

SUBSTANCE ABUSE PARITY.

SB599 • AUTHOR: SENATOR WES CHESBRO



The California Society of Addiction Medicine (CSAM) encourages your vote for providing appropriate substance abuse treatment coverage that is comparable to existing coverage for other medical conditions. The stigma attached to addiction disorders has brought about limits on coverage that are jeopardizing the effectiveness of treatment. Limits on this coverage may cause it to be ineffective in the same way as if a patient took only half the required amount of prescribed antibiotics. Read here to know the myths and understand the evidence – so you know the facts to place an informed vote:

Myth – State will incur increased costs

According to opponents of parity, if this bill is enacted, the cost of health care for the State will increase considerably. CalPERS is estimating the cost to be \$90 million in the first year. Because this mandate will raise the price of health care premiums for employers, opponents argue that there is reason to be concerned that many employers may drop their coverage or pass these increases onto their employees. This would increase the number of working families that would turn to State assistance (Healthy Families and Medical) and would also increase the State's costs

Evidence – State will realize a cost savings

According to the Rand Report of July 2001, the cost increase would be negligible when benefits are increased from the current CalPERS limits to full parity. At the same time, full parity benefits allow treatment to be tailored to the individual needs of each patient. CalPERS already covers 30 days of inpatient care and 20 outpatient visits per year, so there is likely to be minimal further increase in costs for care of substance use disorders in moving to a full parity benefit. And this estimate does not include the savings that the State will reap by reducing the costs of untreated addiction in the crime, health care, unemployment and other areas.

Myth – Substance abuse coverage is not affordable

The California Association of Health Plans argues that health plans clearly recognize the value of substance abuse coverage, most plans offer this coverage with limits on inpatient and outpatient visits and often require higher cost-sharing arrangements than for other services. This current approach makes the benefit more affordable. An expanded benefit could result in unintended consequences of higher uninsured and less overall coverage.

Evidence – Limiting treatment can affect the success

Current benefits are structured to incur much of the front-loaded cost of evaluation and initiation of treatment, while limiting the less expensive follow-up treatment that produces successful outcomes. The current approach to benefits is analogous to covering the high initial cost of evaluating patients for anthrax and then limiting antibiotic treatment to 15 days, when evidence documents the need for 60 days of antibiotic therapy. Current limits do not offer sufficient benefits to reach a therapeutic threshold. They limit covered care to doses that are guaranteed to produce little likelihood of success. The National Institute of Drug Abuse (NIDA) has documented that 90 days of care are necessary to begin to see improvement in achieving successful recovery.

Myth - Prop. 36 patients do not have health insurance

By mandating substance abuse coverage you do not decrease the cost to the State or to the Counties for their Proposition 36 costs. Those who are eligible under Proposition 36 do not have health insurance coverage.

Evidence – Prop. 36 patients do have health insurance

Already, Proposition 36 patients are being treated in the VA system and the Kaiser Permanente system. These systems already have parity for treatment of substance abuse disorders. Expanding parity to all insured is likely to expand availability of treatment resources for Proposition 36 patients. It certainly will not reduce such availability.

Myth - County costs vs. State costs?

Proposition 36 is a County cost and not a State cost, so even if there are a few people who qualify for Proposition 36 and do have coverage, it will not impact State costs.

Evidence – The State benefits from parity

The benefits to the State will come in the form of reduced abuse of children, reduced disruption of families, reduced workplace injuries and absenteeism and safer communities. The Center on Addiction and Substance Abuse at Columbia University released a study that showed that in 1998 states spent \$81.3 billion on substance abuse, 13.1% of all state spending. Of each dollar spent by states, 96 cents went to shovel up the wreckage of substance abuse and addiction. Only 4 cents went toward prevention and treatment.

Myth – Isn't 120 days enough?

Some doctors argue that 120 days is enough time for treatment to be effective, so why do you need complete parity?

Evidence – One size doesn't fit all

Substance use disorders, like other diseases, present with a wide range of severity. While some patients will require shorter periods of treatment, those with more severe disease will require more. Treatment must be individualized and should be based on nationally accepted standards, not on arbitrary benefit limits.

Myth – Kaiser experience doesn't apply to other plans

Proponents have argued that Kaiser's coverage of substance abuse benefits is an excellent model for total parity Statewide, but Kaiser is an special entity. They do not have to contract out and all of their work is done in-house. They are not representative of what most hospitals and doctors have to deal with.

Evidence – Kaiser experience is a good model

Kaiser's cost data are similar to those in the Rand Report from other insurance plans. While most of the care in Kaiser is provided "in-house", much care is provided through contract facilities. Examples are; all recovery home treatment, much inpatient care, and programs for patients with special needs. The issues Kaiser faces are the same as those other insurers would face. Kaiser is simply further along in the process.

Myth – Parity will encourage expensive treatment options

The current language in this bill does not stop insurance providers from having to pay for people to go to "Betty Ford" or some other exclusive treatment facility that they choose. There is also no mention of deductibles.

Evidence – Must utilize patient placement criteria

The best approach to solving this problem would be to utilize proven, nationally accepted placement criteria to determine the level of care appropriate to each patient.

Myth - Treatment causes excessive lost work days

Here is a scenario that an employer might have: An employee who needs treatment is off work for two weeks for the intense portion of his treatment. He returns to work and continues his treatment without missing any work. Two months after he has entered treatment, he relapses and needs to start over from scratch, so I have to pay for him to be off for another two weeks while he goes through intense treatment. It is no longer cost-efficient for me to have this employee. (Robert Downey's situation is excellent example of this behavior.)

Evidence – Treatment minimizes lost work days

The scenario presented here is identical to that presented by all patients with chronic disease. It is no greater or lesser problem with the substance use diseases. Evidence from Dr. McClellan's group at the University of Pennsylvania demonstrates that compliance with treatment recommendations and relapse rates are similar for diabetes, hypertension, asthma and the substance use disorders.