SUBSTANCE ABUSE POLICY RESEARCH PROGRAM
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Policy Brief on: *Substance Abuse Treatment Benefits and Costs*

Authored by: Dennis McCarty, Ph.D., Oregon Health and Science University

Reviewed By: Yih-Ing Hser, Ph.D., University of California at Los Angeles; A. Thomas McLellan, Ph.D., Treatment Research Institute; Janet Mitchell, Ph.D., Research Triangle Institute

Introduction:
The economic costs of drug and alcohol abuse in the United States are estimated to be in excess of $275 billion a year, including lost productivity, medical expenses, crime and other costs. (Substance Abuse: The Nation's Number One Health Problem, RWJF, 2001.) More than 22 million people are in need of addiction treatment. (RWJF Website: APT Goal statement)

In 2001, the United States spent an estimated US$18.3 billion on treatment for alcohol and drug disorders, a total of 1.3 percent of all health care expenditures. Public payers now account for three-quarters of all spending to address drug and alcohol disorders. Consequently, policy makers want to learn more about the costs and benefits of treatment to justify the use of billions of public monies used yearly for this purpose. During the last five years, with support from SAPRP and other sources, both public and private, new studies have begun to examine and evaluate the benefits and cost-effectiveness of investing in treatment.

Policy Implications:
As policy makers debate the merits of funding substance abuse treatment services, they face a dilemma: should state and federal tax dollars be used and to what extent should these benefits be covered? More fundamentally, what is the return on such an investment?

Extensive research shows there are substantial benefits to treating alcohol and drug disorders. Treatment can lead to reductions in overall healthcare costs and utilization of health care services; in one study, for example, a health maintenance organization reported a 30 percent reduction in medical care costs among Medicaid patients who had been treated for substance abuse. But the greatest economic gains seem to arise from a resulting reduction in the costs of criminality (victimization, losses due to crime, and costs of incarceration). The data suggest that policies that link criminal offenders with substance abuse treatment programs—in and out of prison—reduce recidivism, as well as costs associated with arrest, prosecution and imprisonment. A study of 13 California counties also reported a considerable decrease in crime-related costs following treatment. Researchers calculated a benefit-to-cost ratio of 7:1 that included a reduction in the use of emergency medical care, as well as increased employment income among individuals treated for addiction.

Addiction experts suggest that alcohol and drug disorders should be treated as chronic medical conditions, and note that such a model of care may improve cost-effectiveness and provide greater benefits.

Conversely, strategies that reduce or eliminate benefits for treatment of alcohol and drug disorders can impose other social costs. A shift to managed behavioral healthcare carve-outs, for example, has led to a reduction in the use of inpatient and overnight services. Higher insurance co-payments have reduced the use of outpatient and inpatient services, and contributed to elevated rates of re-treatment.

In Oregon, the elimination of Medicaid coverage for outpatient mental health and substance abuse treatment benefits, including methadone treatment, led to a 60% decline in admissions to methadone, and an increase in drug use, as well as legal, medical, psychiatric and employment problems.

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Many states are now debating mandates to require parity in health plan benefits for treatment of mental illness and alcohol and drug disorders, but there is concern about cost. An analysis of seven government-run managed behavioral health care programs reported that the expansion of benefits has had little impact on total expenditures. In fact, current economic analyses would support policy makers who decide to fund a wide range of substance abuse treatment benefits. Treatment has been found to improve the lives of women and men who struggle with alcohol and drug disorders, and recent research suggests that it can be done in a cost-effective manner.

Key Results

- The economic benefits of treatment exceed the costs of treatment and the cost benefit ratio shows that every dollar spent on care results in $7 dollars in benefits. (Ettner et al., 2006); (Gerstein et al., 1994); (Roebuck, French, & McLellan, 2003); (McCollister & French, 2003)
- Treatment benefits include increases in employment income and decreases in avoided costs of criminal activities, incarceration, and hospitalization. (Ettner et al., 2006)
- Treatment in correctional settings plus aftercare in the community when offenders are released leads to substantial reductions in the rates of re-incarceration and the associated costs of arrest, prosecution and incarceration. (McCollister et al., 2004; McCollister et al., 2003b); (McCollister et al., 2003a)
- Treatment for alcohol and drug disorders can lead to reductions in the utilization and cost of medical care. (Walter et al., 2005)
- Managed behavioral healthcare carve-outs appear to reduce the costs of care and support the introduction of parity. (Stein et al., 1999); (Steenrod et al., 2001)
- Higher insurance co-payments reduce the use of outpatient and inpatient treatment for alcohol and drug disorders. (Lo Sasso & Lyons, 2004); (Lo Sasso & Lyons, 2002); (Stein et al., 2000)
- The loss of insurance benefits is associated with restricted access to care, decrements in beneficiary functioning, and closure of drug abuse treatment centers. (Fuller et al., 2006); (Deck et al., 2006)
- Insurance regulations that deny payment for alcohol-involved trauma care inhibit efforts to identify alcohol problems among patients in emergency settings. (Schermer et al., 2003)
- An evaluation of the introduction of parity for mental health and substance use disorders for federal employees concluded that parity had little impact on total costs.
- Cost-benefit analyses are better than cost-effective analyses in judging economic benefits of substance abuse treatment. (Sindelar et al., 2004)

McCarty, D.; Substance Abuse Treatment Benefits and Costs Knowledge Asset, Web site created by the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program; September 2008.
http://saprp.org/knowledgeassets/knowledge_detail.cfm?KAID=1