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J A Rogowski

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Commentary

Insurance Coverage For Drug Abuse
by Jeannette A. Rogowski

To most observers, it has become clear that the nation lacks the capacity to provide drug abuse treatment to all who need it. Recent attention in the policy community has focused on this need for expanded treatment services. The use of treatment services depends on many factors, including the availability of services and the ability of the abuser to pay for treatment. The demand for and availability of services are themselves correlated with existing mechanisms for financing drug abuse treatment. Two financing mechanisms now exist: direct support, largely in the form of government block grants, and insurance. Block grant funding results in the direct provision of treatment services to drug abusers. Insurance increases the ability to pay for treatment services, thereby facilitating treatment on demand. In this Commentary I describe the characteristics of existing types of insurance for drug abuse treatment and discuss the resulting implications for access and use of services. I pay specific attention to the differences between public and private insurance.

In the current policy debate, some have argued that the public sector should move away from the direct provision of treatment toward the provision of more insurance. Given the population in question, Medicaid would seem the most likely public program to carry out this strategy. However, I argue here that the mainstreaming of drug treatment financing into Medicaid is not likely to occur, because of significant institutional barriers.

Direct Funding Versus Insurance

Total drug abuse treatment spending exceeded $2 billion in 1990. Although treatment costs are borne by both the private and public sectors, the public sector provides the majority of the funding, accounting for 59 percent of treatment dollars (Exhibit 1). In contrast, public-

Jeannette Rogowski is an economist with RAND in Washington, D.C.
sector funding accounts for only 41 percent of the nation’s total overall health care spending.\(^6\) The public sector’s large role in financing drug abuse treatment is due to the substantial amount of direct treatment dollars provided by the government through such vehicles as federal block grants. Almost 50 percent of treatment funding comes from either these types of grants or other direct support from state and local governments. Public insurance is relatively rare, however, accounting for only one-fifth of public spending and one-tenth of total treatment dollars.\(^7\) This pattern contrasts sharply with that for general medical care, where almost three-quarters of public expenditures are paid by insurance.

Private insurance plays a more significant role in treatment financing, accounting for 27 percent of total treatment expenditures (Exhibit 1).\(^8\) Two-thirds of private dollars come from insurance.\(^9\) Thus, the mix of financing between insurance and other sources varies considerably between the private and public sectors, with the private sector dominated by insurance and the public sector dominated by direct funding.

The large volume of direct public subsidies for drug treatment has significant implications for the delivery of services to clients of public programs. Given a fixed amount of dollars to be allocated, there is a limit on the amount of treatment services that can be provided, and services must therefore be rationed. Rationing should ideally occur in a way that makes the most effective use of existing treatment funds; that is, preference should be given to those most in need, and patients should be matched to programs that best suit their needs. This is rarely the case for drug treatment. Rationing occurs primarily through waiting lists. This is

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**Exhibit 1**

Expenditures On Drug Abuse Treatment And General Medical Care

<table>
<thead>
<tr>
<th>Percent</th>
<th>Insurance</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td></td>
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<tr>
<td>30</td>
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<td>15</td>
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<tr>
<td>0</td>
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</tr>
</tbody>
</table>

particularly problematic for drug abuse, where it is often difficult for the abuser to recognize that a problem of addiction exists and therefore to initiate treatment. Once turned away from treatment, an abuser may not return later when a slot is available.

Currently, even if enough slots are available, programs are seldom matched to patients' needs. Care is generally received from the provider sought out by the patient, whether or not that provider is best able to meet the patient's needs. Since patients are not in a position to know which programs suit them best or often which programs providers offer, some sort of gatekeeping mechanism is necessary to ensure efficient allocation of resources. Some attempts at gatekeeping do exist, such as in the District of Columbia, where there is a central intake point for all public drug abuse clients. Clients are then referred to the programs most suitable to their needs.

In contrast to direct funding, insurance creates treatment on demand, and rationing mechanisms are theoretically not necessary. The private sector, which is dominated by insurance, has high vacancy rates, as opposed to the public sector, which is essentially operating at capacity. While the provision of insurance coverage avoids rationing through waiting times, it does not necessarily result in a favorable allocation of resources. Patients are triaged into treatment settings by their choice of providers. They are rarely in a position to judge which sort of treatment is optimal. Thus, in the absence of a gatekeeping mechanism to match patients to treatments, resources may not be allocated efficiently.

Although in theory insurance provides for treatment on demand, in practice this is far from true. With insurance coverage, the implicit number of services provided is not capped. From the perspective of policymakers and private insurers, this means that total budgetary outlays for drug treatment cannot be directly controlled; instead, they depend on the amount of services sought by beneficiaries. Insurance benefits for drug abuse treatment are extremely limited in both the public and private sectors. On the public side, this stems from an effort to control program expenditures; on the private side, it stems from the necessity to control health insurance premium costs. The limitation of benefits by private insurers is due in part to the difficulty of assessing responsiveness to treatment and thus of estimating the total cost and duration of treatment. The "public safety net" provided by block grant funding also may contribute to an unwillingness to provide generous benefits. The private sector controls use by such mechanisms as limiting the number of days of treatment that are covered, placing lifetime limits on the number of episodes that are covered, and requiring higher copayments for drug treatment than for other medical services. Given the
recurring nature of the need for treatment among many drug abusers, insurance coverage under such schemes is likely to be quickly exhausted, leaving patients either to pay for treatment out of pocket or to wait for a public treatment slot. The public sector controls use by restrictions on providers such as capping payments to providers on behalf of public beneficiaries and placing restrictions on treatment settings and types of treatments that are covered. These restrictions, described below, have significant implications for policymakers’ ability to mainstream drug treatment financing away from block grant funding and into Medicaid.

### Private Insurance

The availability of private insurance benefits for drug abuse is a recent phenomenon, as reflected in data collected by the Bureau of Labor Statistics (BLS). The BLS conducts an annual survey of health insurance benefits provided by medium and large firms (those with 100 or more employees). Only 37 percent of health plan participants had a separately defined benefit for drug abuse treatment in 1982. By 1988 the number had risen to 74 percent. Recent estimates based on 1989 data indicate that 96 percent of health plan enrollees have some form of coverage for drug abuse. Since most plans provide for detoxification under the general medical benefit, however, the apparently high percentage of persons with treatment benefits may be misleading. Drug abuse treatment usually has two phases: detoxification and rehabilitation. Detoxification, in which the patient undergoes withdrawal from the chemical dependency, is considered a medical treatment and is more likely to be covered than is rehabilitation, which is a psychosocial treatment. Among plan participants with inpatient detoxification coverage, 36 percent had no coverage for inpatient rehabilitation, and 42 percent had no coverage for outpatient care.

Among policies that provide coverage for drug abuse treatment, benefits are generally quite limited. Inpatient care is frequently subject to day limits (typically imposed per year rather than per episode or per lifetime). In the 1989 BLS survey of medium and large firms, approximately 40 percent of plan participants had day limits imposed on inpatient care. A smaller percentage, 20 percent, had day limits on outpatient care. Outpatient care is more likely to be subject to dollar limits. Thirty-five percent of participants had dollar limits on outpatient care, compared with 23 percent who had such limits on inpatient care. Dollar limits are most likely to be imposed per lifetime. Typical lifetime limits under private insurance are $25,000 to $50,000.

Since drug abuse is a chronic, potentially recurring condition, yearly
and lifetime limits on coverage imply that drug abusers are likely to exhaust benefits. In the 1985 Client-Oriented Data Acquisition Process (CODAP) study, which collected detailed data on treatment clients, 60 percent of clients had one or more prior episodes of treatment, and 40 percent had two or more. However, to properly assess whether coverage limitations are adequate, one must compare the limitations with effectiveness standards. Unfortunately, such standards do not exist for the treatment of drug abuse.

In addition to the limitations described above, private plans typically impose higher copayments for outpatient drug abuse treatment than for medical care. Whereas the copayment for medical care is generally 20 percent, among plans that place restrictions, copayments for outpatient drug abuse treatment are typically 50 percent. Higher cost sharing decreases the probability that treatment will be sought. For drug abuse, this is particularly problematic, since it is difficult for abusers to admit that they have a problem and need treatment. Drug treatment is also often excluded from ceilings that apply to out-of-pocket expenses. On the private side, out-of-pocket copayments and lifetime benefit limitations are likely to be the most important factors in decreasing demand for treatment.

### Public Insurance

Public insurance accounts for only 10 percent of overall drug treatment expenditures. The reason for this stems primarily from the highly restrictive eligibility requirements for public programs, which systematically exclude most drug abusers. In addition, among public treatment clients who have insurance coverage, benefits are quite limited. However, unlike in the private sector, restrictions tend to be placed on the provider rather than on the beneficiary. Thus, instead of trying to influence the demand for treatment services, public insurance programs aim to control the quantity of treatment services given by providers and the settings in which care may be received.

Despite the large sizes of the three public insurance programs (Medicaid, Medicare, and CHAMPUS), expenditures for drug abuse are small. It is estimated that in 1989 Medicare spent only $50 million on drug abuse treatment, and Medicaid spent $120 million. By contrast, CHAMPUS—by far the smallest program—spent an estimated $32 million on drug abuse treatment in 1988. Because Medicare and CHAMPUS are limited in the populations covered and therefore in their ability to insure drug abusers, I focus the remainder of the discussion of public insurance on Medicaid, the federal/state program that
provides insurance coverage for certain low-income persons.

**Medicaid and drug treatment coverage.** It has been argued that public financing for drug abuse should be mainstreamed away from block-grant funding and into Medicaid. Several institutional factors, however, make this transition unlikely. First, eligibility requirements for Medicaid are extremely restrictive, excluding a large portion of drug abusers. Second, two key provisions in the Medicaid statutes prohibit coverage for (1) room and board charges for treatment in residential treatment facilities, and (2) medical care for persons ages twenty-two to sixty-four in institutions for mental disease (which include all facilities specializing in drug abuse treatment). Finally, characteristically low payment levels by Medicaid programs may create access problems.

**Restricted eligibility.** Eligibility for Medicaid is generally linked to the welfare system, with several notable exceptions, such as the coverage of poor pregnant women irrespective of their eligibility for other programs. To be eligible for Medicaid, a person must qualify for Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC). AFDC families are defined as those where one parent is absent, incapacitated, or dead. They are primarily households headed by young females. One group most likely to be excluded from Medicaid coverage are males ages twenty-two to sixty-four. This is significant because the household population that is “clearly or probably in need of treatment” is heavily concentrated between ages eighteen and thirty-four and is two-thirds male. Thus, a large part of the poor population that abuses drugs is exempt from eligibility for Medicaid.

**Covered services.** Under current Medicaid guidelines, drug treatment benefits are neither mandatory nor generous, and coverage for drug abuse varies considerably across states. There is currently no thorough understanding of the coverage for drug treatment provided by state Medicaid programs. Under federal guidelines, states are required to provide a set of mandatory medical services. In addition, there is an optional set of services that states can elect to offer. Within both mandatory and optional service categories, states have considerable discretion in determining the scope, amount, and duration of services they provide.

Mandatory services include inpatient hospital services other than services in an institution for mental disease; outpatient hospital services; laboratory and x-ray services; physician services; and early and periodic screening, diagnosis, and treatment (EPSDT) for persons under age twenty-one. Medicaid programs also can use the outpatient hospital setting to provide drug abuse treatment. However, not all outpatient treatment is necessarily covered. In California, for instance, only outpa-
Patient heroin detoxification is covered. On the inpatient side, Medicaid programs must provide all care that is medically necessary, irrespective of diagnosis. This means that any complicating medical condition will be treated as well as any detoxification that is necessary from a medical standpoint. Medicaid programs do not have to provide for rehabilitation services, however, since these are generally psychosocial in nature and therefore not considered medically necessary.

Optional Medicaid services that are relevant to drug abuse include a clinic option and an inpatient psychiatric option. The clinic option allows states to provide outpatient care in a facility that is not part of a hospital but that provides medical care on an outpatient basis. States with this option may also choose to provide drug abuse treatment in this setting. Forty-seven states and the District of Columbia had the clinic option in 1987. The inpatient psychiatric option allows states to provide drug abuse treatment in an inpatient psychiatric hospital for persons under age twenty-one. For adolescents with severe psychological problems in addition to substance abuse problems, this option allows for treatment in certain more specialized facilities. In 1987 only thirty-six states and the District of Columbia had the inpatient psychiatric option.

As I mentioned earlier, two specific restrictions have significant implications for the delivery of medical services in the treatment of drug abuse: (1) Medicaid will not pay for room and board charges for treatment in residential settings; and (2) it will not cover medical care for adults between ages twenty-two and sixty-five in an institution for mental disease (IMD). Since drug abuse is classified as a mental disease in the international classification of diseases, this excludes care provided in facilities that specialize in the treatment of substance abuse.

Although residential treatment facilities are an important setting for inpatient drug abuse treatment, Medicaid regulations provide for inpatient care only in medical facilities, such as inpatient hospitals, skilled nursing facilities, and intermediate care facilities. While Medicaid will pay for medical services provided to persons under age twenty-one and over age sixty-five in residential treatment facilities and also to those ages twenty-two to sixty-four as long as the facility does not meet the definition of an IMD, it will not pay for room and board charges in residential treatment facilities. These charges account for the majority of costs associated with treatment in this setting.

If public financing for drug abuse treatment is to be mainstreamed into Medicaid, then this exclusion would have to change. Currently, inpatient care is only available in the acute hospital care setting—the most expensive setting in which treatment can occur. The standard inpatient treatment package for substance abuse consists of up to seven
days of medically necessary detoxification and twenty-one days of rehabilitation. Thus, fully three-quarters of the standard treatment regimen consists of rehabilitative services. The high overhead of hospitals is not a warranted expense for the rehabilitative phase of drug abuse treatment. This psychosocial service can be provided in other, nonmedical, settings, which have considerably lower costs.\textsuperscript{31}

Even if Medicaid were to extend coverage to residential treatment facilities, treatment of adults in these settings would generally not be possible because Medicaid will not pay for any care received by persons ages twenty-two to sixty-four in an IMD. Classification as an IMD is determined not by the licensure of the facility but by its overall character. An IMD is defined as a facility with more than sixteen beds “that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”\textsuperscript{32} While the IMD exclusion might be waived for drug abuse treatment facilities, this is unlikely to happen, since other facilities, such as those treating alcoholics, would have equally valid demands for an exclusion.

Providing for care in residential settings and relaxing the IMD exclusion should result in a substitution of less-expensive residential care for hospital inpatient care, thereby generating savings to states that provide for care (beyond medically necessary detoxification) in the inpatient setting. However, it would also increase the demand for inpatient drug treatment, thus increasing overall costs to state and federal programs.\textsuperscript{33}

Drug abuse treatment, however, is embedded in the broader world of mental health services delivery. Providing for care in residential settings and relaxing the IMD exclusion for drug abuse would mean that these changes would also probably have to be made for all mental health care. The fiscal implications of this type of change would be quite large. The federal government has not been willing to pay for specialty inpatient mental health care for persons other than the aged and children under Medicaid and is unlikely to make such a sweeping change.

Access to care. Further complications with mainstreaming public financing into Medicaid relate to access to care. Access to care can be limited because of the low payments made to both physicians and hospitals. Physician participation in Medicaid is directly related to payment levels and varies by specialty. Participation rates are particularly low for psychiatrists, the specialists most likely to be treating drug abusers. According to a study by Janet Mitchell and Rachel Schurman, 42 percent of psychiatrists would not accept Medicaid patients.\textsuperscript{34}

For inpatient care, access may also be affected by low hospital reimbursement rates. Before fiscal year 1982 Medicaid was required to pay
hospitals on the basis of reasonable costs. The Omnibus Budget Reconciliation Act (OBRA) of 1981 changed the rules, and now Medicaid is only required to provide hospital reimbursement that is adequate to meet costs in an efficiently run hospital and provide beneficiaries with reasonable access to care. Because these amounts may be considerably less than actual costs, hospitals may not be willing to accept Medicaid patients. Hospitals are under no obligation to accept Medicaid patients except for medical stabilization in the case of emergencies.

Since Medicaid eligibility rules exclude a large number of drug abusers, eligibility would also have to expand if drug abuse treatment were to be a central part of Medicaid. However, barriers exist here as well. If Medicaid eligibility were extended to all low-income persons, the costs of the Medicaid program to both the federal and state governments would increase tremendously. Medicaid would have to provide not only treatment for drug abuse but the whole array of medical services provided under Medicaid for these newly eligible persons. The fiscal implications are so large that this is unlikely to be a feasible option, given states’ current budgetary problems.

Conclusions

As this Commentary has suggested, several options exist for policymakers to increase the availability of treatment services for drug abuse. On the private side, government has the authority to regulate insurance benefits; this regulation can take the form of either mandated availability or mandated benefit packages.

To the extent that certain abusers may now be treated in the private sector as opposed to the public sector, a redistribution of costs between private and public payers may occur. Currently, the majority of states do not have mandated drug treatment benefits. Mandates may take the form either of mandated availability of drug treatment benefits or of a mandated minimum benefit package. Under mandated availability, employers are free to choose the levels and types of benefits provided by their health plans. However, the majority of states with mandates have legislated a minimum level of benefits that all employers must provide.

On the public side, some have argued that public funding for drug abuse treatment should be made part of Medicaid. A number of institutional barriers exist to this approach, making it unlikely that Medicaid as it is currently structured will ever include more widespread coverage for substance abuse. There is currently no thorough understanding of the drug abuse treatment benefits that state Medicaid programs provide. Coverage for drug abuse treatment varies, often considerably, by state.
policymakers want Medicaid to provide uniform treatment for drug abuse, then a specific provision for mandated coverage would have to be promulgated. Under Medicaid, states are required to provide only medically necessary services. Rehabilitation, which is psychosocial in nature, is not considered medically necessary and is not provided by all states.

Even if Medicaid is unable to provide universal coverage, the program could target certain population groups for increased access to drug abuse treatment services. One such group is pregnant women, for whom coverage provisions under Medicaid are particularly problematic. Whereas all poor pregnant women are automatically eligible for Medicaid, treatment for drug abuse is not necessarily provided. The effects of drug exposure on infants, however, would seem a compelling reason to cover drug abuse treatment for pregnant women. A report by the U.S. General Accounting Office found that drug-exposed infants were more likely than nonexposed infants to have a greater range of medical problems and generated hospital costs that were up to four times greater than costs for infants not exposed to drugs.38

While including drug abuse treatment for pregnant women under Medicaid would be beneficial to the women, their infants, and society at large, and might also result in Medicaid cost savings, it addresses only one segment of the drug-abusing population. Further solutions must be devised and explored if our society is to make progress in combatting the complex problems of substance abuse.

This research was funded by the RAND Drug Policy Research Center.

NOTES

2. Sources include published reports, journal articles, insurance manuals, and federal and state regulations. I also interviewed representatives of private insurance companies, Medicare, Medicaid, the Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS), and state insurance regulatory agencies.
5. The National Drug and Alcoholism Treatment Unit Survey (NDATUS) funding service category “other” (which comprised 3 percent of overall expenditures) was included in our category of “public expenditures” for these calculations. Because of underreporting of facilities, both public and private treatment expenditures are likely to be undercounted in NDATUS. Expenditures for drug treatment may also be higher than the figures here suggest, because of its potential inclusion in general medical...


9. The “private other” category in Exhibit 1 includes, among other things, fees paid directly by clients and copayments paid by those with insurance.

10. Of course, if the number of providers is too small to meet demand, then rationing can also occur in the presence of insurance. However, the evidence from the private sector is that as private insurance for drug abuse treatment became more prevalent, the number of private providers grew to meet the demand. This may not be the case in the public sector, because of characteristically low payment rates by public insurers. See Gerstein and Harwood, eds., Treating Drug Problems.

11. Understanding Drug Treatment.

12. For employed private patients, the presence of employee assistance programs (EAPs) in the workplace that refer abusers to treatment centers may result in an effective gatekeeping mechanism. Patients with insurance that involves managed care, such as health maintenance organizations (HMOs), are also subject to gatekeeping.

1.3. A plan participant is a worker covered by a benefit plan to which the employer contributes. The BLS statistics are likely to overestimate the number of persons in the population with employment-related drug abuse coverage, since medium and large firms are more likely than smaller firms to provide health insurance to their employees and to have generous coverage.


15. In 1989 the survey instrument permitted better measurement of inpatient detoxification services. Thus, the large increase observed between 1988 and 1989 is partially due to better measurement. See M. Kronson, “Substance Abuse Coverage Provided by Employer Medical Plans,” Monthly Labor Review (April 1991).

16. Ibid.

17. National Institute on Drug Abuse, Demographic Characteristics and Patterns of Drug Use of Clients Admitted to Drug Abuse Treatment Programs in Selected States (Washington: DHHS, 1985). Since the CODAP study only counts the number of episodes of care to the survey date and not per lifetime, lifetime episodes are likely to be more numerous.

18. Higher outpatient copayments are observed for mental health services in general.


20. W. Manning et al., Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment, RAND Report no. R-3476HHS (Santa Monica, Calif.: The RAND Corporation, February 1988).


22. The reason that drug abuse treatment accounts for such a large fraction of program expenditures is that military facilities generally do not provide such treatments. The vast majority of treatment services must be sought in the civilian sector. CHAMPUS provides insurance coverage for care that is not provided in military facilities.

24. Specifically, room and board charges, which account for the majority of treatment costs, are not paid for in this setting.

25. This is the population that is not under the supervision of the criminal justice system. Gerstein and Harwood, eds., Treating Drug Problems.


28. Several additional outpatient treatments may be covered in California through an interagency agreement with the Department of Alcohol and Drug Programs. However, these benefits are available only in counties that participate in the cost-sharing agreement with Medicaid.


30. In contrast, under Medicare, while care in residential facilities is also not covered, there is no IMD exclusion.

31. Although Medicaid guidelines prohibit federal cost sharing for drug abuse treatment in residential settings, at least one state, Michigan, does provide residential treatment to some Medicaid eligibles. Although the state does not receive matching federal funds for this care, the savings from the lower cost, relative to treatment in a hospital setting, outweigh the lack of a 50 percent federal match. However, since funds are entirely drawn from the state, only a limited amount of residential care is currently available.


33. This may be mitigated by an offsetting decrease in expenditures in state-run facilities.


36. Certain types of facilities, such as those constructed with federal grants under the Hill-Burton Act, must participate in Medicaid.

37. State mandates apply to all employer-provided health insurance, except for plans offered by employers that are self-insured. See W. Thacker, Director, Office of Substance Abuse Services, Commonwealth of Virginia, on behalf of the National Association of State Alcohol and Drug Abuse Directors, “Insurance Coverage and Drug and Alcohol Abuse,” Hearing before the House Energy and Commerce Subcommittee on Commerce, Consumer Protection, and Competitiveness, 100th Congress, 2d Sess., 8 September 1988, Appendix 1.