House Select Committee on Economic Disparity and Fairness in Growth

Roundtable Discussion on **"Substance Use: Destroying Families, Communities, and the Opportunity for Prosperity"**

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Thank you, Chair Himes and distinguished members of the select committee for inviting me to speak today. It's an honor to be here.

Introduction

My name is Jevay Grooms, and I am an Assistant Professor of Economics and Fellow at the Center for Race and Wealth at Howard University. I am also currently a Visiting Scholar at the Sol Price School for Public Policy at the University of Southern California.

I am an applied microeconomist with expertise at the intersection of public economics, health economics, and poverty and inequality. I study impediments to adequate health care delivery and health outcomes of underserved and vulnerable populations with the keen intent to understand how poverty and the legacy of wealth inequality have contributed to health disparities among racial and ethnic minorities.

My work on racial disparities is influenced by my lived experiences. I grew up in the late 1980s and 1990s in Los Angeles, California, and witnessed how the crack cocaine epidemic obliterated the economic and social fabric of Black and Hispanic communities.

This time was marred with high unemployment, increased arrests, increased homicides, an influx of children into the foster care system, and increased fetal death rates. Fast forward to 2011, a close colleague, Dr. Alberto Ortega, and I began to observe the numerous pain clinics popping up throughout Florida while we worked on our graduate studies. It was then that we caught wind of the onset of something that would devastate America. As eager graduate students, we began comparing the crack epidemic and what would later be deemed the opioid

epidemic. We began to compare and contrast the two events and predict how America would respond.

As the opioid epidemic became more widespread, it became quite evident it was impacting white America at a much different rate than Black and other racial and ethnic communities; it also became crystal clear that the response would be much different. There was a shift from addiction to substance use, criminalization to treatment. A much-welcomed change that brought to light two factors that continue to shape my research; 1) structural racism impacts policies even if only by way of implicit biases, 2) stratification economics[1] is essential to ensure issues that impact minority subsets of the population are seen and analyzed.

Today I want to focus my opening remarks on three main topics:

1. Economics and substance use disorders
2. Co-occurrence of substance use disorders and mental health
3. Disparities

Economics and Substance Use Disorders

At its core, health is a determinant in the United States' ability to produce and meet the needs of its citizens. We are all constrained by time, and time spent being ill inhibits our ability to use that precious resource, time, to be productive. At a fundamental level, individuals with a substance use disorder report lower wages and higher levels of unemployment. But it extends beyond labor market conditions; in general, substance use is associated with stress on the criminal, foster-care[2], and healthcare systems to name a few. As a result, resources are diverted from creating opportunities to treat ailments.

For some Americans, substance use disorders are preceded by an employment crisis. As Dr. Anne Case and Dr. Angus Deaton described in their "Deaths of Despair" research[3], hopelessness and helplessness lead Americans to counter-productive behavior (substance use and suicide) to escape the reality of economic hardships faced by the disappearance of the working class. As Americans faced economic hardships, simultaneously the medical industry flooded the market with pain medication, creating a perfect storm.

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[1] Thank you to Dr. Darrick Hamilton, Dr. William Spriggs, and Dr. Rhonda Sharpe who have directly and indirectly informed my research and the importance of disaggregating data to understand the experiences of subsets of the population or sample and not merely the "average" individual.

[2] According to Adoption and Foster Care Analysis and Reporting System (AFCARS) data, in 2019 39% of child removals were for alcohol or drug abuse compared to 19% of removals in 2000. https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.aspx

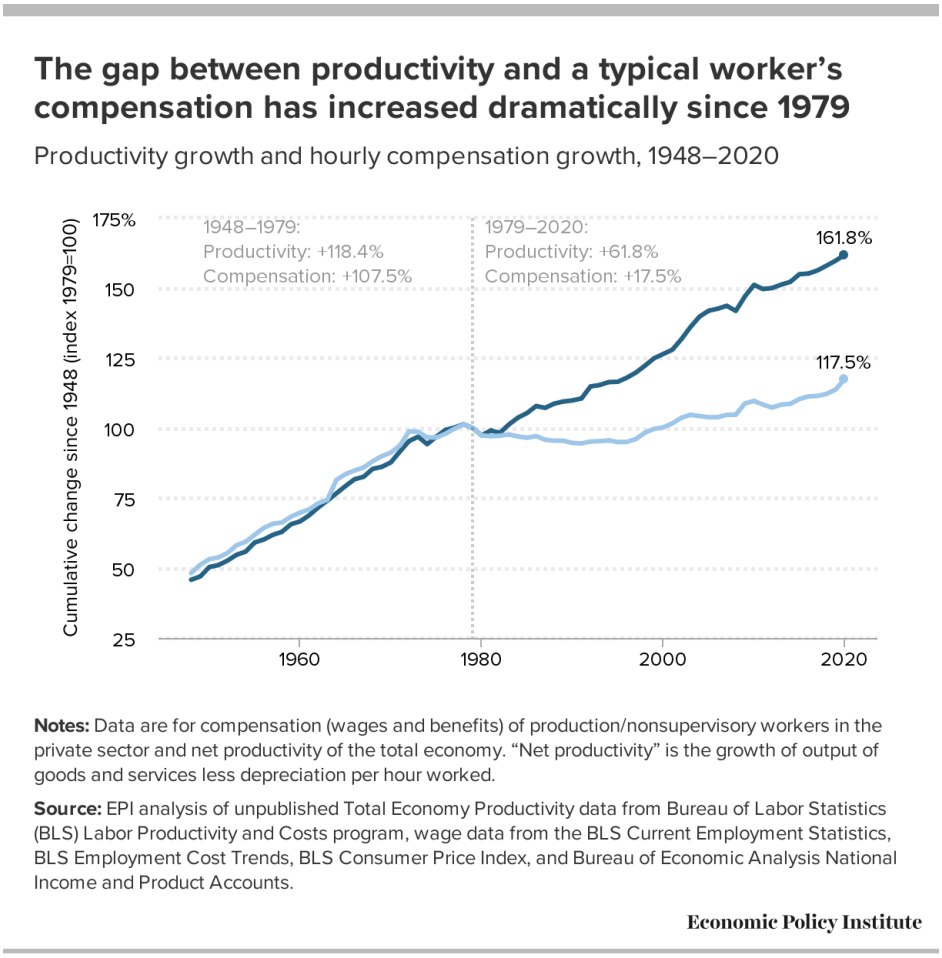
[3] I am referring to their overall body of research pertaining to "Deaths of Despair" which includes the first article listed below, the book and additional articles published pertaining to their research.

Case, A., & Deaton, A. (2015) *Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century.* Proceedings of the National Academy of Science.

While Case and Deaton spoke about the white working-class, we would be remiss to think this is purely a problem that white America faces. The opioid epidemic is the side effect of a more significant problem; thus, efforts to address it at the point of prescription have not been as promising in curbing overdose deaths as previously thought. Some of the underlying circumstance which contributed to the current drug epidemic has impacted other subsets of the population.

To help illustrate this, I want to take a moment to echo the sentiments of Dr. Darrick Hamilton, who spoke to the committee on January 20th of this year, "Over the last half-century essentially all of our nation's productivity gains have gone to the elite and upper middle-classes, while effectively flat-lining real worker wages for everyone else." From 1980 to 2020, the Economic Policy Institute reported (Figure 1)[4] that on average productivity in the U.S. increased by 61.8% while wages increased 17.5%. This is a far cry from the three decades prior, where productivity and compensations nearly mapped 1 to 1.

Figure 1



[4] The Economic Policy Institute, (2021) *The Productivity-Pay Gap*. https://www.epi.org/productivity-pay-gap/

Co-occurrence of SUDs and mental health

While economic stressors could trigger substance use, this dependency could also be influenced by an injury, a traumatic event and other mental health conditions. According to the Substance Abuse and Mental Health Services Administration[5], in 2018, approximately 20.3 million Americans had a substance use disorder, and 9.2 million had a co-occurring mental health condition. Substance use disorders and mental health are often intertwined, but the directionality is less clear. As reported by the National Institute of Drug Abuse, roughly half of all individuals who suffer from a mental health condition will suffer a substance use disorder at some point in their life and vice versa. Thus, it is imperative that we discuss the devastating impacts of substance use in conjunction with the conversation around mental health.

A critical component of treating substance use disorders and other mental health conditions is adequate health insurance. The Mental Health Parity and Addiction Equity Act and the Essential Health Benefits of the Affordable Care Act imposed standards for mental health treatment and set a federal minimum standard for qualified health plans. In addition, the expansion of Medicaid included childless adults who were below 138% of the federal poverty line. Medicaid is the largest payer of mental health services in the United States and research has illustrated the substantial and quantifiable impact of Medicaid expansion on substance use treatment[6].

In ongoing research with Dr. Alberto Ortega, we find that states which expanded Medicaid were associated with significant increases in substance use treatment admissions by Medicaid beneficiaries relative to states which did not expand Medicaid. At the disaggregated level this result holds for Black, Indigenous/Native American, and white admissions to treatment facilities. Recent work by Dr. Elisa Jacome further demonstrates the importance of health insurance and access to medical care. In her study, she found that young men with a mental health diagnosis who were no longer Medicaid eligible were 14% more likely to be incarcerated

[5] National Institute of Drug Abuse, Advancing Addiction Science (2016). *The science of drug abuse and addiction*.

[6] Meinhofer, A. & Witman, A. (2018). *The Role of Health Insurance on Treatment for Opioid Use Disorders: Evidence from the Affordable Care Act Medicaid Expansion, Journal of Health Economics*.

Andrews, C.M., Pollack H.A., Abraham A.J., Grogan C.M., Bersamira C.S., D'Aunno T., & Friedmann P.D. (2019) *Medicaid coverage in substance use disorder treatment after the affordable care act*. Journal of Substance Abuse Treatment.

Grooms, J., & Ortega, A. (2019). *Examining Medicaid expansion and the treatment of substance use disorders*. AEA*:* Papers and Proceedings.

Maclean, J. C., & Saloner, B. (2019). The Effect of Public Insurance Expansions on Substance Use Disorder Treatment: Evidence from the Affordable Care Act. *Journal of policy analysis and management.*

within two years relative to their matched comparison group. This percentage grew to 21% by their 21st birthday.

Health insurance is critical for continued care of substance use disorder and mental health. Whereas most states have expanded Medicaid to help provide health insurance for those individuals who otherwise cannot access coverage, there are still more than 2 million Americans[7] that fall into the coverage gap. They primarily live in southern states and are disproportionately Black and other racial and ethnic minorities.

Disparities

Age-adjusted substance overdose deaths increased from 6 per 100,000 in 1999 to nearly 22 per 100,000 in 2019. Provisional counts for drug overdose deaths last year were over 100,000 in the U.S. While more white lives are lost from drug overdose deaths than any other race or ethnicity, the number of Black drug overdose deaths steadily climbed over the last decade. White drug overdose deaths increased by 87% from 2012 to 2019, Black drug overdose deaths increased by 361%, and Hispanic by 206%[8]. According to the Pew Research Center (Figure 2),[9] the age-adjusted drug overdose death rate is the highest among Black men at 54.1 per 100,000, followed by Indigenous/Native American men.

A co-authored paper published in the Review of Black Political Economy[10] investigated reported mental health distress at the onset of the COVID-19 pandemic. We found that at nearly every - level of employment (employed non-essential, employed essential and unemployed), Black respondents reported elevated levels of mental distress relative to white respondents. That is to suggest economic stressors are not a right only afforded to white Americans. While we must address the deleterious effects of the opioid epidemic, it would be a mistake to assume Black, Hispanic, Latin and Indigenous/Native American communities have not been negatively impacted by the disappearing middleclass.

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[7] Garfield, R., Orgera, K., & Damico, A. (2021) *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid.* The Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[8] Kaiser Family Foundation (KFF) analysis on the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2019 on CDC WONDER Online Database, released 2021. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on February 26, 2021.

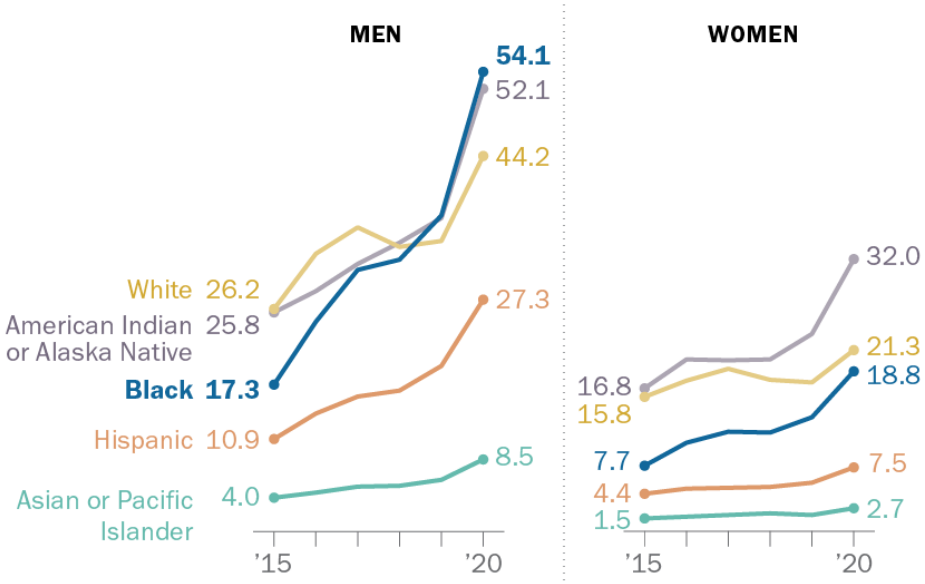
[9] John Gramlich. (2022) *Recent surge in U.S. drug overdose deaths has hit Black men the hardest*. The Pew Research Center. https://www.pewresearch.org/fact-tank/2022/01/19/recent-surge-in-u-s-drug-overdose-deaths-has-hit-black-men-the-hardest

[10] Grooms J, Ortega A, Rubalcaba JA-A, Vargas E. (2021) *Racial and Ethnic Disparities: Essential Workers, Mental Health, and the Coronavirus Pandemic*. The Review of Black Political Economy. https://journals.sagepub.com/doi/abs/10.1177/00346446211034226?journalCode=rbpa

Figure 2

Drug overdose death rate among Black men in the U.S. more than tripled between 2015 and 2020

U.S. drug overdose death rate per 100,000 people, by race and ethnicity (age-adjusted)



Note: All racial categories include people of one race, as well as those who are multiracial. For those who are multiracial, the CDC selects a single race to allow for consistent comparisons. All racial groups refer to non-Hispanic members of those groups, while Hispanics are of any race.
Source: Centers for Disease Control and Prevention.

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Although traditionally, substance use is associated with younger adults, recently published work[12] illustrates the upward trends in substance use among older Americans. Using treatment admission data for the U.S. Dr. Ortega and I observe a rapid increase in admission for substance use for individuals over the age of 50. We also observed that Black and Hispanic admissions are less likely to complete treatment relative to their white comparators and Black admissions were more like to be terminated—asked to leave a treatment facility (Figure 3).

[12] Grooms J, Ortega A. (2022) *Substance use disorders among older populations: What role do race and ethnicity play in treatment and completion?* Journal of Substance Abuse Treatment.

Figure 3

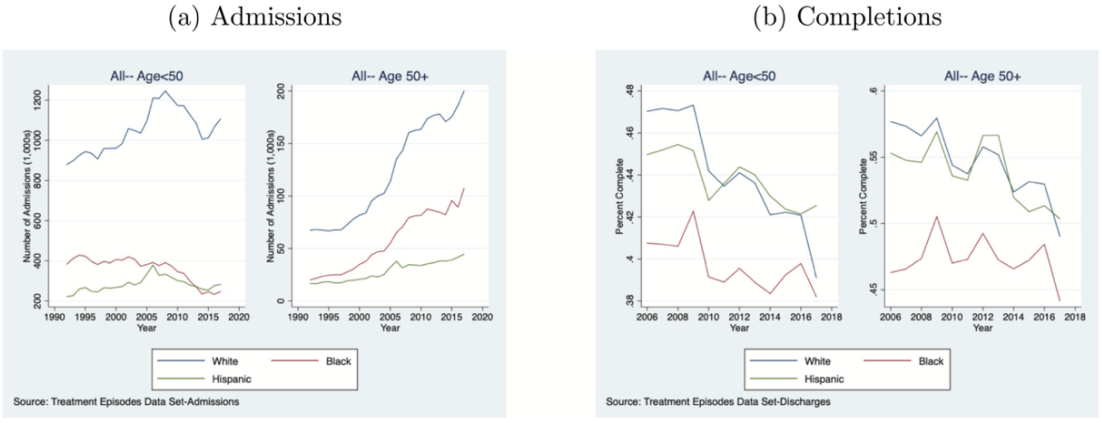

Fig. 1. SUD treatment admissions and completion by age and race/ethnicity.

Final Thoughts

As we strive to alleviate the economic and social burden legal and illegal substances place on our society, it is vital that we engage stakeholders at the community level. Understanding that the lack of economic prosperity is a driving force in the uptick of substance use, it is paramount that we acknowledge the heterogeneity that exists across our landscape, from the Appalachian regions to urban racially and ethnically diverse communities. Unfortunately, there is no magic pill that will alleviate the devastation that we are currently facing. It will take government officials empowering local stakeholders to help create a framework from which local communities can support and provide wrap around services for their residents to help ensure economic and social stability.

As we continue to grapple with the detrimental effects of the prior and current drug epidemic, I urge us to avoid moral panic and focus the discussion addressing the mental health distress nationwide, by way of access to health care and economic opportunities. This work needs to be done even in places where warning bells are not being set off to prevent the next wave of distress.