



Substance Use Disorders and the Role of the States

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much states spend on health care, how and why those amounts have changed, and which policies are containing costs while maintaining or improving health outcomes. For additional information, visit www.pewtrusts.org.

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Kil Huh

Matt McKillop

John D. and Catherine T. MacArthur Foundation

Valerie Chang, *interim managing director of U.S. programs and director of policy research*

Meredith Klein, *communications officer*

External reviewers

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This report is intended for educational and informational purposes. References to specific policymakers or companies have been included solely to advance these purposes and do not constitute an endorsement, sponsorship, or recommendation by The Pew Charitable Trusts or the John D. and Catherine T. MacArthur Foundation.



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Contact: Michelle Blackston, communications officer

Email: mblackston@pewtrusts.org

Phone: 202-540-6627

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Overview

Millions of Americans have substance use disorders,^{*} yet experts estimate that the vast majority of those in need of treatment do not receive any care.¹ These disorders often result in not only serious harm to the health of the individuals, but also enormous financial and social consequences that go beyond the health care system—including the loss of economic productivity due to withdrawal from the workforce and increased rates of crime, disability, and death. According to the National Institute on Drug Abuse, the combined direct and indirect costs of substance use disorder reaches into the hundreds of billions of dollars annually.²

Researchers from the State Health Care Spending Project—a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation—sought to better understand the country's substance use disorder challenges and, in particular, the states' role in addressing them. The project found that:

- In 2013, approximately 21.6 million Americans[†]—8.2 percent of people 12 or older—were classified as having a substance use disorder.³ The rate of disorders varies by state.⁴
- In 2013, 4.1 million people 12 or older received treatment[‡] for a problem related to the use of alcohol or illicit drugs—18 percent of those who needed it.⁵ Two leading factors contributing to this gap were:
 1. The belief by many of those who needed treatment that they did not.
 2. An inability of people with substance use disorders to afford the cost of treatment, in part because of a lack of health insurance coverage.
- In 2009, the most recent year for which data are available, the United States spent \$24 billion on substance use disorder treatment.⁶ Most of the spending—69 percent—came from public sources, such as state and local governments, Medicaid,[§] Medicare,[¶] and federal grants. Private sources, including health insurance^{**} and individual out-of-pocket spending, made up the difference.
- State and local governments spent \$7.6 billion in 2009 (nearly a third of the U.S. total) to combat substance use disorders. These funds were disbursed across several state agencies and departments, including those devoted solely to addressing substance use disorders, as well as child protective services, corrections, and the

* The American Psychiatric Association revised its description of substance-related and addictive disorders in its 2013 *Diagnostic and Statistical Manual of Mental Disorders* 5th edition (DSM-V), to capture a broad spectrum of severity. It combines the terms “substance abuse” and “substance dependence,” where substance abuse is a mild or early stage of substance dependence, into a single term, substance use disorder, referring in this report to dependence on or abuse of alcohol or illicit drugs, including the use of marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription drugs. The former terms—“substance abuse” and “substance dependence”—are still used in some surveys.

† The National Survey on Drug Use and Health (NSDUH) captures the civilian, noninstitutionalized population. This population excludes some subpopulations that may have different drug use patterns. For example, the survey excludes two groups that have been shown to have higher rates of illicit drug use: people living in institutional group quarters, such as prisons and residential drug use treatment centers, and homeless people not living in a shelter. Appendix C of the NSDUH describes other surveys that provide data for some of these populations.

‡ Treatment need is defined as having substance dependence or abuse or receiving substance use treatment at a specialty facility (hospital inpatient, drug or alcohol rehabilitation, or mental health centers) within the past 12 months. In 2013, 22.7 million people 12 or older needed treatment for an illicit drug or alcohol use problem.

§ Medicaid is a state-administered health insurance program, funded jointly with the federal government, for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some states, other adults.

¶ Medicare is a federal health insurance program for Americans 65 and older and certain younger people with disabilities.

** Private insurance includes both employer-sponsored insurance and individual insurance markets.

judiciary. This total does not include state and local Medicaid expenditures; adding those contributions brings total state and local spending up to \$9.4 billion.

- Most treatment occurs in relatively inexpensive settings such as self-help groups and outpatient rehabilitation. But the distribution of spending shows a more equal pattern that reflects the greater cost for inpatient and residential care per treatment—settings where fewer people are treated—compared with the more widely used option of outpatient rehabilitation. Spending has shifted in the last three decades from primarily inpatient care to a combination of outpatient and residential treatment. More recently, spending on prescription drugs to treat opioid addiction has accelerated rapidly.
- Implementation of recent federal legislation is expanding access to public and private insurance coverage for the treatment of substance use disorders. The laws are also expected to increase the imbalance between public and private payors. In the most significant example, the role of Medicaid will continue to grow as states expand their programs in accordance with the Affordable Care Act.

As federal, state, and local policymakers address the country's substance use disorder challenges, this report is intended to help them better understand disease prevalence, treatment practices, and spending trends.

The State Health Care Spending 50-State Study Report Series

The State Health Care Spending Project, a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, is examining seven major areas of state health care spending—Medicaid, the Children's Health Insurance Program, substance use treatment, mental health services, prison health care, active state government employee benefits, and retired state government employee benefits.

The project provides a comprehensive examination of each of these health programs that states fund. The programs vary by state in many ways, so the research highlights those variations and some of the principal factors driving them. The project is concurrently releasing state-by-state data on 20 key health indicators to complement the programmatic spending analysis.

For more information, see <http://www.pewtrusts.org/en/projects/state-health-care-spending>.

Substance use disorder prevalence

In 2013, an estimated 24.6 million Americans 12 or older (9.4 percent of the population) used illicit drugs* in a given month—the highest percentage on record.⁷ Marijuana was the most common illicit drug used, followed by psychotherapeutics such as pain relievers and tranquilizers, and cocaine. And more than 16 million people 12 or older, some of whom also used illicit drugs, engaged in “heavy drinking,” defined as having five or more drinks on at least five occasions within a 30-day period. Illicit drug use and heavy drinking are most commonly found among those ages 18 to 25.

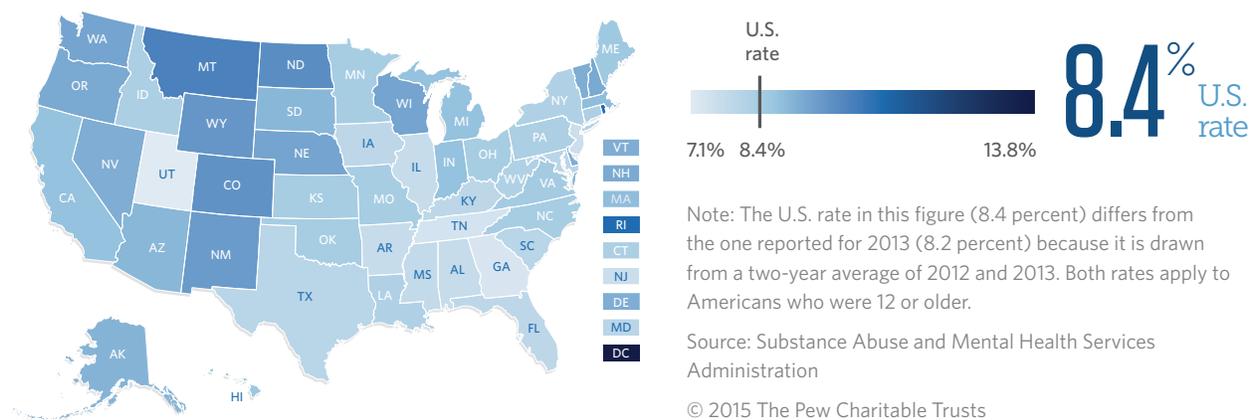
According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), of those who used alcohol or illicit drugs, 21.6 million people (8.2 percent of the population aged 12 or older) met the criteria for having a substance use disorder (substance abuse or dependence†) in the past year, a percentage that has remained stable for at least a decade.⁸ Although more than half of the adults with a substance use disorder were employed full time, unemployed adults were 60 percent more likely to be classified as such than those with full-time jobs. In 2012, among public and private admitting treatment facilities that receive public funding,‡ only 22 percent of admissions 16 or older were employed.⁹ The rest of admissions were split evenly between those who were unemployed and those who were not in the labor force.§

During 2012 and 2013, the most recent years for which state-specific data are available, the rate of substance use disorder ranged from 7.1 percent of residents aged 12 or older (Utah) to 13.8 percent (District of Columbia).¹⁰ (See Figure 1.)

Figure 1

Rate of Substance Use Disorder

Percentage of respondents with self-reported dependence on or abuse of illicit drugs or alcohol in the preceding year, 2012–13



* Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives used nonmedically).

† Substance abuse and dependence are defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress. Substance abuse by itself is a mild or early stage of substance dependence.

‡ These data come from the Treatment Episode Data Set (TEDS), a national data system of annual admissions to substance abuse treatment facilities. TEDS records represent admissions rather than individuals, because a person may be admitted to treatment more than once.

§ “Not in the labor force” refers to people who have not looked for work during the past 30 days or are students, homemakers, disabled, retired, or inmates of an institution.

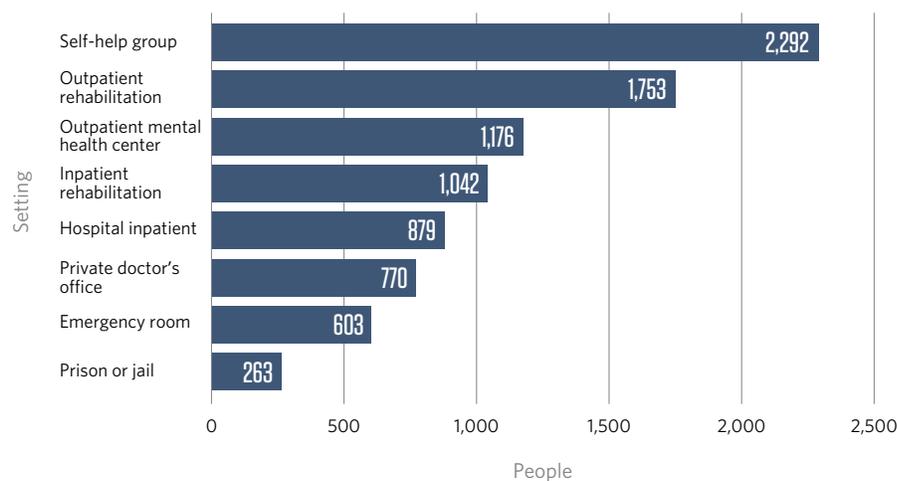
Treatment

Treatment of substance use disorders is a complex, multidimensional, and long-term endeavor that often requires specialized care tailored to the substance and the severity of the pattern of use. A wide array of practitioners provides substance use disorder treatment, including licensed clinicians such as psychiatrists, psychologists, clinical social workers, and counselors. Most people receive treatment from a program or clinic that is licensed by the state. Clinic staff must be certified and/or licensed, and a majority of states require the lead clinicians to be licensed and have graduate-level professional training. Unlicensed people (many of whom are themselves in recovery) can provide limited “technician” services (collect information; and provide patients with information, education, coaching, and mentoring) under the supervision of licensed clinicians, but these clinicians generally must provide the therapeutic services.¹¹

In 2013, 4.1 million people 12 or older received treatment for a problem related to the use of alcohol or illicit drugs—an estimated 18 percent of those who needed it.¹² Several factors contributed to the gap between those who needed treatment and those who received it. Most influential and nearly universal (96 percent) was the perception by the 20.2 million Americans who needed treatment but did not receive it at a specialty facility—such as an inpatient general hospital, a drug or alcohol rehabilitation facility, or a mental health center—that they did not actually require care.¹³ And only one-third of those who recognized a need for treatment but did not receive it had made an effort to access it. The most commonly cited reasons for not receiving care among those in this group was a lack of insurance coverage and an inability to afford the cost.

For those who did access care, the most common setting for treatment* was self-help groups or 12-step programs, such as Alcoholics Anonymous and Narcotics Anonymous. More than half of those who received treatment did so at a specialty facility, including an inpatient general hospital, a drug or alcohol rehabilitation facility, or a mental health center. Other settings included outpatient mental health centers, emergency rooms, and prisons or jails. (See Figure 2.)

Figure 2
Substance Use Disorders Are Treated in a Variety of Settings
Number of persons receiving treatment, 2013 (in thousands)



Note: Data include treatment received in the past year at any location as reported by those surveyed who were 12 or older. Examples of self-help groups include Alcoholics Anonymous or Narcotics Anonymous. Individuals commonly received treatment in more than one setting.

Source: Substance Abuse and Mental Health Services Administration

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* Many individuals received treatment in more than one setting.

For those admitting treatment facilities that receive public funding, ambulatory care* and short-term detoxification made up the majority of admissions† (83 percent) in 2012. Residential care accounted for only 17 percent of admissions.¹⁴ (See Table 1.) Alcohol, opiates,‡ marijuana, cocaine, and methamphetamine/ amphetamines were the drugs most commonly abused by those who were admitted to a facility for treatment. Alcohol has consistently accounted for nearly half of admissions for treatment nationally, though this share has decreased slightly.¹⁵

Table 1
Facility-Based Treatment Varies
 Service types, by percentage of admissions (2012)

Service types	Substance use
Ambulatory Intensive and nonintensive outpatient services	61%
Detoxification (24-hour service) Hospital or freestanding residential setting for safe withdrawal	22%
Rehabilitation/residential Nondetoxification with 24-hour medical care in a hospital; and short-term (30 days or fewer) or long-term (more than 30 days) nonacute care	17%

Note: Ambulatory care is provided on an outpatient basis and typically includes diagnosis, observation, treatment, and rehabilitation services. Nonintensive outpatient services include ambulatory treatment such as individual, family, and/or group services, and these may include pharmacological therapies. Intensive outpatient is not a live-in treatment program, but at a minimum, the client must receive treatment lasting two or more hours per day for three or more days per week.

Source: Substance Abuse and Mental Health Services Administration

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Since 1986, U.S. spending on inpatient treatment has decreased dramatically, while outpatient and residential treatment has increased.¹⁶ These changes resulted largely from tighter controls by managed care organizations on inpatient treatment across the health care system and from spending growth in specialty facilities for outpatient and residential care.¹⁷ The amount of spending on ambulatory and detoxification services is not proportional to the volume of admissions because residential care is generally more expensive per admission, or unit cost, than short-term outpatient services. Accordingly, residential services made up 31 percent of spending and a much smaller proportion of admissions. (See Table 2.)

* Ambulatory care is provided on an outpatient basis and typically includes diagnosis, observation, treatment, and rehabilitation services.

† SAMHSA refers to a substance abuse admission as an episode of care in any setting, beginning with provision of treatment and ending with a discharge.

‡ Common opiates include heroin, hydrocodone, and morphine.

Table 2

Spending on Treatment Shifted From Inpatient Care to Outpatient, Residential

By treatment setting, 1986 and 2009

Substance use disorder treatment setting	Spending, 1986	Spending, 2009
Outpatient Outpatient services provided by general or specialty hospitals, emergency departments, and offices or clinics	27%	39%
Residential 24-hour medical care, including in specialty facilities and nursing homes	17%	31%
Inpatient Acute care by general hospitals, specialty mental health facilities, or substance use disorder hospitals	50%	21%
Prescription drugs Psychotherapeutic medications sold through retail outlets and mail-order pharmacies	0%	4%

Notes: Figures do not total 100 percent. The remaining proportion of spending was directed toward insurance administration, which covered the cost of running various government health care insurance programs, and the administrative costs and profit of private health insurance companies.

Excluded from the prescription drugs total are sales through hospitals, exclusive-to-patient health maintenance organizations, and nursing home pharmacies. Spending on methadone—which is prescribed for pain management—that is dispensed for the treatment of drug abuse is captured as part of spending for specialty substance abuse centers, where methadone is dispensed.

Source: Substance Abuse and Mental Health Services Administration

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One development over the last 10 years is the increased use of medication-assisted treatment that combines medication with behavioral therapies, which has resulted in a dramatic acceleration in spending on prescription drugs to treat substance use disorder. From 1986 to 2003, a negligible portion of treatment spending was directed toward prescription drugs.* But by 2009, medications to treat addiction represented 4 percent of all substance use disorder treatment spending. This was driven by at least two factors. One was an increase in opioid addiction. From 2002 to 2012, the percentage of treatment admissions in which opiates were the primary substance of abuse increased from 18 to 26 percent.¹⁸ The second factor was the emergence of buprenorphine, which reduces or eliminates opioid withdrawal symptoms, and naloxone, which is used to prevent opioid overdose deaths. Buprenorphine was approved by the Food and Drug Administration for use in opioid addiction treatment in October 2002.¹⁹

Several states have taken steps to encourage the implementation and availability of models that combine these medications—and others—with strategies such as group counseling and cognitive-behavioral therapy.† For example, Vermont funds online training for physicians to obtain the necessary credentials to prescribe buprenorphine and works specifically to coordinate the complex care needs for Medicaid enrollees with an opioid dependence.²⁰ In many states, qualified physicians and facilities may bill the Medicaid program for medication-assisted treatment.²¹

* Spending on methadone for drug addiction was not included in this total because it was captured in the 35 percent of spending attributed to community-based substance use disorder organizations.

† Cognitive-behavioral therapy helps patients enhance self-control and develop effective coping strategies.

Distribution of spending

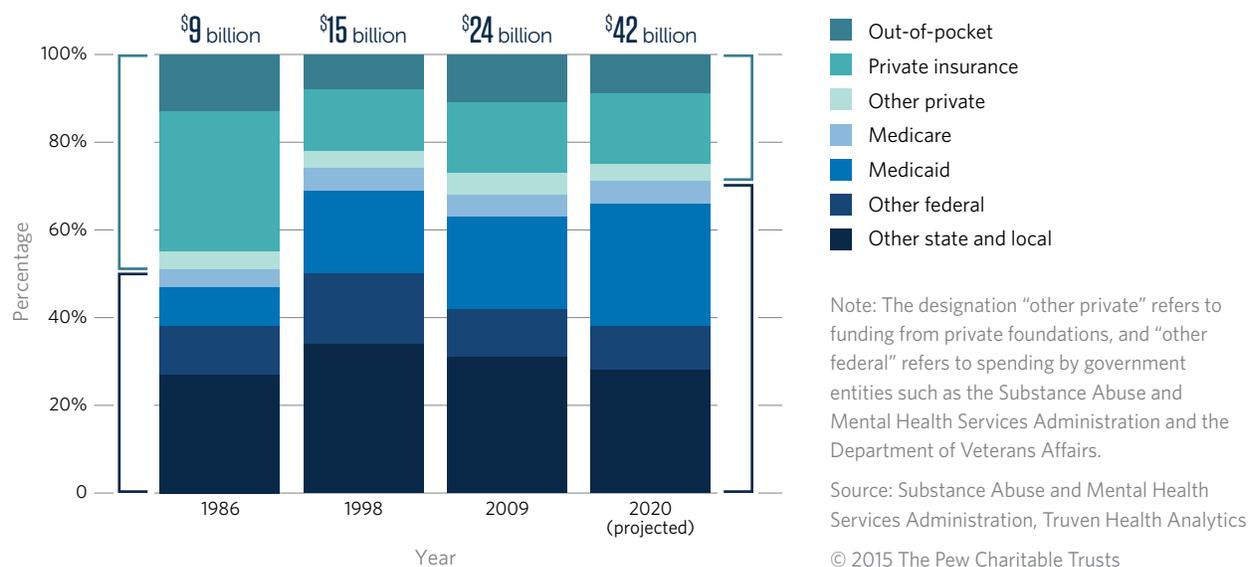
In 2009, the most recent year for which data are available, the United States spent \$24 billion on substance use disorder treatment.²² (See Figure 3.) Most of the spending—69 percent—came from public sources, such as state and local governments, Medicaid, Medicare, and federal grants. Private sources, including health insurance and individual out-of-pocket spending, made up the difference.

This imbalance between public and private spending, which differs significantly from national health expenditures as a whole, has not always existed. In 1986, for example, when the country spent \$9 billion on substance use disorder treatment, roughly equal amounts of funding came from public and private sources. The change has principally been driven by growth in the role of Medicaid and other state and local spending, as well as a steep reduction in the part played by private insurance. This trend is projected to continue as many states expand their Medicaid programs in accordance with the Affordable Care Act. By 2020, researchers expect public spending to represent 71 percent of the total for such treatment, with Medicaid overtaking other state and local outlays as the single largest source of funding.²³

Figure 3

Public Spending Has Grown Faster Than Private Spending

Expenditures for substance use disorder treatment, by payor (1986–2020)



Public payors

State and local governments

States and localities have historically been the largest source of spending on substance use disorder treatment.* In 2009, the latest year for which data are available, their funds covered \$7.6 billion—nearly a third—of total spending on substance use disorder treatment. (See Figure 3.) This total does not include state and local Medicaid expenditures. Adding those contributions brings total state and local spending up to \$9.4 billion.²⁴

* States and localities have been the largest source of spending on substance use disorder treatment since at least 1992.

Spending from substance use disorder agencies across the 50 states and the District of Columbia accounted for \$2.3 billion of state and local dollars in state fiscal year 2009.* (See Table 3.) These agencies are often housed in a larger department—such as human services, public health, or mental or behavioral health—and have a wide range of functions. For example, they license and work with networks of local providers and organizations; develop, implement, and monitor prevention and treatment programs; and ensure provision of services to state residents.²⁵ Additionally, they oversee spending of state general funds for substance use disorder services, the federal Substance Abuse Prevention and Treatment Block Grant,† local funds, and in some cases Medicaid dollars targeted for substance use disorder treatment for its enrollees.

Because money from state substance abuse agencies accounts for a relatively small share of that spent for these services, conclusions cannot be drawn about the adequacy of such funding in any given state. Even so, research should note how states fund substance abuse prevention and treatment as part of their overall health care spending budgets.

The remaining \$5.3 billion (69 percent) of state and local spending on treatment of substance use disorders was managed by other state agencies and departments, including child protective services, corrections, and the judiciary.²⁶

Child protective services (CPS). Approximately 8 million American children live with a parent who has a substance use disorder, increasing a child’s risk of abuse and neglect.²⁷ Estimates suggest that parental substance use disorders are a contributing factor in one-third to two-thirds of CPS cases.²⁸ CPS workers help identify parents with substance use disorders by conducting in-home examinations (checking for drug paraphernalia, observing whether parents appear to be under the influence of a substance), employing screening questionnaires throughout several stages of a case, and assessing whether treatment is needed once screening indicates an individual may have a substance use disorder. Once disorders are identified, and throughout treatment and recovery, caseworkers coordinate with treatment providers to assess and support the needs of parents and children.²⁹

Correctional systems. In 2010, roughly 65 percent of incarcerated adults in prisons or jails met the medical criteria for a substance use disorder, and inmates were seven times more likely than individuals in the community to have such a condition.³⁰ In 2013, people 18 and older who were on probation, parole, or supervised release during the preceding year were four times as likely as other adults to have a substance use disorder.³¹

Treatment can be applied to justice-involved individuals in several ways: as a condition of probation, provided in prison followed by community-based treatment after discharge, and under parole supervision.³² During incarceration, such low-intensity models as outpatient treatment, group counseling, drug education, and relapse prevention, as well as inpatient treatment, can produce high returns as measured by reductions in crime.³³

Drug courts. Drug courts integrate alcohol and drug treatment services into case processing by state and local justice systems. These courts divert drug-involved offenders with substance use disorders from incarceration into supervised programs with treatment and accountability standards. Participants receive intensive treatment and other services and, in return, make frequent court appearances and undergo random drug testing. Successful completion of a program—after a minimum of one year—results in dismissal of charges or lightened sentences and penalties.³⁴ Drug courts have been shown to help reduce recidivism when administered effectively.³⁵

* This total for spending from substance use disorder agencies in 2009 is in nominal dollars. The total presented in Table 3 is adjusted for inflation.

† The federal Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse and Mental Health Services Administration is an important factor in state decisions to fund substance abuse care because of the maintenance-of-effort requirements incorporated into the grant. Specifically, states must maintain comparable levels of spending from one year to the next in order to receive federal block grant money.

Table 3

State Substance Abuse Agency Spending Varies

State general funds, in thousands of dollars

State	Fiscal 2013 spending	State	Fiscal 2013 spending	State	Fiscal 2013 spending
Alabama	\$16,378	Kentucky	\$14,309	North Dakota	\$9,844
Alaska	\$45,437	Louisiana	\$35,750	Ohio	\$72,830
Arizona	\$16,405	Maine	\$14,072	Oklahoma	\$36,246
Arkansas	\$3,279	Maryland	\$117,030	Oregon	\$18,583
California	Data not reported	Massachusetts	\$90,107	Pennsylvania	\$46,772
Colorado	\$21,524	Michigan	\$31,271	Rhode Island	\$10,012
Connecticut	\$185,182	Minnesota	\$114,974	South Carolina	\$6,439
Delaware	\$14,848	Mississippi	Data not reported	South Dakota	\$11,065
District of Columbia	\$24,954	Missouri	\$40,056	Tennessee	\$25,469
Florida	\$85,809	Montana	\$7,470	Texas	\$23,646
Georgia	\$47,946	Nebraska	\$25,027	Utah	\$10,221
Hawaii	Data not reported	Nevada	\$9,533	Vermont	\$8,072
Idaho	\$18,633	New Hampshire	\$4,438	Virginia	\$47,629
Illinois	\$86,027	New Jersey	\$108,586	Washington	\$55,636
Indiana	\$10,254	New Mexico	\$20,240	West Virginia	\$9,677
Iowa	\$18,256	New York	\$413,750	Wisconsin	\$3,750
Kansas	\$15,846	North Carolina	\$119,669	Wyoming	\$34,949
Total of 50 states and the District of Columbia		Fiscal year		Real spending	
		2013		\$ 2,376,409	
		2012		\$ 2,275,827	
		2011		N/A	
		2010		\$ 2,318,589	
		2009		\$ 2,486,807	
		2008		\$ 2,481,338	
		2007		\$ 2,329,371	

Notes: Agency spending includes state funds only. Not included here are Medicaid, grants, and other funds, including federal and local funds that flow through these agencies.

California, Hawaii, and Mississippi did not report spending data to SAMHSA for fiscal year 2013. To estimate national spending totals for fiscal 2007, 2010, 2012, and 2013, project researchers used data from the prior available year in cases where state spending data were not reported to SAMHSA.

Fiscal 2011 data were not available for 18 states because SAMHSA changed its substance abuse block grant reporting rules and did not require states to submit fiscal 2011 numbers. Therefore, the project did not calculate the U.S. aggregate for that year.

Collected data were sent to each state for verification. If a state updated its data, the project used the updated numbers in this report.

All spending figures are in 2013 dollars. Nominal spending data for 2007-12 were converted to 2013 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts.

Source: Substance Abuse and Mental Health Services Administration

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In addition to funding treatment, states also finance prevention activities. Those receiving substance abuse block grants from the SAMHSA must use 20 percent of the grant for prevention. One strategy a state might use could be disseminating information to at-risk groups about, for example, the nature and extent of addiction, including the effect on one's self, the community, and family. Indeed, education-based strategies, such as those that teach how to cope with stress, resist peer pressure, and make healthy or thoughtful decisions, have been shown to help reduce substance use disorders.³⁶ Other approaches include providing people at elevated risk with alternative activities unrelated to alcohol or illicit drugs and providing support to community groups to deploy prevention campaigns.

Substance abuse prevention and treatment block grants

Providing funds to all 50 states and the District of Columbia, the Substance Abuse Prevention and Treatment Block Grant is the largest federal program dedicated to supporting state and local efforts toward planning, implementing, and evaluating activities that prevent and treat substance use disorders. In 2009, the grant represented 5 percent of all substance use disorder treatment spending in the country.³⁷ While states must apply annually to demonstrate statutory and regulatory compliance, the grant—which totaled \$1.6 billion in federal fiscal 2013³⁸—is distributed by SAMHSA based on a congressionally mandated formula.*

Each state's designated agency receives and distributes the funds to local governments and nongovernmental organizations, such as community- and faith-based programs. The grant is targeted at certain populations and service areas, including pregnant women and women with dependent children, intravenous drug users, tuberculosis services, early intervention services for those who are HIV-positive or have AIDS, and primary prevention services.³⁹

Medicaid

Medicaid also provides a large portion of funding for substance use disorder treatment. In fiscal 2009, Medicaid accounted for \$5 billion (21 percent) of total treatment expenditures. States fund about 40 percent of these Medicaid expenditures, on average.⁴⁰

To receive federal matching funds, Medicaid programs are required to cover medically necessary inpatient services for detoxification. In addition, they must cover all substance use disorder services as part of EPSDT (early and periodic screening, diagnostic, and treatment services) for those younger than 21 as deemed medically necessary by the state. State Medicaid programs can also choose to cover additional services for adults, such as stays in specialized residential treatment facilities with 16 or fewer beds[†] methadone treatment, case management, and outpatient care.⁴¹

State-to-state spending figures are limited because of the widespread use of Medicaid managed care plans to cover enrollees. These plans deliver health benefits and additional services to enrollees through contracted arrangements between states and managed care organizations that receive a per-member, per-month payment for health coverage. Spending data are frequently less available from states that provide services to enrollees through managed care organizations than through traditional fee-for-service[‡] arrangements.

* The formula accounts for such factors as states' total personal income, resident population, total taxable resources, population data, and a cost of services index made up of fair market rents and mean hourly (nonmanufacturing) wages.

† Medicaid is prohibited by federal law from covering services for beneficiaries ages 21 to 64 that are delivered in institutions for mental diseases. These institutions are defined as those that have over 16 beds dedicated to treating patients with severe mental illness.

‡ In fee-for-service plans, health care providers are paid directly by the state for each service provided to Medicaid enrollees.

According to an analysis by Mathematica Policy Research, Medicaid spending data on substance use disorder treatment in calendar year 2008 were reported thoroughly enough in 18 states to examine their distribution. In these states, 52 percent of such expenditures were for outpatient care, 35 percent for inpatient hospital care, 8 percent for residential treatment, and the remaining 5 percent for prescription drugs.⁴²

Below these averages, however, lies some notable variation, reflecting—among other factors—differences in treatment coverage and preferences across the country. For example, the proportion of spending directed to outpatient treatment was only 18 percent in South Dakota, which relied much more heavily on residential treatment than most states, whereas it was 72 percent of spending in North Carolina. Similarly, only 8 percent of Vermont’s spending was devoted to inpatient hospitalization, compared with 81 percent in Louisiana, where prescription drugs and residential treatment played a negligible role.⁴³

Medicare

Medicare paid for a relatively small proportion—5 percent—of substance use disorder treatment in 2009. Still, the program covers a wide range of treatments,^{*} including⁴⁴:

- Inpatient hospital stays for drug abuse or alcohol detoxification or rehabilitation.
- Outpatient hospital services for treatment of drug abuse or alcoholism.
- Treatment of alcoholism and drug abuse in a freestanding clinic.
- Withdrawal treatments for narcotic addictions.
- Aversion therapies for treatment of alcoholism.

Private payors

Private payors, such as commercial health insurers and individuals paying out-of-pocket, play a shrinking role in the financing of substance use disorder treatment. In addition to the faster growth of public spending, several other factors contribute to this. One is the high rate of uninsurance[†] and underinsurance[‡] among those with substance use disorders, due in part to a high rate of unemployment. In 2013, 37 percent of those who sought treatment but did not receive it pointed to a lack of insurance coverage and an inability to afford the cost—the most commonly cited reason.⁴⁵ An additional 8 percent of these respondents said their health plans did not cover treatment or did not cover the cost. In 2012, among public and private admitting treatment facilities that received public funding,[§] 55 percent of people 12 or older admitted for substance abuse treatment[¶] reported having no health insurance; 14 percent reported having private insurance.⁴⁶

* Medicare may not cover these services if coverage criteria are not met.

† Defined as not having health insurance.

‡ Definitions vary, but in this context underinsurance refers to having health insurance that does not cover treatment for substance use disorder and/or the out-of-pocket cost-sharing requirements exceed standard measures of affordability.

§ These data come from the Treatment Episode Data Set. TEDS records represent admissions rather than individuals, because a person may be admitted to treatment more than once. The figure reported for private insurance combines “private insurance,” Blue Cross/Blue Shield, and HMO from the TEDS data set.

¶ As a sign of the growing importance of Medicaid, half of those admitted who were insured were enrolled in Medicaid.

State-Level Data Limitations

State-level data on spending and the utilization of treatment services for substance use disorder are sparse and inconsistently reported.⁴⁷ Although states must report their data to the Substance Abuse and Mental Health Services Administration to receive block grant funding, requirements and follow-up on the reliability and consistency of these data vary. Differences can be found in how services are defined, completeness of data collection, and interpretation of what should be reported. For example, some states include the share of the required state match for Medicaid in spending totals for their substance abuse agencies, while others do not. In addition, states have had different fiscal years, so their spending data may cover different periods. However, in reporting year 2012, SAMHSA began trying to standardize reporting periods. Therefore, 50 state-level spending comparisons must be made carefully.

Another limitation is that data reporting on the use of state-funded treatment of substance use disorder—such as a count, without duplicates, of people receiving treatment—is not available at the state level. This makes it impossible to estimate treatment costs per patient or per modality, or even to measure the extent of recurring treatment. More robust data collection by state substance use disorder agencies and others that support such treatment services may allow for a clearer examination of how much states spend on the disorder and the costs per episode of treatment.

Expected impacts of federal legislation

Substance use disorder insurance benefits, when offered, have historically been more restrictive than physical health coverage, with a higher cost-sharing requirement for patients. Federal laws passed in recent years, though, are likely to change that.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 directs health insurance plans to offer mental health and substance use disorder benefits that are at least equal to physical health benefits, if they cover mental health and substance use disorder treatment at all. Small employers were exempt from this requirement.*

The Affordable Care Act also has the potential to change the national landscape for treatment of substance use disorder. To this end, Thomas McLellan, former science adviser to the president and deputy director of the White House Office of National Drug Control Policy, said, “There is no illness that will be more favorably affected [by the Affordable Care Act] than substance abuse. This is the beginning of substance abuse disorders being part of mainstream health care.”⁴⁸

As of 2014, the law mandated that new health insurance plans offered in the individual and small group markets, including those in the new health insurance marketplaces, as well as state Medicaid plans for newly eligible enrollees, cover a set of essential benefits that includes substance use disorder services. Moreover, it builds on the Addiction Equity Act of 2008 by requiring all plans to which the essential benefits rule applies to cover mental health and substance use disorder benefits in a comparable manner to general medical and surgical coverage.

With more than half of states and the District of Columbia expanding Medicaid and millions of individuals enrolling in health insurance marketplaces, access to substance use disorder treatment services has significantly increased. According to 10-year federal estimates, 32 million Americans will gain access through the Affordable Care Act to both mental health and substance use disorder coverage, and an additional 30 million Americans who currently have some level of coverage will benefit from federal parity protections.⁴⁹

Another provision of the Affordable Care Act is likely to affect the treatment of substance use disorders by accelerating a movement toward better integration for treatment of physical and behavioral health conditions.⁵⁰ The Medicaid health home state plan option provides eight quarters of enhanced federal matching funds to states to support establishment of health homes—a term that refers to a care management service model, not a physical facility—for their enrollees. Under this holistic approach, all of a patient’s caregivers communicate with one another so that the entirety of a patient’s needs—including mental health and substance use disorder treatment—are addressed in a comprehensive manner. This can be accomplished, for example, by directly employing behavioral health specialists in a medical practice or by closely associating and collaborating with such specialists to coordinate patient care. Taken together, these services create a virtual health home. This movement that recognizes the interrelatedness of all illness runs counter to the long-standing practice in U.S. medicine that separates physical and behavioral health services.

* Although the Addiction Equity Act became law in 2008, the final rules that guide implementation and put the legislation in action were not released until November 2013.

Conclusion

Substance use disorder is a problem affecting the health and economic prospects of all Americans. As the largest source of treatment funding, states and localities, including state Medicaid programs, play an important role in meeting the needs of those who require treatment. This report provides policymakers with a foundational overview of trends in prevalence, treatment, and spending to support their decision-making.

Appendix: Methodology

Project researchers analyzed the spending of state substance abuse agencies in the 50 states and the District of Columbia from fiscal 2007 to 2013. Project researchers used total state funds as reported in the Substance Abuse State Agency Expenditure Report portion of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Substance Abuse Prevention and Treatment Block Grant applications. These reports were accessed through SAMHSA's Web Block Grant Application System.

Dollars associated only with "state funds" were collected, which include the amounts spent on substance abuse prevention and treatment, primary prevention, tuberculosis services, HIV early intervention services, state hospitals, other 24-hour care, ambulatory/community non-24-hour care, and administration. Expenditures related to the substance abuse block grant, Medicaid, other federal funds, and local funds were not included in the data presented. When a state updated its data in a footnote, the updated spending amount was used. Expenditures from fiscal 2007 to 2012 are current as of October 2013; data from fiscal 2013 are current as of April 2014. All spending figures are in 2013 dollars. Nominal spending data for 2007 to 2012 were converted to 2013 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts.

In some states or years, expenditure periods listed on the spending report were stated inconsistently. In these instances, researchers verified the spending period with unpublished data received from the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and from SAMHSA, where available.⁵¹ When spending and expenditure periods could not be confirmed by either NASADAD or SAMHSA data, researchers used the reporting period for the entire application. Officials of substance abuse agencies in each state reviewed the spending data. If a state updated its data as a result of this review, the project used the updated data in this report.

In 2011, SAMHSA changed systems for submitting block grant applications and did not require states to report expenditures for that year. As a result, data are not available for 18 states for fiscal 2011.

When data were not available for fiscal 2007, 2010, 2012, or 2013, unadjusted spending data from the prior reported year were used to calculate the national total. For example, while Louisiana did not report data for fiscal 2010, its fiscal 2009 spending data were carried forward and used for both years.

Endnotes

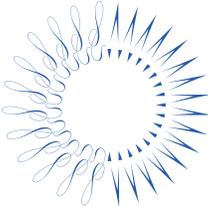
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