The Comorbid Impact of Alcoholism Treatment on Medical Surgical Disorders

And

The Benefit to Cost Impact of EAPs

By

Jim Wrich-1995

IMPLICATIONS AND POTENTIAL CONSEQUENCES

Behavioral health care costs represent roughly 10 percent of total health care expenditures with the other 90 percent expended on medical surgical disorders. In conducting PARETO studies of medical surgical claims, our associates have consistently found that 15 percent of the enrollees represent approximately 80 percent of the claims expenditures including 5 percent who consume 40 percent of the expenditures. It is estimated that chronic behavioral health problems, largely undiagnosed and untreated, are involved in 70 percent of these cases. This means that if behavioral health issues were totally absent in the remaining 85 percent of claimants, they would have a bearing on more than 50 percent of total health expenditures. Case records indicate that the single most frequent behavioral health problem is substance use disorder.

For years the literature has pointed to the strong co-morbid relationship between substance use disorders, primarily alcoholism, and medical surgical costs. The following are but a few examples of such studies:

1. "Alcoholism and Mortality", Per Sunby M. D., University of Norway, Oslo. 1963.

Mortality among alcoholics was double the expected rate for the general Norwegian population, ranging from 1.6 for cardio-vascular disease to 8.0 for suicides.

2. "Frequency Rates of Alcoholics and Controls by Diagnostic Category", Sidney Pell, Ph.D., and C.A. D'Alonzo, M.D., Journal of Occupational Medicine 12: 198-210, 6/70.

Alcoholic employees are twice as likely as non-alcoholics to have any of a number of medical problems resulting in lost time from work. Moreover, the cause of absence among alcoholics is rarely attributed to alcoholism (26 of 984 incidents of absence).

3. Penjerdel Study, Penjerdel Corporation, 1980. The population of identified substance abusers had more than five times as many admissions for diagnoses other than drugs/alcohol than non-abusers (507 per 1000 vs. 92.0 per 1000). Moreover, length of stay was 9.55 days vs. 6.43 days and total days hospitalized was 4797 vs. 592 for substance abusers vs. non-substance abusers.

4. "Alcoholism Treatment Impact on Total Health Care Utilization Costs", Analysis of the Federal Employee Health Benefit Program with Aetna Life Insurance Company, 1985. Alcoholic families used health care services and incurred costs at about twice the rate of similar families with no known alcoholic members (average monthly costs for the two groups 1980-83 were $210 per person vs. $107 per person respectively). It also showed dramatic reductions in medical costs for families of alcoholics after treatment. In addition, it is estimated that the average cost to treat alcoholics could be offset by reductions in other health care costs within 2 to 3 years following treatment.

5. "Alcoholism Treatment, Severity of Alcohol Related Medical Complications and Health Services Utilization", Cook et al, Journal of Mental Health Administration 19:1 Spring, 1992. Using a sample of 63,873 hospitalized alcoholics, this study shows far greater severity of medical complications among those who were not treated for alcoholism vs. those who were.

6. U.S. Department of Health and Human Services: Alcohol and Health, Seventh Annual Special Report, 1990. Research cited in this report clearly establishes the link between long term uncontrolled drinking and the severity of alcohol-related medical complications, particularly neurological, gastronomic and cardio-vascular complications that attend later stage progression of alcoholism.

7. "Adult Inpatient Completers One Year Later", Harrison, P.A. and Hoffman, N.G.

This study showed dramatic reductions in hospital use one year after alcoholism treatment vs. one year before: 50% reduction for medical services; 60% reduction for psychiatric services; 30% reduction in emergency medical admissions; 50% reduction in emergency psychiatric admissions; 75% reduction in admissions for detoxification services.

8. "Per Diem Cost Comparison for Conditions Associated with Untreated Substance Abuse versus Substance Abuse Treatment 1989", MEDSTAT Systems, Inc. 1991.

This analysis shows that the per diem inpatient costs of treating medical conditions associated with substance abuse ranged from $838 per day for toxic hepatitis, $1264 for gastrointestinal disorders and $1967 for esophageal varices vs. $386 per day for inpatient substance abuse treatment.

On the other hand, when behavioral health disorders are identified and properly treated, the benefits are experienced across a broad range of issues. The following are a few examples of such results that have emerged from Employee Assistance Programs whose outcomes have been tracked:

1. General Motors "... about 60,000 GM employees have taken part in our Employee Assistance Program ... when they were surveyed one year after treatment between 60 and 70 percent of those employees were still abstaining from alcohol and drugs". Roger B. Smith, Chairman, General Motors, Washington, D.C. December 11, 1983.

"... for every $1 spent by General Motors for treatment of employees in the program, more than two dollars were being returned to us within a period of three years." Thomas A. Murphy, former Chairman, General Motors, Detroit, Michigan, October 5, 1979.[1]

2. Kimberly Clark reported 43% reduction in absenteeism and a 70% reduction in accidents among a sample of employees who participated in their Employee Assistance Program.

3. Philips Petroleum reported that its Employee Assistance Program saved more than $8 million per year in fewer accidents, less sick leave and higher productivity.[2]

4. Kelsey Hayes Center for Counseling and Guidance tracked 58 plant workers involved in the program and documented in one year's time a recovery of 18,325 hours, an average of 316 hours per employee.[3]

5. "AT & T Looks at Program Evaluation", Gaeta. E., Lynn, R. and Grey, L. EAP Digest Annual, 1981-82. This reports that in the area of job performance 76% of a sample of employees were rated poor at the time of referral to the EAP; 17% fair; 7% good and 0% excellent. Post program results showed 12% poor; 9% fair; 43% good and 36% excellent. The same study showed a decrease in days absent from 421 to 92; a decrease in absence due to disability from 1531 days to 192; a decrease in visits to the medical department from 818 to 439; on the job accidents from 26 to 5 and off-the-job accidents decreased from 26 to 11.[4]

6. At United Airlines a 1980 Benefit to Cost Ratio based only on reduction in sick leave use while including all applicable EAP costs was $7 to $1 projected over five years and $17 to $1 projected over the expected career span of EAP participants.[5]

If such favorable results are possible in programs that penetrate a small portion of the target population for behavioral health problems, one can only imagine the magnitude of the savings that could result if managed behavioral health care programs which currently cover more than 100 million enrollees were as effective. Even greater results would be possible if all medical professionals simply knew how to rule out substance use disorders, a challenge that is relatively simple, non-intrusive and inexpensive.

While one may not expect general practice MD's or MD specialists with virtually no training in substance use and psychiatric disorders to recognize and effectively handle such problems, the same allowance should not be afforded the psychiatrists, psychologists and social workers who are supposed to be the experts in this area. Failure of medical practitioners to diagnose, appropriately refer and effectively treat substance use and psychiatric disorders is probably the single most costly problem in the delivery of health care in the United States and is certainly a major issue in the benefits programs we have audited. Unfortunately, this state is greatly exacerbated by the failure of behavioral health professionals to properly address substance use disorders.

The cost implications can be conservatively assessed as follows:

---

[1] WORKSITE HEALTH PROMOTION AND HUMAN RESOURCES: A Hard Look at the Data, co-sponsored by General Motors Corporation, U.S. Department of Health and Human Services and the Metropolitan Life Insurance Company.

[2] Ibid.

[3] Ibid.

[4] AT&T LOOKS AT PROGRAM EVALUATION, by Eugene Gaeta, Robert Lynn and Lucille Grey, EAP Digest Annual, 1981-1982

[5] The Conference Board, "Substance Abuse in the Workplace", 1985.

Total 1993 U.S. health care costs ..... $920 billion

Administrative Expense ..... $270 billion

Medical surgical expense ..... $557 billion

Behavioral health care expense:

Substance use disorders ..... $23 billion

Psychiatric disorders ..... 70 billion

$ 93 billion

If the potential impact of behavioral health problems on medical surgical claims found in our PARETO audits was halved, and if the health care profession was able to only impact half of that, the savings could be $80 billion per year on medical surgical costs alone. If proportional reductions in associated administrative expense are included the potential savings climb to $115 billion. When one considers the other costs to society -- workplace productivity loss, criminal justice expense, related auto and casualty insurance costs, related welfare and education expenditures, family violence, child abuse and neglect -- these estimates pale in comparison.

Appropriately delivered managed behavioral health care can be a major factor in reducing overall health care costs. However, this requires that their patients be provided the right care, the first time at a reasonable cost. This in turn requires consistently accurate diagnoses, appropriate referral and adequate follow-up.

Inappropriately delivered managed behavioral health care, on the other hand, can drive health care costs even higher than if nothing had been done, because it adds expense with negative value. In the mean time through denial of care, it simultaneously destroys the treatment system that could potentially provide a solution.

We are in an extremely critical period of time. Managed behavioral health programs need to be carefully monitored and evaluated, and meaningful standards geared to appropriate care must be established. Not only is this necessary to assure the right care to those who need it but to prevent serious additional financial and human damage that could be irreversible.