatient capacity in many areas of the country, although shortages in the array of alternative service options exist almost everywhere. Further, the limited benefits have resulted in shifting both the responsibility and cost of care into the public sector mental health and substance abuse systems ("dumping"). For children and adolescents, the burden and cost of care also have been shifted to the child welfare, education, and juvenile justice systems.

Scientific evidence and experience have led to the recognition that a comprehensive array of services, along with the flexibility to provide such services to individuals based upon medical and psychological necessity, produces better outcomes than those experienced with traditional benefits. There is also scientific evidence that capitated approaches result in more efficient use of health care services. Thus, the trend in both the public and private sectors has been toward the development of a comprehensive range of services, many under capitated arrangements, along with management mechanisms to ensure appropriate service delivery.

II. PRINCIPLES GUIDING BENEFIT STRUCTURE

The development of the mental health and substance abuse (MH/SA) benefit was guided by the following principles:

- o The benefit structure should ensure that persons of all ages with mental and substance abuse disorders and their families participate fully in the health care system and that mental health and substance abuse services are available on the same terms and conditions as other medical and health services.
- o The benefit structure should ensure that persons with mental and substance abuse disorders have access to a comprehensive array of services for both acute and extended care, with the flexibility to provide the appropriate types, mix, level, and duration of services based upon medical and psychological necessity for each individual consumer.
- o The benefit structure should encourage the development and use of alternatives to hospitalization, maximize the use of home and community-based treatment approaches, and ensure that services are delivered in the least restrictive environment appropriate to the needs of the individual.
- o The benefit structure should minimize the current two-class, two-tiered service delivery system, shifting of costs and responsibilities, and fragmentation of service delivery by integrating the public and private delivery systems.
- o The benefit structure should encourage early intervention, incorporate incentives to overcome reluctance to initiate mental health and substance abuse treatment, and remove financial barriers to early intervention.
- o The benefit structure should ensure the availability and provision of comprehensive and appropriate services within organized systems of care for individuals with serious and persistent mental and substance abuse disorders.

There is considerable consensus among multiple and diverse constituencies including policy makers, providers, researchers, educators, advocates, families, and members of the business community regarding these principles.

III. ELIGIBILITY

Mental and substance abuse disorders occur at yearly rates comparable to other diseases, and service use rates also are analogous to those for other disorders, with approximately 5.9 percent of the U.S. population using specialty mental health services. Despite comparability to other health services, continuing concerns raised with respect to mental health and substance abuse benefits are related to ensuring appropriate utilization of resources. One such concern is that, without the imposition of special limits, services may potentially be overused or inappropriately used. In fact, there is evidence to support the countervailing view that individuals who should be receiving treatment often avoid it, costing themselves, their families, and society "unnecessary" expense in the long run. Another

concern is the potential for undertreatment of mental health and substance abuse disorders because that has largely been the history of managed care. In the new health care system, financial incentives, along with appropriate standards and monitoring activities, are required to ensure that necessary and appropriate mental health and substance abuse treatment is provided.

To protect against inappropriate use of services and to better target resources, the following eligibility criteria are suggested: All persons are eligible for screening and assessment and 24-hour crisis services. Persons are eligible for mental health and substance abuse services other than screening and assessment and crisis services if they have, or have had in the past year, a diagnosable mental or substance abuse disorder that resulted in or poses a serious risk for functional impairment in family, work, school, or community activities. Further, family members of an eligible enrollee may receive necessary and appropriately related services (so-called collateral treatment).

IV. STRUCTURE OF BENEFIT

The benefit provides access to a broad array of services for persons of all ages with mental health and substance abuse disorders. It covers acute, extended, and rehabilitative care and eliminates arbitrary limits, thereby making mental health benefits consistent with other health benefits. AHPs have the flexibility to determine the most appropriate mix, volume, and duration of services for each individual based upon medical and psychological necessity. The approach creates a capitated budget for the treatment of persons with MH/SA disorders and relies upon a variety of management approaches to ensure that appropriate and cost-effective services are delivered. Cost sharing for mental health and substance abuse services is based upon the same principles as cost sharing requirements for other health services. By covering both acute and extended care services, the approach creates an integrated system of MH/SA services, eliminating the historically two-tiered system. Further, the approach shifts incentives from expensive hospital and institutional care by providing coverage for a wide range of cost-effective, community-based service options.

The array of the services included in the benefit is comprised of:

- o Screening and Assessment
- o 24 - Hour Crisis Services - Telephone Crisis Services, Walk-in Crisis Services, Mobile Outreach Crisis Services, Crisis Residential Services
- o Nonresidential Treatment Services - Medical Management, Prescription Drugs, Somatic Treatments, Ambulatory Detoxification, Outpatient Therapy (Individual, Family, and Group Therapy; Family Education/Support; Substance Abuse Counseling; Substance Abuse Relapse Prevention), Home and Community Services (Assertive Community Treatment; Home-Based Services; Therapeutic Respite Services; Behavioral Aide Services), Day Services (Partial Hospitalization; Day Treatment; Psychosocial Rehabilitation)
- o Residential Treatment and Inpatient Services - Residential Treatment Services (Therapeutic Family Homes; Therapeutic Group Homes; Residential Treatment Centers; Community Residential Treatment - Adults; Community Residential Treatment and Recovery - Substance Abuse; Residential Detoxification Services; Other Residential Treatment), Inpatient Hospital Services
- o Case Management Services - Service Coordination, Clinical Case Management Services

The services included in the MH/SA benefit can be provided in a wide range of settings and environments including offices, clinics, community mental health centers, homes, schools, hospitals, residential treatment facilities and other locations appropriate to the needs of consumers. In addition, all services will be provided by qualified MH/SA professionals, certified paraprofessionals, and staff under the supervision of licensed or certified MH/SA providers. States will continue to be responsible for licensing and certifying professionals and treatment facilities.

AHPs must ensure appropriate access to MH/SA services by having available multiple MH/SA specialists. For persons with serious and persistent MH/SA disorders, it is expected that AHPs will use multidisciplinary teams to develop individualized treatment plans and will have organized systems of care that provide an array of services, intensive case management, frequent case review, and close coordination with other agencies providing related services such as education and housing. It is recognized that other related and supportive services are required by persons with serious MH/SA disorders. AHPs must ensure that MH/SA providers establish linkages with agencies providing these services (e.g. education, child welfare, housing, vocational rehabilitation, transportation, legal, etc.) and that, at the client level, case managers are available to access and coordinate related and supportive services. A federal "enabling fund" is recommended to facilitate linkages at the HIPC, AHP, and client levels with other systems and agencies providing related services.

VI. MANAGEMENT APPROACHES

As noted, the MH/SA benefit makes available a wide range of diagnostic, treatment, and rehabilitative services to AHP enrollees, with service delivery based upon medical and psychological necessity rather than arbitrary constraints established by benefit design. Universal access to such coverage, however, does not mean that all people, at their own discretion, receive unlimited services. Rather, the approach is capitated, which establishes budgetary parameters for MH/SA service delivery (consistent with the overall reformed health care system), and is dependent upon specific management approaches to ensure that services and resources are utilized appropriately. Some previous attempts at managed care functioned with severely limited mental health benefits along with the ability to shift costs to the public sector, resulting in a tendency to focus more on managing costs than on managing care. The MH/SA benefit structure under health care reform emphasizes mechanisms to manage care and to ensure that individuals receive the appropriate scope, volume, and duration of services commensurate with need and severity of illness. Management strategies may include screeners with MH/SA expertise, case management, multidisciplinary teams to develop and monitor individualized treatment plans for persons with complex disorders, precertification, concurrent review, various provider arrangements, and organized systems of care for persons with severe and persistent MH/SA disorders.

While some degree of choice may be forfeited under this approach, consumers gain access to a broad array of treatment and rehabilitative services and are protected from financial risk resulting from MH/SA disorders -- neither of which consumers currently enjoy. Further, consumers receiving services from the public sector rarely have the opportunity to select either the agencies or providers from whom they will receive services. Demonstration research has shown that not only does this type of flexible, managed benefit structure result in more appropriate care, but it does so at reasonable cost. In fact, capitation coupled with management mechanisms have been shown to be more effective in controlling utilization and costs than the often-used limits on benefits and high cost sharing requirements. Examples of such approaches in both public and private sector environments have

resulted in reductions in utilization of inpatient and residential treatment, expanded use of an array of alternative home and community-based services, cost savings, and high levels of consumer satisfaction.

Within this framework, strategies are necessary to address possible incentives for risk selection and undertreatment. The approach incorporates the use of risk adjustment along with standards, quality measures, and monitoring mechanisms to reverse any such incentives. A combined prospective and retrospective risk adjustment approach is recommended, and specific standards and measures are recommended in order to monitor service access, quality, and outcomes, with particular attention to populations with severe and persistent MH/SA disorders and typically underserved populations.

VII. PUBLIC SECTOR ROLE

The MH/SA benefit integrates the public and private sectors, placing responsibility for MH/SA care within the new health care system. This approach requires that the current state and local investment in MH/SA services be retained and incorporated in the new system in order to ensure financial viability. The approach also necessitates a shift in the role of state-supported public mental health and substance abuse systems which, unlike general health care, have historically played a major service delivery role. Under the new system, state mental health delivery systems will continue to provide forensic beds and retain responsibility for this population and will also retain some number of state psychiatric beds which can be purchased by AHPs based on customary costs per bed day. Beyond these basic service delivery functions, states will have considerable latitude to determine the role of its existing public sector delivery system.

There are compelling reasons to retain publicly funded programs that would contribute to the new MH/SA system both during a transition period and thereafter. Publicly funded providers with MH/SA service capacity may be, at state discretion, designated as "preferred providers" to be part of the MH/SA service networks provided by AHPs for a specified period of time (five years is recommended) after which they would be viewed as competitors. State MH/SA agencies will retain primary responsibility for planning, regulating, monitoring, capacity development, outreach, and prevention activities.

VIII. MAJOR ADVANTAGES AND CHALLENGES

The MH/SA benefit presents an unprecedented opportunity to create an integrated MH/SA service delivery system which provides a continuum of services and in which service delivery is based upon need. The approach has many clear advantages including:

- o Expands coverage for MH/SA services to persons who are currently uninsured and those with limited coverage and eliminates patient financial risk.
- o Creates a unitary, integrated MH/SA treatment system, eliminating the current two-tiered, two-class system and minimizing the potential for cost shifting to the public sector, fragmentation, and gaming.
- o Encourages the development and use of more cost-effective home and community-based services and discourages the use of more costly, more restrictive service options.
- o Incorporates the flexibility to provide services based upon need rather than on arbitrary limits or a narrow range of covered services established by benefit design, relying upon management

- approaches to ensure appropriate service utilization.
- o Creates organized systems of care for persons with severe and persistent disorders.
- o Distributes the risk pool fairly by spreading risk across the broadest population group.
- o Is consistent with the benefit plan created for other health services.

The effective implementation of the MH/SA benefit within the new health care system involves successfully addressing several inherent challenges. First, the system must incorporate safeguards to counter potential incentives of capitation for undertreatment, particularly for persons with severe disorders. Risk adjustment of AHP premiums, standards, and monitoring mechanisms are among the strategies proposed to minimize potential undertreatment and to ensure that persons with severe disorders receive appropriate services.

A second major challenge stems from the recognition that allowable services are not uniformly available or accessible and that many providers have little experience in providing services beyond traditional inpatient and outpatient care. The approach requires an investment in the development of both the service capacities and human resources needed to provide the services included in the benefit package. It is recommended that service capacity and human resource development be a responsibility shared by federal and state governments and that a specific funding stream be created to develop needed MH/SA service capacities and train MH/SA providers.

MENTAL HEALTH AND SUBSTANCE ABUSE

Background

- ▶ Estimates put the annual economic cost to society of mental illness and substance abuse at \$273 billion including direct care, lost productivity, social welfare and the criminal justice system.
- ▶ In the health care system, mental and addictive disorders account for \$80.7 billion of the total cost, or 12 percent.
- ▶ Subtracting research and education costs, that amounts to an overall cost of about \$300 per person per year in current system.
- ▶ Approximately 5.9 percent of U.S. population -- 10.9 million people -- use mental health and substance abuse services.

THE CURRENT SYSTEM

- ▶ **The current delivery system is fragmented.**
- ▶ **Traditional insurance benefit packages discriminate between mental health care and general medical care by arbitrarily limiting the number of days of treatment, number of visits to clinics or lifetime benefits. Most exclude preexisting conditions.**
- ▶ **Existing system creates two classes of care, one private and one public, with marked differences in quality.**
 - o **Most insured care delivered through private providers, which includes acute, long-term and out-patient care.**
 - o **States and local governments spend \$17.3 billion – 29 percent of total spending for mental and addictive disorders.**
 - o **Two-tiered system creates incentives for "dumping" severely ill.**
- ▶ **Traditional insurance creates financial barriers to early intervention.**

PRINCIPLES GUIDING MENTAL HEALTH AND SUBSTANCE ABUSE PLAN DEVELOPMENT

- ▶ **Each of the options that will be described founded on set of critical principles. They are:**
 - o **The need to recognize that mental health and substance abuse problems fundamentally resemble all other health problems.**
 - o **Treatments are available that are as effective as treatments for other forms of illness.**
 - o **Treatment produces important effects, including:**
 - **Improvement to overall health**
 - **Increased productivity**
 - **Reduced health care costs**
 - **Potential savings in social welfare spending**
 - **Potential reductions in crime and criminal justice expenditures**
- ▶ **To reap those benefits, health care reform must end fragmentation, integrate services and remove barriers to care.**

Needed change involves:

- o **Altering financing mechanisms to create incentives for the development of integrated delivery systems, consistent with health care reform.**

- o Providing a comprehensive benefit for both short-term acute care and extended care.**
 - o Assuring adequate access to care for low-income, under-insured and underserved populations.**
- ▶ Health care reform also must allow flexibility to assure the delivery of appropriate care. Including:**
 - o Encouraging the development and use of lower-cost alternatives to hospitalization**
 - o Making available a broad array of community and home-based services**
 - o Removing financial barriers to early intervention**
- ▶ In sum, it must include coverage for mental health and substance abuse in the comprehensive national benefits package on same basis as other illnesses.**

OPTION I **COMPREHENSIVE** **PLAN**

- ▶ This model based on research findings that ability to deliver a comprehensive array of treatment is most effective.
- ▶ Create a capitated budget for the treatment of patients with mental illness and substance addiction, consistent with managed competition and health care reform.

Benefit

- ▶ Makes benefit consistent with other health care, eliminating arbitrary limits and simplifying design.
- ▶ Covers both acute and extended care, providing access to appropriate -- or cost effective -- services.
 - Comprehensive array of services includes: inpatient, partial hospitalization, home-based care, medical management, psychotherapy, substance abuse counseling, intensive case management, rehabilitation, extended day treatment, respite care, half-way houses, and therapeutic community treatment for substance abuse.
- ▶ Allows Accountable Health Plan flexibility to determine the volume and mix of services.

Implications of this Model

- ▶ **Integrates acute and extended care systems.**
 - Carries potential to eliminate public sector safety net.
- ▶ **Requires shifting \$17.3 billion of current state and local funding into new health care system.**
 - Possible mechanisms such as: re-insurance, state and local match, shared funding formula, or some other mechanism.
 - Under this model, each state will determine role of its existing public sector.
 - States will have flexibility to integrate public sector with a range that include: retaining public providers in some role or function, competing as a provider, or phasing out direct service delivery.
 - Federal government could require maintenance of some public sector safety net (capacity) for forensic patients and the 34,000 people who remain in state psychiatric hospitals year round.

COST ESTIMATE FOR COMPREHENSIVE PLAN

Plan Cost
per enrollee

Out-of-Pocket Cost

Public Cost
per capita
U.S. Pop.

\$233*

\$0

\$57.25**

*Includes Medicaid, VA, state and local mental health and substance abuse funding

**Nursing home care mentally ill aged 65+

OPTION II

- ▶ **This model offers some improvement over typical benefit package, provides some increased flexibility and incentives to use lower-cost treatment approaches.**

Benefit

- ▶ **Covers 90 percent of acute-care treatment, eliminating two-class system for that level of care.**
- ▶ **Features more sophisticated benefit design than traditional insurance package:**
 - **Variable cost-sharing (on psychotherapy initial 12 visits with 20 percent co-payment increasing to 50 percent co-payment for additional visits).**
 - **Allows substitution of less costly services (i.e., trade annual limit on hospital days for less expensive "partial hospitalization" or home-based services).**
- ▶ **Covers evaluation, assessment and clinical management.**
- ▶ **Expands range of services (including alternative in-patient settings, partial hospitalization and home-based services).**

Implications of this Model:

- **Requires retention of the public sector safety net.**
- **Perpetuates two-tier system with public focus on extended care and hard-to-treat patients.**
- **Amounts to a reduction in services to disabled under Medicaid in some states.**
- **Perpetuates exposure to significant financial risk for patients and their families.**

COST ESTIMATE FEE FOR SERVICE OPTION

Plan Cost
per enrollee

Out-of-Pocket Cost

Public Cost
per capita
U.S. Pop.

\$131.59*

\$50.55

\$132**

*premium cost for currently insured, and currently uninsured, excludes Medicaid, Medicare, and continuing care costs in public system

**includes continuing care under Medicaid, public system, VA, and Medicare

ASPECTS OF BOTH PLANS

- ▶ **Both models depend on implementation of clinical care guidelines and outcome measures.**
- ▶ **Health care reform builds into system strong incentives and safeguards against over-treatment, assuring appropriate use of resources.**
- ▶ **As discussed in an earlier briefing, health care reform will include mechanisms for safeguarding vulnerable populations.**

That protection will serve to counterbalance incentives to under-treat people with severe mental illness and substance abuse disorders

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

SERVICES	OPTION I COMPREHENSIVE	OPTION II
<u>24 HOUR CARE AND ALTERNATIVES</u> Inpatient hospital Other treatment centers	Acute and extended care covered. Accountable Health Plans have flexibility to determine the volume and mix of services without limitations	Acute care: 30 days per episode 90 day annual / can be reserve One day de- ductible ----- Substance Abuse residential care (no inpatient acute hospital except for detox) 30 days per episode 60 days annual / can be reserve one day deductible
Hospital Detox for substance abuse	Flexible coverage based on treatment guidelines	No limit on medical detox Non-medical detox covered above

Services Partial/day hospital/ psychosocial rehab	Comprehensive Flexible coverage based on treatment guidelines	Plan I Two for one trade against 90 day annual up to 180 days one day deductible Substance Abuse Two for one trade up to 120 days
Home-based (not less than 4 hrs./day or 10 hours per week)	flexible coverage with treatment guidelines	Three for one trade up to 180 days one day deductible Not applicable to substance abuse
<u>Outpatient</u> Assessment and diagnosis Crisis management Medical management and medications	Flexible coverage based on treatment guidelines	Parity with other health care
Psychotherapy individual, group, family Substance Abuse Counseling (lower reimbursement rate than psychotherapy)	Flexible coverage based on treatment guidelines Flexible coverage based on treatment guidelines	20% co-pay for 12 visits, then 50% copay No limits on visits 20% co-pay with 55 visit limit 20% co-pay with 10 visit limit for other affected family members

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February 4, 1994

Jose Cerda
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Dear Jose:

We are pleased to provide a copy of a new report **Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches**, prepared by Lewin-VHI, Inc.

The report contains the most up-to-date and detailed information on what our Nation currently spends on substance abuse treatment and the scope, cost and duration of care in both the public and private treatment sectors. It also discusses the cost of various models for reforming the substance abuse treatment system, including the benefit in the Health Security Act and a comprehensive substance abuse benefit. We believe this information will be invaluable as you continue to craft health care reform legislation.

Among the most important findings of the report is that a comprehensive substance abuse benefit would cost only \$45/covered life -- \$3 less than the \$48/covered life the Administration has estimated the limited substance abuse benefit in the Health Security Act to cost.

This cost is a drop-in-the-bucket compared to the \$700 each American pays every year for the health, social, and criminal costs resulting from drug and alcohol use. Indeed, the Treatment Outcome Prospective Study (TOPS) found that the savings realized in these areas while someone is in treatment is by itself sufficient to pay for that care.

The report was prepared for six national organizations that focus on drug and alcohol issues: the Legal Action Center, National Association of Addiction Treatment Providers, National Association of Alcoholism and Drug Abuse Counselors, National Council on Alcoholism and Drug Dependence, Therapeutic Communities of America and Hazelden Foundation.

Please contact Ellen Weber or Susan Galbraith at (202)544-5478 if you have questions about the report.

Sincerely,



Paul N. Samuels
Director/President



Ellen M. Weber
Co-Director for
National Policy



Susan Galbraith
Co-Director for
National Policy

Final Report

**HEALTHCARE REFORM AND SUBSTANCE ABUSE TREATMENT:
The Cost of Financing Under Alternative Approaches**

by

**Henrick J. Harwood
Martin Thomsom
Travis Nesmith**

**Lewin-VHI, Inc.
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For

**Legal Action Center
National Association of Addiction Treatment Providers
National Association of Alcoholism and Drug Abuse Counselors
National Council on Alcoholism and Drug Dependence
Therapeutic Communities of America**

February 2, 1994

HEALTHCARE REFORM AND SUBSTANCE ABUSE TREATMENT:

The Cost of Financing Under Alternative Approaches

Executive Summary

Lewin-VHI, Inc.
9302 Lee Highway, Fairfax, VA 22031

Healthcare reform holds out both a significant opportunity and a major threat to the goal of providing universal and timely access to effective substance abuse treatment. The threat is posed by reforms that would implement a limited benefit that does not provide for a full continuum of services needed by individuals with drug and alcohol problems, while at the same time inadequately funding the existing publicly funded system that has served as a "safety net" for all individuals, whether privately insured or not.

The opportunity exists to fashion a comprehensive substance abuse benefit to:

- provide universal and timely access to substance abuse treatment;
- cover the complete continuum of services (from clinical preventive services, to acute hospital care, extended residential and ambulatory services, and continuing care);
- provide for adequate quality, intensity and duration of care; and
- use uniform assessment and placement criteria.

It should be emphasized that there are different ways in which this goal can be achieved, encompassing private market-oriented systems, public systems of various types and "mixed" systems. This analysis does not endorse a particular approach. Rather, the objective is twofold: first, it will illuminate some fundamental characteristics of the current system of financing substance abuse services. Second, it will examine the cost and treatment utilization of five broadly-cast, alternative approaches to reform, including the Administration's substance abuse benefit as described in the Health Security Act.

This report does not examine the implications of subtle changes in coverage, such as differences in deductibles and copayments, or specific types or amounts of services. The data and empirical literature on the financing of and demand for substance abuse treatment is not adequate to provide support for such analysis.

Summary statistics for the current treatment system and the five alternatives are presented in Exhibit A. Because the alternative proposals have different objectives in terms of the publicly- and privately-reimbursed treatment systems, respectively, the summary data are presented for these two treatment delivery sectors, as well as for the complete national treatment system.

The Current System

It is estimated that in 1993 about 3 million persons obtained specialized substance abuse treatment at a cost of about \$6.7 billion. This generally excludes care not delivered by specialized providers, such as treatment of substance abusers in the general wards of hospitals, or by most physicians in their offices. Hospital care delivered in specialty wards accounts for about \$1.7 billion, versus \$2.2 billion for outpatient treatment, \$1.1 billion for long-term residential, \$950 million for short-term residential, \$480 million for methadone treatment \$250 million for detoxification centers and \$90 million for private practitioners (e.g., psychiatrists and psychologists). These estimates include the cost of about 600,000 hospital-based inpatient episodes delivered in specialty wards at a cost of almost \$3,000 per admission.

Inpatient treatment episodes delivered in general hospital wards are excluded from the above estimates and all subsequent calculations because: such care does not generally provide specialized rehabilitation services for substance abuse; is often motivated by comorbidities of substance abuse (e.g., liver disease) or acute emergencies related to alcohol or drug poisoning/overdose or withdrawal. Most importantly, these costs should not generally be attributed to a substance abuse treatment (rehabilitation) benefit because such acute care would virtually always be delivered to an afflicted patient even if substance abuse services were not covered in an acutely "life-threatening" situation.

Most of the \$6.7 billion in 1993 funding came from public sources (\$4.33 billion), with private insurance payments of \$1.6 billion and client payments of \$770 million. It is plausible that 20 percent of public reimbursements are for clients that have private health insurance. Roughly 160 million persons had private health insurance, and another 100 million persons depended on public financing of health services through Medicaid, Medicare, the Department of Veterans' Affairs, or direct funding of care for the uninsured.

There are major differences in the types of care purchased by private insurance and by public financing. Private insurance purchases proportionately more hospital and short-term residential care, while public programs generally provide more outpatient and long-term residential care. Privately-reimbursed care usually has limits on the amount of care that will be reimbursed, and is generally of significantly shorter duration than publicly-reimbursed treatment. These differences between care reimbursed under private insurance and by publicly-subsidized programs are the primary source of the differences between the five general approaches to healthcare financing reform that are analyzed below.

A Comprehensive Benefit

A comprehensive substance abuse treatment expansion and improvement benefit similar to that proposed by the Legal Action Center (LAC) is estimated to cost \$11.725 billion per year (\$45.10 per person in the U.S.). This is \$4 billion above the \$6.7 billion that will be spent to treat 3 million persons in 1993 (\$25.75 per person). The comprehensive benefit would apply to both private and public health insurance plans, with provisions for patient assessment and referral, coverage of a complete range of services, generous limits on services, and increased intensity of therapeutic services with increased levels of reimbursement for non-hospital services

Under a comprehensive benefit improved quality treatment would be delivered to 3.3 million persons per year, who would utilize a total of 6.3 million treatment episodes. These estimates are dependent on the assumption that a comprehensive plan would increase the number of persons accessing care by 10 percent. It is possible that the increase could be greater than this level, based on the experience of the Minnesota Consolidated Fund, and the differentials in utilization of general health care services between the uninsured and insured populations.

The Health Security Act Proposal

The Health Security Act (HSA) by itself is unlikely to alleviate the existing problem of limited access to substance abuse treatment. Up to 60 million currently uninsured and Medicaid beneficiaries will gain coverage under Health Plans set up under the HSA. However, both this population and those currently insured will continue to have a heavy reliance on publicly funded treatment for a number of years. This is because coverage under the HSA is oriented to "brief interventions" and short-term treatment and generally would not cover more intensive and longer-term services many of the 3 million clients in substance abuse treatment now receive.

The 225 million persons that would be enrolled in Health Plans would use Plan-covered substance abuse treatment services costing \$3 billion. Plans would pay \$2.3 billion, and patients would make copayments for plan-covered services of \$754 million. Estimates are based on 1993 population and costs. However, this would provide only relatively short duration services that may not be appropriate for severe/chronic substance abusers. Consequently, such individuals would need to make recourse to the publicly-subsidized treatment system for further treatment. Costs for services in excess of those covered under the HSA for the 225 million persons in Health Plans could require an additional \$2.24 billion in publicly-funded treatment services (plus out-of-pocket payments of \$121 million). This is the cost for enrollees to receive about the same level of care currently being utilized.

The 35 million persons not expected to join HSA Health Plans--the disabled and elderly Medicare population and others reliant on government programs (e.g. veterans, Native Americans)--are expected to continue to require \$1.4 billion in publicly-funded substance abuse services and pay about \$75 million out-of-pocket for these services

Improved Public "Safety Net" Coverage: The Minnesota Consolidated Fund

If health care reform does not happen, or takes a limited approach either in terms of how many people are covered, or what or how many services are covered it will be incumbent to maintain a publicly-subsidized substance abuse treatment "safety net". One approach analyzed was modeled after the Minnesota "Consolidated Fund".

The Consolidated Fund: covered those with low incomes; uses standardized assessment and referral criteria; coordinates disparate public payment sources (Medicaid, General Assistance, state appropriations and Federal Block Grant funds); and covers a broad range of services (e.g., hospital, residential, outpatient and combined, but not detoxification services). Costs of using this approach are relatively high because the Minnesota Consolidated Fund pays for relatively more inpatient and residential care than is customary in other states, and average stay in treatment

appears to be greater. A typical treatment admission costs Minnesota about \$2800, compared to a national average of about \$1200. Therefore, while the Consolidated Fund may be an appropriate model for building an improved "safety net," it is not clear that the cost of services would mirror the Minnesota experience.

Under this approach it would cost the public system \$11.5 billion to treat an estimated 2.3 million persons, who would utilize 4.4 million episodes of publicly-subsidized care. There would also be continued costs of \$2.17 billion for the privately financed system, for total costs of \$13.7 billion. Based on the estimate that about 20 percent of publicly-subsidized treatment is provided to privately insured persons, this suggests that \$2.236 billion in public treatment funds would go to subsidize those with private insurance (with out of pocket payments of \$119).

An Expanded Private Insurance Residential and Outpatient Benefit

This proposal would yield clear benefits for privately-insured patients, and might provide about \$500 million in relief to the public treatment system by reduced use by privately-insured patients. The proposal would require private insurance coverage of short-term residential treatment (and substitute this type of care for much rehabilitation currently delivered in hospitals) and would increase the reimbursable amount of ambulatory care up to 130 hours per year. Such a proposal would result in a modest increase in treatment expenditures for privately-insured individuals, from \$2.11 billion under the current plans to \$2.36 billion per year (for both insurance payments plus client out-of-pocket payments). This would pay for increased amounts of treatment of 1 million individuals that currently obtain substance abuse treatment under private insurance.

The proposal implies significant shifts for privately insured individuals in where and how services are delivered: hospital utilization would drop from \$1.067 billion (for 219,000 patients) to \$355 million (for an equivalent of 73,000 patients); short-term residential services would rise from \$385 million (for 153,000 patients) to \$825 million (for an equivalent of 239,000 patients); and outpatient services would increase from \$497 million to \$1.009 billion for the same number of clients due to a significant increase in the length of stay.

It is assumed that the publicly-subsidized system would maintain funding and services at its current level, however there would be a material reduction in the utilization of this financing system by those with private insurance. The publicly-subsidized treatment system could gain about \$500 million from reduced use by privately-insured individuals that exhaust their coverage and need more treatment. This could be used to expand services for those without private insurance.

Limited Private or Small Market Reform

Enactment of a very limited private insurance benefit modeled after "tightly managed" benefits often provided by HMOs (and increasingly used by many private insurance plans) would cost insurance plans \$1.49 billion (\$9.30 per covered life per year). The minimum coverage would be 30 days per year for inpatient/residential care, and 20 outpatient visits, with heavy reliance on managed care to keep treatment episodes down to short durations and exclusion of chronic/severe patients (with referral to the public "safety net" programs).

The public system would require funding of \$5.97 billion in order to treat its current clients plus treat the additional privately-insured clients that might no longer receive treatment under this approach to reform.

Based on service delivery patterns of HMOs it is projected that 5.3 million of the 160 million privately-insured persons per year would access some substance abuse-related service, but only 740,000 treatment episodes would be delivered to 390,000 persons--the remainder would receive other services such as "brief interventions." This would imply a decrease of about 610,000 persons receiving privately-insured treatment, that could potentially place an added requirement for \$1.4 billion in treatment services on the public system (over and above the \$866 million currently delivered to privately insured persons persons by the public system).

EXHIBIT A
SUBSTANCE ABUSE EXPENDITURES AND CLIENTS SERVED IN 1993
AND UNDER FIVE HEALTHCARE REFORM PROPOSALS

	Current System	Compre- hensive Plan	Health Security Act	Minnesota Consolidated Fund	Private Sector	
					Expanded Benefit	Limited Benefit
Total System						
Expenditures (\$ in Billions)	\$6.70	\$11.73	\$6.74 ¹	\$13.72	\$6.93	\$7.46
Lives Covered (Millions)	260	260	260	260	260	260
\$ per Covered Life	\$25.75	\$45.10	\$25.90	\$52.75	\$26.65	\$28.70
Annual Clients (Millions)	3	3.3	3	3.3	3	3
Admissions (Millions)	5.8	6.4	5.8	6.3	5.8	5.7
ALOS (Days/year)	125	145	101	155	137	130
Publicly-Subsidized System						
Expenditures (\$ in Billions)	\$4.57	NA	\$3.69	\$11.55	\$4.57	\$5.97
Lives Covered (Millions)	100	NA	35	130	100	100
\$ per Covered Life	\$45.70	NA	\$105.45	\$88.85	\$45.70	\$59.70
Annual Clients (Millions)	2	NA	1.6	2.3	2	2.6
Admissions (Millions)	3.9	NA	3.1	4.4	3.9	4.95
ALOS (Days/year)	140	NA	140	194	140	140
Public Subsidy to Privately Insured (\$ in Millions)	\$866	NA	\$2,284	\$2,236	\$300	\$2,198
Privately-Reimbursed System						
Expenditures (\$ in Billions)	\$2.17	NA	\$3.05	\$2.17	\$2.36	\$1.49
Lives Covered (Millions)	160	NA	225	160	160	160
\$ per Covered Life	\$13.55	NA	\$13.55	\$13.55	\$14.75	\$9.30
Annual Clients (Millions)	1	NA	1.4	1	1	0.39
Admissions (Millions)	1.9	NA	2.7	1.9	1.9	0.74
ALOS (Days/year)	65	NA	65	65	130	63

Source: Analysis by Lewin-VHI, Inc.

ALOS: Average length of stay, or time enrolled in treatment per year.

¹The Administration has estimated current expenditures on substance abuse treatment at \$11 billion, or about \$48 per covered life for about 230 million persons (Memorandum dated January 5, 1994 from the Office of Health Policy, DHHS). The large difference between this study and Administration estimates is due to their use of much higher estimates of the cost of hospital care for substance abuse treatment.

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HEALTHCARE REFORM AND SUBSTANCE ABUSE TREATMENT: The Cost of Financing Under Alternative Approaches

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I. Introduction

Treatment for substance abuse is a successful, proven strategy to reduce the prevalence and consequences of substance abuse. Substance abusers that enter treatment have a fighting chance to end or reduce their dependence on alcohol and illicit drugs. Without treatment the odds of a substance abuser ending or reducing their dependence are significantly poorer. While substantial work is underway to improve the delivery of current treatments and develop new and better treatments, the clear weight of research has concluded that treatment is "cost-beneficial," or at the least a "good bet" for our nation to invest in (Institute of Medicine, 1990a; Institute of Medicine, 1990b). Expanding access to cost-effective substance abuse treatment is a major and viable option for public policy.

This report estimates that currently about 3 million persons per year get specialized substance abuse treatment. This number can be contrasted to estimates that there are 18 million alcohol abusers and alcoholics and 5 to 6 million abusers of illicit drugs. The purpose of this report is to analyze five options for reforming the financing of substance abuse treatment. Estimates are presented for the cost of several "prototypical" financing reform proposals that are designed to change the organization, delivery and access to treatment.

There are both financial and other reasons for this treatment "gap" between the number of persons that "need" treatment and the number that obtain treatment. Many experts assert that the main reason is that substance abusers resist going to treatment because drug and alcohol problems are stigmatized diseases and disclosure of such conditions may have serious implications. In addition, clinicians point out that most substance abusers deny that they even have a problem. However, it is also clear that public and private financing of treatment can influence the number of those that currently seek to, and actually enter treatment, either voluntarily or due to external motivations (such as family, job-related or legal pressures).

In general, this report makes the conservative assumption that changed (increased) financing would evoke only a modest overall increase in the demand for and utilization of substance abuse treatment. This is predicated on the reality that many substance abusers resist going to treatment, and the experience of the State of Minnesota that a major reform in treatment financing was only accompanied by total increase in treatment utilization of about 10 percent over about two years. In fact, most of the health reform options examined in this report do not propose expanded funding

for treatment, but rather changes in the organization and management of treatment and treatment financing.

Other forces that might increase the demand for treatment are excluded from this analysis, although they may well be more important and of greater absolute magnitude than improved financing in influencing the demand for treatment in a given time or place. For example, society has only made limited efforts at attracting substance abusers into treatment through community and medical practitioner outreach, work site programs or criminal justice programs. Much more could easily be done and it can be anticipated that such efforts would have dramatic effects in increasing the demand for treatment, whether funding is available to satisfy that demand or not.

It has not been our objective to either model epidemiological trends in use and abuse of alcohol and illicit drugs, nor to evaluate how actively society will work to attract substance abusers into treatment through community and medical practitioner outreach, work site programs, or criminal justice efforts. For example, there are about 14 million arrests per year, and it is conceivable that one quarter to a third of these individuals could benefit from treatment for alcohol or drug problems.

Nonetheless, at the present time it appears that only a fraction of those that could benefit from treatment actually get services. It is assumed for the purposes of this analysis that society will neither substantially increase nor reduce its efforts to identify substance abusers through its various institutions and get them into treatment and that factors such as denial and stigma will continue to limit the number of individuals who come forward for treatment.

Another central assumption of this report is that alcohol and drug abuse treatment is effective and should be made more widely available. Treatment effectiveness has been widely debated, and several major recent studies have concluded that the evidence for effectiveness is very good, if not definitive (Institute of Medicine 1990a; Institute of Medicine 1990b).

Also, this report explores the cost impact of several different patterns of matching patients to types of treatment. There are strong differences in referral/matching patterns between privately and publicly reimbursed treatment, and within publicly reimbursed systems there are further differences, as evidenced by the Minnesota Consolidated Fund data examined in this report. However, it should be noted that there is strong evidence that long term treatment retention (more than three months) is generally strongly correlated with improved treatment outcomes, both for alcohol and drug treatment.

The following sections of this report will briefly review what is known about the need for substance abuse treatment in the United States, examine data on the economic impact of alcohol and drug abuse, present an original analysis of the current provision of substance abuse treatment in the United States, describe several major approaches to reforming the financing for substance abuse treatment and define how they have been modeled. The results are summarized for the reform options, and then some implications of these findings are briefly discussed.

II. The Need for Substance Abuse Treatment

There are 21 to 22 million individuals with alcohol or drug problems that could benefit from treatment. Most of these--18 million--have alcohol problems (NIAAA, 1990). About 5 to 6 million persons have drug problems (Institute of Medicine, 1990; ONDCP 1991) of whom probably half (2.5 to 3 million) are also counted in the estimates of alcohol problems.

The prevalence of substance abuse is difficult, but not impossible to measure. Household surveys (e.g., the National Household Survey of Drug Abuse) provide useful evidence of the scope of drug use within the total population; however, these surveys may underestimate drug use because many heavy drug users do not live in households, and because many individuals may be reluctant to report use of illicit drugs (ONDCP, 1991). Other targeted studies attempt to estimate the prevalence of substance use in special populations (e.g., pregnant women, criminal justice populations, the homeless).

Estimates from the 1991 National Household Survey on Drug Abuse indicate that about 103 million people used alcohol and 12.6 million people used any illicit drug in the 30 days prior to the survey, including about 1.9 million people who used cocaine (NIDA, 1992). About 1.6 million people reportedly used cocaine 12 or more times in the prior year. Almost 43 million people used alcohol at least once a week in the year prior to the survey. Recent estimates of heroin use suggest that there are about 0.7 million regular heroin users (ONDCP, June 1991).

Recognizing that many persons who use alcohol and other drugs do not require treatment, recent studies have attempted to identify the need for substance abuse treatment within the population of users (Institute of Medicine, 1990). The IOM study estimated the need for treatment among individuals who had used drugs other than alcohol in the past 30 days on a scale ranging from an "unlikely" need for treatment to a "clear" need for treatment. As shown in Exhibit 1, these estimates suggest that in 1988 there were about 5.5 million persons in clear or probable need of treatment for drug [non-alcohol] problems in the U.S., including about 1.1 million individuals who are clients of the criminal justice system. Comparable estimates have been developed for internal use by DHHS, and have been referred to in documents by ONDCP.

Another 18 million persons could probably benefit from treatment for alcohol (NIAAA, 1990); another 100 million use alcohol, but probably do not need treatment. Studies on alcohol problems suggest that about 11 million persons have symptoms of dependence on alcohol, and another 7 million experience alcohol "problems" that clinicians would define as alcohol "abuse".

Motivations for treatment are similarly diverse. Studies have found, however, that treatment is often sought when an individual faces uncontrollable and urgent problems related to physical or mental health, or other negative consequences, such as potential job loss or imprisonment. For example, many substance abuse treatment

Exhibit 1

Estimated Need for Drug Treatment (in thousands) Among Surveyed Populations 1987-1988

Population	Total	Those who Need Treatment
Household	198,000	
Clear need		1,500
Probable need		3,100
Homeless (sheltered, street, and transient)	1,225	170
Criminal justice clients		
Correctional custody	925	320
Probation and parole	2,600	730
Pregnancies (live births)	3,875	105
(Less overlaps)		(-470)
Total needing treatment		5,455

Sources: Institute of Medicine (1990a).

clients are in treatment as a result of referral by the criminal justice system as a diversion from incarceration (Hubbard et al., 1989), or entered treatment while on probation or parole. Indeed, pressure from the criminal justice system is reportedly the strongest motivation for seeking publicly provided treatment (Institute of Medicine, 1990a).

III. The Consequences of Alcohol and Drug Abuse

To the extent that substance abuse treatment is effective, it can alleviate enormous burdens on society. Indeed, it is largely the health, economic, and other costs associated with alcohol and drug abuse that motivate society to support the financing of these services either through health insurance or through public financing.

Health and Social Consequences. There are substantial health consequences of substance abuse including liver disease, GI problems, nutritional disorders, and fetal alcohol syndrome in children born to alcohol abusing women. It has been estimated that almost one-third of all AIDS cases are related to intravenous drug use, and that 70 percent of all pediatric AIDS cases are related to maternal exposure to HIV through drug use or sex with a drug user (Centers for Disease Control, 1993). There is growing evidence that perinatal substance abuse results in poor birth outcomes, including low-birth weight, and many suspect that perinatal substance abuse is responsible for developmental delay and disability in young children (US DHHS, 1992). In addition, substance abusers often manifest psychological and emotional instability, and frequently suffer from a variety of mental disorders, such as depression (persons identified as substance abusers and who are also determined to be mentally ill are typically referred to as the "dually diagnosed").

Substance abuse has many consequences for family members, employers and the public at large. Substance abusers often shirk responsibilities, and are not fully productive at work. High rates of accidents and absenteeism on the job are also reported among substance abusers. Furthermore, alcohol and drug abuse are strongly associated with motor vehicle and other accidents, and violent and acquisitive crime. In prison populations very high proportions admit to both alcohol and drug related problems (Innes, 1988). One major study found that 41 percent of all treatment clients examined admitted to having committed at least one "predatory crime" (e.g., aggravated assault, robbery, burglary) in the year prior to admission (Hubbard, et al., 1989). Moreover, criminal activity was found to be more likely among poly-drug users with serious abuse patterns, than among those with alcohol/marijuana or minimal use patterns (Hubbard et al., 1989).

Economic Costs. The costs associated with alcohol and drug abuse include the real (direct) costs of providing substance abuse treatment, the expenditures associated with treating the sequelae of alcohol and drug abuse (e.g., liver disease, HIV infection), reduced or lost productivity in the workplace, and costs associated with crime and motor vehicle and other accidents related to substance abuse. The total economic costs of substance abuse in 1990 were estimated to be \$166 billion (estimate by D. Rice, in Brandeis University, 1993).

Of the \$166 billion, \$99 billion (60 percent) were costs related to alcohol abuse, and \$67 billion were related to drug abuse. Direct health services costs related to alcohol and drug abuse (e.g., costs of treatment and prevention for alcohol and drug abuse and costs related to treating comorbidities associated with substance abuse) amounted to 10 percent of total costs of alcohol abuse, and 5 percent of total costs for drug abuse in estimates for prior years. The costs of AIDS and fetal alcohol syndrome alone were estimated to be about 2 percent of the total economic costs of substance abuse (Rice et al., 1990). AIDS costs have dramatically increased since 1985 due to the progression of the HIV/AIDS epidemic..

Other related costs include costs of crime and motor vehicle accidents, and indirect costs of morbidity and mortality. The morbidity costs include the value of goods and services lost by individuals unable to perform their usual activities because of alcohol and drug abuse problems, or unable to perform them at a level of full effectiveness (e.g., income loss), while mortality costs are the present value of future output (i.e., earnings and household productivity) lost due to premature death as a result of alcohol and drug abuse (Rice et al., 1990).

IV. Substance Abuse Services and Expenditures

In 1993 an estimated 3 million individual patients received alcohol or drug treatment in the specialty substance abuse treatment sector at a total cost of \$6.7 billion. In a given month 1 million persons received treatment. Over the year the 3 million individuals had about 5.8 million admissions to treatment.

This report has estimated the number of people who currently receive substance abuse services, the type and amount of services received, and the expenditures to provide this care. This has never before been studied in adequate detail for the purposes of a report such as this. Interested readers should refer to previous analyses performed by Cruze et al. (1981), Harwood et al. (1984) and Schlesinger et al. (1991) for the most comprehensive efforts to document the breadth of treatment services delivered for substance abuse. A discussion of the analytic approach is included in the appendix. Estimates of the types and amounts of substance abuse treatment that will be delivered in 1993 are presented in Exhibits 2 to 5. This is based on data from 1991 and adjusted for inflation to 1993 values.

A. Total Services and Revenues

An estimated \$6.7 billion were spent in 1993 to treat 3 million individuals. There were about 5.8 million admissions to treatment among this population, due to the high propensity to relapse from these disorders. This is almost \$1,200 per admission. At a given time about 1 million persons were enrolled in treatment.

The estimates for clients and revenues in Exhibit 2 are distributed across different types of treatment. The average cost per admission for each modality is equal to total revenues divided by annual admissions. Because various types of treatment have different lengths of stay the distribution of clients across modalities is different for "current clients" and "annual unduplicated clients". For example, outpatients tend to stay in treatment for much long periods than inpatients. About 90 percent of current clients are enrolled in outpatient treatment, however, over a year only about two-thirds of clients are in outpatient treatment. The estimates of annual unduplicated clients and of admissions have been adjusted to account for patients that receive multiple types of treatment and/or relapse and are re-admitted to treatment in a year (the implications of alternative assumptions are discussed in the Appendix).

Exhibit 2
SUBSTANCE ABUSE SERVICES AND REVENUES, 1993
BY TREATMENT MODALITY
 (CLIENTS IN THOUSANDS; DOLLARS IN MILLIONS)

MODALITIES	Current Clients	Unduplicated Clients	Annual Admissions	Total Revenues
Hospital	17.5	296.0	591.7	\$1,718
Freestanding Detox Center	7.3	210.2	420.2	\$247
Short Term Residential	20.7	248.3	498.5	\$957
Long Term Residential	63.8	213.4	428.4	\$1,072
Outpatient	816.2	1,879.5	3,449.0	\$2,159
Methadone	117.0	145.1	345.3	\$480
Other Providers	11.1	44.5	81.7	\$89
TOTAL	1,053.6	3,036.9	5,814.8	\$6,723

SOURCE: Analysis by Lewin-VHI, Inc.

B. Location/Type of Facility Where Treated

Exhibit 3 indicates the location and type of facility at which individuals were treated. Note that type of facility is not synonymous with type of treatment. Numerous programs offer more than one "modality" or type of care. For example, it is common for hospitals to provide inpatient as well as outpatient services (and to deliver methadone services as part of their outpatient operation). Programs reported data on current clients by type of treatment in which they were currently enrolled, however data on annual unduplicated clients and annual revenue were not reported in this manner. The analysis has used regression analysis to statistically adjust these estimates for multi-modality programs.

Over one third of patients accessed care through freestanding non-residential treatment programs specializing in substance abuse treatment. Mental health providers (including community mental health centers and mental/psychiatric hospitals) treated about 23 percent of annual patients. General hospitals treated about 11 percent of annual unduplicated clients. Specialized substance abuse residential and hospital providers treated about 16 percent of clients.

Exhibit 3
SUBSTANCE ABUSE SERVICE UTILIZATION
BY TREATMENT LOCATION, 1993
(Clients in thousands, Dollars in millions)

LOCATIONS	Current Clients	Admissions	Total Revenues
Community mental health centers/ inpatient/ partial/ emergency	262.2	630.5	\$774.2
Freestanding/Other non-residential facility	519.4	1,149.9	\$1,614.8
General Hospital (Includes VA)/ usually short term	76.4	342.8	\$1,295.0
Alcoholism Hospital	4.1	35.9	\$271.9
Mental/Psychiatric Hospital	8.9	71.5	\$420.3
Other Specialized Hospital	6.6	32.6	\$195.3
Halfway house/ usually California	19.5	86.3	\$301.4
Other residential facility/ Freestanding	63.4	349.8	\$1,100.2
Other	14.5	46.5	\$107.1
Multiple sites	67.5	246.6	\$554.1
Other Professionals	11.1	44.5	\$89.1
TOTAL	1,053.6	3,036.9	\$6,723.5

SOURCE: Analysis by Lewin-VHI, Inc.

C. Primary Substances Abused by Clients (Alcohol, Drugs)

It is worth while to note from Exhibit 4 that very similar proportions of annual clients served have primary alcohol and drug problems, or present with both problems (39, 32 and 29 percent, respectively). However, the number of current clients in treatment is weighted toward alcohol, followed by drugs and combined (48, 28 and 24 percent, respectively). These relative distributions primarily reflect the fact that primary alcohol patients in outpatient care appear to have greater retention than patients with primary drug or combined drug and alcohol problems. The primary alcohol patients may be more likely to have DUI charges, which could motivate improved retention. Also, this table demonstrates that primary alcohol patients have a higher utilization of hospital-based and residential-detoxification services than do the other types of patients, who have higher rates of short- and long-term residential services.

From this analysis it would appear that drug abusers were much more likely to receive treatment than alcohol abusers. A total of 1.82 million persons with primary drug problems or combined drug-alcohol problems received treatment in 1993. This is 33 percent of the perhaps 5.5 million persons with drug abuse/dependence problems. In contrast, an estimated 2.04 million persons with primary alcohol, or combined alcohol-drug problems were treated, which is 11.3 percent of the 18 million persons experiencing alcohol problems in a year.

Exhibit 4
CURRENT AND ANNUAL CLIENTS TREATED, 1991
BY PRIMARY SUBSTANCE OF ABUSE
(Clients in thousands)

MODALITIES	Primary Substance Abuse Problem					
	Drug	Alcohol	Both	Drug	Alcohol	Both
	Current Clients			Annual Unduplicated Clients		
Hospital	3.0	6.8	7.7	54.2	131.2	110.6
Freestanding Detox Center	1.4	3.6	2.3	60.8	117.9	31.5
Short Term Residential	3.8	9.0	7.9	88.7	61.6	98.0
Long Term Residential	19.9	16.4	27.6	84.1	46.4	82.8
Outpatient	148.2	460.6	207.4	520.2	818.5	540.7
Methadone	117.0	0.0	0.0	145.1	0.0	0.0
Other Providers	0.0	0.0	11.1	0.0	0.0	44.5
TOTAL	293.3	496.4	264	953.1	1175.6	908.1

SOURCE: Analysis by Lewin-VHI, Inc.

D. Public and Private Financing of Treatment, by Modality

Public sources (including Medicare, Medicaid, and direct government appropriations) paid \$4.3 billion of the \$6.7 billion spent on substance abuse treatment in 1993 (Exhibit 5). Private insurance paid \$1.6 billion, and client out-of-pocket payments totaled \$770 million. Not surprisingly, private insurance was a disproportionate purchaser of hospital treatment, which constituted over 50 percent of private insurance payments, but only 16 percent of public subsidies and 21 percent of client out-of-pocket payments. The other type of treatment heavily reimbursed by private insurance was short-term residential, with 22 percent of outlays, or roughly twice as high as public and client outlays.

The simulation analysis builds on the differences between privately and publicly-reimbursed care. In specific, there are three critical aspects of service delivery, management, and financing that differ between the two major financing sources and drive costs: referral patterns, average length of stay, and reimbursement rates. Differences in these factors across the public and private systems are examined in the following three sections.

Exhibit 5
REVENUES FOR SUBSTANCE ABUSE TREATMENT
BY MODALITY AND SOURCE OF PAYMENT
(1993 DOLLARS IN MILLIONS)

MODALITIES	Total Revenues	Public Sources	Private Sources	Clients
Hospital	\$1,718	\$712	\$844	\$162
Freestanding Detox Center	\$247	\$198	\$34	\$15
Short Term Residential	\$957	\$501	\$367	\$90
Long Term Residential	\$1,072	\$900	\$78	\$94
Outpatient	\$2,159	\$1,565	\$280	\$314
Methadone	\$480	\$386	\$12	\$82
Other Providers	\$89	\$65	\$12	\$13
TOTAL	\$6,723	\$4,328	\$1,626	\$770

"Public sources" include general appropriations, the Federal Block Grant, and services reimbursed by Medicaid, Medicare and the Department of Veteran's Affairs. "Private sources" include private health insurance plans, meaning both indemnity plans and prepaid plans (e.g. HMOs). "Clients" includes payments made by patients or their families out-of-pocket.

SOURCE: Analysis by Lewin-VHI, Inc.

E. Patient-Treatment Matching by Primary Source of Payment

There are significant differences in where publicly- and privately-financed patients were treated in 1993. Publicly-financed clients tended to be concentrated in treatment types with lower costs per day of care (Exhibit 6).

Public financing makes disproportionately greater use of outpatient treatment (both drug free and methadone) and long-term residential treatment. Private financing makes disproportionately greater use of hospital-based and short-term residential treatment.

Exhibit 6
DISTRIBUTION OF PATIENT ADMISSIONS (IN PERCENT) BY
MODALITY AND SOURCE OF PAYMENT 1993

Modality	Reimbursement Source	
	Private	Public
Hospital	22.8	7.0
Freestanding Detox Center	5.6	8.7
Short-term Residential	17.0	6.4
Long-term Residential	3.5	9.1
Methadone	0.9	6.5
Outpatient-Drug Free	50.2	62.2
Total	100.0	100.0

Source: Analysis by Lewin-VHI, Inc.

F. Average Length of Stay by Primary Source of Payment

Another material difference between publicly and privately financed treatment is that average length of stay appears to be greater in the former (Exhibit 7). This average as calculated from NDATUS is estimated to be 125 days enrolled in treatment averaged across all episodes of care. It is estimated that over fifty percent of clients have multiple treatment admissions per year (Brandeis University, 1992).

As noted above, privately reimbursed patients are more likely to be treated in high-cost modalities/sites, however, they tend to have shorter stays in treatment, regardless of the type of treatment. For example, the average hospital stay for substance abuse patients is estimated to be 13 days for privately-reimbursed clients and 22 days for publicly-reimbursed clients.

Exhibit 7
AVERAGE LENGTH OF STAY IN DAYS
BY SOURCE OF PAYMENT

Modality	Reimbursement Source	
	Private	Public
Hospital	13	22
Freestanding Detox Center	8	13
Short-term Residential	18	32
Long-term Residential	59	94
Methadone	159	224
Outpatient-Drug Free	73	158

Source: Analysis by Lewin-VHI, Inc.

G. Average Price of One Day of Treatment by Primary Source of Payment

The following table (Exhibit 8) presents estimates of the average cost per day of maintaining a patient in treatment, by type of treatment (based on 1991 data, adjusted for inflation to 1993). For outpatient care this does not represent the cost of a "visit", but averages costs for all visits during an episode of treatment over the duration of time in treatment.

Costs are not differentiated by funding source (e.g., private and public), but represent an average. There are often large differences in "charges" between publicly- and privately-funded treatment, especially in hospital care, but also in care delivered by private practitioners. Such differences in public and private sector prices are attributable to many and complex causes which are beyond the scope of this study. These differences would probably be eliminated by a comprehensive health care reform plan, and are thus not relevant for the purposes of this report.

The "enhanced" prices in Exhibit 8 represent the expense of augmenting selected types of treatment to approximate the level of funding in the late 1970's. It was found in the study by the IOM (1990a) that funding per client in long-term residential and outpatient programs had fallen by this amount. Under an "enhanced" reform proposal this funding gap would be made up, and treatment services would be improved accordingly.

Exhibit 8
AVERAGE PRICE OF ONE DAY OF TREATMENT
BY SOURCE OF PAYMENT (1993 DOLLARS)

Modality	Reimbursement Source	
	Cost	Enhanced
Hospital	\$266.50	\$266.50
Freestanding Detox Center	\$85.90	\$85.90
Short-term Residential	\$119.30	\$179.00
Long-term Residential	\$48.00	\$71.90
Methadone	\$11.60	\$17.40
Outpatient-Drug Free	\$8.90	\$13.40

Source: Analysis by Lewin-VHI, Inc.

V. A Graphical Representation of the Public and Private Financing Situation

The current debate over health care reform and substance abuse treatment has drawn a sharp line between those persons with private health insurance (about 160 million) and those that rely primarily on publicly funded programs, such as Medicaid and Medicare or that have no health insurance but are likely to rely on indigent care programs (a total of about 100 million persons). This distinction has fundamental implications for understanding how substance abuse treatment might be affected by health care reform.

Simplified analyses represent these as two distinct populations from a financing perspective, and, by implication, in terms of their need for treatment. This report has estimated that private insurance paid for \$1.63 billion in SAT services (client copayments were an estimated additional \$535 million, based on about a 20 percent copayment for inpatient care and 50 percent for outpatient) for apparent expenditures per privately-insured individual of \$13.55 per person per year. In contrast, public sector expenditures were \$4.33 billion, with client payments of \$235 million (either as client copayments or for wholly client reimbursed services). Apparent public sector expenditures per client are about \$45.70 per person per year. The national average is \$25.75 per person per year. These values are graphed in Figure 1.

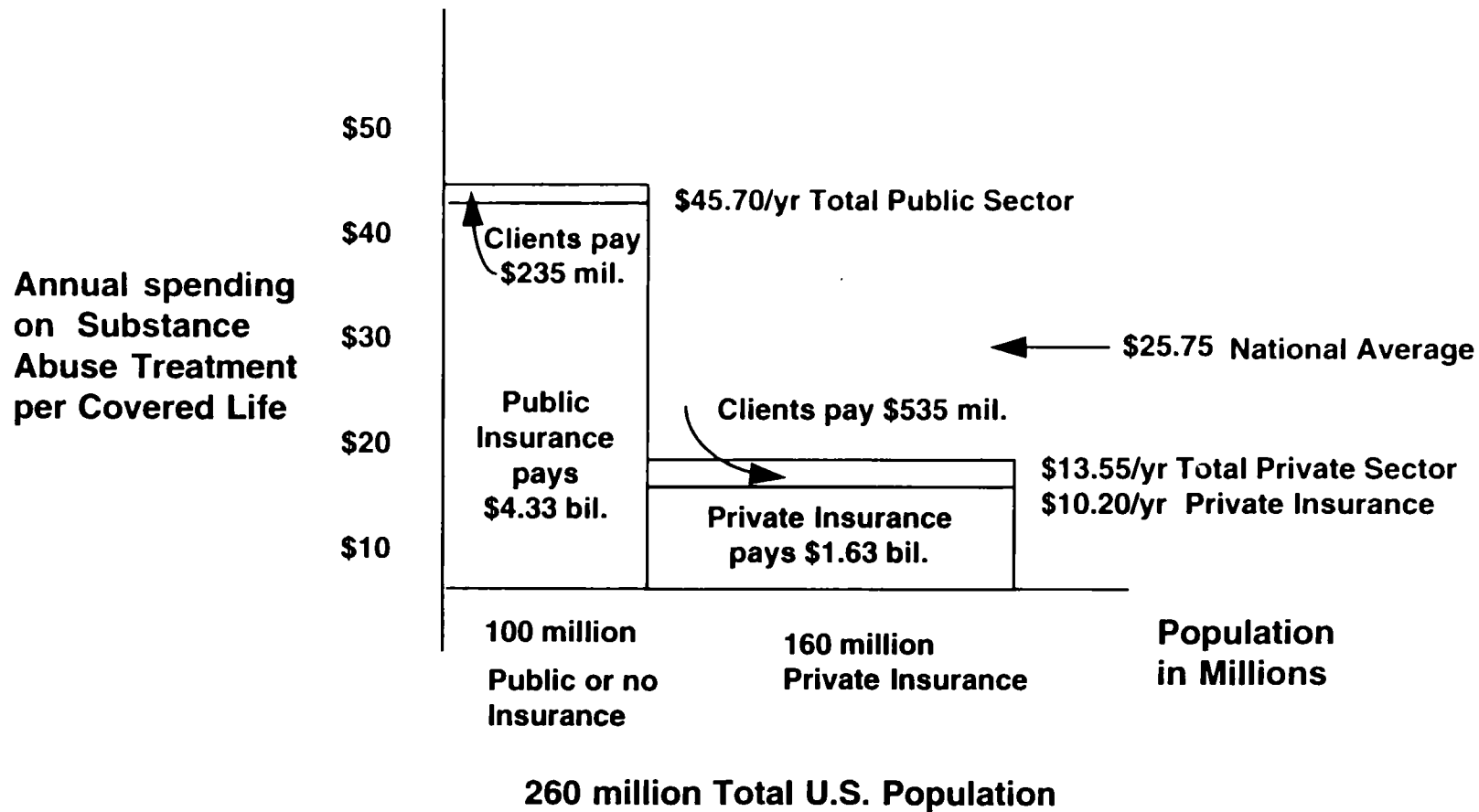
The simple--but incorrect--reading of these values suggests that private insurance is either much more cost-effective in delivering SAT services, or that the privately insured population has a dramatically lower need for SAT services than those that are without medical insurance, or that have coverage through public programs such as Medicaid or Medicare, or the Department of Veterans' Affairs.

There are two major problems with this interpretation. First, these estimates of current expenditures do not reflect the need for SAT services by either the privately or publicly insured (it is well established that need is greater than funding). Second, those figures do not reflect the impact of privately-insured patients using the public system due to exhausting coverage under their private insurance (patient "dumping").

Patient dumping can have two effects. First, patients may not get the amount or type of treatment they need due to an inability (or unwillingness) to pay out of pocket. Second, some number of these patients with private insurance coverage seek and obtain treatment from public programs. This utilization of publicly-subsidized treatment serves to inflate apparent expenditures for the 100 million persons dependent on public system financing of SAT services. This is represented in Figure 2.

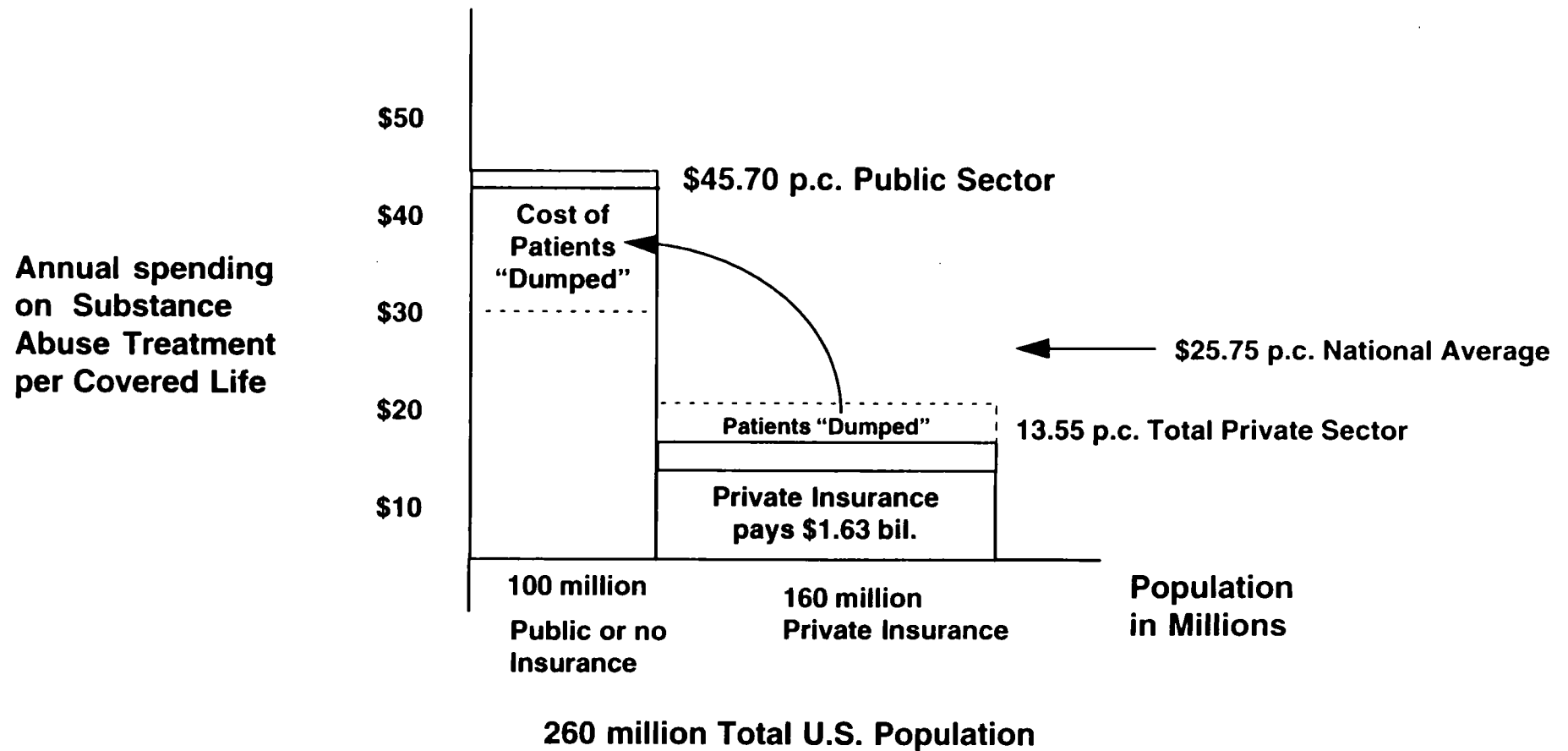
This problem has been studied very little, but it is fundamental to the analysis and understanding of substance abuse funding issues. Inferences from the DSRS survey (Brandeis University, 1991) about employment and insurance coverage of substance abuse patients indicate it is plausible that as much as 35 percent of government-funded treatment may be delivered to individuals that currently have private health insurance. It was found that 41 percent of drug and drug-alcohol clients were employed, and 59 percent of clients in alcohol-only treatment. Adding clients with an employed spouse or parent it is plausible that up to 70 percent of substance abuse

Figure 1
Public and Private Sector Financing
of Substance Abuse Treatment, 1993



Source: Analysis by Lewin-VHI, Inc.

Figure 2
The Impact of Limited Private Insurance Coverage
on the Need for Public Financing



Source: Analysis by Lewin-VHI, Inc.

patients were from a family with an employed member, and some significant proportion of these would have health insurance. However, DSRS estimated that only 13.5 percent of all patients were using private insurance to pay for treatment.

Given these factors (and absent any specific research on this topic) this report adopts a figure of 20 percent of patients in publicly funded treatment had private health insurance that was not paying for treatment. This suggests that individuals with health insurance are using \$866 million in publicly-funded substance abuse treatment services in 1993. This is about \$5.40 per each of the 160 million persons with private health insurance in 1993, or an additional 40 percent over the apparent expenditures of \$13.55 per person (insurance plus out-of-pocket payments).

Another major implication of this analysis is that many analyses may yield an exaggerated estimate of the cost of incorporating significant numbers of the uninsured, Medicaid and Medicare populations under health care reform plans that build on private health insurance. If it is believed that it only costs about \$10 per covered life per year for private insurance to serve SAT needs, there is likely to be resistance to including a large number of persons with SAT service needs in excess of \$40 per covered life per year, in addition to the other health needs. Coverage of this population may only be acceptable if the benefit is subject to tight limits, and the government is willing to allow those with private insurance to be under-served or to subsidize private insurance plans by covering high-cost substance abuse patients.

VI. Proposals for Financing Treatment

This report estimates and compares the numbers of patients treated, patterns and levels of service delivery, and costs of five alternative approaches for financing the expanded provision of substance abuse treatment in the United States:

- a "comprehensive" system;
- the system proposed in the Health Security Act;
- an improved public "safety net" modeled after the Minnesota "Consolidated Fund".
- an expanded private insurance residential and outpatient treatment benefit; and
- limited private, or small market reform.

Each of these simulations is built on estimates for 1993 and assumptions about how various systems would affect:

utilization of treatment;
patterns of patient-treatment matching;
duration of treatment; and
how much is paid for services.

The following section presents the findings of the simulations, with brief definitions and discussions of the assumptions employed for each of the models.

A. A Comprehensive Plan

A comprehensive substance abuse treatment (SAT) benefit covering 260 million persons would allow 3.3 million persons to be treated per year at a cost of \$11.725 billion. Daily enrollment in treatment would be 1.1 million persons. Due to relapse on the part of some patients there would be an expected 6 million treatment episodes per year.

This simulation estimates the cost of funding a comprehensive program to meet the needs for substance abuse treatment in the nation. The objective of the plan would be to accomplish universal and timely access to a full continuum of services of efficacious duration and intensity.

One vision of such a comprehensive benefit is the plan that has been developed and advocated by the Legal Action Center (or LAC, 1993a). The LAC plan is designed for incorporation into both private and public model insurance plans. The objective of this proposal would be that individuals have access to comprehensive coverage that is consistent across all sources of health coverage. The plan specifies a package of services that would be covered, with minimum limits that could be placed on respective benefits on an annual basis. The critical features of this benefit are:

- individualized assessment and referral to appropriate type/duration of treatment;
- a full continuum of care shall be available, from prevention and intervention to residential/hospital care, outpatient services through "continuing care";
- the minimum durations of coverage would be appreciably greater than typical provisions in private plans; and
- copayments, if necessary, would be graduated by income.

It has not been possible to directly "cost out" the LAC proposal. An estimate of the magnitude of these costs has been developed by building upon the estimates of current national estimates of persons served and expenditures on substance abuse treatment services presented above. In particular, the cost of this benefit is based on assumptions about: how many total persons would seek treatment; the number of episodes of care they would utilize; the kinds of treatment they enter; their length of stay in treatment; and the cost per unit of treatment. Each of these assumptions is discussed in turn.

The total cost of a comprehensive plan is estimated at \$11.725 billion per year, or about \$45.10 per covered life per year (using population estimates and prices). This is in contrast to the estimated \$6.7 billion (or \$25.75 per covered life) that will be spent on treatment in 1993. Thus the comprehensive plan would increase total expenditures by 75 percent compared to current estimated expenditures. Most of this increase would result from increased reimbursement rates for non-hospital services in order to improve quality of the system. Only 10 percent of the increase is due to increased numbers of persons accessing care.

The first assumption in the simulation is that under a comprehensive plan the total number of people under public or private coverage seeking and getting treatment

per year would increase by 10 percent. In 1993 these are estimated to be 3 million persons accessing 5.8 million admissions to treatment. This assumption is based on the logic that even though coverage would improve, the increase in persons accessing treatment will be low because of the well known problems of "denial" and resistance to treatment exhibited by most substance abusers.

There is some precedent for this conservative 10 percent assumption in the experience of the State of Minnesota when it established the "Consolidated Chemical Dependency Treatment Fund" (Minnesota Department of Human Services, 1993; the Minnesota experience is discussed more below). The Consolidated Fund was created to improve the public "safety net" providing access to SAT for the uninsured, those relying on Medicaid and Medicare, and those with private insurance that exhausted their limits on services. With the advent of the Consolidated Fund total (private plus public) access to treatment increased by almost 10 percent between the first 6 months of 1988 and the second complete year of its operation (1989-90).

It is also possible that total increase could be somewhat greater than 10 percent. For example, in Minnesota, although total treatment access (public plus private) only increased by 10 percent, the increase through the public Consolidated Fund was 25 percent. It should also be noted that Minnesota had a lower proportion of uninsured population in the state (about 9 percent versus a national average of 14 percent), and possibly better private coverage for SAT than the rest of the nation. Thus, the "treatment gap" being filled by the Consolidated Fund may have been smaller than the gap at the national level. To establish an upper threshold for expansion under a comprehensive plan, studies comparing utilization of general health care services (hospital and ambulatory care) by uninsured and insured populations find that the insured use about 50 percent more health services than the uninsured (Needleman et al., 1990).

The second major assumption is that clients will access treatment modalities in the proportions delivered by the publicly-subsidized system (see Exhibit 6). The public system uses less hospital care and more ambulatory and residential services than the privately funded system. Patients are assumed to stay in treatment slightly longer than the duration currently experienced in the public treatment system (Exhibit 7). It is assumed that patient length of stay will increase by 10 percent in response to improved quality of treatment resulting from increased funding per client. This assumption has been adopted from analyses in "Treating Drug Problems" (Institute of Medicine, 1990a).

Funding per unit of service is assumed to be 50 percent greater than the cost of currently delivering services (Exhibit 8), except for hospital inpatient and freestanding detoxification center services (these costs are assumed constant). It was found in the Institute of Medicine (1990a) study that funding per unit of service in the public sector had eroded by this amount, and quality of care was thereby probably diminished.

B. The Health Security Act

The Health Security Act (HSA) by itself is unlikely to alleviate the existing problem of limited access to substance abuse treatment. About 60 million currently uninsured and Medicaid beneficiaries will gain coverage under Health Plans set up under the HSA. However, both this population and those currently insured will continue to have a heavy reliance on publicly funded treatment for a number of years. This is because coverage under the HSA is oriented to "brief interventions" and short-term treatment and generally would not cover more intensive and longer-term services many of the 3 million clients in substance abuse treatment now receive.

The 225 million persons enrolled in Health Plans would use Plan-covered substance abuse treatment services costing \$3 billion. Plans would pay \$2.3 billion, and patients would make copayments for plan-covered services of \$754 million. Estimates are based on 1993 population and costs.

The costs for services in excess of those covered under the HSA for the 225 million persons in Health Plans could require an additional \$2.24 billion in publicly-funded treatment services (plus out-of-pocket payments of \$121 million). This is the cost for enrollees to receive about the same level of care currently being utilized.

The 35 million persons not expected to join HSA Health Plans--the disabled and elderly Medicare population and others reliant on government health programs (e.g. veterans, Native Americans)--are expected to continue to require \$1.4 billion in publicly-funded substance abuse services and pay \$75 million out-of-pocket for these services.

The Health Security Act can be characterized as having coverage for substance abuse services which are comparable to many "private sector" policies, and will depend on managed care to control costs for this benefit. Actually, the HSA recognizes the continued need for a public substance abuse treatment system, and that certain individuals and services will not be fully covered by Health Plans (for example, Title III, Subtitle F provides additional funding for support services and facilities). The HSA proposes that service limits would be eliminated in the year 2001 (Section 1115) and envisions an integration of public substance abuse treatment service delivery with the coverage of Health Plans at that time (Section 3501).

The HSA "Public Health Initiatives" does propose new funding to promote service system integration as well as planning, data acquisition, and patient outreach and to guarantee loans for the construction of treatment facilities (Sections 3502 and 3503).

The major provisions of the HSA with respect to coverage of substance abuse treatment are:

- Coverage of up to 30 days of inpatient/residential treatment per year; hospital care only reimbursable for detoxification (Section 1115(c)); the covered amount of residential treatment is reduced if the beneficiary uses intensive nonresidential or outpatient services;
- Coverage of up to 30 outpatient group therapy visits to substance abuse treatment providers if an individual was initially served in a residential or intensive nonresidential setting, and up to 120 outpatient visits by swapping 1 residential day for 4 visits;
- Up to 60 days of intensive nonresidential treatment per year by swapping 1 residential day for 2 intensive nonresidential days, and up to 60 additional days if the plan authorizes (Section 1115(d));
- The "lower cost-sharing" plans would charge no deductible or copayment for inpatient/residential or the first 60 days of intensive nonresidential services; outpatient services would have a copayment of \$10 per visit, with no deductible; "higher cost-sharing" plans will have a 20 percent copayment (Section 1135); low income families will likely be in "lower cost-sharing" plans and AFDC and SSI families will have \$2 copayments for outpatient services (Section 1371(c));
- Medicaid eligibles would be included in Health Plans, and Medicare beneficiaries would have the option to enroll in Health Plans.

This benefit package is in major respects similar to what is commonly offered through private insurance plans. Coverage is limited in duration, and would not be adequate to pay for annual treatment costs of chronic/severe substance abusers (although there are no lifetime limits).

In reality, though, access to substance abuse treatment benefits will continue to be a major question. The Health Security Act generally envisions a delivery system that gives managed care a central role in controlling access to services. While managed care has been used extensively with privately insured populations, it has not yet been widely used and proven to be effective and appropriate with chronic/severe substance abuse populations. The HSA does include certain relevant definitions and protections pertinent to protecting or denying patient access to care. For example, Section 1115(b)(1) defines eligibility for coverage of substance abuse treatment (a diagnosable substance abuse disorder with "functional impairment"), while Section 1141(a) allows exclusion of coverage because a service is not medically necessary or appropriate), and these provisions would appear to be generally consistent with existing managed care standards.

The impact of the Health Security Act will be quite different for the populations that currently depend on private health insurance and on public programs (e.g., Medicaid, Medicare, public health services in general), respectively. These are discussed in turn. Estimates are based on population values and costs for 1993.

The Privately Insured Population. The population with private health insurance should see few if any changes in terms of accessing substance abuse treatment. It is estimated (assumed) that under the Health Security Act these 160 million persons would have unchanged access to and utilization of substance abuse treatment, with insurance payments of \$1.63 billion for treatment and patient payments (for deductibles and copayments) of \$535 million in 1993.

There are several factors that explain the conclusion that the Health Security Act will have minimal impact on treatment access by those with private health insurance. First, the mandated benefits under the HSA are very similar to those already contained in many private health insurance plans. Second, Health Plans will probably depend on managed care protocols to control access to treatment. Since managed care for substance abuse treatment is already widely used, it seems unlikely that the implementation of Health Plans under the HSA will change utilization of treatment by those that currently have health insurance.

As is currently the case, this population would continue to depend on the publicly-funded treatment system for more intensive and longer treatment. This issue has been studied very little, but it is fundamental to the analysis and understanding of substance abuse funding issues. Inferences from the DSRS survey (Brandeis University, 1991) about employment and insurance coverage of substance abuse patients indicate it is plausible that as much as 35 percent of government-funded treatment may be delivered to individuals that currently have private health insurance. This report adopts a figure of 20 percent for purposes of generating estimates. This suggests that individuals with health insurance are using \$866 million in publicly-funded substance abuse treatment services in 1993. This requirement for public funding of treatment for those currently with private insurance is likely to continue under the Health Security Act.

The Publicly Insured or Uninsured Population. The Health Security Act could have significant impacts on the access to treatment of the 65 million plus persons that join Health Plans from the Medicaid and uninsured populations: These impacts could be both positive and negative. Positive impacts could arise if the Health Plans are more proactive than the current indigent care health system at screening, identifying and referring substance abusers to treatment. Increased delivery of such preventive interventions are theoretical objectives of integrated delivery networks like the Health Plans envisioned in the Health Security Act.

However, access to care could also be adversely impacted, and these patients are likely to rely on publicly funded treatment over and above that provided through their Health Plans. This is because the coverage under the Health Security Act (at least until the year 2001) will be more limited than the care generally delivered by the publicly-funded treatment system. There will be a burden on both the Health Plans and the public treatment system to coordinate the care for chronic and severe substance abuse patients that exhaust coverage under their Health Plan and must take recourse to the public system for care. In the current substance abuse treatment system systematic transitions of coverage from private insurance to public programs are reported to be rare and patients must navigate their own way.

The Health Security Act is predicted to give coverage to 65 million persons that presently are uncovered or rely on Medicaid. Assuming that they access treatment through their Health Plans at rates and costs equivalent to those that now have private insurance, this would generate \$662 million in treatment revenue from Health Plans and \$218 million in client copayments for plan-covered services. However, this would leave a requirement for public funding for this population of \$1.42 billion (plus client

copayments of \$77 million) in order to deliver about the same amount of treatment services to this population as before enrollment in Health Plans.

The 35 million persons not expected to join HSA Health Plans--the disabled and elderly Medicare population and others reliant on government programs (e.g. veterans, Native Americans)--are expected to continue to require \$1.4 billion in publicly-funded substance abuse services and pay about \$75 million out-of-pocket for these services.

Summary. Expanding access to substance abuse treatment is not itself a significant objective of the Health Security Act. While the design of Health Plans should promote access to "brief interventions" and short-term treatment through more early screening, identification and referral, the benefit is very limited and many patients (particularly chronic/severe patients) will need to access intensive/longer term treatment through the public system. The "design" of the national treatment system should carefully assess the need for and role of the public substance abuse treatment "safety net".

Expanded treatment access will primarily depend on funding for the public system from States and federal programs. The HSA has no proposals for funding the public substance abuse treatment system. Provisions for fiscal year 1995 and subsequent years will be contained in the Budget presented to Congress in early 1994.

C. An Improved Safety-Net: The Minnesota Consolidated Fund

A comprehensive public "safety net" plan modeled after the Minnesota Consolidated Fund would cover over 130 million persons, including lower- and middle-income persons (incomes up to 115 percent of median income) that might exhaust private insurance benefits. It would cost \$11.55 billion to pay for 4.4 million treatment episodes for 2.3 million individuals.

A public "safety net" substance abuse treatment system will be required if health care reform is not universal and comprehensive with respect to substance abusers and SAT services. As discussed above, the shape and size of that system will be contingent on the coverage which is contained in reformed private and public health care plans. More limited treatment coverage will call for greater resources for the "safety net", while broader benefits will require a smaller "safety net".

This section examines the implications of projecting the Minnesota approach to the national level. At its broadest coverage (there have been some curtailments in eligibility) the Minnesota Consolidated Fund (MCF) had the following characteristics:

- coverage of individuals with household incomes of up to 115 per cent of the state median family income (subsequently cut back to 60 percent);
- coordination of a wide range of payment sources, including local funds, state general appropriations and categorical funds (Medicaid and General Assistance), Federal funds (Block Grants and categorical) and provides for recovery of payments from insurance companies and clients able to pay;

- coverage of a broad set of services, including hospital-based, residential, outpatient and combined inpatient-outpatient treatments; and
- assessment and referral of patients to appropriate levels of care using state-established criteria.

Minnesota undertook a very creative and ambitious effort to expand access to substance abuse treatment for those without insurance coverage beginning in 1988. The Consolidated Chemical Dependency Treatment Fund was established to coordinate several different sources for funding these services (e.g., Medicaid, General Assistance, state appropriations, Federal Block Grant funds) and to manage patient access to appropriate levels of care (Minnesota Department of Human Services, 1993). Although the Consolidated Fund initially covered those with incomes of up to 115 percent of the state median family income, coverage was subsequently limited to those at or below 60 percent of state median family income in the face of state fiscal constraints.

The system also has the goal of cutting costs. This has been accomplished primarily by patient management policies (managed care) that gradually referred smaller proportions of patients to inpatient care (declining from 38 percent to 27 percent from 1989 to 1992) and more into outpatient care (from 32 percent in 1989 to 40 percent in 1992). The MCF spent \$2,750 per admission to all modalities (not per unduplicated client) in state fiscal year 1992, or about \$3,000 per admission in 1993 with inflation adjustments. About 6 percent of this was recovered via collections from insurance companies and individuals (Minnesota Department of Human Services, 1993).

The costs of applying the MCF model to build a national "safety net" are estimated at \$11.3 billion per year. There were an estimated 5.3 million admissions to substance abuse treatment in 1993 (excluding admissions to freestanding detox centers), of which there were 3.5 million publicly subsidized admissions. Under the MCF it is assumed that total national treatment admissions would increase by 10 percent (or 530,00 additional admissions), but that all of the increase would be paid for by the public system (about a 15 percent increase for the public system). Note that Minnesota experienced a 25 percent increase in the rate of publicly-subsidized treatment admissions from the first six month period of operation in 1988 to the second complete year of operation in 1990-91, although there was only less than a 5 percent increase in privately reimbursed treatment admissions, and only about a 10 percent increase in total (public plus private) admissions. For this calculation the report projects a 10 percent increase in utilization of the total treatment system. Within the Minnesota system, treatment cost about \$3,000 per admission (less 6 percent cost recovery). This indicates expenditures under a broad eligibility Minnesota-type safety net would be \$11.3 billion per year.

To this must be added the costs of 400,000 detoxification admissions, which the MCF does not pay for. This adds an equivalent of 200,000 more persons at a cost of \$250 million to the public system.

These projections of the MCF to the nation are contingent on several factors: the increased access to treatment; patterns of referral; and costs of treatment. First, it is uncertain if national experience will equal, exceed or lag the 25 percent increase in

the rate of publicly-subsidized treatment admissions experienced between early 1988 and 1989-90 in Minnesota. It is possible that the increase could be greater than 25 percent, because, unlike the rest of the nation, about 65 percent of treatment admissions in Minnesota are covered by private insurance (versus about 35 percent at the national level). The Minnesota public system has a smaller burden to carry because Minnesota has a higher than average income, and fewer people are uninsured (9 percent in Minnesota, versus 14 percent nationally). It is also possible that the 25 percent increase may have been influenced by factors that may have curtailed private treatment access such as reductions in coverage or other changes in private treatment referral patterns, which could have increased the demand for publicly-subsidized treatment.

Second, Minnesota has a strong tradition of delivering high quality treatment and a higher proportion of residential/inpatient-based services than most other state systems (implying substantially higher costs per patient). Most other state treatment systems have put greater reliance on less intensive ambulatory services (see the State Alcohol and Drug Abuse Profile, or SADAP, compiled by the National Association of State Alcohol and Drug Abuse Directors). The "Minnesota" model of treatment gained wide acceptance among private insurance plans in the 1970s and early 1980s; however, managed care providers have severely reduced use of this type of treatment in favor of briefer stays and more outpatient treatment. Over several years of operation the Minnesota Consolidated Fund has modestly reduced utilization of residential/inpatient care, but it is still delivering a different mix of services than other state SAT systems (see Exhibit 6, above, on the national distribution of publicly-reimbursed patients by modality). It is not clear that other states would adopt the Minnesota criteria for patient assessment and referral into types of treatment.

D. An Expanded Private Insurance Residential and Outpatient Benefit

This proposal would result in a modest total increase in treatment expenditures for privately insured individuals, from \$2.11 billion to \$2.36 billion per year (for both insurance payments plus client out-of-pocket payments). This would pay for treatment of 1 million individuals with private insurance coverage.

The proposal implies significant shifts in where and how services are delivered: hospital utilization would drop from \$957 million (for 219,000 patients) to \$319 million (for an equivalent of 73,000 patients); short-term residential services would rise from \$345 million (for 153,000 patients) to \$740 million (for an equivalent of 239,000 patients); and outpatient services would increase from \$446 million to \$905 million.

This is a succinct proposal for improving coverage under private insurance plans. The Hazelden Foundation has been instrumental in development of this proposal, although other substance abuse providers have been involved with and/or support the proposal as an incremental improvement in "private sector" coverage. It is recognized that this is not a comprehensive plan that would obviate the need for a

publicly subsidized treatment delivery system. The proposal identifies and addresses several areas of private insurance coverage concerning the types of institutions that are approved for reimbursement, the importance of longer duration outpatient and "aftercare" to the recovery of patients, and several issues related to quality and consistency in care.

The characteristics of the proposal with major cost implications are:

- coverage of up to 30 days per year in residential or inpatient settings;
- coverage of 130 hours of outpatient and/or aftercare per year; and
- plans must allow treatment in licensed freestanding residential programs.

This proposal points out that often health insurance plans do not allow treatment in freestanding residential programs, although such programs offer substance abuse treatment of equal intensity to that provided by hospitals (but not medical services), and therefore at a substantially lower cost. Thus, potentially significant cost savings might be achieved by reduced reliance on hospitals in deference to short-term residential programs for the many patients without need for access to full hospital services.

In contrast, this proposal calls for coverage for outpatient services (and/or aftercare) to be substantially expanded to 130 hours per year, from the typical limit of 20 or 30 visits per year. This recommendation involves increases in costs. The proposal builds on the frequent finding that long-term clinical support is correlated with better patient outcomes. Accordingly, many short-term inpatient and residential treatment programs (with average durations of less than 30 days) strongly recommend that patients engage in intensive outpatient treatment and/or aftercare for several months or even longer following discharge from inpatient and residential programs.

While the expanded residential and outpatient proposal calls for standardized treatment placement criteria (recommending the American Society of Addiction Medicine model) and regulation of the qualifications of managed care professionals, this proposal does not address the role of managed care in limiting the duration of treatment. For purposes of this simulation this issue is ignored, and estimates are developed of the cost of increased length of stay in outpatient treatment.

The implications of this proposal have been modeled by making several very simple assumptions. First, the provision for the required coverage of residential treatment facilities is assumed to result in a two-thirds reduction in utilization of hospital-based care (from 219,000 annual unduplicated patients to 73,000 unduplicated patients) and this number of patients (equivalent to 146,000 annual patients) are added to the total of residential episodes. The second assumption is that the average duration of outpatient treatment episodes rises from the value for privately-reimbursed care to that for publicly-reimbursed care (from about 10.5 weeks to about 22.5 weeks, respectively).

The implications of this proposal in terms of changes in annual patients served and costs, by treatment modality, are presented in Exhibit 9. The primary implications are in terms of where patients are treated, and for how long.

There are no direct implications of this proposal for initial access to treatment, thus the total number of patients treated under private health insurance--1.253 million--does not change. The adjusted total patients--1.003 million--represents an attempt to adjust for the fact that patients are often treated in multiple programs over the course of a year, or even a given treatment episode. It is estimated that these 1 million patients will have about 2 million admissions to treatment per year. [The report recognizes that many patients may receive treatment in more than one program and/or modality in a given episode of care (initiating treatment in a hospital or residential program, and continuing in outpatient care) and in a year (due to relapse). Unfortunately there is very little data on this issue. This is discussed in the Appendix.]

This proposal would favorably affect the public treatment system. While the system primarily serves about 2 million individuals with no insurance or public insurance, it is plausible that up to 20 percent or more of these services are used by patients that have private health insurance, but can not get reimbursement for further services. Expanded private insurance outpatient coverage would reduce the reliance of those with private insurance on the public system. This "cross system" reliance has been plausibly estimated at \$866 million per year in Section V, above. Under this enhanced benefit privately-insured patients are projected to receive an additional \$512 million in outpatient services (an increase from \$497 million to \$1.009 billion). This reduced utilization of the public system by privately-insured persons would allow an additional 446,000 uninsured persons per year to receive publicly-subsidized treatment at no increase in cost to the treatment system. Alternatively, programs could use these funds to improve the quality of outpatient treatment, or for other purposes such as to deliver more or better treatment of different types, for treatment outreach, or to provide health care services to substance abusers.

Exhibit 9

A PROPOSAL FOR EXPANDED PRIVATE INSURANCE COVERAGE OF RESIDENTIAL & OUTPATIENT TREATMENT

(Clients in thousands, Dollars in millions)

MODALITIES	Annual Clients		Annual Costs	
	Actual	Expanded Proposal	Actual	Expanded Proposal
Hospital	219	73	\$1067	\$355
Freestanding Detox	53	53	\$45	\$45
Short Term Residential	153	299	\$385	\$825
Long Term Residential	34	34	\$97	\$97
Outpatient Drug Free	780	780	\$497	\$1009
Methadone	14	14	\$24	\$24
Total	1,253	1,253	\$2,114	\$2,355
Adjusted Total	1,003	1,003	NR	NR

Adjusted total" of clients is adjusted for client admissions to multiple treatment programs.
SOURCE: Analysis by Lewin-VHI, Inc.

E. Limited, Private or Small Market Reform

Applying a limited and "closely managed" HMO-type benefit to the 160 million persons currently covered by private health insurance plans would result in 5.3 million beneficiaries accessing substance abuse services through the private system (of whom about 390,000 persons would use 740,000 treatment episodes and the remaining 4.9 million would receive other services such as "brief interventions") at a total cost of \$1.5 billion per year (\$9.30 per beneficiary per year).

By this estimate about 610,000 persons currently having treatment reimbursed by private insurance would probably only receive "brief interventions." If these individuals seek care from the public system, at an average cost of \$2,300 per person treated this could impose an added cost of about \$1.4 billion per year, over and above the \$866 million burden that may currently occur due to privately-insured individuals exhausting private insurance coverage and accessing publicly-subsidized treatment.

This minimal approach to reform assumes the maintenance of a public SAT "safety net". The public system would continue to serve the 100 million persons depending on Medicaid, Medicare, veterans programs, and indigent care services (those exhausting private benefits), and would treat 2 million patients annually, accessing 3.8 million treatment admissions. This would require \$4.33 billion per year in public funds plus \$235 million in client payments.

The most limited health care reform proposals with respect to coverage of substance abuse services would concentrate on private insurance reform. A number of these contain substance abuse coverage provisions very similar to coverage offered by most Health Maintenance Organizations (HMOs). These are also similar to the coverage provisions contained in many private health insurance plans and in a number of state substance abuse treatment mandates.

The assumptions underlying this benefit are:

- coverage for SAT would be similar to current limits for Federally-qualified HMOs (minimums of 30 days of inpatient/hospital care and 20 outpatient visits), and there would be a 50 percent copayment on outpatient services;
- the plan would not cover chronic/severe patients, who would be referred to the public "safety net" system for care;
- access to SAT would be closely managed through utilization review, which would keep most treatment episodes down to very short durations;
- up to 80 percent of those currently without health insurance would gain coverage via a working member of the household; and
- Medicaid and Medicare would not change in the near future.

This approach to health care reform would control access to and utilization of SAT through managed care. Together with the tight caps/limits on services mentioned above, plans employ management of patients (managed care) that usually requires screening and referral of patients by primary care practitioners, and rigorous external utilization review before and during treatment. Moreover, most plans exclude coverage of treatment for chronic and severe cases, and plans refer such patients to private providers or the public system. Consequently, when plan enrollees access SAT services it is virtually always for relatively brief episodes of care compared to patients that access treatment through the publicly-subsidized direct delivery SAT system.

While there is a database on which to estimate the impact of such a reform approach, there are also significant uncertainties. The basic cost and utilization estimates can build upon data from health maintenance organizations. A recent national study of HMOs (Christianson et al., 1992) found that SAT expenditures per enrollee were about \$7.50 per year in 1989 (\$9.30 adjusted for inflation to 1993), out of total mental health plus substance abuse expenditures of about \$32 per year in 1989 (or \$40 in 1993). About 3.3 percent of total plan enrollees per year accessed some kind of service related to a problem with substance abuse. However, the vast majority of services delivered was apparently limited to services such as a "positive" screen for substance abuse (perhaps followed by a "brief intervention") by a primary care practitioner or a beneficiary-initiated telephone consultation. Utilization of hospital inpatient services were about 6 days per 1,000 enrollees (average length of stay was about 10 days per episode), and utilization of ambulatory services were about 40 days per 1,000 enrollees (two thirds of patients "complete" mental health/SAT ambulatory care in under 10 sessions).

Incorporation of a limited HMO-type benefit for SAT would cost \$9.30 per covered life per year. Under this approach insurance expenditures for SAT would total \$1.49 billion (160 million persons times \$9.30).

Based on service delivery patterns of HMOs it is projected that 5.3 million privately-insured persons per year would access some substance abuse-related service, but only 390,000 would receive a total of 740,000 treatment episodes--the remainder would receive other services such as "brief interventions." This would imply a decrease of about 610,000 persons receiving privately-insured treatment, that could potentially place an added requirement for \$1.4 billion in treatment services on the public system.

This approach would be critically dependent on maintenance of a publicly subsidized SAT system to serve chronic and severe cases that require either more extensive, different types of, or more episodes of treatment than covered in this limited benefit. There would be a continuing requirement for public funding of SAT estimated to be at least \$4.57 billion per year (with the additional requirements noted in the paragraph above to serve those receiving fewer services): access to care would not significantly change for those dependent on the public treatment system for some or all of their care. It is estimated that 2 million persons with no insurance or with public health insurance would continue to access 3.8 million admissions to treatment per year. This level of funding would only maintain aggregate service provision at current levels. It would not provide for an expansion or improvement of SAT service delivery to meet unserved needs.

VII. Discussion

In 1993 expenditures on specialized substance abuse treatment services are about \$6.7 billion, or \$25.75 per person in the U.S. About 3 million persons per year are accessing 5.8 million treatment admissions per year at an average cost of almost \$1200 treatment admission, or \$2,350 per person treated per year..

Private insurance is paying for about \$1.63 billion in substance abuse treatment services from the specialized treatment delivery system, which is about \$10.00 for each of the nearly 160 million persons in the United States with private health insurance. Out-of-pocket payments for these privately insured individuals are estimated at another \$535 million. It is plausible that the privately insured are using about \$866 million in publicly funded treatment due to inadequate private coverage. In contrast, public spending (Medicaid plus Medicare, the Department of Veteran's Affairs and general appropriations) of \$3.46 billion per year amount to about \$34.60 for each of the approximately 100 million persons relying on public health finance plans or without health insurance. Client out-of-pocket payments for this population are about \$235 million.

One comprehensive model of substance abuse treatment coverage would cost an estimated \$11.725 billion from all payment sources per year to implement. This would be \$45.10 per person in the U.S. It is estimated that 3.3 million persons would obtain 6.4 million admissions to treatment per year under this plan. This is based on an estimate that the total number of persons accessing care would increase by 10 percent. Treatment would cost over \$1800 per admission, an increase from the \$1200 per admission in the current system. This value rises primarily due to restoring inflation-adjusted funding per client in treatment to the levels that prevailed before 1980.

The other proposals that are analyzed actually only explicitly deal with reforming financing for the "private" or the "public" components of the substance abuse treatment system, respectively.

The recently presented Health Security Act (HSA) proposes that in the immediate future there would only be a limited effort at improving access to substance abuse treatment through increased access to a limited private insurance-like benefit. There are no major provisions to expand or improve the publicly-subsidized treatment system, although the HSA recognizes a continued major role for this system. There is an intent in the HSA that the public system would be integrated with the private system by the year 2001, at which time the HSA benefit would be expanded.

Under the HSA total national expenditures on substance abuse treatment are predicted to remain at about \$6.7 billion. It is estimated that about \$2.3 in treatment funding would flow through Health Plans, and clients would make out-of-pocket payments of an additional \$754 million. The Health Plans could promote access to treatment through early screening, diagnosis and referral. However, coverage under the Health Security Act is limited, and patients that seek more than short term treatment will generally need to pay out-of-pocket or access the public treatment system.

The HSA explicitly envisions a continued role for the public treatment system, although it contains no funding proposals for expanded delivery of treatment. There would be a requirement for \$3.5 billion in public funding plus client payments of about \$200 million for the public system to simply maintain the current level of services being delivered. The HSA proposal is not expected to expand treatment availability or access.

An improved publicly-subsidized "safety net" could also be constructed to bolster the private system. The Minnesota Consolidated Fund represents one of the leading efforts by states to accomplish this task. If the Consolidated Fund approach as implemented in 1988-1990 were adopted at the national level it would cost an estimated \$11.55 billion to pay for publicly subsidized care. This plan would assure access to treatment for those low income individuals dependent on public support as well as low and middle income persons that exhaust their insurance coverage. It is estimated that 2.3 million persons per year would receive treatment under this plan, and would receive 4.4 million admissions to treatment. The Consolidated Fund spent \$2750 per admission in 1992 (\$3000 in 1993 adjusted for inflation). This is in contrast to the roughly \$1200 per admission spent nationally in 1993. The difference in cost per admission is primarily due to greater reliance in Minnesota on inpatient treatment than in the rest of the nation.

Another "expanded private residential and outpatient benefit" proposes a coverage plan that would encourage residential/inpatient treatment to be delivered in less-expensive short-term residential treatment facilities instead of hospitals (but only when medically appropriate) and encourage longer outpatient treatment (plus "aftercare) durations. This approach could reduce the estimated \$866 million dependence of those with private medical insurance on the public treatment system by about \$500 million per year. These funds could be used by the public system to expand or enhance services.

A very limited proposal that concentrates on reforming private insurance coverage and includes coverage like that of most HMOs (and currently included in numerous private insurance plans) would cost insurance plans \$1.49 billion (versus current reimbursements of an estimated \$1.63 billion). However, there would be continued requirements for \$5.97 billion for the public "safety net" system to maintain current services for patients not covered by private insurance plans as well as make up for the lower level of services delivered under such a plan.

This report has included costs where treatment was primarily directed at a substance abuse problem and the service was delivered in a treatment setting where specialized services are provided. Therefore costs from primary care settings such as general wards in hospitals, and care in emergency rooms and physician's offices have been excluded, since the services are more likely to be oriented to treatment of comorbidities. It is inappropriate to count the cost of treating comorbidities against the expenses of substance abuse treatment.

What must be emphasized, but has not been modeled in this report, is that effective substance abuse treatment will reduce the costs of treating comorbidities. As noted above, abuse of alcohol and drugs causes numerous health problems including a significant amount of trauma (deliberate and unintentional injuries).

Appendix ESTIMATING CURRENT SERVICES FOR SUBSTANCE ABUSE TREATMENT
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The primary analytic approach has been to build on the data included in NDATUS, with adjustments for known limitations. The findings from NDATUS have then been compared to data from the other sources identified above, in order to identify substance abuse treatment services above and beyond those reported to or deducible from NDATUS. The major limitations of this data base include the following:

- the data is for FY 1991 (the system has changed in three years);
- there is unfortunately missing data on some forms;
- several key data items are either aggregated, or not collected
- not all known treatment programs filed data forms; and
- NDATUS does not survey independent professional practitioners.

The following sections define our approach to estimating these overlaps in coverage and adjusting for double counting and present estimates of unduplicated clients, services and expenditures for substance abuse treatment services.

Survey and Data Source Coverage of Substance Abuse Providers

Most specialized substance abuse treatment services are delivered by identified specialized providers, such as certified alcoholism and drug abuse counselors, or programs including specialized hospitals (or units), residential facilities, various types of stand-alone ambulatory care providers. Such providers are classified under the rubric of the "specialty substance abuse treatment system". In addition, however, some modest amount of care for substance abuse disorders (this does not include treatment for sequelae of substance abuse) is delivered by other types of health care providers, including short-term general hospitals, and mental health providers (see Cruze et al, 1980).

There are a number of distinct surveys which collect and report data about service delivery and expenditures. The primary surveys for the specialty substance abuse treatment system include the National Drug and Alcohol Treatment Unit Survey (NDATUS) and the Drug Services Research Survey (DSRS). These are the primary data sources and references used for this report in compiling estimates. In addition, these have been complemented by accessing data from the specialty mental health system (the Inventory of Mental Health Organizations, or IMHO) and the general health system (e.g., National Health Expenditures (NHE), Hospital Statistics (HS), the National Hospital Discharge Survey (NHDS), the National Ambulatory Medical Care Survey (NAMCS)).

A critical analytic issue is that there are overlaps in the coverage of the respective surveys. For example, hospitals, as the major health delivery institutions in the health care system, are covered by NDATUS, DSRS, the IMHO, HS and NHDS. Another major overlap is between freestanding facilities reporting to both NDATUS,

DSRS and the IMHO. For purposes of this report these data sources and surveys have been carefully analyzed and compared in order to construct a comprehensive estimate of what kind of treatment is being delivered, in what amounts, and by what kind of providers.

After intensive comparison of data from the various sources it has been concluded that NDATUS is the single best data source on specialty substance abuse providers. Also, when NDATUS is adjusted for known deficiencies (in particular program and item non-response, discussed below), it is believed to represent the vast majority of specialized substance abuse treatment services. The lone exception is for substance abusers treated at mental health centers.

While the 1991 NDATUS did obtain data from 1,307 community mental health centers, analysis of the most recent Inventory of Mental Health Organizations indicated that even after adjusting for program non-response that NDATUS underestimated clients served and revenues for substance abuse treatment services by about one third. This adjustment is contained in all of the estimates presented in this report.

Another critical type of service is that of inpatient hospital care. Some experts have questioned whether NDATUS obtains data for hospitals of equal quality to that for other types of substance abuse providers. Based on this analysis it appears that with adjustments NDATUS provides estimates of at least adequate quality.

Analysis of NDATUS with adjustments indicates that 17,500 patients are in such treatment on a given night, and that a total of 296,000 unduplicated patients received hospital inpatient care in 1991. Due to relapse and the need for multiple treatment episodes there were an estimated 593,000 hospital admissions for specialized substance abuse treatment.

The AHA Hospital Statistics (American Hospital Association, 1992) reported that there were 34,000 beds in specialized alcoholism/chemical dependency hospitals and units in 1990. Other studies have found that occupancy in such hospitals and units ranges from fifty to sixty percent. Also, analysis of the National Hospital Discharge Survey finds that there were just over 500,000 discharges from short-term hospitals in 1990 for primary diagnoses of alcohol and/or drug problems.

Apart from mental health programs and hospitals there are no other major types of providers of substance abuse treatment that are both covered by NDATUS and another major data system.

Other Providers

Another class of providers that NDATUS does not include is that of mental health professionals in private practice. Just as community mental health centers serve substance abusers, so do these professionals, both in community health centers, as professionals at substance abuse programs, and potentially in private practice. However, it is not clear that significant numbers of individuals are being treated for substance abuse problems by these professionals in private practice.

The best data available is for psychiatrists in private practice. The National Ambulatory Care Survey (NAMCS) studies a nationally representative sample of Medical Doctors in private practice. The 1989 NAMCS estimated that only 1.2 percent of visits to psychiatrists was for the treatment of a primary substance abuse disorder (although another 1.8 percent of visits had substance abuse as a secondary disorder). There are an estimated 43,000 practicing psychiatrists in the United States (AMA, 1991), of whom an estimated 45 percent are engaged in private practice seeing an average of 1440 appointments per year (Dorwart et al., 1992). At an average charge of \$140 per visit, this indicates that \$47 million was spent on private practice psychiatrists to treat substance abuse.

Private practice psychologists and social workers also may treat substance abusers. There are 42,000 and 72,000 of such private practitioners engaged primarily in private practice (Health Resources Services Administration, 1991). Rates are assumed to be 75 percent and 50 percent less per visit than those for psychiatrists. If it is assumed that these professionals also see 1.2 percent of visits to treat substance abuse this indicates that \$29 million and \$13 million, respectively, were spent on their services.

In addition, it has been estimated that there are about 35,000 substance abuse counselors according to the National Association of Alcoholism and Drug Abuse Counselors. The vast majority of these professionals primarily practice within programs, therefore these services have been estimated elsewhere. A relatively small proportion also have private practices. Moreover, some of these professionals probably are counted in national estimates of private practice psychologists and social workers, because these are the disciplines in which many counselors have their advanced training. Therefore, separate estimates have not been developed for substance abuse counselors.

Adjustment from 1991 to 1993

The 1991 NDATUS values have been adjusted to 1993 to account for medical price inflation (which averaged 5.6 percent per year), but not for any changes in substance abuse service delivery.

Most analyses of health care reform are attempting to use current 1993 values, in order to facilitate comparisons with current public appropriations and private insurance data on health expenditures. Current estimates of medical cost inflation by the Health Care Financing Administration are for an average of 5.6 percent per year in 1991 through 1995.

The assumption that there has been no increase in services delivered per year seems warranted in the light of the minimal real (inflation adjusted) federal increases in funding for substance abuse services, and the fact that most states have struggled simply to maintain flat funding over the last several years due to fiscal pressures. There is not believed to have been any significant increase in private sector funding of treatment over this period. If anything, private insurance may have reduced purchases of services through active utilization of managed care.

Non-response Adjustments

Adjustments were made for program non-response and survey item non-response.

Two kinds of adjustments were made: for program non-response and for survey item non-response. The 1991 NDATUS census of specialized substance abuse treatment units achieved a response rate of 81 percent. All estimates (programs, current clients, annual unduplicated clients, and annual revenues) were adjusted up by 23.5 percent (computed as $100/81$ percent). It is assumed for this analysis that non-response indicated failure of a program to complete the survey, rather than non-existence of a program. This assumption seems justified because before the NDATUS survey was mailed out intensive work was put into identifying the universe of operating programs by contacts with State licensing authorities and associations of types of providers in compiling the census for survey.

Item non-response on selected variables was dealt with by statistical analysis. In particular, annual unduplicated clients and annual program revenues were affected, with item response rates of 62 and 82 percent, respectively. Imputation values were developed by regressing unduplicated clients and total program revenue, respectively, on current clients (by modality of treatment). There are strong differences in these relationships by modality, as it would be expected.

The 5,449 programs with data on unduplicated clients reported serving 1.77 million clients in the prior year. Imputations for the 3,386 programs with missing estimates of unduplicated clients added 1.24 million clients, for a 70 percent increase. Then the second adjustment of 23.5 percent for program non-response increased the total to 3.72 million. This estimate was later adjusted downward to 2.99 million to account for patients that were probably treated by more than one program over the course of the year (discussed below).

Revenues were not reported by 1,514 programs. Again, regression analysis was used to make imputations of \$785 million, or 19.5 percent. The final adjustment of 23.5 percent increased the total estimate to \$5.95 billion in revenues.

Adjustment of Client Estimates for Relapse

The estimates of annual unduplicated clients and of admissions were adjusted to account for patients that receive multiple types of treatment and/or relapsed and were re-admitted to treatment in a year. The Drug Services Research Survey (or DSRS; Brandeis University, 1992) found that over 50 percent of patients admitted to treatment had received treatment from the same or another program within the 12 months prior to the current treatment admission (data on prior admissions was not recorded for about 12 percent of patients). These previously admitted clients had an average of 1.4 to 1.5 admissions in the prior year. Thus on average substance abuse

patients had about 1.9 treatment admissions per year (including the episode counted by DSRS).

The national estimates of annual unduplicated clients and annual admissions are highly sensitive to whether relapsed clients were re-admitted to the same or different treatment programs. For example, calculations from NDATUS (adjusted for item and program nonresponse, as adjusted above) indicated that there were about 3.7 million annual unduplicated clients. If it is assumed that relapse always resulted in admission to the same treatment program (and as a result there is no duplication of clients treated in data for different programs), then the 3.7 million individuals had 1.9 treatment episodes each, for a national total of about 7 million episodes. However, if relapsing clients always enter a different treatment program, then the estimate of 3.7 million unduplicated clients must be adjusted down (divided by 1.9 episodes per person) to account for clients that were treated in more than one program in a year. Thus 1.9 million unduplicated clients (3.7 million divided by 1.9 episodes per person) would have received a total of 3.7 million treatment admissions. If it is assumed that relapsing clients are equally likely to enter the same or a different program then the national totals are 2.5 million unduplicated clients receiving 4.8 million treatment episodes.

This study has assumed that relapsing clients usually (in 75 percent of the cases) reenter the same treatment program. The logic for this assumption is that clients have previously received help from the institution, and the client is believed to be more likely to turn to therapists and institutions that have helped them at least once before. This assumption implies that the estimate of 3.7 million unduplicated clients is actually 3.0 million after adjustment, and that there were a total of 5.7 million treatment admissions for these clients.

Cost Shifting

One of the major issues in health care reform is the shifting of costs from the public sector to the private sector (Dobson, 1993). The fact that government does not pay the full cost of services that it purchases, has motivated medical providers to raise prices for private clients in order to cover losses. Medicare and Medicaid appear to reimburse at rates of less than 90 and 80 percent of costs, respectively. Medical providers appear to have raised prices almost 40 percent above "costs" to cover losses on Medicare and Medicaid patients (Dobson, 1993).

Comprehensive reforms of health care financing will probably address cost shifting by establishing cost-based rates, because the private sector is progressively unwilling and unable to cross-subsidize Medicare and Medicaid, and other un-reimbursed care through cost-shifting. Cost shifting has caused many employers with insurance plans to seriously consider dropping this employee benefit. If this occurs, it will exacerbate health care financing crisis as millions of individuals and families lose health insurance coverage and face the even higher expense of purchasing non-group policies.

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HEALTH REFORM FOR COMMUNITIES:

Recommendations on Financing Substance Abuse Services

Join Together, a national program helping communities fight substance abuse, convened a national policy panel to explore ways communities can ensure financing for substance abuse services. The panel heard testimony from community leaders and experts in the field of substance abuse. Here are the seven recommendations that this national panel will present to Congress and bring to communities across the nation during the process of reforming our nation's health care system.



Substance abuse treatment should be financed through the same sources that fund general health care.

- New and additional sources of health care financing should include increased taxes on alcohol and tobacco.



Substance abuse prevention should be adequately financed through a combination of public and private sector funding sources.

- The existing federal block grants should be strengthened and coordinated with funds from other federal, state, and local organizations, private businesses, and religious, civic, and educational organizations.
- Proceeds from drug-related asset forfeitures and seizures should be available to enhance spending for prevention at local discretion.



The nation must make a commitment to adopt and enforce cost containment mechanisms to control the rise in health care costs throughout the health care system; substance abuse prevention and treatment in and of themselves are essential components of any overall health care cost-control strategy.



There should be universal and timely access to substance abuse diagnosis and appropriate treatment services.

- All Americans should be covered continuously for a standard set of health care benefits, including substance abuse treatment.
- Individuals involved with the criminal justice system — incarcerated, on probation, or on parole — should be guaranteed the same standard health benefits as all other Americans.
- Interim treatment must be made available to individuals who must wait for admission to more intensive programs.



A broad continuum of substance abuse treatment services, related human services, and prevention must be available and accessible to all.

- Substance abuse treatment services must be explicitly included as part of a standard benefit package proposed for health care reform.
- Substance abuse treatment should be subject to the same coverage criteria (e.g., limits) as other health services.
- Coverage for substance abuse treatment services should include services provided by a range of trained, qualified professionals, including medical and non-medical personnel (e.g., counselors), in the most appropriate setting for the individual, including hospital and non-hospital settings.



Substance abuse treatment should be managed and coordinated to encourage the delivery of appropriate, cost effective care.

- Essential human services (e.g., outreach, transportation, child care, job training) needed by substance abusers must be available and accessible through linkages with substance abuse treatment.
- Substance abuse treatment services should be closely linked with mental health and other medical services to appropriately meet the needs of individuals with additional health problems.



Standard health care benefits should cover the cost of clinical preventive education, case finding, brief intervention counseling, and/or referral for alcohol, tobacco, and other drug problems.

To obtain a copy of the panel's full report, *Health Reform for Communities: Financing Substance Abuse Services, Recommendations from a Join Together Policy Panel*, or if you would like to sponsor a community meeting to educate people and groups about funding for substance abuse services in national health care reform, please call Join Together at (617) 437-1500, or send a message via HandsNet: HN1267@handsnet.org

JOIN TOGETHER ♦
A NATIONAL RESOURCE FOR COMMUNITIES FIGHTING SUBSTANCE ABUSE

Join Together is funded by a grant from THE ROBERT WOOD JOHNSON FOUNDATION to the BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH

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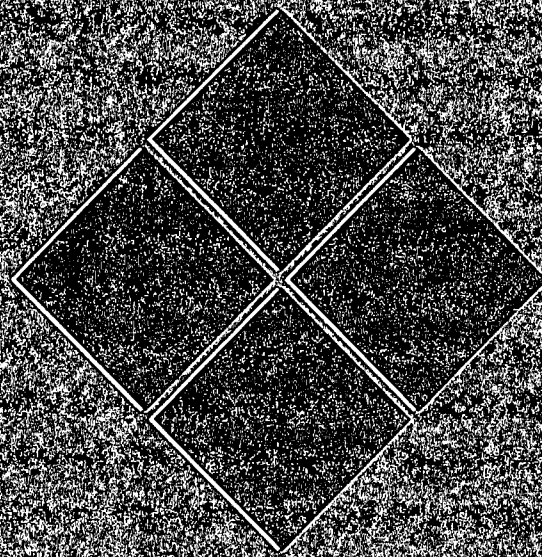
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Health Reform for Communities:

Financing Substance Abuse Services

Recommendations
from a
Join Together Policy Panel



JOIN TOGETHER ♦
NATIONAL RESOURCE FOR COMMUNITIES FIGHTING SUBSTANCE ABUSE

REMARKS BY DR. LEE P. BROWN
DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY
ON
HEALTH CARE REFORM

KANSAS CITY, KANSAS
SEPTEMBER 23, 1993

Thank you Secretary (Donna) Whiteman (alt: Governor Finney) for your very generous and warm introduction, for your willingness to receive me on such short notice, and for offering me lunch and the opportunity to talk with you today. I am truly glad to be in here.

As you know, I am here to talk about the President's Health Care Reform Proposal -- what it means overall, how it will benefit all Americans, and its impact on the area of my special concern, the fight against drug abuse.

Many of you know that the nation's current health care system, no matter how good many of its separate elements may be, has gone terribly wrong:

- o over the next two years, one out of four Americans will be without health coverage at some point
- o Today's system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Many will drop clients who get sick. Individuals with pre-existing conditions, usually cannot get any kind of health insurance at all
- o Insurance companies charge small business as much

as 35% more than larger companies

- o Only 29% of employers with less than 500 employees offer any choice of health plan
- o Twenty-five cents of every dollar on a hospital bill goes to administrative costs. It buys no patient care
- o Fraud and abuse cost the country \$80 billion -- or ten cents of every health care dollar
- o Health costs have nearly quadrupled since 1980. Today, one of every eight dollar our country spends goes to health care. By the year 2000, the figure will be one of every five dollars

To many of us, of course, the issue is not abstract. Many -- perhaps most -- have some story, some personal history, that illustrates how difficult -- indeed, how corrosive -- the problem has become.

(NOTE: INSERT HERE A PERSONAL EXAMPLE FROM DR. BROWN'S EXPERIENCE)

The current health care system, in short, is broken. Worse, its problems threaten to overwhelm us and our children. To fix it is a pressing task on whose success the future welfare of our country depends. That is what I want to talk to you about today: how to meet the need.

As you know, the President has proposed a new health care reform plan -- the Health Security Act of 1993. The proposal rests upon six cardinal principles. Let me give these to you, and explain how the proposal addresses them, and what they involve:

Principle #1 is that insurance coverage must be guaranteed -- no matter what. For one matter, the President's plan makes it illegal for insurance companies not to cover individuals because of a pre-existing condition. Insurers cannot raise premiums or drop someone if he or she becomes sick. For another, coverage is guaranteed, even if one loses one's job. The envisioned employer-paid portion -- which I will say more about later -- will be covered from "sin taxes" and Medicaid savings. As well, coverage is guaranteed if one switches jobs, moves, or starts a small business -- which is not the case today. And the plan guarantees coverage for early retirees, so that they don't have to worry about being without coverage after they retire and before they are covered by Medicare.

Principle No. 2 is that the health benefits package must be comprehensive. All Americans will be guaranteed a benefits package as comprehensive as those offered by most Fortune 500 companies. The benefits will emphasize preventive care, and cover fundamental services such as immunizations, mammograms and prenatal care. It also guarantees coverage of prescription drugs, hospital care, doctors' visits, emergency services, laboratory and diagnostic services, children's preventive dental care, vision and hearing care, and hospice care. Most importantly, it puts special emphasis on keeping people healthy, rather than waiting until they get sick.

The third principle is that health care costs must be contained. The President's plan will limit how much insurance companies can raise your premium. It will introduce competition to the health care marketplace. It will reduce health-care fraud. It asks the drug companies to hold down prescription drug prices, and squeeze the waste out of Medicare and Medicaid.

A fourth principal of the President's plan is that the quality of American health care must be improved. I've mentioned that the plan emphasizes preventive care, thereby improving the quality of care by keeping people healthy before they get sick. It will empower consumers to evaluate the quality of health through "report cards"

on specific health care programs. And -- importantly for those who live in rural states -- will give rural residents access to the latest technology and emergency services through new communications links between doctors and specialists, and provide incentives for more family doctors in rural as well as urban areas.

A fifth principle is that choices for consumers must be increased. Under the President's health care reform plan, individuals will keep the right to choose their own doctor -- and follow their doctor to any plan he or she might join. It will increase your choice of health plan, permitting you to choose from among all the health plans offered in the area where you live. It will increase options for long-term care, and make it possible for more Americans to receive care while living at home. In short, it will put consumers in the driver's seat, and level the playing field for individuals and small businesses.

Finally, any new health care plan must reduce paperwork and simplify the health care system as a whole. This one does exactly that. It will streamline and simplify claims by instituting a single, standard claim form. It will eliminate the fine print -- what you get will be spelled out in easy-to-understand language. For doctors, nurses and hospitals, it will set standard

rules for payment. And for the consumer, it will allow electronic billing.

This is a general overview of the President's plan. Now, what does it mean specifically for substance abuse, the issue with which I am most directly concerned?

You may know that currently, most private insurance plans cover only a very narrow band of mental health services -- limited inpatient hospital care and severely limited outpatient visits to a mental health professional. And standard health insurance plans impose arbitrary restrictions on treatment for mental and addictive disorders.

The President's health care plan integrates mental health and substance abuse services with the national system of health care, covering a comprehensive array of services and providing flexibility to manage these according to medical and psychological necessity. This promises to be a historic event in the treatment of mental illness and substance abuse, and will need a phase-in period to allow time to develop the service system capacity to deliver and manage this more comprehensive benefit. These are some of its more important elements:

- o Beginning in 1996, every American will have some mental health and substance abuse coverage.
- o Lifetime and annual mental health and substance abuse coverage will be eliminated.
- o Exclusion from insurance coverage based on pre-existing conditions will be eliminated.
- o The plan includes many non-residential options, including partial hospitalization, day treatment, ambulatory detoxification, home-based services, and behavioral aide services. It is designed to encourage the use of innovative alternatives to inpatient treatment.
- o Outpatient service are covered to encourage early intervention and less restrictive treatment options.
- o Family members may receive medically necessary, related services -- so-called collateral treatment.
- o As the treatment system adapts to anticipated changes, the annual limit for inpatient treatment will increase to 90 days in 1988 and is to be replaced by benefit management by 2001.

- o During the phase-in period, the Federal government will support state demonstrations of comprehensive, integrated mental health and substance abuse treatment.

I will be frank that the plan does not cover every drug abuse situation or condition. But where there is a special need for drug treatment within particular groups or areas -- the U.S. prison population is a case in point -- I plan to be personally engaged with the concerned Federal agencies (here, Mrs. Shalala and Janet Reno) to work out ways to ensure that substance abuse health care is available there, too.

Now, how will this be paid for? What are the financial consequences of such a dramatic change in our national health care system?

We plan to finance the plan from four major sources:

1. Employer and employee contributions. We will ask everyone to pay for something, even if the contribution is small. Everyone will be asked to assume responsibility. Today, the overwhelming majority of employers cover their employees. But the businesses that provide insurance are paying for those who don't. The new plan is equitable: no

one will get a free ride.

2. Medicare and Medicaid savings -- these are specific areas of savings achieved by slowing the rate of growth of these programs. And the savings will be channeled back into benefits for the people whom these programs serve.
3. Coverage of uncompensated care. This is savings from money now used to pay hospitals for providing care for the uninsured.
4. Sin taxes and other additional Federal revenue. Money will be raised by additional excises on tobacco and alcohol -- both substances that pose specific threat to our national health. And, reductions in tax deductions for medical expenses will make more Federal money available for health care reform.

The financing proposal for the President's plan was developed under the most rigorous and conservative forecasting standards. For the first, time, representatives from every Federal agency involved in fiscal accounting and financial projections were brought together to ensure that the numbers are correct. And teams of actuaries, health economists and other

financial analysts from outside the government have been acting as auditors and consultants throughout the process.

All of this sounds very ambitious, I know. But, if we are to regain our future, we must address and reform, forcefully and with vision, our current, broken system of national health care.

I ask you to join me in supporting this plan, and to making it work for us all.

Thank you . Please let me know if you have any questions -- including questions about the drug situation in the country and how we plan to address it.

September 20, 1993

NOTE TO DR. BROWN

Attached is summary of the major provisions of Health Care Reform as it pertains to the drug benefit. It should be used as background for today's 5:00 p.m. briefing by HHS on this subject.

Ricia McMahon

cc: Ed Jurith
Jose Cerda
John Gregrich
Babette Hankey
John Carnevale

Substance Abuse Benefits Under Health Care Reform

1. The Health Care Reform Proposal provides benefits for:

o Inpatient and Residential Treatment

- Including inpatient hospital, residential detoxification, and residential treatment centers,
- Up to 30 days per episode and up to 60 days per year (increasing to 90 days per year in 1998),
- Deductibles apply under certain plan options until 2000;

o Intensive, Non-residential Treatment

- Including partial hospitalization, ambulatory detoxification, and day treatment,
- Up to 120 days per year with limitation dropped in 2001,
- Co-payment of up to 20 percent under certain plan options;

o Professional and Outpatient Treatment

- Including diagnosis, substance abuse and relapse prevention counseling, clinical management (e.g., methadone maintenance), and outpatient psychotherapy.
- Up to 30 visits per year for services other than substance abuse counseling and clinical management, which are not limited. Limitation dropped in 2000.
- Co-payments of up to 50 percent under certain plan options. To be reduced in 2000.

2. The Health Care Reform Proposal does not cover:

o Treatment for Prisoners;

o Drug Abuse Prevention;

o Systems Development, such as management and monitoring capacity of state or regional service systems; or

o Supplemental Services, such as outreach, child care, shelter, transportation, case management, monitoring, and criminal justice supervision.

3. Legislative action is anticipated in this Congress.

- o The President's Health Care Reform Proposal will likely receive attention from five Congressional Committees with major jurisdiction and up to 12 with joint jurisdiction.
- o The Administration's target date for Health Care Reform to become law is spring of 1994.
- o States may begin implementation as early as January 1, 1995, and are offered monetary and administrative incentives to do so before January 1, 1997.

4. Transition from the present system is planned through 1997.

- o For substance abuse programs, a major part of this transition is the replacement of most direct public drug treatment services (e.g., under block grant programs) with benefit coverage under the new plan.
 - HHS estimates, as of 9/15/93, that \$900 million of the \$1.3 billion now spent by the Public Health Service on substance abuse goes for direct services.
 - HHS further estimates that \$700 million in services will be covered by benefits under Health Care Reform, once implemented.
 - Thus, block grants can be cut back eventually to reflect these savings and focused on supplemental and other services not covered under the plan.
- o When the transition is complete, HHS envisions a tripartite program:
 - Health Care Reform providing services,
 - Block grant programs providing linkage to and supplementing services, and
 - Demonstration programs developing infrastructure.
- o A strategic plan, addressing the transition and related public health initiatives will be released by HHS by November 1993.

5. Certain issues are raised by the proposal.

- o In general, its focus on preventive and short-term acute care, while appropriate for medical and most mental health services, is at non sequiturs with substance abuse treatment, which is essentially chronic care.

-- This problem is apparent conceptually in the proposal's intended "integration" of substance abuse and mental health services, as opposed to its intended "linkage" of substance abuse treatment with primary medical care. The latter is essential, the former potentially dysfunctional.

-- Practical and specific reflection of this problem is found in the drug treatment benefit limitations, which are set in terms of days rather than dollars.

This is especially problematic for residential care. Although only a minority of drug users require residential treatment, those who do will certainly require more than the 30 days per episode and 60 days per year allowed. Indeed, there is nothing in the research to suggest that 30 days has any beneficial effect for those who require residential treatment, and little measurable benefit has been found for programs of less than 90 days duration.

-- A less expensive and more functional alternative to capping days would be to set a dollar cap. A somewhat more cumbersome but more functional alternative would be to set and enforce rigorous criteria for the use of residential treatment.

-- Nonetheless, HHS appears committed to this approach and it is consistent with the approach taken by the recently-concluded commission on state drug laws.

o Of major concern to those who administer or oversee publicly-funded drug treatment programs is the phasing of the transition from public to insurance funding.

-- In simple terms, they fear that public program cuts will precede (and exceed) actual insurance coverage and projected cost savings from such coverage.

-- These groups are likely to seek continued full funding of the block grant program for as long as possible and to further seek the support of the block grant at the expense of competitive discretionary programs like CEP.

Given the opportunity, ONDCP should:

o Seek to have the benefit limitation for residential drug treatment revised, and

o Continue strong support for discretionary programs to expand capacity, demonstrate new approaches, and build infrastructure.



U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF THE ADMINISTRATOR

*Cookie -
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TO: Chiefs of Staff Oct. 6, 1993
FROM: Katie Broeren *Katie*
SUBJECT: *Health Security Act: Benefits for Business* brochure

The enclosed diskette contains the brochure "*Health Security Act: Benefits for Business*" in ASCII format and also in Word Perfect 5.1 for use in your own department or agency. Please feel free to disseminate it to your employees and customers in hard copy or electronically.

If your staff should have any technical questions regarding distribution via electronic bulletin board, they can contact Diane Gannon of SBA's Information Resources Management staff on (202) 205-6253.

I've also enclosed a few of the brochures and a copy of one of Erskine's recent speeches on the Health Security Act proposals. I hope you find this information useful.

Enclosures

THE CLINTON HEALTH CARE PLAN

A Chance For Small Business To Be Healthy Again

I am very pleased that you asked me to come today and speak with you about the Clinton health care plan. I want you to know up front that I am excited about this plan and I am excited about what it can do for small business -- For the first time ever, small business will be able to buy rock solid, comprehensive insurance at an affordable rate. I think this plan will be good for small business and it will create jobs.

I am also frightened by what could happen to our country and to small business if we don't enact health care reform and do it now. Let's talk about what the current health care system is doing to our country first, and then what it is doing to small business.

MACRO VIEWPOINT - THE BIG PROBLEM

Every month, two million people lose their health care coverage -- That's every month, two million more people without health care. During the next two years, one out of four Americans will be without health care for some period of time -- that's 63 million people. There are 37 million Americans without insurance today, and another 22 million who are underinsured.

And the rising cost of health care could literally bankrupt this country. The U.S. today spends more per capital on health care than any other country in the world; more than double what Japan spends and 40% more than Canada, which is the second most expensive country. Twenty-five years ago, health care consumed 5.9% of GDP. In 1992, that number topped 14% for a total of a staggering \$840 billion. If this trend continues, we will see annual health care spending rise above \$1 trillion by 1994. If left unchecked, by the year 2000 we will see health care spending top \$1.6 trillion and approach 20% of GDP. If we do nothing, health care costs will consume about two-thirds of the increase of GDP in the rest of this decade. This is simply unacceptable.

What's amazing to me is that while spending 14% of our gross domestic product on health care, we are only able to cover 86% of our population. Our primary competitors in Germany, Japan, Canada and England all spend less than 9% of GDP on health care and are able to cover almost 100% of their population. There is not a single business person in this room who, if you look at your income statement and saw an expense item at 14% and all your competitors at 8% to 9%, wouldn't think you had a real problem. There is also not a single one of you who wouldn't believe that you ought to be able to operate your business more efficiently and more effectively and bring this cost down to industry levels. This would especially be so if you looked at the opposite side of the ledger and saw that you were only servicing 86% of the marketplace while spending 14% of revenues and the rest of your competitors were serving 100% of the marketplace while spending only 8% to 9%.

Just think, in 1965 health care costs ate up just 8.4% of American businesses' pre-tax profits. By 1989, health care costs consumed over half of all pre-tax profits. In 1965, health care costs took 14% of after-tax profits. Twenty-four years later, health care costs consumed almost 100% of after-tax profits.

Clearly, from a macro viewpoint we have a serious problem in this country with our health care costs.

TODAY'S SKYROCKETING HEALTH CARE COSTS HURT SMALL BUSINESS

As it relates to health care today, small business is faced with the worst of all worlds. The two-thirds of all small businesses that are still able to afford to provide their employees with health care coverage are experiencing absolutely skyrocketing cost increases. Small business health care costs have increased at a rate of 20% to 50% a year. Small businesses pay 35% more for the same insurance than do big businesses. The rate of increase in the cost of health care for small businesses is 50% higher than the rate of increase for big businesses. Unfortunately, the smaller the company, the more disproportionate are the costs they pay for health insurance.

ABUSES OF CURRENT HEALTH CARE SYSTEM LOADED ON SMALL BUSINESS

Not only have small businesses experienced skyrocketing increases in the cost of health care, they have also been subjected to every one of the most blatant abuses that occur within the health care system. These abuses include such practices as occupational redlining, whereby insurers will simply refuse to cover entire industries perceived to be too high a risk. These industries often include such basic businesses as automobile dealerships, florists, grocery stores, barber and beauty shops, construction companies, and trucking firms. Insurance companies also engage in price baiting and gouging, a practice whereby many insurers engage in offering discounted rates for the first year of coverage, only to charge much higher rates in the next year when pre-existing condition exclusions expire. Many insurance companies make it a policy to refuse to renew insurance policies if one of the employees of a small business happens to get sick and really needs their insurance. When this happens, many insurers either pull the policy or jack up the cost whereby the company can no longer afford it.

OTHER WAYS THE CURRENT HEALTH CARE SYSTEM PENALIZES SMALL BUSINESS

In today's market environment, small business owners also must spend an inordinate amount of time and effort to just try to understand enough about the insurance market to cover their employees. Unlike large firms, small businesses don't generally have a benefits department. Therefore, most small business owners, or a very valued employee, must perform all the functions of such a department by themselves. In doing so, they frequently must deal with an insurance market that changes its rules at every stage of the game. Therefore, the small business owner not only loses

valuable time away from his customers and his business, but he also deals at a real disadvantage with trying to negotiate the purchase of a benefit for his employees that is extraordinarily complicated to understand and is constantly changing.

In today's marketplace, a self-employed individual also operates at a significant disadvantage because of the inequitable tax policies for the self-employed. A self-employed individual is only allowed to deduct as a business expense up to 25% of the cost of health care coverage. All other businesses are able to deduct the full cost of coverage. This is clearly unfair to the self-employed and almost, by definition, increases their cost of insurance for their families.

In today's health care marketplace, workers compensation has also become a bigger and bigger burden to small business owners. Today's increases in health care costs are surpassed only by the incredible growth in workers compensation costs. Increasing at an even faster rate than the rest of the health care system, workers compensation medical costs grew more than one and a half times as fast as medical costs between 1980 and 1985. Between 1982 and 1992, the average workers compensation medical claim rose from \$2,584 to \$8,900. Truly, the only expense item on a small business's income statement that is growing at a faster rate than the cost of health care is the cost of workers compensation.

SMALL BUSINESS HAS WORKED HARD TO CONTROL COSTS

Clearly, small businesses have a large stake in solving the health care crisis in this country. And small business owners have done all they can by themselves to control costs, yet costs continue to skyrocket. Small businesses have tried changing programs, managed care, self-insurance, and cost sharing. They have tried passing along a higher percentage of cost to their employees and reducing benefits, but nothing helps. The cost of health care continues to skyrocket. Despite all the efforts made to date, small business is still affected by the worst abuses of the insurance system. And again, unfortunately, the smaller the company, the more expensive the insurance and the worse are the abuses that are impacted upon the small business.

Still, according the Employee Benefit Research Institute, two-thirds of small businesses with fewer than 100 employees provide health care coverage to their employees. However, because it is all they can afford to do, many of these small businesses provide either very "bare bones" coverage for their employees or insurance that has such a large deductible that the policy purchased really only provides coverage for catastrophic events.

As tough as it is for small businesses that do provide insurance, it is even worse for that minority of small businesses that do not. Many small businesses that do not provide insurance would love to, they simply cannot afford to because the costs are too great today. The annual increases in insurance cost are simply too unpredictable and the benefits they can currently afford to purchase simply

aren't good enough to make it worth the cost. Many small businesses would provide insurance to their workers if they could provide their workers good coverage at a reasonable cost and they were assured that next year's premiums weren't going to go through the roof. Unfortunately, the private sector has not provided this mechanism. The insurance companies are so powerful and small business is so vulnerable, that this just hasn't happened.

THERE IS NO SOLUTION WITHOUT UNIVERSAL COVERAGE

Today, three major groups finance the cost of health care in this country:

1. The government;
2. Self-insured companies -- generally big corporations; and
3. Businesses which insure through traditional insurance companies -- generally small businesses.

Together with individuals, these groups finance virtually all of the nation's health care spending. When one of these groups pays less, the others must pay more to cover the cost. The federal government system, which sets the amounts Medicare pays for particular services, can reduce the government's expenses for Medicare. However, when this action is taken, it has done nothing to lower the overall cost of health care and government has actually driven up costs for the privately insured.

When health care providers cannot get adequate compensation from the government, they simply raise the prices charged to everyone else. Large, self-insured plans frequently have a great deal of clout in a given area and can negotiate with providers to reduce the impact of this cost shift on them. However, small employers have no ability to reduce this cost shift and must bear its full brunt.

This same cost shifting scenario also occurs when providers deliver uncompensated care, primarily to the uninsured. Make no mistake about it, the uninsured are provided health care in this country. They simply get it at the emergency room at four or five times the cost it would be at the doctor's office. And because there is no insurance coverage, someone has to pay for this treatment. Today this cost is shifted onto the backs of small business. Clearly, no part of the business community is hit harder by the high cost of the uninsured than small business.

A partial solution that doesn't offer universal coverage for the 37 million workers who are uninsured is simply no solution. Unless these uninsured Americans are provided insurance, we will continue to have the cost shifting that has gone on in the past. Unfortunately, the sector of the economy that will bear a big portion of this cost shift will be the small businesses that are currently paying as much as 35% more for the same insurance that big business pays today.

HOW THE CLINTON HEALTH CARE PLAN WORKS FOR SMALL BUSINESS

The Clinton health care plan provides small business with comprehensive insurance coverage at an affordable rate. The President worked hard to protect small business so the solution he offered would be real, so the insurance that was provided would be comprehensive, so the insurance couldn't be just jerked away, and so that the insurance was priced reasonably so that small business could afford it.

The Clinton health care plan will control the skyrocketing cost of health insurance by increasing competition in health care, reducing administrative costs, and imposing budget discipline. By forming buying groups and health care alliances, the Clinton health care plan shifts the power of the marketplace to the buyer of insurance and changes the supply and demand equation from favoring the provider of health care to benefiting the consumer.

The Clinton health care plan simplifies the health care system and takes wasted costs out of health care. The plan reduces administrative costs through standardized forms, uniform billing, electronic claims submission, coordinating benefits, and malpractice reform. Today, 25¢ out of every dollar on your hospital bill pays for administrative costs. It doesn't buy a nickel's worth of health care. Today, 10¢ of every health care dollar goes to fraud and abuse. That's wrong and the Clinton plan stops it.

The Clinton health care plan also reduces the enormous burden of paperwork and administration that currently falls on small business, as well as its regulatory billing and reporting requirements. The cost of administering coverage in small companies declines because they purchase through health alliances that exercise market power reserved only for large employers in today's system.

Clearly, the Clinton health care plan gives small business what it needs:

1. Rock solid, comprehensive insurance coverage, not a bare bones plan or just catastrophic coverage, but real insurance.
2. It gives small business insurance it can afford by providing caps and subsidies to hold down the cost of health insurance for small businesses. National Small Business United estimates that the average small business without insurance has a payroll of \$7,400. If this is accurate, then the average small business without insurance will be able to supply comprehensive, rock solid insurance coverage to each of its employees at a cost of only \$259 a year. That's less than \$1.00 a day per employee for rock solid, comprehensive insurance. National Small Business United also estimates that the average small business that currently provides its employees insurance has a payroll of \$15,600. If that is the case, then these small businesses will see their annual

insurance cost fall to only \$827 per employee. That's about \$2.25 a day per employee, representing a significant savings for that average small business currently purchasing insurance.

3. The plan sets up mechanisms to make absolutely sure that the cost of health care is brought under control, to ensure that the cost of health care will increase by approximately the rate of growth of wages, as opposed to the skyrocketing costs that small businesses have incurred in the past.
4. The plan removes all of the abuses of the current health care system. If one worker in a small business becomes seriously ill, the business will no longer see their rates jacked up beyond belief or lose coverage for the sick employee or dependent.
5. The plan enables the self-employed to deduct 100% of the cost of health care coverage from their taxes, instead of the 25% it can in today's marketplace.
6. The plan is combined with the health portion of workers compensation. That brings this skyrocketing expense under control.
7. The plan calls for a significant percentage of the cost of insurance to be paid by the employee so that the employee has the same incentive to hold down the cost of health care as does the employer.
8. While the cost to the employer stays the same, the plan calls for the employee to pay more for health care insurance if they choose more expensive health care coverage, therefore the employee has a strong incentive to choose an economical provider group.
9. The plan removes all the hassle that small business now has to go through in dealing with insurance companies and frees up valuable time for the small business owner to manage and grow their business.

I am confident that when each small business that has insurance lays the Clinton health care plan side by side with that it currently offers its employees, that the vast majority of them will see both a decrease in cost and better coverage. Clearly, every small business will not be better off but the vast majority will. Those small businesses that have wanted to offer their employees insurance but couldn't afford it are going to see a comprehensive plan that they can now afford. Those small businesses that have been scared off by the constantly escalating cost of health insurance and the relatively poor coverage will see a plan that they can afford to offer. These small business owners are also going to see a plan that is worth buying. And those very small businesses that are only able to pay their employees very low wages are going to be able to offer their employees rock-solid,

comprehensive insurance coverage that will cost the small business owner as little as \$1.00 to \$2.00 a day per employee.

In summary, I am absolutely positive that small business will benefit from the Clinton health care plan. I am absolutely positive that if the trade organizations don't scare off small business by going around yelling about mandates, that small businesses, after looking at the facts of this plan, will get behind it. The Clinton health care plan is good for small business and, as Administrator of the Small Business Administration, I am very proud to support it.