Understanding the True Causes of the U.S. Methamphetamine Problem

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EXECUTIVE SUMMARY

Methamphetamine (meth) use has been a significant problem in the United States for the last two decades. Federal and state legislative efforts to address meth production have largely focused on restricting access to non-prescription cold and allergy medicines containing pseudoephedrine (PSE), a decongestant that can be used in the production of meth. Policies that restrict access to PSE medicines fail to address core underlying issues: continued demand for meth in the United States and an increase in foreign supply of the drug.

Because up to 90 percent of meth used in the United States now comes from Mexico, this paper recommends that federal and state lawmakers and other stakeholders engaged in legislative efforts to address the issue acknowledge that domestic production is one part of a larger problem. To address the problem in its full scope, states and the federal government must increase efforts to both impede foreign supply and reduce domestic demand.

Some stakeholders in the United States are preoccupied with a misguided solution: requiring prescriptions for non-prescription medicines containing PSE. Each year in the United States, 18 million families buy PSE-based products to combat colds and allergies. These medicines are approved by the U.S. Food and Drug Administration for purchase and use without a doctor's intervention. Prescription-only laws would make it more difficult for these people to access the medicines they need. In addition to significantly reducing legitimate utilization of PSE medicines, these laws place a substantial economic burden on individuals, federal and state governments, and private payors. The new doctor visits that a national prescription-only law would require would alone generate enormous costs. In the first year, these costs would total nearly $130 million, broken down in the accompanying table.

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PSE medicines are restricted. Policymakers should reject prescription-only requirements and focus instead on addressing the dual problem of foreign supply and domestic demand. Two sound policy approaches include:

- **Support Federal Efforts to Increase Drug Interdiction at the U.S.-Mexico Border.** To address foreign meth supply, state leaders should support federal efforts to increase drug interdiction at the U.S.-Mexico border through legislation like the Stop Drugs at the Border Act of 2015.
- **Address Demand through Increased Education and Behavioral Intervention.** Economics tells us—and experience has shown—that as long as demand remains high, supply will rise to meet it. Therefore, it is vital to pair efforts to reduce meth production and importation with a serious education campaign, particularly before abuse starts.

INTRODUCTION

Methamphetamine (meth) use has been a significant problem in the United States for the last two decades. Congress enacted legislation between 1996 and 2005 to address domestic meth production, and states have continued to pursue policies aimed at curbing the production of meth within their borders. Because up to 90 percent of meth used in the United States now comes from Mexico, this paper recommends that federal and state lawmakers and other stakeholders engaged in legislative efforts to address the issue acknowledge that domestic production is one part of a larger problem. To address the problem in its full scope, states and the federal government must increase efforts to both impede foreign supply and reduce domestic demand.

Some stakeholders are preoccupied with a misguided solution to the meth problem: requiring prescriptions for non-prescription medicines containing pseudoephedrine (PSE), a drug used to treat colds and allergies that can also be used in the production of meth. Consumers already face restrictions on the purchase of PSE medicines, and requiring a prescription would impose unnecessary additional costs and burdens on the 18 million American families who need these medicines each year to provide relief from colds and allergies. This paper highlights the well-documented economic impact of this type of policy and demonstrates why a different approach is needed—namely, one that addresses the dual problem of foreign supply and domestic demand.

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METH SUPPLY AND DEMAND IN THE UNITED STATES

U.S. Demand for Meth

Meth use, which began to be a problem in the United States in the 1960s, rose dramatically in the 1990s.[1] Between 1994 and 2004, the number of people age 12 and over who had tried meth increased from less than 2 percent of the U.S. population to 5 percent.[2]

In recent years, the number of people starting to use meth each year has remained relatively constant. In 2013, new users totaled 144,000, approximately the same as in 2007.[3] The average age at first use has hovered between 18 and 22, roughly, since 2002.[4] The number of current users—595,000 in 2013—has increased gradually since 2010.[5] Since the beginning of the meth problem, meth use in the United States has differed dramatically by region, with the highest rates in the West and Midwest.[6]

Domestic Meth Supply

In the last decade, as the federal government and states have implemented various measures to curb meth production, meth lab incidents in the United States have ebbed and flowed but fallen significantly overall. Between 2004 and 2013, lab incidents nationwide saw a net decline of more

than 50 percent, dropping from 24,202 to 11,573.[7] Among states, meth lab incidents in this same period were down in 35 states and the District of Columbia. Of the remaining 15 states, six had fewer than ten meth lab incidents in 2013.[8]

States have differing standards for what qualifies as a "meth lab." For example, one state may consider a garage with 100 bottles to be a single "incident" and thus a single "meth lab." Another state may consider each of those 100 bottles its own lab, or incident. One thing, however, is certain: the vast majority of meth used in the United States is not produced domestically.

Meth Supply from Mexico

U.S. demand for meth has increasingly been met by Mexican drug cartels. The U.S. Drug Enforcement Administration estimates that Mexican producers supply 70–90 percent of the meth in the United States.[9] Meth seizures at the southern U.S. border increased more than fivefold between 2009 and 2014, reaching a record high.[10] Mexico banned PSE products in 2007,[11] but this clearly did not eliminate meth production in the country. The majority of Mexican meth is now made using phenyl-2-propanone rather than PSE.[12]

The rise of Mexican meth has driven meth prices down and average purity up. Manufactured by sophisticated cartels, Mexican meth is more potent than most U.S.-made meth, and is available in larger quantities at cheap prices.[13] The price and purity of meth used in the United States have fluctuated somewhat in the last decade for which data are available, but on net, price has declined significantly while purity has shot up. The price per gram for purchases of 10 grams or less fell from $189 in 2002 to $123 in 2011—a 35 percent decline.[14] The price per gram for larger purchases (10–100 grams) also fell.[15] Average purity for purchases of 10 grams or less increased from 66 percent in 2002 to 88 percent in 2011.[16] The increase in the purity of seizures and purchases of 100 grams or more (i.e., a batch size almost exclusively produced by Mexican drug-trafficking organizations[17]) is even more dramatic, rising from 39 percent in 2002 to 99 percent in 2011.[18]

FEDERAL AND STATE EFFORTS TO COMBAT THE RISE OF METH

The meth problem in the United States has prompted federal and state lawmakers to attempt to make domestic meth production more difficult, often by restricting access to cold and allergy medicines containing PSE. Policies that restrict access to PSE medicines fail to address core underlying issues: continued demand for meth in the United States and an increase in foreign supply of the drug.

Federal Legislation to Address Domestic Meth Production

Responding to the rapid increase in meth use in the 1990s, Congress enacted the Comprehensive Methamphetamine Control Act of 1996, which increased penalties for trafficking meth ingredients and set stiffer regulatory requirements for the production of those compounds. In spite of this legislation, the U.S. meth problem continued to expand. In 2005, Congress enacted the Combat Methamphetamine Epidemic Act, which set a

nine-gram monthly limit on consumer purchases of PSE and required retailers to keep products containing PSE in a locked cabinet or behind the counter. It also required retailers to keep a log of all PSE purchases.

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Though it has been nearly a decade since Congress passed major legislation aimed at curbing meth production and use, federal lawmakers continue to monitor the issue. Smaller meth-related bills were passed in 2008 and 2010, and in 2014 Representative Blaine Luetkemeyer (R-MO) introduced the Stop Meth Labs and Enhance Patient Access Act. Congress has not considered legislation to require a doctor's prescription to buy products that contain PSE, but federal lawmakers have pushed the issue in other ways. For example, Senator Joe Manchin (D-WV) has pressured retailers to institute their own restrictions on PSE-based cold and allergy medicines. In addition, state legislatures have taken up this idea in legislation.

State Strategies to Deter Domestic Meth Production

Much like federal lawmakers, state officials have focused their efforts to deter domestic meth production on controlling access to products that contain PSE. Some states have set stricter annual or monthly purchase limits than the federal limit of nine grams per month. To comply with federal law, all states, except Oregon and Mississippi, require that consumers show identification when purchasing over-the-counter medicines that contain PSE.

Oregon and Mississippi are the only states that do not allow PSE medicines to be purchased over the counter. Instead, a patient must have a doctor's prescription to obtain these medicines. Since 2010, there have been more than 110 bills with prescription-only provisions filed in 27 states, but none have passed. States have instead favored other approaches, typically beginning with the National Precursor Log Exchange (NPLEx) system and continuing with targeted efforts to stop criminals and drug offenders from making or using meth.

The NPLEx system is a privately run program that allows law enforcement to electronically track the purchase of PSE-based medicines in real time. Currently used in 32 states, NPLEx was created after Congress passed legislation in 2008 to allow retailers to electronically track PSE sales, making it easier for law enforcement to identify potential criminal activity. The National Association of Drug Diversion Investigators runs NPLEx, and drug manufacturers sponsor it.

In order for law enforcement to use NPLEx, states must first pass legislation to authorize the program. That legislation often comes in tandem with other efforts to combat meth, including the creation of a meth-offender "block list," which typically prohibits those convicted of a meth-related felony from purchasing PSE-based products. It is up to the state executive branch and law enforcement agencies to build a robust list, which means that a block list is only as effective as state officials' commitment to it.

Most states—including those hardest hit by the meth problem—have opted against prescription-only laws in favor of these other approaches. But a prescription-only requirement for PSE medicines continues to linger as a potential policy solution. This recurrence is troubling because, as has been thoroughly documented, requiring a prescription for cold and allergy medicines that contain PSE places significant burdens on law-abiding citizens.

A RECURRING MISGUIDED SOLUTION: PRESCRIPTION-ONLY PSEUDOEPHEDRINE

Proponents of legislation that would require a doctor's prescription for PSE medicines argue that these laws are beneficial because they have reduced the number of meth labs.[19] While there has been a reduction in meth lab seizures in Oregon and Mississippi—the two states that require prescriptions for PSE medicines—it is unclear that this is a result of the states' prescription-only laws, as a recent study from the National Alliance for Model State Drug Laws notes.[20] In both states, the decline in meth lab incidents started before passage of the prescription-only law, and the drop in meth production has tracked that of neighboring states.[21] At the same time, meth from Mexico has been identified as a serious problem in both states.[22]

Economic Impact of Prescription-Only Laws

Supporters of prescription-only laws often reference the public safety costs of dealing with domestic meth production.[23] While these costs are significant, there is little evidence that prescription-only laws stem meth abuse. Moreover, prescription-only PSE laws impose substantial burdens on law-abiding citizens and the medical community. In short, state and federal lawmakers must properly weigh public safety concerns against the very real consumer and health care costs that arise when purchases of PSE medicines are restricted.

Each year, 18 million American families buy PSE-based products to combat colds and allergies.[24] PSE is pharmacologically different than other decongestants. It is the only decongestant available for 12- and 24-hour relief, and for some people, it is the only oral decongestant that works. Prescription-only laws make it more difficult for people to access the medicines they need. In addition, these laws place a substantial economic burden on individuals, federal and state governments, and private payors.

According to Avalere Health, a national prescription-only policy for PSE medicines would result in an estimated 1.3 million new doctor visits per year.[25] The consumer costs associated with these new visits would total $42.7 million in the first year; of this increased cost, uninsured consumers would bear more than $28 million.[26] Private payor costs would go up by $56 million in the first year, while Medicare and Medicaid costs would rise by nearly $20 million.[27] See the accompanying table for the estimated increased costs, broken down by payor, arising from new doctor visits.

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State-based studies in Indiana, Missouri, Oklahoma, Tennessee, and West Virginia have drawn similar conclusions.[28] For example, in Missouri, adding a prescription requirement for PSE medicines is estimated to increase health care costs in the state by $43 million.[29] In addition to increased Medicaid spending, states would also suffer an estimated loss of $325.8 million in state tax revenues over ten years should PSE medicines no longer be sold over the counter.[30]

Employers would also be burdened by a prescription-only requirement for PSE medicines. Absenteeism and lost work productivity in the United States due to common colds already cost an estimated $25 billion annually,[31] and requiring a prescription for PSE medicines could result in more missed work.

In addition to significantly reducing the legitimate utilization of PSE medicines, prescription-only rules would also force consumers to pay higher prices for these medicines due to the overall cost difference between a prescription-only product and an over-the-counter one. Avalere Health has found that prescription-only policies increase drug prices by an average of 35 percent.[32]

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STATE, FEDERAL, AND PUBLIC-PRIVATE POLICY OPTIONS

Policymakers should not abandon their efforts to combat U.S. meth production, but they must expand their focus to include greater efforts to address Mexican meth and decrease U.S. demand.

Support Federal Efforts to Increase Drug Interdiction at the U.S.-Mexico Border

To address supply, state leaders should support federal efforts to increase drug interdiction at the U.S.-Mexico border. In February 2015, Senators Shelley Moore Capito (R-WV) and Joe Donnelly (D-IN) introduced the Stop Drugs at the Border Act of 2015, which "would require the Office of National Drug Control Policy to ensure that its Southwest Border Counternarcotics Strategy specifically responds to the recent increase in heroin and methamphetamine trafficking along the international border between the U.S. and Mexico" and require U.S. Customs and Border Protection to submit a report to Congress within four months of the bill's enactment detailing the resources it needs to respond to the Mexican meth epidemic.[33] This bill would be an important first step toward curtailing foreign supply.

Address Demand through Increased Education and Intervention

State lawmakers would be wise to invest in meth education and outreach programs as well as behavioral intervention and rehabilitation for people addicted to meth in their states, as opposed to promoting

prescription-only PSE legislation. Several states have been largely successful in educational efforts, with documented reduction in meth abuse. For example, six states—Colorado, Georgia, Hawaii, Idaho, Montana, and Wyoming—have partnered with the Meth Project, a program run by the Partnership for Drug-Free Kids that educates young people on the dangers of meth use through marketing campaigns, community action programs, and outreach in schools. The Meth Project has an especially significant impact on young people. According to the president of the American Board of Addiction Medicine:

> The data clearly demonstrates that if teens understand the risks of meth use, they will make better informed decisions, and usage declines. Until now, there has not been a central place where teens could get all the facts about methamphetamine. MethProject.org fills that gap and is a definitive source of information about meth for young people.[34]

Economic theory tells us—and experience has shown—that as long as demand remains high, supply will rise to meet it. Therefore, it is vital to pair efforts to reduce meth production and importation with serious education and rehabilitation campaigns.

CONCLUSION

Given that the majority of meth is coming into the United States from Mexico, policymakers should increase their efforts to reduce U.S. demand and crack down on foreign supply. However, domestic meth production remains a significant concern in many states, and under pressure from the public and law enforcement, policymakers will continue to explore a legislative response. In doing so, they must weigh the efficacy of policy options with the economic cost of the restrictions under consideration. It is important that legislators and others recognize the economic burden of prescription-only laws for PSE medicines and the lack of evidence of their effectiveness at reducing abuse, and consider other policy options for addressing meth abuse.

SOURCES

1 Dana Hunt, Sarah Kuck, and Linda Truitt, *Methamphetamine Use: Lessons Learned*, February 2006, available at www.ncjrs.gov/pdffiles1/nij/grants/209730.pdf.

2 Ibid.

3 Substance Abuse and Mental Health Services Administration, "Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings," September 2014, available at www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf.

4 Ibid.

5 Ibid.

6 Dana Hunt, Sarah Kuck, and Linda Truitt, *Methamphetamine Use: Lessons Learned*.

7 Missouri Highway Patrol, "Meth Stats: National Incidents," available through www.mshp.dps.missouri.gov/MSHPWeb/DevelopersPages/DDCC/methLabDisclaimer.html.

8 Ibid.

9 Kimberly Brouwer et al., "Trends in Production, Trafficking, and Consumption of Methamphetamine and Cocaine in Mexico," *Substance Use & Misuse* 41, no. 5 (2006): 707–727.

10 *Washington Post*, "Southwest Border Drug Seizures," available at http://apps.washingtonpost.com/g/page/world/southwest-border-drug-seizures/1543; and Sandra Dibble, "Record Border Meth Seizures," *San Diego Union-Tribune*, January 3, 2015.

11 *El Universal*, "Prohibirán Definitivamente Uso de Pseudoefedrina," December 2, 2007, available at www.eluniversal.com.mx/notas/465055.html.

12 J. C. Maxwell and M. Brecht, "Methamphetamine: Here We Go Again?" *Addictive Behaviors* 36, no. 12 (2011): 1168–73.

13 Drug Enforcement Administration, *2014 National Drug Threat Assessment Summary*, November 2014, available at www.dea.gov/resource-center/dir-ndta-unclass.pdf.

14 Office of National Drug Control Policy, *National Drug Control Strategy*, 2013, "Table 64. Average Price and Purity of Methamphetamine in the United States, 1981–2011," available at www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/2013_data_supplement_final2.pdf.

15 Ibid.

16 Ibid.

17 Government Accountability Office, "State Approaches Taken to Control Access to Key Methamphetamine Ingredient Show Varied Impact on Domestic Drug Labs," January 2013, available at www.gao.gov/assets/660/651709.pdf.

18 Office of National Drug Control Policy, *National Drug Control Strategy*, 2013, "Table 64. Average Price and Purity of Methamphetamine in the United States, 1981–2011."

19 See, for example, Office of Senator Joe Manchin, "Manchin to WV Legislature: Act Now to Curb Statewide Meth Production," news release, January 29, 2015, available at www.manchin.senate.gov/public/index.cfm/2015/1/manchin-to-wv-legislature-act-now-to-curb-statewide-meth-production.

20 National Alliance for Model State Drug Laws, "Pseudoephedrine Prescription Laws in Oregon and Mississippi: A Study of the Current Methamphetamine Landscape," June 30, 2015.

21 Christopher Stomberg and Arun Sharma, "Making Cold Medicine Rx Only Did Not Reduce Meth Use," Cascade Policy Institute, February 2012, available at www.cascadepolicy.org/pdf/pub/Oregon_Meth_Law.pdf; and Missouri Highway Patrol, "Meth Stats: National Incidents."

22 Oregon Department of Justice, "Program Year 2015, Threat Assessment and Counter Drug Strategy," June 2014, available at http://media.oregonlive.com/marijuana/other/2014/06/2015%20Oregon%20HIDTA%20Threat.pdf; and Associated Press, "Mexican Drug Cartels Shipping Crystal Meth from Super Labs to Mississippi," March 2, 2014.

23 See, for example, Barry P. Staubus, "Requiring Prescription for Pseudoephedrine Best Anti-Meth Plan," *Kingsport Times-News*, March 8, 2014, available at www.timesnews.net/article/9074206/barry-staubus-column-requiring-prescription-for-pseudoephedrine-best-anti-meth-plan.

24 Avalere Health, "Managing Access to Pseudoephedrine: Potential Impacts of a Prescription-Only Policy versus Real-Time Stop Sale Technology," April 23, 2014, available through www.avalerehealth.net/news/managing-access-to-pseudoephedrine-potential-impacts-of-a-prescription-only.

25 Ibid.

26 Ibid.

27 Ibid.

28 Economic Impact Group, LLC, January 2011; Serkan Catma, West Liberty University, February 2014; Missouri Wonk, August 2014; Martin D. Kennedy, 2014; and Srikant Devaraj, Michael Hicks, and Karthik Balaji, Center for Business and Economic Research, Ball State University, March 2015.

29 Missouri Wonk, August 2014.

30 Avalere Health, "Managing Access to Pseudoephedrine: Potential Impacts of a Prescription-Only Policy versus Real-Time Stop Sale Technology."

31 Thomas J. Bramley, Debra Lerner, and Matthew Sarnes, "Productivity Losses Related to the Common Cold," *Journal of Occupational and Environmental Medicine* 44, no. 9 (September 2002).

32 Avalere Health, "Managing Access to Pseudoephedrine: Potential Impacts of a Prescription-Only Policy versus Real-Time Stop Sale Technology."

33 Office of Senator Shelley Moore Capito, "Capito, Donnelly: We Must Do More to Combat Heroin, Meth Trafficking along U.S. Southwest Border," news release, February 5, 2015, available at www.capito.senate.gov/content/capito-donnelly-we-must-do-more-combat-heroin-meth-trafficking-along-us-southwest-border.

34 Quoted in Montana Meth Project, "Montana Meth Project Promotes Prevention," news release, December 2011, available at www.montanameth.org/News/articles/12012011.php.

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