initiative 3

Parity in Access to Care, Treatment Benefits, and Clinical Outcomes

- **A model state substance abuse parity act should be developed and endorsed by major organizations in the field of substance abuse treatment.** Data source: Legal Action Center

- **Amend the Mental Health Parity Act of 1996 or adopt new legislation to include substance abuse treatment services and to require parity with other chronic diseases in terms of service limits, limits on outpatient care, cost sharing and deductibles.** Data source: United States Code

- **Increase the number of states having adopted legislation requiring third party payers to provide parity of coverage for substance abuse.** Data source: Substance Abuse and Mental Health Services Administration

- **Increase the proportion of health insurance plans giving parity for substance abuse treatment.** Data source: Health Plan Employer Data and Information Set scorecard

"Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned."

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POLICY RECOMMENDATIONS

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Health plans and third-party payers typically provide less extensive coverage for substance abuse treatment than for other general medical services. Some insurance companies provide no support for treatment benefits and programs. Offering equitable medical coverage would accord substance abuse "parity" with other chronic conditions in the provision of health care, making access to treatment more feasible. Private insurance coverage would also help to stimulate private sector developments of treatment programs, medications, and protocols, which are discouraged economically in the current system. The 1996 Mental Health Parity Act passed by Congress requires health plans to provide the same annual and lifetime benefits for mental health as already guaranteed for other aspects of health care.[1] No equivalent federal bill has been passed for substance abuse benefits, however.

A recent landmark initiative to provide mental health benefits to Federal employees did include substance abuse coverage. On June 7, 1999, President Clinton directed the Office of Personnel Management to achieve parity for mental health and substance abuse coverage in the Federal Employees Health Benefits Program (FEHBP) by 2001. In addition, Clinton noted that the FEHBP's action could serve as a model for other employers and insurance providers.[2] State action will also be important for achieving substance abuse parity, although to date only five states have passed substance abuse parity laws. At least forty states' legislatures have considered mental health and substance abuse parity bills.[3]

The primary argument against providing substance abuse parity is the fear that the cost to third-party payers will be too high.[4] Few seem to doubt the benefits of providing treatment for drug addiction, especially given the extensive favorable scientific evidence. However, many people do doubt the practicality of requiring insurance providers to cover the costs for substance abuse treatment. Many of these doubts have been addressed by studies that examine the costs of parity for substance abuse treatment. In fact, a government study published in 1998 showed that the costs of substance abuse parity are small and that the demonstrable benefits to individuals, employers, and society are significant.[5]

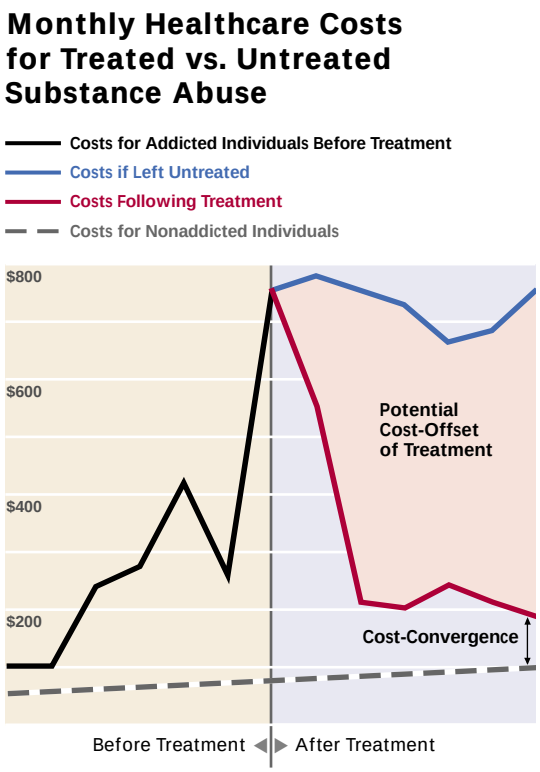
Cost of Full Parity for Substance Abuse Treatment

Cost per Insured Individual

0.2%	Average Premium Increase
43¢	Monthly Annual Insurance Cost Increase
or	
$5.11	Yearly Annual Insurance Cost Increase

SOURCES: Substance Abuse and Mental Health Services Administration, *The Costs and Effects of Parity for Substance Abuse Insurance Benefits* (Washington DC: SAMHSA, U.S. Department of Health and Human Services, 1998); Sturm, R, Zhang, W, and Schoenbaum, M, How Expensive are Unlimited Substance Abuse Benefits Under Managed Care? *The Journal of Behavioral Health Services & Research* 26(2): 203-210 (1999).

The study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that offering full parity for substance abuse treatment would increase insurance premiums by only 0.2% (see table above). A more recent parity study, by the RAND Corporation, concluded that the cost for large corporations and HMOs to provide complete substance abuse benefits would be 43¢ per month or $5.11 annually per employee.[6] The report also showed that, "Changing even stringent limits on annual SA [substance abuse] benefits has a small absolute effect on overall insurance costs under managed care, even though a large percentage of substance abuse patients are affected. Removing an annual limit of $10,000 per year on substance abuse care is estimated to increase insurance payments by about 6 cents per member per year, removing a limit of $1,000 increases payments by about $3.40." A 1998 survey by the actuarial firm Milliman &



Treatment Cost Offset. SOURCE: Langenbucher J, Offsets Are Not Add-Ons: The Place of Addictions Treatment in American Health Care Reform, *Journal of Substance Abuse* 6: 117-122 (1994).

Robertson Inc. found the additional cost for drug abuse treatment to be less than 1%.[7]

While comprehensive parity coverage comes at a small price, the potential cost offset produced by substance abuse treatment is significant. Health care utilization of a treated patient group is observed to fall dramatically and eventually, in most cases, will nearly converge to the level of the normative population. Only in cases where the physical damage done by drinking or drug use is permanent, or where the patient is no longer physically resilient, will significant convergence not be observed. Even in such cases, there may be attractive cost-offsets since medical problems are contained or at least brought under greater control. Currently, substance abusers are among the highest cost users of medical care in the United States, although only 5-10% of those costs are due directly to addiction treatment.[8]

One study, which followed 161 methadone patients, found that nearly half had at least one comorbid medical condition that required immediate treatment.[9] Eighteen percent required treatment for a sexually transmitted disease, 16% for tuberculosis, 15% for HIV/AIDS, and 7.5% for hypertension. A number of other medical conditions requiring treatment were noted in smaller numbers of patients including infections, liver disease, and anemia. Providing treatment for drug addiction results in more effective health care utilization for other medical problems by addicts and their families. A study from the Harvard School of Public Health computed the cost per year of life saved for a variety of behavioral, medical, and safety interventions, analyzing 500 different interventions.[10] Substance abuse treatments were found to be in the most favorable category of interventions, ranking in the top 10% for their savings in money and lives.

Public opinion around parity legislation may be largely connected to perceived cost. A 1998 survey about substance abuse and mental health benefits found that the majority of surveyed individuals did support expanding treatment benefits, but only if such expansion did not require extensive increases in taxes or health insurance premiums.[11]

Researchers for the Substance Abuse and Mental Health Services Administration (SAMHSA) analyzed a number of studies of states with parity laws and concluded:

- **Most state parity laws are limited in scope or application and few address substance abuse treatment. Many exempt small employers from participation.**

- **State parity laws have had a small effect on premiums. Cost increases have been lowest in systems with tightly managed care and generous baseline benefits.**

- **Employers have not avoided parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees. The low costs of adopting parity allows employers to keep employee health care contributions at the same level they were before parity.**

- **Costs have not shifted from the public to private sector. Most people who receive publicly funded services are not privately insured.**

- **Based on the updated actuarial model, full parity for substance abuse services alone is estimated to increase services by 0.2%, on average. This translates to an approximate cost of $1 per month for most families.**[12]

In another government report, researchers from the Center for Substance Abuse Treatment's (CSAT) Office of Managed Care as well as the Center for Mental Health Services (CMHS) reviewed studies of five states with parity laws (California, Ohio, Oregon, Minnesota, and Washington). They found that the costs associated with substance abuse benefits tend to have little impact on premiums or the overall spending of insurance companies, and the initial costs are offset by the resultant social benefits of treatment.[13]

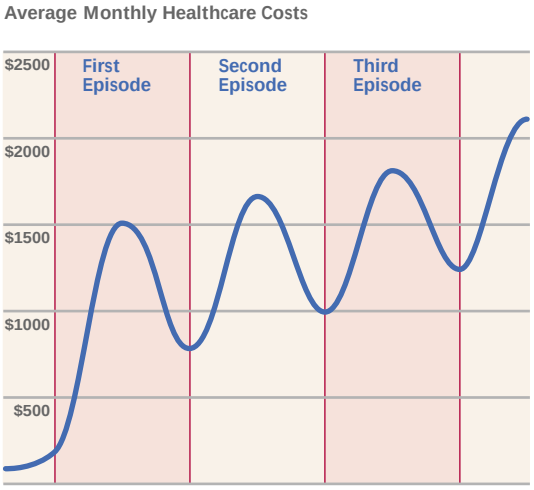
A recently published study of the costs and benefits of publicly-funded outpatient treatment services in the city of Philadelphia found similar results.[14] The average cost for treatment in an outpatient drug-free program was $1,275 while the benefits gained by avoiding health care and crime costs were estimated to be $8,408 per person. Even greater cost benefits were found for the outpatient methadone maintenance program: treatment cost slightly more, $1,873 per person, but saved over $34,000 through reduced medical costs, increased rates of employment, and decreased crime rates.

In addition, several major political and professional organizations have published statements of support for parity legislation. The Office of National Drug Control Policy (ONDCP) cited four major reasons for its support of parity: 1) Parity will help to close the treatment gap, 2) Parity will correct discrimination, 3) Parity is affordable, 4) Parity will reduce the overall burden of substance abuse to society.[15]

Similarly, many medical and professional organizations have affirmed their support for parity for substance abuse, including: American Society of Addiction Medicine (ASAM), American Psychiatric Association (APA), American Academy of Addiction Psychiatry (AAAP), American Managed Behavioral Healthcare Association (AMBHA), and American Medical Association (AMA).[16]

A report on Vermont's Mental Health and Substance Abuse Parity Act (Act 25) by the Vermont Department of Banking, Insurance, Securities and Health Care

Healthcare Cost Profile of Untreated Addictive Diseases



Escalating costs of repeated relapse episodes of untreated drug addiction. SOURCES: Blose J, Holder H, The Utilization of Medical Care by Treated Alcoholics: Longitudinal Patterns by Age, Gender, and Type of Care, *Journal of Substance Abuse* 3: 13-27 (1991); Langenbucher J, Prescription for Health Care Costs: Resolving Addictions in the General Medical Setting, *Alcoholism: Clinical and Experimental Research* 18: 1033-1036 (1994); Luce B, Elizxhauser A, *Standards for the Socioeconomic Evaluation of Health Care Services* (New York: Springer-Verlag, 1990). Data compiled by James Langenbucher, PhD.

Administration details the implementation of the Act, measures taken to ensure compliance, comparisons between treatment conditions, and estimated impact on health insurance costs.[17] The key points of the report follow:

- **Act 25 applies to all health plans (except self-insured plans) offered by Vermont insurance companies, including HMOs. The law went into effect in 1998 for all new insurance policies and upon the date of renewal for existing insurance policies, collective bargaining agreements, or employment contracts.**

- **Health insurance companies estimated that their premiums would increase, on average, in the 1–3% range. Generally, managed care companies filed the lowest percent of premium increase attributable to parity while indemnity insurers filed the highest.**

- **In most areas of Vermont, providers expressed a desire to learn how to effectively communicate and work with managed care organizations, and an ongoing need for managed care organizations to develop effective means of outreach to local providers.**

- **Companies (as of June 1998) had not moved in large numbers into self-insurance; there had been no major dropping of insurance by employers; there had been compliance by the health plans with the provisions of the law; and the stakeholders had together generated a common, "can-do" spirit of parity implementation.**

In a like manner, many businesses have already found that managing the costs of treatment for drug addiction can easily be incorporated into their existing health care management procedures.[18] Many corporations, in order to examine their spending on health care benefits and the outcomes of medical treatments—for all medical problems, including substance abuse—have assembled relational databases. These databases usually contain medical, surgical, psychiatric, substance abuse treatment, employee assistance, Worker's Compensation, disability, and human resources data.

By using such relational databases, substance abuse treatment can be linked with drug testing and other factors to examine potential outcomes. These databases are used to evaluate existing programs with the goal of not only minimizing costs for employers, but also of maximizing benefits to employees. In other words, relational databases help employers and health insurance providers determine which treatment options are working best for its employees and which treatment options should be eliminated.

In the future, large companies with relational databases may consider consolidating their data to better examine potential outcomes. Such comparisons might be of further use to smaller companies or insurance providers who have not had extensive experience with substance abuse treatment options. In particular, while patient placement guidelines have been developed by ASAM and treatment guidelines have been developed by the APA, purchasers of health services still perceive a need for consolidated disease management protocols similar to those for other chronic diseases (e.g. diabetes or hypertension).

ENDNOTES: INITIATIVE #3

1 President Clinton signed the Mental Health Parity Act of 1996 (P.L. 104-204) into law on September 26, 1997. The law took effect on January 1, 1998.

2 U.S. Office of Personnel Management, OPM News Release, White House Directs OPM to Achieve Mental Health and Substance Abuse Health Coverage Parity, June 7, 1999.

3 Amaro H, An Expensive Policy: The Impact of Inadequate Funding for Substance Abuse Treatment, *American Journal of Public Health* 89(5): 657-659 (1999).

4 Frank R, Some Economic Aspects of Parity Legislation for Substance Abuse Coverage in Private Insurance, *Insights on Managing Care* 2(2): 1-4 (1999); Goldin D, The Effect of the Mental Health Parity Act on Behavioral Health Carve-Out Contracts in Fortune 500 Firms, *Insights on Managing Care* 2(2): 5-6 (1999).

5 Substance Abuse and Mental Health Services Administration (SAMHSA), *The Costs and Effects of Parity for Substance Abuse Insurance Benefits* (Washington, DC: SAMHSA, U.S. Department of Health and Human Services, 1998).

6 Sturm R, Zhang W, and Schoenbaum M, How Expensive are Unlimited Substance Abuse Benefits Under Managed Care? *The Journal of Behavioral Health Services & Research* 26(2): 203-210 (1999).

7 Milliman & Robertson, Inc. (National Center for Policy Analysis), Estimated Additional Costs for Certain Benefits (March 18, 1997).

8 The President's Commission on Model State Drug Laws (The White House), *Socioeconomic Evaluations of Addictions Treatment* (December 1993).

9 Umbricht-Schneiter A, Ginn DH, Pabst KM, Bigelow GE, Providing Medical Care to Methadone Clinic Patients: Referral vs. On-Site Care, *American Journal of Public Health* 84(2): 207-210 (February 1994).

10 Tengs T, Adams M, Pliskin J, Safran D, Siegel J, Weinstein M, Graham J, Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness, *Risk Analysis* 15(3): 369-90 (1995).

11 Hanson K, Public Opinion and the Mental Health Parity Debate, *Psychiatric Services* 49(8): 1059-1066 (1998).

12 Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services), *The Costs and Effects of Parity for Substance Abuse Insurance Benefits* (Washington DC: SAMHSA, 1998): i-ii.

13 Center for Substance Abuse Treatment, Office of Managed Care, *Perspectives on Cost Offsets: Although the Costs of Increased Substance Abuse Benefits Are Low, the Advantages Are Significant* (Rockville, MD: CSAT, February 1, 1999).

14 French M, Salome HJJ, Sindelar J, McLellan AT, BeneF9 1ost Analysis of Ancillary Social Services in Publicly Supported Addiction Treatment, In Submission to *Archives of General Psychiatry*, summarized in *CSAT By Fax* Vol. 4, Issue 7 (August 11, 1999).

15 Office of National Drug ontrol Policy (Executive Office of the President), Statement on Parity for Substance Abuse Treatment (January 22, 1999).

16 American Society of Addiction Medicine, Medical Specialty Society Reaffirms its Position on Parity and Pharmacological Therapies, *Addiction Medicine* (April 28, 1999); American Psychiatric Association, Letter Supporting Senator Paul Wellstone's Substance Abuse Parity Bill (Fairness in Treatment: Drug and Alcohol Addiction Recovery Act of 1999) (July 27, 1999); American Academy of Addiction Psychiatry, Letter Formally Endorsing the PLNDP onsensus Statement from AAAP President Thomas R. Kosten, MD to David C. Lewis, MD (September 30, 1999); American Society of Addiction Medicine, Public Policy Statement on Parity in Benefit overage: A Joint Statement by the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association (October 1997); American Medical Association, Policies of House of Delegates – I-98, H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs (Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98).

17 Report of the Department of Banking, Insurance, Securities and Health Care Administration on Mental Health and Substance Abuse Parity (Act 25) to the Vermont General Assembly (January 15, 1999).

18 Information on corporate healthcare databases was provided by Robert Hunter, MD, orporate Medical Director, Shell Oil ompany.