

AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Health Financing and Committee on Substance Abuse

Improving Substance Abuse Prevention, Assessment, and Treatment Financing for Children and Adolescents

ABSTRACT. The numbers of children, adolescents, and families affected by substance abuse have sharply increased since the early 1990s. The American Academy of Pediatrics recognizes the scope and urgency of this problem and has developed this policy statement for consideration by Congress, federal and state agencies, employers, national organizations, health care professionals, health insurers, managed care organizations, advocacy groups, and families.

ABBREVIATIONS. SCHIP, State Children's Health Insurance Program; LSD, lysergic acid diethylamide; PCP, phencyclidine hydrochloride; ADHD, attention-deficit/hyperactivity disorder.

INTRODUCTION

Leading the list of Americans' concerns for children is drug abuse, according to a 1997 Harvard study.¹ The numbers of children, adolescents, and families affected by substance abuse have sharply increased since the early 1990s.² Unfortunately, the availability of and financing for substance abuse prevention, assessment, and treatment have not kept pace with the needs of young people. Access to substance abuse services has decreased during the past decade because of inadequate insurance coverage, managed care controls, and low reimbursement rates. Although there are no national estimates of unmet need for substance abuse services for children, the surgeon general estimated that as many as 75% to 80% of children who are in need of mental health treatment fail to receive it.³ The consequences of failing to intervene early and not providing age-appropriate substance abuse and mental health treatment are substantial and long-term.

This policy statement includes a summary of the prevalence of substance abuse among children and adolescents along with a review of financing problems experienced by those who are insured through private health insurance, Medicaid, and the State Children's Health Insurance Program (SCHIP), and those who are uninsured. The statement concludes with specific recommendations for financing substance abuse prevention, assessment, and treatment for children and adolescents. By necessity, these recommendations incorporate mental health problems and interventions because of the high prevalence of

comorbid psychiatric disorders among children with substance abuse problems.

PREVALENCE AND IMPACT OF SUBSTANCE ABUSE AMONG CHILDREN AND ADOLESCENTS

Substance abuse by young people has increased in the past decade, and it is occurring at younger ages. According to results from the *Monitoring the Future Study* conducted in 1999 at the University of Michigan Institute for Social Research, 33% of 12th graders and 9% of eighth graders reported being drunk 1 or more times during the last 30 days.² As many as 23% of high school seniors and 10% of eighth graders reported using marijuana in the last 30 days, up from 14% and 3%, respectively, in 1991. The percentage of adolescents who reported using hallucinogens, lysergic acid diethylamide (LSD), phencyclidine hydrochloride (PCP), cocaine and crack cocaine, heroin, amphetamines, methamphetamines, barbiturates, and tranquilizers also increased between 1991 and 1999. In addition, cigarette use among adolescents, which is a risk factor for use of marijuana and other illicit drugs, also markedly increased during this decade. In 1999, 35% of 12th graders reported smoking cigarettes during the last 30 days, up from 28% in 1991. Among eighth graders, the reported 30-day cigarette use rate increased from 14% to 18%.

Epidemiologic data revealed that 9% of adolescent females and 20% of adolescent males meet adult diagnostic criteria for an alcohol use disorder.⁴ Among adolescents and young adults with a substance abuse disorder, 41% to 65% also have a mental health disorder.³ The most common of these are depression, conduct disorder, and attention-deficit/hyperactivity disorder (ADHD) in combination with conduct disorder. ADHD and learning disorders in combination with depression and anxiety disorders also carry a high risk of substance abuse. If the significant number of drug-exposed infants and the 1 in 6 children exposed to substance abuse within their families are added to these estimates, the size of the population affected by substance abuse and, therefore, potentially needing assistance dramatically increases.⁵

Obtaining accurate estimates of the prevalence of substance abuse among children and adolescents is very difficult. Most national studies survey only students, but many high-risk youth do not regularly attend school and, thus, are not included in these estimates. Other difficulties in obtaining reliable estimates are the results of coverage and reimbursement problems. Rather than using a substance abuse

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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diagnosis, health care professionals may be using procedure codes for treating associated symptoms of substance abuse, such as fatigue, irritability, weight loss, headache, abdominal pain, or depression. The lack of use of substance abuse codes may also reflect health care professionals' attempt to avoid stigmatizing a child. Consequently, existing prevalence data likely underestimate the scope of the problem.

Data specific to adolescents are limited, but there is growing evidence that successful early intervention and treatment carries significant benefit for the individual and society.⁶ The most appropriate assessment of costs and benefits of treatment are based on broader outcome measures rather than abstinence alone. Despite the fact that there is no single treatment approach that works for all patients, standard treatments have been shown to produce significant decreases in drug use and in drug-related problems of crime, family violence, unemployment, welfare dependence, underachievement, and other antisocial behaviors.⁷

EXTENT OF FINANCING PROBLEMS FOR SUBSTANCE ABUSE SERVICES

Although most families whose children require substance abuse services experience financial difficulties related to high out-of-pocket expenses, those who are uninsured are at the greatest disadvantage. An estimated 14 million or 15.9% of children younger than 22 years had no health insurance coverage in 1999.⁸ These families must rely exclusively on publicly funded services through their state's substance abuse and mental health agencies or must pay for care themselves. Often, uninsured youth receive uncompensated hospital and emergency care for acute symptoms only, which is seldom coordinated with primary care and behavioral health services. Unfortunately, publicly supported substance abuse and mental health services are underfunded and are typically available only for youth with serious emotional disturbances whose families meet a certain income threshold. Many young people, particularly those who are just beginning to abuse alcohol and other drugs, do not have serious emotional disturbances and, therefore, do not qualify for state-funded services. Moreover, children who are privately insured but without adequate substance abuse and mental health benefits are seldom eligible for state-funded services.

Most children under age 22 (65.4% or 57.7 million) are privately insured by plans purchased by their families individually or through their employers.⁸ Often, these families rapidly exhaust their annual and even lifetime allotment of substance abuse benefits and must pay for needed services themselves or rely exclusively on self-help organizations, such as Alcoholics Anonymous and Narcotics Anonymous. Most private health insurance plans impose benefit limitations and cost-sharing requirements on substance abuse and mental health services that are greater than those imposed on general medical services.^{9,10} For example, coverage of outpatient substance abuse services, when available, is typically short in duration and is often capped at an inadequate

number of visits. Family therapy is often excluded. Inpatient substance abuse services are sometimes excluded altogether or covered only for acute detoxification purposes. Coverage of prevention, assessment, early intervention, relapse prevention, crisis intervention, partial hospitalization or day treatment, and residential care is seldom covered by private plans. Mental health benefits, however, are often provided somewhat more generously than are substance abuse benefits.^{2,11}

In addition to benefit limitations, many private insurance plans require higher copayments or coinsurance in addition to separate deductibles for substance abuse benefits.¹¹ The Mental Health Parity Act of 1996 prohibits plans from imposing higher annual and lifetime out-of-pocket maximums for mental health services than for general medical services.¹² Although many states have passed mental health parity legislation, substance abuse parity is often not included. Thus, many of the gains that have been made in achieving parity only apply to mental health. This may perpetuate the pattern of physicians using procedure codes for treating associated symptoms of substance abuse rather than codes for a substance abuse diagnosis, which further distorts prevalence statistics. Also, the lack of specific data furthers the misconception that substance abuse is a consequence of mental illness rather than a primary disease, a comorbidity, or a significant precipitant of mental health problems.

Medicaid, the source of insurance for 16.4 million or 18.7% of all children younger than 22 years, has historically covered fewer adolescents than younger children.⁸ Not until the enactment of SCHIP have many states taken the option to expand Medicaid to cover all adolescents from families with incomes at 100% of the federal poverty level. Unlike private coverage, Medicaid's benefits for children and adolescents are comprehensive and cover a continuum of inpatient and outpatient substance abuse and mental health services. Although Medicaid benefits are expansive, reimbursement rates have been very low and, as a result, serve as a disincentive to provide qualified pediatric and substance abuse services.

Regardless of the source of health insurance coverage, most substance abuse and mental health services are delivered by managed behavioral plans, distinct from general managed care plans and primary pediatric medical care. Although the literature shows that managed behavioral health plans have provided greater overall access to mental health services and a greater continuum of care, it also shows that as a result of tight utilization management, rates of ambulatory visits and hospitalizations have decreased.³ Pediatricians and other referring health care providers report persistent problems in obtaining authorization for substance abuse treatment for children and adolescents. Often, utilization review criteria address the needs of adults, and children's conditions must be severe or associated with comorbidities to warrant extended counseling or hospital stays. For example, criteria such as chronicity, loss of work, and adult comorbidities—which are inappro-

appropriate for young people—are often used to determine whether substance abuse treatment is medically necessary. Moreover, many behavioral health plans have closed panels of mental health professionals with limited pediatric substance abuse training or experience. Seldom does coordination between primary care and behavioral health care take place effectively. Problems have also been reported in sharing medical information between behavioral health plans and primary care providers.

Compounding these difficulties is the overall shortage of ambulatory and inpatient substance abuse and mental health services for children and adolescents. Many inpatient facilities have closed during recent years. These shortages have resulted from many factors, including historically low rates of reimbursement provided to substance abuse and mental health professionals. To serve this population effectively is very labor intensive, and insurance dollars and public funds consistently fail to provide adequate reimbursement. Also contributing to payment and service gaps is the fact few insurers recognize the new *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition: Primary Care Version*, which was developed jointly by the pediatric and mental health communities to encourage earlier identification and primary behavioral interventions.¹³ In addition, pediatricians are seldom able to receive reimbursement for providing counseling and education services to children at high risk of developing substance abuse problems.

Serious problems exist in the availability and organization of behavioral health services for the treatment of substance abuse problems among youth. Although there are substantial problems with low payment and persistent obstacles in gaining access to needed interventions, pediatricians are in a unique role to identify and intervene with children and adolescents who have or are at risk of substance abuse problems.¹⁴ In addition, a cadre of physicians needs to be trained in the field of pediatric addiction medicine. However, the recruitment and retention of pediatricians and other health care providers in the field of addiction medicine has been very difficult, which seriously compromises the provision of high-quality substance abuse care.¹⁴

FINANCING RECOMMENDATIONS

Many changes need to be made to the financing and delivery of substance abuse care to improve the availability of services for all children and adolescents. Change in this area, however, is not likely to occur without the participation of a coalition of national and state legislators, public purchasers, employers, health professionals, families, and health services researchers. The American Academy of Pediatrics, together with other participating behavioral health organizations and consumer groups, released a consensus statement on insurance coverage for mental health and substance abuse services for children and adolescents, which highlights the deterioration of mental health and substance abuse services and recommends access, coordination, and monitoring strategies for achieving service improvements.¹⁵

That article and this policy statement on financing should serve as blueprints for Congress, federal and state policy-makers, and employers.

The American Academy of Pediatrics recommends that Congress authorize the Substance Abuse and Mental Health Services Administration to conduct a comprehensive national study of the supply, distribution, financing, and quality of substance abuse prevention, assessment, and treatment services for children and adolescents.

Additional recommendations address the needs of all children, regardless of insurance status. In addition, there are specific recommendations that apply to those with private insurance, those with Medicaid or SCHIP coverage, and those who are uninsured.

For All Children and Adolescents, Regardless of Insurance Status

1. Ensure that substance abuse and mental health benefits are sufficient in amount, duration, and scope to reasonably achieve their purpose.
2. Allow pediatricians and safety net providers trained or experienced in substance abuse prevention, assessment, evaluation, and management services to be included in panels of professionals that provide these services.
3. Create an integrated system of referral and treatment for substance abuse that is consistent with the referral and treatment process of other chronic diseases.
4. Simplify and coordinate processes for families attempting to access substance abuse and mental health services for their children across public and private insurers plans, and public programs.
5. Improve preauthorization and utilization review criteria to be consistent with national standards on the treatment of substance abuse among youth developed by the American Academy of Pediatrics,¹⁶ the Substance Abuse and Mental Health Services Administration,¹⁷ the National Institute on Alcohol Abuse and Alcoholism,¹⁸ and the American Society of Addiction Medicine.¹⁹
6. Provide reasonable compensation and allow reimbursement of counseling, coordination, and consultation procedure codes to enable pediatricians and other primary care providers to provide primary substance abuse and mental health services.
7. Adjust capitation rates to take into account substance abuse service needs and recommended clinical guidelines for length of care for children and adolescents rather than relying on historic utilization rates to establish capitation amounts.¹⁹
8. Encourage payers to reimburse for individual and group counseling and risk factor reduction interventions for children at risk of substance abuse problems.
9. Establish financing mechanism for smoking cessation programs for children.
10. Create financial incentives for comanagement of substance abuse treatment between primary care and behavioral health care (eg, transferring some behavioral health dollars into primary care).

11. Create mechanisms for sharing risk among public and private payors to allow for coverage of a comprehensive set of interventions to better manage children with complex cases.
12. Establish clear delineation of responsibilities with regard to children involved with multiple state agencies and required court-ordered treatment.
13. Ensure that health plans and health care providers adopt medical record and billing procedures to protect the confidentiality of children and adolescents.

For Privately Insured Children and Adolescents

1. Extend benefits to include a broader array of substance abuse prevention, assessment, and treatment services.
2. Establish parity between medical services and substance abuse and mental health services so that coverage of the management of substance abuse and mental health disorders is the same as coverage of other chronic conditions.
3. Reduce limitations on substance abuse and mental health services and allow for substitution of mental health and substance abuse benefits and use of alternative sites of care, including schools and homes.
4. Eliminate exclusions for specific diagnostic categories, chronic disorders, and preexisting conditions.
5. Reduce cost-sharing requirements for substance abuse services to encourage their use.

For Medicaid and SCHIP Insured Children and Adolescents

1. Target outreach efforts to ensure that Medicaid- and SCHIP-eligible adolescents are covered.
2. Ensure that a continuum of substance abuse and mental health services for children and adolescents are specified in state Medicaid plans and contracts, using a variety of benefit categories, including Early and Periodic Screening, Diagnosis, and Treatment expanded services.
3. In non-Medicaid SCHIP programs, offer supplemental or wraparound benefits to allow expanded behavioral health coverage for those who meet certain risk criteria.

For Uninsured Children and Adolescents

1. Expand SCHIP income eligibility levels to the maximum possible.
2. Expand the eligibility criteria of states' substance abuse and mental health service programs to include children with all levels of substance abuse and mental health risk.
3. Increase funding of state substance abuse and mental health programs for children and adolescents on the basis of comprehensive needs assessments and behavioral risk profiles of local communities.
4. Earmark a reasonable share of state block grants for prevention, assessment, and treatment services for children and adolescents.

5. Identify new revenue sources to increase availability of substance abuse services, including tobacco settlement funds and new taxes on alcohol.

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ERRATUM

An error occurred in the policy statement "Transfer of Drugs and Other Chemicals Into Human Milk" (*Pediatrics* 2001;108:776-789). In the first paragraph under "Breastfeeding and Smoking," line 14, the word "acotinine" should be "cotinine."

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