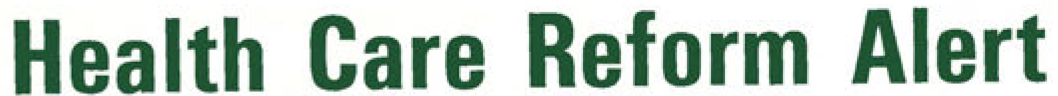


AMERICAN SOCIETY OF ADDICTION MEDICINE

Health Care Reform Alert

A REPORT FROM THE EXECUTIVE VICE PRESIDENT

Call to action!

January is the month to contact your members of Congress to keep addictions treatment in the national health reform plan. The *American Health Security Act* (H.R.3600/S.1757) introduced by the President Clinton in November is now under consideration by the Congress. While ASAM initially was optimistic about addictions coverage, based on a draft of the plan released in October, the current bill has serious flaws in its addiction treatment provisions. An added threat is the strong danger that the addiction benefit will be eliminated entirely, because the "price tag" put on the benefit by HHS actuaries has led some policymakers to conclude that it is too expensive!

Congress will reconvene *January 25th*, and is expected to begin hearings immediately. *We must act now to improve this bill as it works its way through Congress.* Sen. Edward Kennedy and other key committee chairs have announced that they expect to complete their committee work by March 1994, so *we must get to members immediately!*

ACTION NEEDED:

- *Visit your Senators and Representatives. If you don't know who your members of Congress are, call the Congressional Information Line at (202) 224-3121. (All you have to provide is your zip code.)*

- *If you can't visit in person, call or write. Tell your representatives why it's so important to have a sound addiction treatment benefit. You may want to share your own experiences in caring for addicted patients, or use the sample letter in the November-December 1993 issue of ASAM News. (Also in that issue, see the article by ASAM member Beth Howell, M.D., on "How to Communicate with Congress.") The full text of ASAM's recommended Core Benefit is found on pages 4-5 of the March-April 1993 ASAM News.*

- *Let the ASAM office know who you contacted and how they responded. This will help us identify potential allies, as well as Congress members who need to be further educated.*

ASAM leadership and staff will continue to work with the Administration and the Congress to be sure health system reform embodies access to appropriate services for patients with alcohol and other drug dependencies and related disorders. However, we cannot do this job alone. Only an engaged, energetic ASAM membership can carry the message about addiction medicine to all the Administration and Congressional leaders who will have a hand in the decisions yet to be made.

ASAM also is working to assure adequate addiction coverage...

in the Required Benefits Package endorsed by the American Medical Association. The AMA benefit covers unlimited outpatient visits with physicians for individual or group therapy, including day-night hospital services. ASAM has been told that detoxification is covered as a medical benefit. We are not yet certain that this is so, and are seeking confirmation in writing.

The AMA's inpatient benefit is limited to "one 28-day treatment program up to $3,000 per lifetime." ASAM contested this benefit when it first was presented to the AMA's House of Delegates in June 1992 by introducing a resolution calling for coverage of addictive disorders on the same basis as any other chronic disease. ASAM also has submitted a report to the AMA providing data on treatment costs and effectiveness. In September 1993, the AMA replied that available data did not justify a more generous benefit. The ASAM Healthcare Reform Task Force is meeting to develop data and will submit a formal report to the AMA. In the interim, discussions with AMA staff continue.

ACTION NEEDED: Contact your state medical association/specialty societies and ask them to support the ASAM resolution calling for an AMA Required Benefits Package that includes coverage for alcohol, nicotine and other drug dependencies on the same basis as any other medical care.

Members of the 103rd Congress are beginning to hear from constituents...

as details of the Administration's health reform plan become clear. In testimony before the House Subcommittee on Health, Ellen Webber of the Legal Action Center told Congress members that the addiction treatment benefit as currently structured "does not meet several of the Administration's health care reform principles....[It] does not guarantee a uniform set of drug and alcohol treatment services across all health plans, and it does not simplify the delivery of these services for consumers or health professionals."

Testifying on behalf of 20 state alcohol and drug abuse provider organizations, Ms. Webber said "we have grave concerns that....the benefit's length of stay limitations, cost-sharing requirements and utilization-review standards may dramatically limit access to services and leave the most seriously ill individuals worse off."

Specifically, the National Coalition of State Alcohol and Drug Treatment and Prevention Associations have criticized the following features of the Clinton plan:

- <u>Lack of adequate coverage for individuals who need longer term care.</u> The Administration's proposed benefit may be appropriate for individuals who are employed, have a fairly stable family or support system, and whose addiction problem was diagnosed at an early stage. However, *it is not adequate for those with the most serious and chronic problems.*

  The Clinton plan also makes intensive nonresidential treatment and case management services totally discretionary, even though these levels of care hold out the greatest promise for chronically ill persons. This feature also would allow health plans to continue risk selection because it would let them avoid providing services to individuals with HIV/AIDS, TB, etc., by simply not offering these levels of care.

- <u>Limited coverage because of the merged addiction and mental health benefit.</u> This means that individuals with both mental health and addictive disorders, and those with HIV disease who also need mental health counseling and addiction treatment, could rapidly exhaust the benefit and be without care. (*No other set of illnesses is merged by the Clinton plan in this fashion.*) In her testimony, Ellen Webber compared it to "saying that a woman who has been hospitalized for a heart condition cannot get hospital care in the same year for breast cancer because she has exhausted her inpatient benefit, or that a man who has been treated with prostate cancer cannot receive inpatient treatment in the same year for injuries resulting from a car accident.")

- <u>Cost-sharing requirements will pose a barrier to care for many persons.</u> The Clinton plan would impose cost-sharing for outpatient addiction counseling and applies specific deductibles and co-insurance requirements for residential care. Thus, many poor persons would have to pay $10 for every outpatient addiction counseling session and $25 for every family counseling session. Moreover, no outpatient counseling expenses or expenses for the second 60 days of intensive nonresidential care is counted toward the out-of-pocket spending limit. *These are the only services in the Administration's plan for which the expenses do not apply toward the out-of-pocket limit.*

- <u>Unregulated utilization review may result in inappropriate care.</u> Under the Administration's plan, utilization of addiction services would be managed by a "health professional designated by the plan." For example, this individual would determine whether a patient could receive more than 30 days' residential care at one time and whether a person who relapsed after an initial detoxification would have another chance at medically supervised detoxification. *Yet, unlike other benefit areas, the Administration's plan does not impose any standards for this utilization manager's professional qualifications, experience or knowledge of addictive disorders.*

ACTION NEEDED: Identify these issues as key concerns when you contact your Senators and Representatives. Let them know that health care reform legislation should include the provision of the ASAM Core Benefit that "caps or limits on numbers of treatment visits, days or payments should be applied in the same manner as with any chronic disease," without discrimination.

Adequate addiction coverage is not only humane but also a cost-saver... according to data assembled by the consulting firm Lewin/VHI. Citing estimates that the cost of untreated drug and alcohol abuse in 1990 exceeded $166 billion, the Lewin study concluded that providing appropriate treatment would eliminate or dramatically reduce these costs. For example, Lewin researchers found that:

- Between 25% and 40% of all general hospital patients have alcohol-related complications.
- The rate of alcohol-related hospitalizations among elderly persons is the same as the rate of hospital stays for heart conditions. In 1989, hospital care for elderly persons with a primary alcohol diagnosis (38% of the cases) cost Medicare $233 million.
- In a California study, children born suffering prenatal exposure to alcohol or drugs have Medicaid expenditures almost twice those of other children. The total annual cost of caring for children with fetal alcohol syndrome alone is estimated to be $1.6 billion.
- Over 32% of AIDS cases are linked to injecting drug use and 70% of all pediatric AIDS cases are linked to maternal exposure to HIV through drug use or sexual contact with a drug user. The medical cost of treating such persons ranges from $85,000 to $150,000 per patient.

While the costs of <u>not</u> treating addictive disorders is enormous, the cost of comprehensive treatment of these problems is minuscule. For example, the Lewin study estimates the cost of a comprehensive addiction treatment benefit as $45 per person per year. Such a benefit would provide a full continuum of services, assume a 10% increase in utilization, a 50% increase in the funding of services to improve the quality of care, and provide lengths of stay similar to the longer stays now found in the public treatment system.

Also concluding that *the price tag for addiction coverage is far less than White House estimates* is a team from Hewitt Associates who testified in December before the Senate Committee on Labor and Human Resources. (Hewitt designs and administers benefit plans for more than half the Fortune 500 companies.)

Frank McArdle, Ph.D., manager of the research group at Hewitt, told the Senators that a comprehensive and flexible package that includes both mental health and addiction services could be provided for $190 per person per year. Such a benefit would include unlimited outpatient visits and a 20% co-payment. (By contrast, Clinton Administration actuaries have estimated a cost of $241 for a much more restrictive benefit.) Moreover, Mr. McArdle estimated that removing the Clinton plan's one-day inpatient deductible would cost only $5 per year per covered individual.

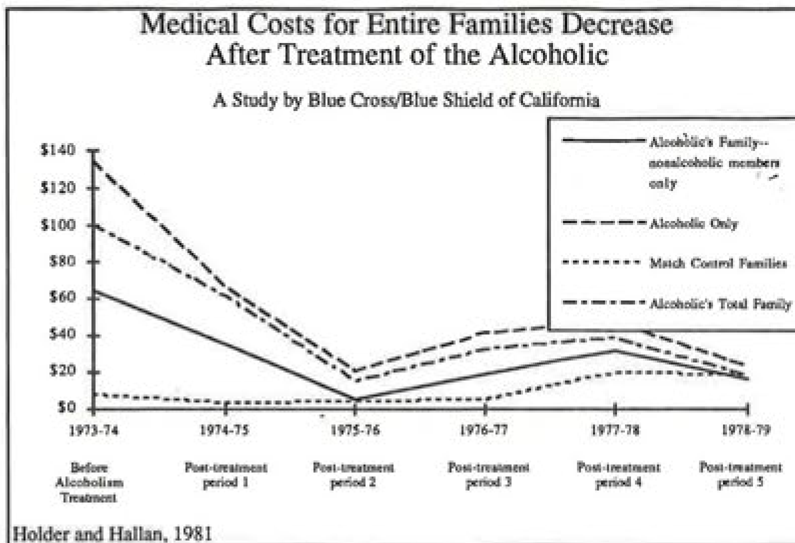
The Hewitt team emphasized that its figures are based on growing experience with plans that provide high quality care, with caregivers and consumers making appropriate choices about what kind of care is needed--whether inpatient, outpatient or intensive nonresidential care.

McArdle was joined in his testimony by Bernard Arons, M.D., acting director of the Center for Mental Health Services; Richard Frank, Ph.D., a professor of health economics at Johns Hopkins University; and leaders of the mental health community. Their testimony was cited in a letter to Ira Magaziner, senior advisor on health policy to the Clintons, signed by Senators Paul Wellstone (D-MN), Edward Kennedy (D-MA), Daniel Inouye (D-HA), Pete Domenici (R-NM), Paul Simon (D-IL) and Alan Simpson (R-MT). Warning that the Clinton plan's addiction treatment and mental health benefits "are less than people now have" and "would create such additional bureaucracy that cost savings in the first three years would be difficult to achieve," the Senators concluded with a request that the Administration "re-examine this subject with an openness to new, more recent data, and with a willingness to take issue with those who encourage more administrative restrictions that add to costs when the goal is to save money."

ACTION NEEDED: Use these data to support inclusion of the ASAM comprehensive addiction benefit in all proposals for health care reform.

Why should a national health care plan include treatment of addictive disorders?

Because addiction treatment saves more health care dollars than it costs.



© Hazelden. May be reproduced for purposes of public education.

Source: Holder, H.D. & Hallan, J.B. Impact of alcoholism treatment on total health care costs: A six year study. Advances in Alcohol & Substance Abuse, Fall 1986, Vol. 6, Page 1.

From James F. Callahan, D.P.A., ASAM Executive Vice President and CEO

For more information, phone ASAM at (202) 244-8948 or FAX (202) 537-7252

American Society of Addiction Medicine
5225 Wisconsin Ave., N.W., Suite 409
Washington, D.C. 20015

Non-profit
US Postage Paid
Washington, DC
20015
Permit No. 4737