

Effects of the Elimination of Substance Abuse and Mental Health Treatment Benefits on Oregon's Most Vulnerable Citizens

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Introduction

Coping with the nation's highest unemployment rate and dealing with its worst fiscal recession since World War II, in 2003 Oregon's legislature made sweeping changes to the Oregon Health Plan (OHP)—a visionary and progressive health policy that captured national interest nearly a decade earlier (Laws et al., 2002). Included in these cost-saving measures were the elimination of substance abuse (SA) and mental health (MH) treatment benefits for the previous "newly eligible" or "expansion" population in March, 2003; and increased responsibility for self-payment of premiums and health care copays for these, the most vulnerable of the state's citizens.

Prior to these financially driven changes, the authors' research demonstrated dramatic increases in SA treatment access in both traditional and newly eligible subpopulations (now termed OHP Plus and OHP Standard, respectively) with no cost-shifting or adverse selection operating between Medicaid and other public funding sources (Deck et al., 2000; Deck & McFarland, 2002). Projected system-wide cost savings associated with timely provision of SA treatment to those in need had little effect on legislative action at this time (Gabriel & Deck, 2003).

The effects on OHP enrollment and use of health services of these policy changes were abrupt and significant. Within 6 months, OHP Standard enrollment declined from over 100,000 to just over 50,000. Individuals in the zero income bracket and those with the greatest need for medical and behavioral health care were disproportionately represented among disenrollees (McConnell & Wallace, 2004; Carlson & Wright, 2004).

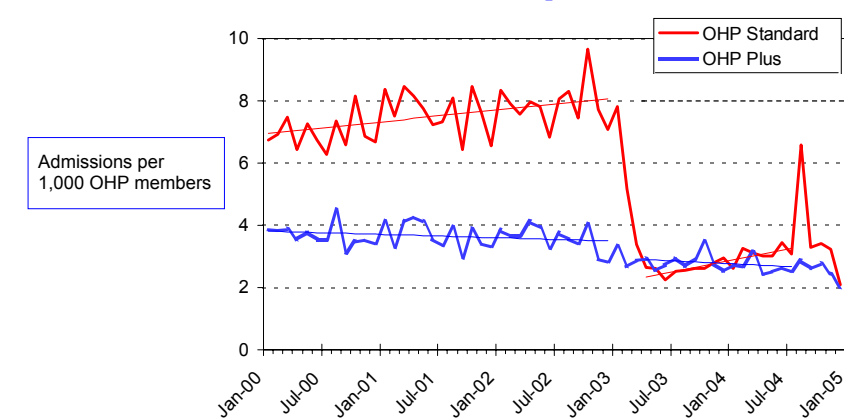
In August 2004, 17 months after the initial policy shifts, the legislature restored the SA and MH treatment benefits for the OHP Standard population. However, enrollment in OHP Standard was capped, allowing no new enrollments at this point in time. The "natural experiment" afforded by the state's legislative action is represented in Table 1.

Table 1
Substance Abuse and Mental Health Benefit Coverage by OHP Eligibility Group and Policy Change Periods

	OHP Policy and Benefit Change Periods		
	Prior to Benefit Cuts (01/00-02/03)	SA/MH Benefits Eliminated (03/03-07/04)	SA/MH Benefits Restored (08/04-12/05)
OHP Standard	Covered	Not covered	Covered
OHP Plus	Covered	Covered	Covered

Previous work by the authors has documented the effects of these policy changes on the full OHP population (e.g., Deck, Gabriel, et al., 2005). Figure 1 shows the dramatic decline in admissions to outpatient substance abuse treatment for OHP Standard members (approximately 75%) following the elimination of these benefits in March, 2003. Reductions in MH treatment admissions were similarly dramatic. Surprisingly, since their OHP benefits were not changed, there was also a significant decline in SA services for OHP Plus members. Qualitative inquiry suggested these policy changes effected an overall change in system capacity (agency closures, staff layoffs), which would affect access to treatment for all individuals regardless of their health coverage.

Figure 1
Monthly Admissions to Outpatient Substance Abuse Treatment OHP Standard and OHP Plus Populations 2000-2005



This presentation examines these effects from the perspectives of a more limited segment of the OHP Standard and OHP Plus population—those adults that had either expressed a need for, or recently received, SA or MH treatment services.

Methods

RMC Research interviewed 190 OHP Standard and Plus members using a 40-page, structured interview protocol that included questions about their:

- Demographics
- OHP enrollment
- Medical care
- Criminal justice involvement
- Employment
- Substance use
- Substance abuse services received
- Mental health problems
- Mental health services received

Using a calendar-based, modified Time Line Follow Back (TLFB) methodology (Sobell & Sobell, 1992), field interviewers obtained this information on a monthly basis dating back to January 2002, over a year before the initial OHP policy change in March 2003, and through the date of the interview, summer/fall 2005.

The Interview Sample

The interview sample was selected from 2 sources:

1. a subsample of a statewide OHP sample surveyed on a variety of health-related issues, and
2. a sample of OHP members currently receiving SA treatment.

In 2003 and 2005, Wright et al (2005) surveyed nearly 4,000 OHP Standard and Plus members statewide to determine their need for and receipt of health care since the OHP policy changes in 2003 and 2004. A few questions within their survey focused on respondents' self-reported need for SA treatment and their use of—or need—for MH treatment services. Through these investigators, and following IRB approval, the RMC Research team contacted a sample of individuals that endorsed these items and solicited their participation in the current, more behavioral health-focused, interview.

Since the prevalence of self-reported need for SA or MH treatment was low in this survey sample, concerns for sufficient sample size prompted the authors to augment their initial sampling strategy by recruiting OHP Standard and Plus members who were currently receiving SA treatment.

Demographic Characteristics of the Samples

Descriptive characteristics of the 2 subsamples for the current study are shown in Table 2, broken out by OHP Standard and Plus coverage.

Table 2
OHP Standard and Plus Sample Characteristics^a
From OHP Survey and Current Treatment Samples

Characteristic	OHP Survey Sample (n = 100)		Current Treatment Sample (n = 90)		Total Sample (n = 190)
	OHP Standard	OHP Plus	OHP Standard	OHP Plus	
Female*	76%	82%	57%	81%	75%
White	78%	69%	71%	69%	72%
30 and younger**	16%	18%	33%	44%	27%
Married*	28%	16%	26%	29%	25%
HS education or less	33%	51%	60%	58%	50%
Living independently	69%	67%	66%	58%	64%
Employed***	36%	16%	24%	8%	22%
Ever arrested***	15%	7%	43%	31%	23%

^aAt time of OHP Policy Change, March, 2003
^bp < .05; **p < .01; ***p < .001

In general, the interview sample was largely white (72%), female (75%) and over 30 years of age (73%). At the time of the elimination of SA/MH benefits in 2003, sample interviewees were typically unmarried (75%), living independently (64%) and not employed (78%). Half had more than a high school education (50%). Consistent with traditional Medicaid eligibility criteria, OHP Plus members were more likely to be female (82% vs. 68%) and unemployed (88% vs. 69%) compared to OHP Standard members. Those currently in treatment were more likely to be younger, unemployed, have a high school education or more, and have been arrested compared to the OHP survey sample.

Problem Severity

In Table 3, the prevalence of alcohol and other drug (AOD) use from January 2002 to the interview date and lifetime mental health problems are summarized for the 4 samples. For the entire sample the most commonly used substances were alcohol (76%) and marijuana (55%). Experience with all substances other than alcohol evidence significant differences among the subsamples. Just under half the adults in the OHP Survey sample had used marijuana during the study period, while approximately 70% of the treatment sample had used this drug. Differences in methamphetamine and other illicit drug use are more extreme. Methamphetamine (69% vs. 16%), heroin (30% vs. 7%), and crack cocaine (52% vs. 12%) use was over 4 times as likely in the current treatment sample compared to the OHP survey sample, and use of opiates (32% vs. 12%) and other illicit substance (24% vs. 7%) was 3 times more likely among current treatment participants. The only significant difference between the OHP Standard and Plus members was use of opiates with 28% of the OHP Standard members using opiates compared to 14% of the Plus members.

Among the mental health problems asked in the interview, experience with depression was most common (62% of entire sample), followed by anxiety (56%), and major depression (50%). Adults in the OHP Survey sample were more likely to experience anxiety (64% vs. 46%), sleep eating or other somatic disorders (52% vs. 35%), depression (70% vs. 51%), schizophrenia (18% vs. 3%), and other mental breakdown (55% vs. 35%) while those in the Current Treatment sample were more likely to experience post traumatic stress disorder (55% vs. 36%). OHP Plus members reported more lifetime mental health problems including anxiety (65% vs. 46%), major depression (57% vs. 43%), and schizophrenia (19% vs. 7%) compared to Standard members.

Table 3
Prior Substance Abuse and Mental Health Problems^a
From OHP Survey and Current Treatment Samples

	OHP Survey Sample (n = 100)		Current Treatment Sample (n = 90)		Total Sample (n = 190)
	OHP Standard	OHP Plus	OHP Standard	OHP Plus	
Recent AOD Use					
Alcohol	71%	67%	79%	86%	76%
Marijuana*	42%	44%	64%	73%	55%
Methamphetamine ***	16%	18%	71%	65%	41%
Heroin***	11%	2%	33%	25%	17%
Opiates***	20%	2%	38%	25%	21%
Crack/Cocaine***	13%	11%	60%	44%	31%
Other illicit drug**	9%	4%	29%	19%	15%
Lifetime MH Problem					
Anxiety**	53%	76%	38%	56%	56%
Sleep/eating disorder	53%	51%	33%	35%	44%
Major depression*	54%	55%	29%	58%	50%
PTSD*	40%	31%	43%	63%	44%
Depression**	73%	67%	38%	65%	62%
Schizophrenia***	7%	31%	7%	8%	13%
Other mental breakdown*	55%	53%	26%	44%	45%

Note: Yellow-highlighted areas denote groups significantly more severe than others.

^aAt time of interview, July to December 2005

*p < .05; **p < .01; ***p < .001

Patterns of Coverage

Interruption in health coverage has been shown to be strongly associated with access to treatment (e.g., Deck et al., 2005). In Table 4, the patterns of OHP coverage across the 3-year study period are summarized for the study samples. Half of the entire sample (50%) retained OHP coverage throughout the study period. Those that did not retain OHP coverage were nearly equally divided between those that regained coverage at some point (24%) and those that did not (26%). Among the subsamples, OHP Plus members were more likely to be covered for the entire study period (59%) than were their OHP Standard counterparts (36%). Adults in the OHP Survey sample were also more likely to retain their coverage through the entire study period (61%) while the Current Treatment sample was most likely to lose their coverage and not regain it (35%).

Table 4
Prevalence of OHP Coverage for the Study Period¹

	OHP Survey Sample (n = 100)		Current Treatment Sample (n = 90)		Total Sample (n = 190)
	OHP Standard	OHP Plus	OHP Standard	OHP Plus	
Coverage the entire study period	47%	78%	24%	50%	50%
Lost and regained coverage	29%	18%	26%	21%	24%
Had coverage but never regained coverage	24%	4%	50%	29%	26%

¹From January 2002 to interview date.

Results

To examine the effects of the OHP policy changes on these samples, in terms of their use of SA or MH services, the OHP Standard and Plus samples were first divided by whether they had had these services before the changes to the OHP took effect.

- Nearly 1/3 of the OHP Standard sample (32%) had SA treatment in the year prior to the policy change. Only 14% of the OHP Plus members had had these services.
- About 1/4 of the OHP Standard sample (23%) used MH treatment services in the year prior to the policy change. Nearly twice that many in the OHP Plus sample (43%) used MH services.

Table 5 presents a cross-sectional look at access to both SA and MH treatment for the OHP Standard and Plus samples at the 3 policy-relevant time periods shown previously in Table 1. There is little change in access to either SA or MH treatment for these samples during the Benefit Cuts period and after the reinstatement of benefits. While prior treatment access rates differed substantially for the OHP Survey and Current Treatment samples (not shown here), each of these groups held the line on their access rates for both SA and MH treatment during the Benefit Cuts period. Data shown in Table 5 are in dramatic contrast to those presented previously for the full OHP population (Figure 1). Again, however, these findings are on a distinct subpopulation of the full OHP population—those adults that had already received, or expressed a need for, substance abuse or mental health treatment (roughly 15% of the full OHP population)

Table 5
Prevalence of SA and MH Treatment Access Prior to and After OHP Policy Changes

OHP Sample	Treatment Participation	Prior to Benefit Cuts (1/02-2/03)		After Benefit Cuts (3/03-7/04)		After Benefits Restored (8/04-2/31)	
		SA	MH	SA	MH	SA	MH
OHP Standard (n = 97)		32%	23%	32%	30%	32%	33%
OHP Plus (n = 93)		14%	43%	16%	43%	15%	34%

Qualitative evidence from the SA provider community indicated that many of these professionals found creative ways to fund services for those already in their service systems. The data in Table 5 are cross-sectional, i.e., there is no indication as to whether these service recipients had already been in the service system prior to the benefit cuts. In Table 6, prior participation in SA or MH treatment is represented, and these 4 groups are followed through the 2 policy change periods in terms of their prevalence for receiving SA or MH services. For substance abuse services, approximately 2/3 of OHP Standard members who had prior participation in SA treatment were able to obtain these services after the benefit was eliminated. When it was restored, their access rate was the same (65%). Among OHP Plus members (who did not lose the benefit) 85% of prior SA treatment participants received SA treatment during this period. In contrast, among those who had not participated in SA treatment in the year prior to the benefit cuts, far fewer were able to gain access to treatment once the benefits were cut (17% and 5% of OHP Standard and Plus members, respectively).

Table 6
Prevalence of SA or MH Treatment Participation During Benefit Cut and Restoration Periods For Prior Treatment Participants and Nonparticipants

	OHP Standard		OHP Plus	
	During Benefit Cut Period (3/03-7/04)	After Restoration of Benefit (8/04-2/31)	During Benefit Cut Period (3/03-7/04)	After Restoration of Benefit (8/04-2/31)
SA Treatment				
Prior Tx	65%	65%	85%	54%
No prior Tx	17%	17%	5%	9%
MH Treatment				
Prior Tx	68%	64%	80%	68%
No prior Tx	19%	24%	15%	9%

The trends are similar for MH services. About 68% of OHP Standard members who had received MH services before were able to access them in the Benefit Cuts period; while the corresponding access rate among OHP Plus members is 80%. After the benefits were restored, access rate remained the same for OHP Standard (64%) but decreased for OHP Plus (68%). Of those who had not participated in MH treatment before, only 15%-19% of either group could obtain these services in the Benefit Cuts period. When the benefits were restored OHP Standard access to MH services remained essentially the same and Plus decreased from 15% to 9%.

Discussion

Studying a subsample of OHP members who had been in the publicly funded treatment system prior to the elimination of their SA and MH benefits yielded several findings in stark contrast to those of the full OHP population. The dramatic population-wide decline in SA treatment access (nearly 75%, see Figure 1) was not in evidence for the current sample, representing OHP members who expressed a need for or had recently participated in SA or MH treatment.

Even before looking at trends in services over these policy-relevant time periods, a relationship between the type of OHP coverage and treatment services received. Traditional Medicaid-eligibles (OHP Plus) were 3 times more likely to be receiving MH services (43% than SA services (14%) prior to these policy changes. There was no change in this balance during the Benefit Cuts period. In contrast, those termed the "expansion" or "newly eligible" Medicaid group from the formative years of the Oregon Health Plan (OHP Standard) were more likely to be receiving SA services (32%) than MH services (23%) prior to the policy changes.

Although there was no apparent reduction in access to SA or MH services during the Benefit Cuts period, further analysis showed that this was largely the case only for those OHP members who were already being served in either system. In the OHP Standard population, nearly 2/3 of those that had been served (in either SA or MH system) in the year prior to the benefit cut were able to retain services after their benefit was eliminated. Again, qualitative evidence has suggested a number of ways that treatment providers found to continue services to this needy population. In Oregon's largest county, a special tax was approved by the voters during this period to bolster funding for an array of human services, including SA and MH treatment. The absence of OHP SA/MH benefits had a more severe effect on those OHP Standard members that were not in the system the year prior to the cuts, however. Only 1 in 6 (17%) of these individuals was able to access SA treatment during the Benefit Cuts period. Approximately 1 in 4 (25%) were able to access MH treatment.

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