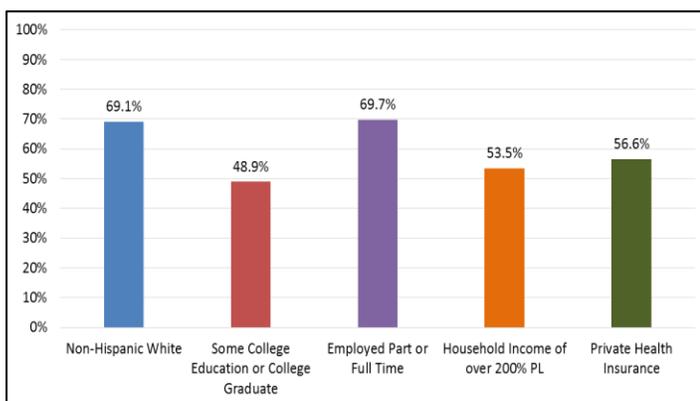


Addiction Treatment Today and Tomorrow: Implications and Policy Recommendations

Purpose: The National Association of Psychiatric Health Systems (NAPHS) commissioned Dobson DaVanzo & Associates, LLC, an independent health care policy and economics consulting firm, to define the substance use disorder population and to appraise existing policies regarding the coverage, funding, and delivery of addiction treatment. Our findings are based on a focused review of the relevant literature, as well as information gleaned from a series of key informant interviews with clinical, policy, and other substance use experts. (This document provides a high-level summary of our key findings and policy recommendations.)

Scope of Problem: According to the Substance Abuse and Mental Health Services Administration (SAMHSA), nearly 22.7 million persons 12 years and older in 2013, or 8.2 percent of the U.S. population aged 12 or older, fit the diagnostic criteria for dependence or abuse of alcohol and/or illicit drug(s).¹ Substance use disorders are widely distributed across a broad range of socio-demographic populations with varying levels of educational attainment and financial resources (Exhibit 1).²

Exhibit 1: Characteristics of Persons with Potential Substance Use Disorders (2008-2009)



Source: Saloner B and Le Cook B. An ACA provision increased treatment for young adults with possible mental illnesses relative to comparison group. *Health Aff.* 2014; 33(8):1425-34.

Each year substance use disorders have a tangible impact on the societal and economic well-being of the United States, leading to:

- Approximately 88,000 alcohol-related³ and 43,982 drug overdose-related deaths,⁴
- 2.5 million avoidable emergency department visits from drug misuse,⁵
- Involvement of nearly 85 percent of the incarcerated population with substance use,⁶ and
- An estimated \$343 billion in costs for direct and indirect resources and lost productivity.^{7,8}

Recent growth in illicit use of prescription opioids has led to increases in heroin use and heroin overdose deaths as well.⁹

Despite these costs, only 11 percent of individuals with a substance use disorder receive treatment.^{1,10} The marked disparity between the treated (2.5 million) and un/undertreated populations (20.2 million) in 2013 reflects the many structural barriers to accessing care, including:

- Large gaps in public and commercial insurance coverage of addiction treatment,
- Limitations in treatment infrastructure and capacity,
- Fragmented care delivery system that is poorly integrated with medical providers, community resources, and public health programs,
- A lack of evidence-based addiction treatment research to support clinical practice standards, and
- Stigma.

Transformative Policies: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and specific provisions of the Affordable Care Act of 2010 (ACA) sought to improve access to treatment caused by prior insurance coverage restrictions. Under MHPAEA, the financial requirements (e.g., co-pays, deductibles, and out-of-pocket limits) and treatment limits (days and visits) on addiction treatment services offered by large group health plans were made equivalent to other medical benefits. In addition, an early provision of the ACA allowed young adults aged 19 to 25, a demographic group disproportionately affected by substance use disorders,² to remain on their parents' health insurance as dependents starting in 2010. Finally, starting in 2014 under a separate ACA provision, parity coverage regulations modeled after the MHPAEA were extended to require all new small group and individual market plans, as well as Medicaid expansion programs, to cover addiction treatment as an "Essential Health Benefit."¹¹

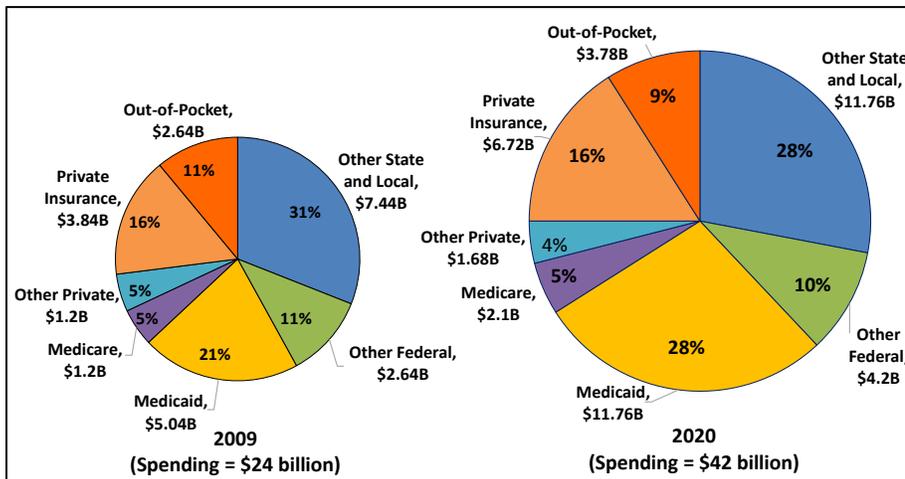
The full impact of MHPAEA and ACA on patients' access to addiction treatment is difficult to assess given the recent and phased-in implementation of both laws. Coverage gaps not addressed in either piece of legislation (e.g., federal statutory prohibition on payment for acute psychiatric hospital and residential treatment services for adult Medicaid enrollees) will likely persist in underinsured populations.⁹ Preliminary evaluations of both laws show mixed effect on expanding access to care for young adults.^{2,12}

Over the next 10 years, the full impact of the ACA is expected to change the delivery of addiction treatment in significant ways by, most notably, better integrating these services with primary care and facility- and community-based providers.¹³ Due to Medicaid expansion under the ACA, the Medicaid

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program will fund the majority of this growth in spending (Exhibit 2). Although overall funding for addiction treatment is expected to grow,¹⁴ continued evaluation of these programs, as well as increased consumer transparency of covered benefits are needed to identify and monitor coverage gaps, financial resources, and related shifts in care delivery that may adversely affect patients' access to treatment.

Exhibit 2: Distribution of Addiction Treatment Spending by Payer in 2009 and Expected Spending in 2020



Source: SAMHSA (2014). Projections of National Expenditures for Mental Health Services and Substance Abuse Disorders, 2010-2020.

Evidence-Based Treatment and Research: Medication-assisted regimens and psychosocial therapies are provided to patients with substance use disorders. There is a need for greater research to develop more standardized protocols for addiction treatment. To advance the quality of addiction interventions, a culture shift toward evidence-based medicine and an influx of funding for basic-science and health services research are needed.

Conclusion and Policy Recommendations: Over 8 percent of the U.S. population aged 12 and older fit the diagnostic criteria for dependence or abuse of alcohol and/or illicit drug(s). Substance use disorders affect most social, economic, and demographic populations, and their societal and economic impacts are enormous. Treating substance use disorders has been shown to reduce overall health care spending, lower costs associated with lost employment, and generate savings for the criminal justice system.¹⁵ While MHPAEA and ACA were intended to improve patient access to addiction treatment, significant coverage gaps persist. Additional policy changes and funding for clinical research are still needed to close these gaps and improve quality of care, such as:

- Full implementation of ACA and MHPAEA to ensure patient access continues to improve,
 - Coverage of benefits and services across the full continuum of care,
 - Focus on long-term patient engagement and the treatment of substance use disorders as chronic diseases,
 - Modification of the Medicaid Institutions for Mental Disease (IMD) exclusion,
 - Modernization of Medicare (to cover a full range of benefits, including residential treatment services)
 - Better integration of addiction treatment with existing behavioral health and medical care systems, and
 - More research to collect National Outcome Measures, with abstinence being just one of many outcomes that indicate effective treatment (e.g., improved health status and productivity).
- As payment systems change from volume-based (i.e., fee-for-service) to value-based systems over time, providers of addiction treatment will need to show “value” to

patients, payers, and policymakers and become an integral component of population health management.

¹ SAMHSA (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings.

² Saloner B and Le Cook B. An ACA provision increased treatment for young adults with possible mental illnesses relative to comparison group. *Health Aff.* 2014; 33(8):1425-34.

³ Centers for Disease Control and Prevention. Alcohol Related Disease Impact (ARDI) application, 2013. Available at: http://apps.nccd.cdc.gov/DACH_ARDI/Default.aspx

⁴ Centers for Disease Control and Prevention. National Vital Statistics System mortality data. (2015) Available from URL: <http://www.cdc.gov/nchs/deaths.htm>.

⁵ Center for Behavioral Health Statistics and Quality. *The DAWN Report: Highlights of the 2011 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits.* (Rockville, MD: SAMHSA).

⁶ National Center on Addiction and Substance Abuse at Columbia University. Behind bars II: Substance abuse and America's prison population.

⁷ Harwood, H. (2000). Updating estimates of the economic costs of alcohol abuse in the United States: Estimates, update methods, and data. Washington, DC: National Institute on Alcohol Abuse and Alcoholism.

⁸ Miller, T. and Hendrie, D (2008). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No. (SMA) 07-4298. (Rockville, MD: SAMHSA).

⁹ Kuehn, B. (2013). SAMHSA: Pain medication abuse a common path to heroin. *JAMA* 310(14): 1433-1434.

¹⁰ McLellan, T. (2013, July). Commentary: Getting past the stigma and treating addiction as a chronic disease.

¹¹ Beronio K, Po R, Skopec L, and Glied S. Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans. Department of Health and Human Services (DHHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE). ASPE Research Brief; February 20, 2013.

¹² Health Care Cost Institute. The impact of the Mental Health Parity and Addiction Equity Act on inpatient admissions. Issue Brief 5. February 2013.

¹³ Buck JA. The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Aff* 2011; 30(8): 1402-10.

¹⁴ SAMHSA (2014). Projections of National Expenditure for mental health services and substance abuse disorders, 2010-2020.

¹⁵ National Institute on Drug Abuse. “Understanding Drug Abuse and Addiction: What Science Says.” Available at: <http://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment>