July 20, 2001

Review of Health Coverage for Substance Abuse Treatment

Chapter 305, Statutes of 2000 (SB 1764, Chesbro), requires the Legislative Analyst's Office to review existing data and research on health insurance coverage for substance abuse treatment (both alcohol and drug use). Specifically, Chapter 305 calls for the office to report on (1) the range and utilization of treatment services offered and their costs, (2) the cost effectiveness of parity with standard medical care for insured expenses and limits on care, and (3) private facilities that provide alcohol and drug treatment services and the number of clients they serve.

RANGE AND UTILIZATION OF SERVICES OFFERED

Current Law

Under current state law, companies providing *group* health insurance—health maintenance organizations (HMOs) and insurance companies offering health coverage—must offer to provide coverage to treat alcoholism but are not required to offer coverage for drug abuse treatment. Current law does not require HMOs and insurance companies to offer any substance abuse (alcohol or drugs) treatment coverage for policies purchased by *individuals*.

Substance Abuse Treatment Coverage

Substance abuse treatment falls into two main categories—detoxification and rehabilitation. Detoxification refers to short-term medical treatment provided to manage withdrawal symptoms. This kind of treatment can be offered in inpatient or outpatient settings. Rehabilitation refers to longer-term counseling and classes designed to help addicts remain sober. Rehabilitative care can be offered in residential and outpatient settings.

As noted above, current law requires HMOs and insurance companies to offer alcohol abuse treatment coverage for group insurance policies. In addition, many HMOs and insurance companies, though not required by law, also offer drug abuse treatment coverage. These coverages vary from plan to plan and typically include limits on the number of doctor visits, number of days in treatment, and/or annual or lifetime expenditures. These limits are usually more restrictive than limits on standard medical care.

Detoxification. In general, a basic group health insurance policy covers hospitalization (inpatient) and outpatient care for detoxification (either alcohol or drugs) as standard medical treatment. This usually includes payment of 100 percent of costs for an unlimited number of days for inpatient care. A few plans require the patient to pay 10 percent or 20 percent of the bill (referred to as coinsurance) and/or limit the number of days per year (anywhere from 5 to 30 days, for example) an individual can receive

inpatient treatment. For outpatient detoxification, a basic policy typically limits the number of doctor visits to 20 per year and requires a copayment.

Rehabilitation. In many cases, a basic policy covers outpatient care (such as counseling) for rehabilitation (alcohol and drug abuse), but there is usually a 20-visit limit per year with a copayment for each visit. Most basic policies, however, do not offer coverage for residential rehabilitative care. In this case, HMOs and insurance companies sometimes offer supplemental options, or "riders," the policyholder can elect—for an additional premium cost—to augment a basic policy.

Larger groups covered by an insurance policy (businesses with more than 50 employees) are more likely to have the option to purchase a rider that provides a greater level of coverage for substance abuse treatment. For example, HMOs and insurance companies will sometimes offer riders for rehabilitative care for large group policies, but exclude them from small employers. In addition, large groups often are given options to include a higher limit on outpatient visits and/or lower or no copayments.

Utilization

There are little data available on the extent to which insured individuals receive care for substance abuse. The HMOs and insurance companies we contacted did not have data on their enrollees' use of these services. (Appendix 1 provides a listing of organizations we contacted in the course of completing this report.) However, a 1999 RAND study we reviewed indicates that 0.3 percent of the enrollees in its data set received substance abuse treatment and noted that this was consistent with the results of a prior larger study. Although few people receive care, substance abuse treatment is relatively expensive on a per-patient basis because intensive outpatient and residential care is often required. For the enrollees cited in the study mentioned above, 43 percent had treatment costs above $1,000, with 23 percent above $2,500 (see Figure 1). However, since few members receive this treatment, the resulting increase in cost to the insurer is relatively small compared to overall health expenditures.

Figure 1

RAND Analysis of Substance Abuse Treatment Costs

Cost of Treatment	Percent of Patients With Costs in Range
$1 to 100	27.3%
$101 to 250	9.8
$251 to 500	10.6
$501 to 1,000	9.0
$1,001 to 2,500	20.8
$2,501 to 5,000	11.1
$5,001 to 10,000	10.1
>$10,000	1.3
Total	**100%**

COST OF SUBSTANCE ABUSE TREATMENT COVERAGE

There are few studies on the additional cost of health insurance coverage for alcohol and drug abuse treatment. Below, however, we discuss two studies that have been widely cited.

The RAND Analysis

The 1999 RAND study noted above examined insurance payments for 25 group health plans with substance abuse treatment services provided by one of the largest HMOs that specializes in mental health and substance abuse treatment. The 25 plans were comprehensive, covering inpatient, outpatient, and residential care for detoxification and rehabilitation. In addition, the plans had no coverage limits on total dollars spent, days in treatment, number of sessions, or types of treatment. The study analyzed insurance claims that occurred in 38 states during 1996 and 1997. To simulate the impact of annual dollar limits on substance abuse treatment, the analysis imposed various dollar limits on the claims data and then calculated total insurance payments and the cost per group policy member for each imposed limit.

As shown in Figure 2, the study found that annual insurance payments for substance abuse treatment provided without dollar limits cost $5.11 per group policy member. ("Member" includes all covered persons—employees and dependents—not just the employees.) The author concluded that this represented less than 0.5 percent of an HMO premium cost per member. The most restrictive scenario tested—a $1,000 annual spending limit—resulted in a cost of $1.72 per member per year and would have limited insured treatment for 43 percent of recipients.

Figure 2

RAND Analysis of Annual Dollar Limits on Substance Abuse Treatment

Annual Limit	Annual Cost Per Group Policy Member	Percent of Insurance Claims Above Limit
None	$5.11	0%
$10,000	5.05	1.3
$5,000	4.33	11.3
$1,000	1.72	43.0

The Health and Human Services Study

A 1998 United States Department of Health and Human Services analysis used an actuarial model to estimate the additional premium cost of one full parity and two partial parity benefit options for mental health and substance abuse treatment coverage. The study defined full parity as equivalent coverages for standard medical care and mental health/substance abuse treatment in three areas—copays, limits on doctor visits and inpatient hospital stays, and annual or lifetime dollar limits. The first partial parity scenario included equivalent copays and dollar limits. The second partial parity scenario included equivalent doctor visit/hospital stay limits and dollar limits. The study compared these three parity scenarios with a baseline substance abuse treatment plan that included the following limits: $50,000 lifetime expenditures, 30 days for inpatient hospital days, and 20 doctor visits. Copays for the baseline plan were equivalent with those for standard medical care.

This analysis concluded that full parity for substance abuse treatment coverage would result in a weighted average premium increase of 0.2 percent. The first partial parity scenario—copays and dollar limits equivalent to standard medical care—resulted in an average premium increase of 0.1 percent. The second partial parity scenario—equivalent limits on number of outpatient visits or days in the hospital and dollar limits—resulted in an average premium increase of 0.03 percent.

These estimated premium increases vary depending on the type of health plan. Fee-for-service plans would experience larger increases, whereas HMOs would have smaller increases because of the greater degree to which care is managed. In addition, individuals and smaller employers would likely have bigger premium increases than larger companies.

Public Employees' Retirement System (PERS) Health Insurance Program

The health program administered by PERS for state employees and retirees covers inpatient and outpatient care for detoxification. The state program, however, does not cover rehabilitation, with some exceptions for plans that include such care as part of their basic packages. The PERS requires the HMOs it contracts with to provide a premium breakdown showing the cost of the substance abuse benefits in the state's health insurance program. Based on this information, PERS indicated that the average annual premium cost is $4.32 per member. Depending on the HMO, this annual premium component ranges from 24 cents to $12.36. As a point of comparison, the average per-member annual premium cost exceeds $1,600. Thus, the substance abuse benefits represent less than 0.3 percent of the average annual premium cost for the state's HMO plans.

Cost-Effectiveness

We are not aware of any broad-based studies on the cost-effectiveness of substance abuse coverage. Kaiser Permanente has published a few analyses showing the offsetting savings of the alcohol and drug abuse treatment programs it provides to its members. As an example, a 2001 Kaiser Permanente study examined medical utilization and costs 18 months before and 18 months after a member received outpatient substance abuse treatment. The study found that members who received this treatment were less likely to be hospitalized and spent fewer days in the hospital after treatment. These individuals also were less likely to end up in a hospital emergency room. As a consequence, Kaiser Permanente concluded that for these members, inpatient costs declined by 35 percent, emergency room costs declined by 39 percent, and total medical costs declined by 26 percent. The study indicated that this conclusion is consistent with other studies on medical cost offsets that have shown alcohol and drug abusers have higher medical costs and receive more medical treatment before substance abuse treatment than after.

This study did not address the added costs of the substance abuse care provided. Consequently, it does not provide a benefit-cost analysis. It does show, however, that substance abuse treatment costs are at least partially offset by future avoided medical costs.

PRIVATE RESOURCES AVAILABLE AND CLIENTS SERVED

Based on available information, the Department of Alcohol and Drug Programs (ADP) indicates there are approximately 1,800 facilities in California that provide alcohol and drug abuse treatment services. (This includes community-based and faith-based organizations.) Of these, ADP has licensed 877 facilities that either provide residential care or dispense medications such as methadone to treat narcotics addiction. The de-

partment has also certified another 600 or so outpatient treatment facilities. Certification is required for centers providing outpatient medicating services to Medi-Cal recipients and those treating drug offenders pursuant to Proposition 36. Otherwise, certification is voluntary. The ADP Web site includes a directory of facilities that are licensed for narcotics treatment and a directory of licensed residential centers and certified outpatient facilities providing alcohol and drug abuse treatment.

According to ADP, in 2000 treatment providers either receiving state or federal funds or providing medications to treat narcotics addiction reported 214,000 admissions. The department does not receive data from other facilities. Thus, information is not available on the total number of admissions statewide.

Conclusion

Basic large group health insurance policies already cover short-term substance abuse treatment—namely detoxification and a limited number of outpatient visits. Expanding insured care to cover more intensive outpatient and residential rehabilitation would result in an additional cost of about 0.5 percent per member on average. (Employers could insulate themselves from these increases to some degree by raising copays or adopting limits on substance abuse treatment.) However, mandating these additional coverages would limit to some degree the control HMOs and insurance companies have to manage this type of care and limit its cost.

Our review of existing studies shows that while substance abuse treatment is relatively expensive on an individual basis, the cost is comparatively small when compared to overall health expenditures and when spread out over all enrolled members. This is because few members receive substance abuse treatment. In addition, in the longer term there appear to be offsetting savings from avoided future medical care. This avoided expense would tend to hold down total health expenditures and offset the cost of treatment for alcohol and drug abuse.

APPENDIX 1

Organizations Contacted for This Study

Association of California Life and Health Insurance Companies
Blue Cross of California
Blue Shield of California
California Association of Alcohol and Drug Program Executives
California Association of Health Plans
CIGNA
Department of Alcohol and Drug Programs
Department of Insurance
Department of Managed Health Care
Kaiser Permanente
Lifeguard
PacifiCare
Pacific Life
Public Employees' Retirement System
Santa Clara Family Health Plan