SUBSTANCE ABUSE TREATMENT PARITY: A VIABLE SOLUTION TO THE NATION'S EPIDEMIC OF ADDICTION?

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

OCTOBER 21, 1999

Serial No. 106–138

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

66–251 CC WASHINGTON : 2000

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SUBSTANCE ABUSE TREATMENT PARITY: A VIABLE SOLUTION TO THE NATION'S EPIDEMIC OF ADDICTION?

THURSDAY, OCTOBER 21, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Barr, Souder, Hutchinson, Ose, Mink, Kucinich, Tierney, and Schakowsky.

Staff present: Sharon Pinkerton, staff director and chief counsel; Steve Dillingham and Mason Alinger, professional staff members; Lisa Wandler, clerk; Cherri Branson, minority counsel; and Jean Gosa, minority staff assistant.

Mr. MICA. I would like to call this hearing to order this morning. We do have a full schedule, and so we will go ahead and proceed.

The subject of today's hearing is Substance Abuse Treatment Parity: A Viable Solution to Our Nation's Epidemic of Addiction, is the question that is asked and before our subcommittee. I am pleased that we have three panels of witnesses who are providing testimony.

I will start today's hearing with an opening statement and then yield to our ranking member and other Members who will be joining us, but we do want to go ahead and proceed since we do have a lengthy schedule.

The Subcommittee on Criminal Justice, Drug Policy, and Human Resources convenes today to discuss our country's war on drugs from a perspective that is different from that of previous hearings. Recently, we have held a number of hearings on topics that impact the supply of drugs in our Nation. Our hearings have ranked from international narcoterrorism developments in Colombia to interdiction operations and resource needs across our southwest border. Last week, we held an important and insightful hearing on what is being done through our now federally funded media campaign to reduce the demand for drugs.

Today, we will examine another important component of national efforts to reduce the demand for drugs. We will focus on drug treatment and funding options that might be affordable and make a difference in the drug war. Treatment generally receives less coverage

in the press and is often misunderstood. We will examine carefully how treatment might be used to reduce drug-related deaths and destruction.

Today, we will hear more about the positive consequences of successfully treating drug abuse. We are especially grateful to our witness who has come forward to tell us about her personal experiences. Her testimony will illustrate how some people with alcohol and illicit drug addictions have broken those terrible chains and regained control of their lives.

We all agree that the number of such positive outcomes from addiction should be increased to the greatest extent possible. Accordingly, drug treatment benefits and funding options deserve our close attention.

Since 1996, Congress increased Federal spending from $13 billion to almost $17.8 billion for drug control programs and activities. Most of this increased funding has been targeted toward reducing demand. Of the $4 billion increase, 26 percent was set aside for improving treatment options.

However, despite the commitment of more dollars and an emphasis on treatment and reducing the demand for drugs, alarming trends demonstrate the need for further action. We know, for example, that from 1993 to 1997 the number of Americans reporting heroin use rose from 68,000 to 725,000—more than quadrupling.

With an estimated 26 million Americans addicted to drugs and alcohol, the human toll is ever present. In mid-August, drugs claimed the life of a young 13-year-old in central Florida. The soon-to-be eighth grader, Jonathan Hilaire, died of a cocaine overdose while visiting Disney World in Orlando.

How can this happen? What can be done to save these young lives? I think we can all agree that more action is needed.

Mrs. Mink, I don't know if you saw, we have the most recent statistics on drug-induced deaths; and it has now climbed to over 15,000, I think it is 15,200, which is a 7.8 percent increase over last year.

In fact, combating substance abuse requires the best efforts of our Federal, State and local governments; our families and communities; our social and religious institutions; and our employers and private sector businesses.

In recent years, some observers have adopted the view that drug addiction should be considered as a brain disease, because of accompanying biological changes that occur in the brain. Others argue that addiction is primarily a behavioral disorder, often as the result of personal or character weaknesses over which individuals can and should exercise personal control.

These differing views also must factor in the realization that we expect the criminal justice system to respond to drug-related crimes—and to encourage law-abiding behaviors. This responsibility often includes the treatment of offenders for drug addictions. Numerous studies indicate that the longer a person stays in an attempt program, the better the outcome will be. Treatment options enforceable under the law provide added leverage to ensure an abuser's participation.

Today, we will discuss options for including substance abuse treatment in employee health plans.

Too often, we stereotype drug addicts as being people unable to hold down regular jobs. A Bureau of Labor Statistics report released earlier this year reports that more than 70 percent of those using illicit drugs and 75 percent of alcoholics do, in fact, hold down regular jobs. This represents a significant portion of the country's substance abusers. Many of these employees have, or may acquire, access to some form of employer-provided health care coverage.

Today, it has been estimated that only about 2 percent of substance abusers are fortunate enough to be covered by health plans that provide for adequate treatment. I recognize that a handful of States already have passed legislation that includes substance abuse parity provisions. I also fully realize that unwise Federal mandates can disrupt markets, cause inefficiencies, and have other unintended negative consequences. For these reasons, any new Federal mandates should be considered only under exceptional circumstances of demonstrated need.

In light of the impact of drugs on our lives and livelihood, we must consider all appropriate and promising measures. If affordable and effective, employee access to substance abuse treatment through employee health plans might be a viable weapon in reducing the demand for drugs in this country. The National Institute for Drug Abuse [NIDA] estimates that drug treatment reduces use by 40 to 60 percent and significantly decreases criminal activity after treatment.

In addition to preventing human misery, promoting substance abuse treatment potentially could have significant economic benefits.

The costs of both drug and alcohol addiction to society—including costs for health care, substance abuse prevention, treatment for addiction, combating substance-related crimes and lost resources resulting from reduced worker productivity and deaths—are enormous. Estimates range from $67 billion annually up to $246 billion—almost a quarter trillion dollars.

The Substance Abuse and Mental Health Administration [SAMHSA], claims that dollars spent on substance abuse treatment can have tremendous savings—saving society as much as $4 to $7 for each dollar that is wisely invested in effective drug treatment. If accurate, spending a comparatively small percentage of our business dollars for prevention and treatment—an amount less than what would be needed to recoup the costs of lost productivity due to addictions—might be a wise and cost-effective investment.

Legislative proposals for providing substance abuse treatment in employee health plans have taken varying approaches. The different proposals introduced in this Congress focus on providing insurance benefits for substance abuse treatment that are equal to benefits for other medical and surgical care. While these bills promote access to substance abuse treatment through employee health plans, consensus has not been reached regarding the scope of coverage and the cost that employees and employers must bear.

The panels of witnesses before us this morning will discuss treatment successes, studies, legislative proposals and possible treatment payment options.

In some instances, comparisons will be made to the Mental Health Parity Act of 1996 and how that law has impacted employers, insurers, treatment providers, participants and others. The act imposed a national minimum benefit standard for mental health benefits on employer-sponsored health insurance for the first time.

Key questions we must consider are whether the approach taken with mental health treatment benefits is working and whether this approach is fully applicable to alcohol and substance abuse treatment benefits.

Our first two panelists are very respected Members of Congress. We are very pleased to have one individual leader on this subject from the U.S. Senate and another fellow colleague of ours who has been a champion in the House of Representatives. Each has worked long and hard to promote substance abuse treatment parity at a national level. We look forward to hearing their thoughts and proposals on the subject, and I will introduce them in just a minute as our first panel.

The panelist on our second panel has graciously agreed to come and share her personal story of addiction. Her remarks will serve to enlighten us about the difficulties faced by those who struggle to overcome substance abuse, and we will hear her personal success in meeting that challenge.

Our third panel is made up of experts from the field who will discuss the costs and benefits of treatment and their ideas and concerns regarding substance abuse treatment parity in health care plans.

These officials, experts, and persons with firsthand knowledge of addiction and treatment will give us a better understanding of this critical issue and how we might promote effective substance abuse treatment in our efforts to combat addiction and illegal narcotics. We look forward to hearing this testimony.

I am pleased at this time to yield to our ranking member on the panel, the distinguished gentlelady from Hawaii, Mrs. Mink.

Mrs. MINK. Thank you, Mr. Chairman. I especially want to commend you for holding these hearings on substance abuse treatment. I want to thank Senator Wellstone and Representative Ramstad for coming and taking the time to give us their own perspective on this very important issue.

Mr. Chairman, we all know that there are a wide variety of approaches toward this drug menace in our country. Law enforcement, interdiction, and prevention programs are all important. However, when the individual becomes addicted to drugs, we must have in place access to treatment.

The Office of National Drug Control Policy reports that 50 percent of the adults and 80 percent of the children who need substance abuse treatment do not receive it. That is really the heart of our hearing today. Numerous studies show that treatment is both effective and cost effective in saving lives. Therefore, Congress, I feel, should move quickly to require private coverage. This is certainly one area which, if we ignore, vast numbers of people who are uninsured may not be able to get the treatment that they need.

I hope that as a result of the hearings today, Mr. Chairman, that we will not only have a greater understanding of the problem, but

come closer to finding a solution so that those individuals who need treatment have access to them out of national policy as well as State and local.

Thank you very much, Mr. Chairman.

Mr. MICA. Thank you.

We will allow other Members to submit their opening statements or statements for the record. We will leave the record open for at least 10 days for submissions.

I would like to proceed now with our first panel which consists of two very distinguished Members of Congress, one from the Senate and one from the House, two leaders who have fought to bring the problem of chemical dependency to the forefront of the Congress and the Nation.

The first individual I will recognize is a leader from the Senate side. He is the senior Senator from Minnesota. His committees include Health, Education, Labor and Pension Committee. He is also on Foreign Relations, Small Business, Indian Affairs and Veterans Committee. In the 105th Congress, he was the author of the Substance Abuse Treatment Parity Act of 1997. In the 106th Congress, he was the sponsor of the Fairness in Treatment, the Drug and Alcohol Addiction Recover Act of 1999.

We certainly applaud your leadership on these issues and welcome you to our panel over on the House side this morning. We would like to recognize you at this time.

STATEMENT OF HON. PAUL WELLSTONE, A U.S. SENATOR IN CONGRESS FROM THE STATE OF MINNESOTA

Senator WELLSTONE. Thank you, Chairman Mica and Ranking Member Mink, for the opportunity to speak to this subcommittee on the important issue of parity for alcohol and drug addiction treatment.

I want to thank my colleague, Jim Ramstad. It has been productive and really a very rewarding experience to work with him on this legislation, and I think he has really been one of the leaders in the country because he has used his own very empowering and personal experience as a successful and I think as a highly respected representative who speaks out about what he has been through, and I think his voice is terribly important.

I also want to thank Michael Conley, the chairman of the Board of Trustees of Hazelden from Minnesota.

You mentioned Susan Rook, Mr. Chairman. I would like to thank Susan for her courage as well.

And I want to make a quick apology to the panelists. There are a lot of people here, and you speak and you leave, and it almost seems like you don't care. I am not even going to get a chance to hear Jim's testimony. I have two committees and a vote that is coming up in the next 20 minutes, and so I will try to be brief.

I have introduced a full parity bill, S. 1447, and basically what we are talking about is full parity or ending discrimination in insurance coverage for drug and alcohol addiction, and I am pleased to say that this bill was introduced with Senator Daschle, who is our minority leader in the Senate, Senators Kennedy, Moynihan, Inouye and also Senator Johnson.

The bill provides, and this is I think really the key point, for nondiscriminatory coverage of drug and alcohol addiction treatment service by private health insurers. The bill does not require that drug and alcohol be a part of any health care benefits package. It doesn't require that. So in that sense there is no mandate whatsoever. It prohibits discrimination by health plans who offer such benefits but all too often place restrictions on the treatment that are different from other medical services.

It is my full intention to move this bill forward in the Senate, and I am looking forward to working with you all on the House side. I want to applaud the administration's efforts during the last year to recognize the need for this coverage for Federal employees. I think that was a positive step forward.

I want to applaud the work of General McCaffrey and to recognize his efforts to end drug addiction; and the point that he makes which is he will not be successful if we just focus on the supply side, although we must, but we must also focus on the demand side and you mentioned that as well, Mr. Chairman.

I will gloss over the statistics. I think we all know them. The disease, I use that word deliberately, of alcohol and drug addiction, costs our Nation $246 billion annually, $1,000 for every man, woman and child; and the fact of the matter is that it doesn't tell us anything in personal terms about broken dreams and broken lives and broken families and all of the people who, if they had treatment like Congressman Ramstad, could live such a productive life, could do so much for our country and do so much for our community.

I would like to thank Congresswoman Mink for her statistics on those who don't receive the coverage. Therefore, I am not going to go over those figures at all.

The question that is posed in the title of the subcommittee hearing is this: Is substance abuse treatment parity a viable solution to the Nation's epidemic of addiction? The answer, Mr. Chairman, is yes. Not only is it viable, but it is necessary. At this point the crisis of drug and alcohol addiction in this country warrants solutions from all sectors of our society, all levels of government, the insurance industry, education and health care as well.

Now, most private health insurance plans that cover alcohol and drug treatment, this is the problem, set discriminatory and unrealistic annual lifetime and visit limits on the treatment, and these limits fly directly in the face of the scientific recognition of addiction as a chronic, recurrent condition.

As a result of these limits, most people who seek treatment who seriously want to end their addiction can't get the treatment. I think Congresswoman Mink made this point very well. That is really what this is about. Proper medical treatment for the disease of addiction is an essential part of this recovery.

When privately insured individuals have no benefits, or when you have a plan which does not provide any coverage for this addiction, quite often the public sector has to pick it up. That is what happens. Or, I am very sorry to say that all too often children and sometimes adults basically wind up in correctional facilities for their treatment program, which is wrong—and that kind of treatment is terribly inadequate.

Now there will be others who talk about the cost issue, just to mention that the RAND study is extremely important. As a matter of fact, the costs for full parity for drug and alcohol treatment addiction are very low, but the costs for failure for treatment are terribly high. That is what we want to say.

Finally, let me conclude this way. I want to emphasize the research. I want to emphasize the data, and the scientific evidence, the work that is being done at NIH, the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism which basically say that treatment is effective. We know from this research that addiction causes long-lasting changes in the brain, changes that in fact contribute to relapse. We are talking about a chronic and relapsing disease that can be treated if there is that treatment, and what we want to do in this legislation is not a mandate but just end the discrimination.

Now, the principle of ending this discrimination in insurance coverage for treatment has received strong support from the White House, from General McCaffrey, former Surgeon General C. Everett Koop, former President and Mrs. Gerald Ford, the U.S. Conference of Mayors, Kaiser Permanente Health Plans and many leading figures in medicine, business, government, journalism and entertainment who have successfully fought this battle of addiction with the help of treatment.

We had hearings last year in the Senate which were very helpful, and that is why I appreciate these hearings. We had hearings in the Senate Appropriations Committee and in the Committee on Labor, Education and Pensions which highlighted all of the recent major advances in scientific information about the disease, the biological causes of addiction, and the effectiveness and low cost of treatment, and the many painful personal stories of people, including children, who have been denied treatment. That is part of the record of the Senate.

It is time for this disease to be treated with fairness, and it is time to end the discrimination against those with this disease. I commend this subcommittee for holding this hearing today. I commend you for bringing this important issue to light. And, most important of all, Mr. Chairman, by forming an alliance between those who support supply and demand side solutions, we as a country will be able to help millions of Americans affected by this disease. I think that is what this hearing is about.

I thank my colleague, and again I apologize to other Congressmen that have come in that I have to leave, but thank you very much.

Mr. MICA. Senator, before you scoot, and I know that you have to get away, if we could get just one or two quick questions. There are about eight States I think that have adopted similar measures. I am not really that familiar with what each State has to what you are proposing, including Minnesota.

One of the constant things that we hear is that there may be significant additional costs in premiums to the insurance insurers and those paying the premiums. To your knowledge, in the eight States or Minnesota, has there been any significant difference in costs since they passed these parity requirements?

Senator WELLSTONE. I appreciate the question, and Jim may have the exact figures. It is a perfect question to ask and a perfect question for me to answer.

Actually, in Minnesota we have done both the mental health and substance abuse in ending discrimination, and all of the reports have been that it is extremely cost effective, hardly any rise in premiums. But there is also, and you may have it, Jim, the estimates of the savings for the State. In other words, these costs are no longer dumped on the public sector, and the productivity of people who have been treated adds to the cost effectiveness.

So the reports that we have out there show very strong support both by Democrats and Republicans, and we have not had that problem at all.

I think Ronald Sturm is going to be testifying for RAND Corp. about the study of the costs nationally.

The interesting thing is that in this particular area every study I have seen, every analysis that I have seen, including independent analyses, points out that not only can the treatment be effective but it is quite cost effective as well.

In Minnesota—one problem is that we can't get self-insured plans. That is the whole ERISA question, in which case people look to us in Congress to try to pass some kind of legislation that will deal with this discrimination.

Mr. MICA. Mrs. Mink.

Mrs. MINK. Mr. Chairman, I don't know if you are putting this letter from General McCaffrey into the record.

Mr. MICA. We would be so glad to. Without objection, so ordered.

[The information referred to follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

20 October 1999

The Honorable Patsy T. Mink
United States House of Representatives
Washington, DC 20515

Dear Representative Mink:

The Office of National Drug Control Policy commends your leadership in the upcoming hearing on substance abuse treatment insurance parity. We are pleased that the Subcommittee on Criminal Justice, Drug Policy and Human Resources is examining this important component of a balanced national drug control strategy.

ONDCP believes that parity is both sound health care and drug control policy. Despite the fact that NIH research has clearly and unequivocally classified addiction as a chronic and relapsing disorder -- similar to diabetes or hypertension in its treatment and management -- insurance coverage often imposes arbitrary discriminatory restrictions on medical care for the addicted.

In the United States today, only 50 percent of adults and 20 percent of adolescents in immediate need of treatment for substance abuse have access to the services they require. Insurance plans can impede access to appropriate substance abuse treatment by limiting visits and establishing lifetime caps that are more restrictive than for other medical conditions. Substance-abuse parity would help close the treatment gap, representing an essential step forward in the effort to make treatment affordable and available to those who need it.

The Federal government took an unprecedented step on 7 June 1999 when President Clinton announced that the Federal Employee Health Benefit Program would offer parity for mental health and substance abuse coverage by 2001. This initiative will provide access to substance abuse treatment for 9 million people including federal employees, retirees and their families. ONDCP is supporting a study of cost-offsets associated with substance abuse treatment parity. We expect the report to be completed by the end of this year and will share the report's results with you when they become available.

I have enclosed information for your consideration. Parity would help move drug treatment into the mainstream of health care, thus reducing the stigma associated with addiction, and encouraging private sector development of pharmaceuticals for treatment. ONDCP looks forward to working with you on this important issue.

Respectfully,

Barry R. McCaffrey
Director

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

5 May 1999

Office of National Drug Control Policy
Statement on Parity for Substance Abuse Treatment

The Office of National Drug Control Policy (ONDCP) supports the concept of parity for substance abuse treatment, as an important element of drug control policy. Effective drug control policy requires a balanced approach, the foundation of which is a strong demand reduction component. The National Drug Control Strategy's goal of reducing drug use by 50 percent in the next ten years can only be accomplished with a significant expansion of capacity to treat the nation's drug users. Parity offers an immediate opportunity to expand treatment capacity.

Under parity substance abuse treatment would be subject to the same benefit levels and limitations as other chronic relapsing disorders. From a scientific standpoint, the treatment and management of addiction is essentially similar to that for any chronic and relapsing disorder, such as diabetes or hypertension; yet the insurance industry continues to impose discriminatory restrictions on treatment for the addicted. These restrictions cannot be justified as sound health care or drug control policy.

There are four major reasons ONDCP supports parity:

(1) Parity will help close the treatment gap

While about half of adults in immediate need of drug treatment receive it, estimates indicate that treatment capacity is sufficient for only about 20 percent of adolescents with the same immediate need. Adolescents, many of whom are covered by parents' insurance plans and policies, will benefit significantly from parity. Drug use continues to be a serious problem among the nation's youth and is especially severe among the youngest ages (12 - 15). ONDCP has two major programs that are designed to prevent youth drug use: the National Youth Anti-Drug Media Campaign and the Drug-Free Community Coalition program. Parity will couple these prevention efforts with increased access to drug treatment for youth who are already using drugs.

Statistics show that 70 percent of drug users are employed. The majority of these employed drug users have private health insurance. Moreover, about 70 percent of the population under age 65 was covered by health insurance purchased through an employer or union, or purchased privately as an individual in 1996. This represents approximately 186 million workers and their dependents that were covered by employer-sponsored insurance.

Yet 20 percent of public treatment funds were spent on people with private health insurance in

1993. These statistics demonstrate both the inadequacy of private sector insurance coverage for treatment of substance abuse and the potential relief that improved private sector benefits would provide our overburdened public sector treatment system. A May 1999 RAND study concluded that for patients who have exhausted their insurance coverage, premature treatment termination or a switch to coverage by the public sector were likely outcomes.

(2) Parity will correct discrimination

Research by NIDA and NIAAA, and the recent report by the Physician Leadership on National Drug Policy, demonstrates that drug dependence meets the criteria for a treatable, chronic, medical condition and is as diagnosable as other illnesses. Furthermore, the genetic contribution to addiction is comparable to that of other chronic diseases, and addiction treatment has outcomes comparable to treatment for other chronic diseases. Providing parity in drug treatment coverage for working Americans and their dependents will help bring drug treatment more fully into mainstream health care.

Parity will also encourage the development of more pharmaceuticals to treat addiction. Two reports, one by the Institute of Medicine (IOM), and another sponsored the U.S. Department Health and Human Services (DHHS) reached similar conclusions -- lack of private insurance for substance abuse treatment discourages pharmaceutical companies from developing new therapies. The IOM study (*The Development of Medications for the Treatment of Opiate and Cocaine Addictions,* 1995) reported that because few patients have private insurance coverage, and need to rely on direct public subsidies to pay for treatment, private sector development of anti-addiction medications is deterred. The September 1997 DHHS report (*Market Barriers to the Development of Pharmacotherapies for the Treatment of Cocaine Abuse and Addiction*) found that limited and uncertain payments for pharmacotherapy for substance abuse act as a disincentive for the development of new therapies.

(3) Parity is affordable

Research has shown that the cost of substance abuse parity is minimal.

- According to an actuarial study by the Substance Abuse and Mental Health Services Administration, the average premium increase for full parity of substance abuse treatment is estimated to be 0.2 percent. This translates into an approximate cost of one dollar per month for most families. A study by the National Institute of Mental Health found that in states where parity was introduced, the actual costs *were even lower* than was expected from actuarial estimates.

- Medical expenses incurred by treated patients are less than for untreated clients. A five-year follow-up study of clients receiving publicly funded substance abuse treatment in Washington State found that treated clients incurred lower medical expenses than did those who did not receive treatment ($9,000 per year compared to $4,500 per year).

- A March 1999 SAMHSA report, *Effects of the Mental Health Parity Act of 1996*, found the majority of those employers who made changes to comply with the Act did not increase their costs or require major changes to other benefit provisions. Among employers who made changes as a result of the Act, 86 percent indicated that they made no compensatory changes to their benefits, primarily because expected cost increases were judged minimal or nonexistent.

- A May 1999 RAND study concluded that parity for substance abuse in employer-sponsored health plans is very affordable under comprehensively managed care. The study found that where there were *no limits* on coverage for substance abuse care, insurance payments went up just $5.11 per member per year.

- There is growing evidence of cost savings for employers. Some states provide unemployment insurance discounts for employers who maintain drug-free workplaces. Some insurance companies will also provide discounts for workers' compensation insurance if the employer maintains a drug-free workplace. The McDonnell-Douglas Corporation found that its Employee Assistance Program generated a return of three dollars for every one dollar invested through reductions in employee absenteeism, employee medical claims, and dependent medical claims.

(4) Parity will reduce the overall burden of substance abuse to society

Illegal drugs cost our society approximately $110 billion each year. In the workplace, drug users are more likely than drug-free workers to have an unexcused absence (12.1 percent versus 6.1 percent, get fired (4.6 percent versus 1.4 percent), or switch jobs (32.1 percent versus 17.9 percent). According to the 1997 National Household Survey on Drug Abuse, an estimated 6.5 million current illegal drug users were employed full-time -- representing approximately 6.2 percent of the full-time labor force aged 18 years and older.

The costs of illegal drug use are avoidable. Data from several major studies -- Drug Abuse Treatment Outcome Study (DATOS), Services Research Outcome Study on Treatment Effectiveness (SROS), and National Treatment Improvement Evaluation Study (NTIES) -- have demonstrated that addicts in drug treatment programs have shown decreased drug use, lower crime rates, better social functioning and reduced likelihood of transmitting HIV and hepatitis viruses through needle-sharing and other risky behaviors.

Studies from several states have consistently shown that drug treatment is a cost-effective approach to the problem. Specifically:

- ***California.*** Its study, Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA) found that criminal activity declined by 66 percent, drug and alcohol use declined by 40 percent, and

hospitalizations declined by 33 percent. *Moreover, every dollar invested in drug treatment averaged a seven dollar return.*

- ***Ohio.*** The State of Ohio realized eleven dollars in savings on health care costs for every dollar spent on prevention and treatment.

- ***Minnesota.*** The State of Minnesota found that nearly 80 percent of the costs for treating substance abusers were offset in the first year alone by reductions in medical and substance abuse hospitalization, detoxification, and arrests.

- ***Oregon.*** An Oregon study of societal outcomes and cost savings found that $5.60 is saved by taxpayers for every dollar spent on those who complete treatment.

These state experiences demonstrate that treatment results in marked decreases in drug use and illegal behavior across the board. Drug treatment is good for business and is cost beneficial to taxpayers.

Congressional legislation supporting parity will help move drug treatment into the mainstream of health care, reduce the stigma associated with addiction, and encourage private sector development of pharmaceuticals for treatment. Parity is an important step forward in the effort to make treatment affordable and available to those who need it. Access to treatment is a key element of any successful anti-drug abuse strategy. Based on this analysis, ONDCP has concluded that substance abuse parity will contribute significantly to the *National Drug Control Strategy* and supports efforts to bring about parity for substance abuse services.

ONDCP:ODR:5/05/99

FOR IMMEDIATE RELEASE
Contact: Steve Pariton (202) 395-6618
July 27, 1999

National Drug Control Policy Director Barry R. McCaffrey Issues Statement on Substance Abuse Parity in Health Insurance Coverage

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(Washington, D.C.) National Drug Control Policy Director Barry R. McCaffrey today made the following statement about national policy on substance abuse parity. "Substance abuse parity in health insurance coverage is both good drug control policy and good health policy. The President's June 7, 1999 decision to require substance abuse parity for 9 million federal employees underscores the administration's commitment to parity for all Americans." President Clinton's decision was influenced by the following:

- **Parity is an important element of drug control policy.** The National Drug Control Strategy's goal of reducing drug use by 50 percent in the next ten years can only be accomplished with a significant expansion of capacity to treat the nation's drug users.

- **Parity can help close the treatment capacity gap.** Seventy percent of drug users are employed and most have private health insurance. Yet 20 percent of public treatment funds were spent on people with private health insurance in 1993, due to limitations on their policies.

- **Adolescents will benefit most.** Adolescents, many of whom are covered by parents' insurance plans and policies, will benefit significantly from parity. While about half of adults in immediate need of drug treatment receive it, HHS estimates that treatment capacity is sufficient for only about 20 percent of adolescents with the same immediate need. Parity will facilitate access to appropriate care for adolescents.

- **Parity is affordable.** According to a 1998 study by the Substance Abuse and Mental Health Services Administration, of both actuarial models and case studies of states that have adopted parity, the average premium increase for full parity of substance abuse treatment is 0.2 percent, about one dollar per month for most families.

    - A March 1999 SAMHSA report, Effects of the Mental Health Parity Act of 1996, found that among employers who made changes as a result of the Act,

86 percent made no compensatory changes to their benefits, primarily because expected cost increases were judged minimal or nonexistent. A May 1999 study by RAND found a cost to managed care health plans of just over $5 per person each year to give employees of large companies unlimited substance abuse benefits.

- The alternative is to continue paying the high cost of medical care by waiting to treat the physical effects of substance abuse: long-term effects like liver and other organ damage and acute effects like heart attack and stroke.

- **Parity will reduce the overall burden of substance abuse to society.** Illegal drugs cost our society approximately $110 billion each year in avoidable costs. Drug treatment results in decreased drug use and crime, better social functioning, and reduced transmission of disease.

"Parity is an important element of the National Drug Control Strategy," said McCaffrey. "Parity will improve public understanding of addiction, increase access to care, bring drug treatment into the mainstream of health care, and reduce suffering for millions of Americans."

FOR IMMEDIATE RELEASE
Contact: Rafael Lemaitre or Bob Weiner (202) 395-6618
June 7, 1999

Administration Advocates Equal Health Insurance Coverage For Mental Illness and Substance Abuse Treatment

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The White House announced today the intent to provide Federal employees and their dependents with health insurance coverage for the treatment of mental illness and drug dependence parallel to coverage for treatment of other medical and health problems. At the White House conference on mental health at Howard University today, National Drug Policy Director Barry McCaffrey discussed the rationale for the Administration's action on "parity":

Parity is an important element of drug control policy. The *National Drug Control Strategy's* goal of reducing drug use by 50 percent in the next ten years can only be accomplished with a significant expansion of capacity to treat the nation's drug users.

Parity can help close the treatment capacity gap. Seventy percent of drug users are employed and most have private health insurance. Yet 20 percent of public treatment funds were spent on people with private health insurance in 1993, due to limitations on their policies.

Adolescents will benefit most. Adolescents, many of whom are covered by parents' insurance plans and policies, will benefit significantly from parity. While about half of adults in immediate need of drug treatment receive it, HHS estimates that treatment capacity is sufficient for only about 20 percent of adolescents with the same immediate need.

Parity is affordable. According to a 1998 study by the Substance Abuse and Mental Health Services Administration, of both actuarial models and case studies of states that have adopted parity, the average premium increase for full parity of substance abuse treatment is 0.2 percent, *about one dollar per month for most families.*

A 1998 study by the National Institute of Mental Health found that in states where parity was introduced, the actual costs *were even lower* than expected from actuarial estimates.

A March 1999 SAMHSA report, *Effects of the Mental Health Parity Act of 1996*, found that among employers who made changes as a result of the Act, 86 percent made no compensatory changes to their benefits, primarily because expected cost

increases were judged minimal or nonexistent.

A May 1999 study by RAND finds a cost to managed care health plans of just over *$5 per person each year to give employees of large companies unlimited substance abuse benefits.*

The alternative is to continue paying the high cost of medical care by waiting to treat the physical effects of substance abuse:

> long-term effects like liver and other organ damage;
> Acute effects like heart attack and stroke.

Parity has public support. A recent survey conducted for the Family Research Council found that 61 percent of all respondents would be willing to pay the additional dollar a month for parity coverage for their families. Of those with an opinion, 68.5 percent would be willing to pay.

Parity will reduce the overall burden of substance abuse to society. Illegal drugs cost our society approximately $110 billion each year in avoidable costs. Drug treatment results in decreased drug use and crime, better social functioning, and reduced transmission of disease.

Parity will improve public understanding of addiction. Drug dependence meets the scientific criteria for a treatable, chronic, medical condition and is as diagnosable as other illnesses. The genetic contribution is comparable to that of other chronic diseases, and drug treatment has outcomes comparable to treatment for other chronic diseases. Parity in coverage for working Americans will help bring drug treatment into the mainstream of health care.

Chapter III.
United States Efforts to Reduce Demand for Drugs

B. Treatment

1. Close the Public System Treatment Gap

Although treatment services are available to more people today than ever before, ONDCP and SAMHSA recognize that treatment need has expanded more rapidly than the service system designed to meet that need. Nationwide, there continues to be a great need for additional capacity for effective drug treatment. The largest problem in treatment (the "gap") revolves around three issues: accessibility, affordability, and availability. These three issues effect both private and public funding. The efforts of this initiative focus on the federal responsibilities in relation to closing the public system treatment gap. Drug treatment overall is funded in FY 1999 at over $3 billion. The *National Drug Control Strategy* also addresses private sector treatment issues through its efforts to ensure parity for substance abuse treatment.

Block Grants to States: For FY 1999, the Substance Abuse Prevention and Treatment (SAPT) Block Grant is funded at over $1.6 billion, an increase of $275 million over FY 1998. Of this increase, $185 million will be used for the provision of substance abuse treatment services that will reduce the public system treatment gap. Additional requests include funding for the SAPT Block Grant and the Targeted Capacity Expansion Program. The Substance Abuse Block Grant provides funding to states and has been a cornerstone of federal efforts to close the public system treatment gap.

Targeted Capacity Expansion Program: This program differs from the block grant in that all of its funds are directed toward providing treatment services. In addition, the Targeted Capacity Expansion program makes awards directly to states, localities, and service providers based on their ability to demonstrate an emerging or existing need for expanded treatment services.

Parity for Substance Abuse: The Office of National Drug Control Policy (ONDCP) supports the concept of parity --health insurance coverage for the treatment of drug dependence that is essentially similar to the coverage for treatment of other medical and health problems. The *National Drug Control Strategy's* goal of reducing drug use by 50 percent in the next ten years can only be accomplished with a significant expansion of capacity to treat chronic drug users. Parity offers an immediate opportunity to expand capacity. ONDCP has developed a position paper and is working with the Federal drug control agencies to establish parity

as Federal policy.

2. Expansion of Treatment in the Criminal Justice System

At midyear 1997, more than 1.7 million U.S. residents were incarcerated. Of this amount, 99,175 inmates were in federal prisons and the remainder in state and local prisons. Since FY 1990, prisoners sentenced for drug offenses constituted the single largest group of federal inmates--approximately 60 percent. (Note: Similar statistics do not presently exist for state facilities. However, the Bureau of Justice Statistics' census of state and federal correction facilities showed that an estimated 23 percent of state prisoners were serving time for a drug-related offense.) From 1990 to 1996 the increase of nearly 24,000 drug offenders accounted for 72 percent of the total growth in federal inmate population. This population is expected to exceed 168,400 by 2004. By 2004, if current trends continue, over 104,400 inmates will be serving time for drug offenses. As the *National Drug Control Strategy* states "our nation has an obligation to assist all who are in the criminal justice system to become and remain drug-free." In order to break the cycle of drug abuse and its consequences, all drug-abusing inmates must have access to effective drug treatment programs. This initiative seeks to build upon established drug treatment programs targeted toward the criminal justice system. The Federal Bureau of Prisons (BOP) provides drug treatment to all eligible inmates, prior to their release from Bureau custody. The number of institutions offering residential treatment has grown from 32 to 42 since FY 1994. In FY 1997, nearly 31,000 inmates participated in Bureau treatment programs (education, 12,960; non-residential, 4,733; residential, 7,895; community transition, 5,315). This program is funded at over $26 million.

Provide Drug Testing and Intervention Programs: Research has shown that when drug testing is combined with effective interventions, such as meaningful, graduated sanctions, drug use can be curtailed within the criminal justice population. Further, recent studies demonstrate that drug-dependent individuals who receive comprehensive treatment decrease their drug use, decrease their criminal behavior, increase their employment, improve their social and interpersonal functioning, and improve their physical health. Moreover, when compared to substance abusers who voluntarily enter treatment, those coerced into treatment through the criminal justice system are just as likely to succeed. Since the majority of drug users are processed through some part of the criminal justice system during their drug-use careers, it makes sense to consider that system for intervention. The Administration's proposal for this program would provide drug testing and intervention programs to non-incarcerated populations. (Note: Incarcerated populations would receive drug treatment services under the Criminal Justice Treatment Priority

through Office of Justice Program's (OJP) Residential Substance Abuse Treatment Program and the Federal Bureau of Prisons' Residential Treatment Program.) The President's Drug Testing Program for Federal Probationers is funded at $4.7 million in the federal courts.

Treatment Reduces Crime

Changes in Criminal Activity in 12 Months Before Versus 12 Months After Treatment Exit

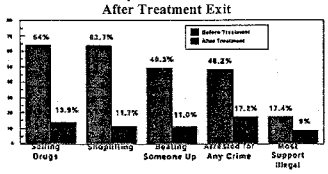

Figure 10

Drug Courts: The criminal justice system often fails to subject nonviolent, substance-abusing adult and juvenile offenders to intervention measures that provide the sanctions and services necessary to change their deviant behaviors. Many of these individuals repeatedly cycle through our courts, corrections, and probation systems. Title V of the Violent Crime Control and Law Enforcement Act of 1994 authorizes the Attorney General to make grants to states and local units of government to establish drug courts. Statistics collected by recently established drug courts show a significant reduction in recidivism among drug court program graduates. This program seeks to provide alternatives to incarceration through using the coercive power of the court to force abstinence and alter behavior. A combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs are used to teach responsibility and to transition offenders back into the community.

The Department of Justice provides $40 million in grants to localities for Drug Courts. This initiative expands the Drug Court program to more sites, expands both national and local evaluations of drug courts, as well as builds the state and local capacity to incorporate drug courts into established court management systems. It includes the following components: 1) development of state level technical assistance and training capacity; 2) provision of drug court management information system development assistance; 3) national-scope evaluations, with 1-2 year follow-up periods, of 20 to 30 sites to examine which aspects of drug courts produce the best outcomes; 4) provision of assistance to local drug courts so that local evaluations are of high quality; 5) double the current number of drug courts; and 6) target as wide a range of defendants who are eligible for release as possible. The results of this demonstration

will assist in the modification or development of future criminal justice drug control programs.

Breaking-The-Cycle (BTC): BTC combines the coercive power of the criminal justice system with research-based treatment for populations under supervision of the criminal justice system. BTC activities include a range of drug testing options, as appropriate, and the use of relapse prevention and control measures such as graduated sanctions to bring about behavioral change.

On November 10, 1998, ONDCP and NIJ announced the three jurisdictions selected to participate with Birmingham, Alabama in the BTC initiative. Jacksonville, Florida and Tacoma, Washington, will introduce BTC into their adult criminal justice systems. Eugene, Oregon will implement the initiative in its juvenile justice system. Each jurisdiction received a multi-year, multi-million dollar grant, as well as extensive technical assistance and other support coordinated by the National Institute of Justice.

BTC programs include: drug testing; individual and group counseling; academic and vocational instruction; and training. This initiative will increase the capacity of the criminal justice system to refer addicts and heavy drug users to treatment and rehabilitation and monitor their progress.

Although Congress provided no funding in the FY 1999 budget to expand BTC further, they included a provision that would allow up to ten percent of funds going to states for prison construction (up to $50 million) to be used for drug testing and treatment during and after incarceration. Related initiatives expand the Bureau of Prisons residential drug treatment program, continue support for prison Residential Substance Abuse Treatment at the level of $63 million for Department of Justice grants to states, and expand the Arrestee Drug Abuse Monitoring System (ADAM).

3. Treatment Research Development and Evaluation

National Institute on Drug Abuse (NIDA): Recent intramural and extramural research in the area of pharmacotherapies and behavioral therapies for the treatment of the dependence on and abuse of cocaine/crack, marijuana, opiates, and stimulants, including methamphetamine, has shown great promise. In the past several years, significant strides have been made in drug abuse research: we have learned not only how drugs affect the brain in ways that affect behavior, but also that behavioral and environmental factors may influence brain function. One of the most significant breakthroughs has been the identification of areas of the brain that are specifically involved in craving,

probably the most important factor that can lead to relapse. Working with modern, high resolution, neuro-imaging equipment, scientists discovered many underlying causes of addiction. Research using positron emission tomography scans shows that when addicts experience cravings for a drug, specific areas of the brain show high levels of activation. Armed with this knowledge, scientists are now determining pre-addiction physiological and psychological characteristics so that "at risk" subjects can be identified *before* addiction or drug abuse takes place. A major focus of NIDA's research has been on developing new medications. During the past year, several compounds have been identified that show promise as long-acting cocaine treatment medications.

Medications for Cocaine Dependence: Researchers at NIDA have discovered compounds that can block the effects of cocaine without interfering with the normal mood-modulating effects of dopamine. NIDA studies have led to the discovery of receptors in the brain which act as re-uptake transporters for dopamine, a chemical that causes pleasure responses in the brain, much like cocaine. Also, research has found that there are multiple dopamine receptors that respond differently to various compounds. For example, one type of dopamine receptor, D1, suppresses drug seeking behavior and relapse, where as activation of the D2, triggers drug-seeking behavior. These findings have been used for clinical studies.

Using equipment such as the positron emission tomography (PET), to identify brain regions that are particularly responsive to cocaine associated-stimuli, researchers have been able to identify brain activity associated with drug craving. This could help lead to the development of treatments that might prevent or reduce craving.

The conclusion of animal studies published in August 1998 in the journal *Synapse* showed that the epilepsy drug gamma vinyl-GABA, or GVG, blocked cocaine's effect in the brains of primates, including the process that causes "high" feelings in humans. The GVG research was sponsored by the Department of Energy's Office of Energy Research and the National Institute of Mental Health with the involvement of NIDA.

Methadone and Other Opioid Agonists: The use of methadone and, more recently, other opioid agonists such as bupernorphine is widely accepted in drug treatment. Methadone treatment, along with counseling and other interventions, has been used successfully to treat heroin addictions. Approximately 115,000 Americans are able to lead stable lives as a result of methadone treatment received at the more than 900 methadone treatment programs. The *Drug Abuse Treatment Outcome Study (DATOS),* conducted by NIDA, found that among participants in outpatient

methadone treatment, weekly heroin use decreased 69 percent, illegal activity decreased 52 percent, and full time work increased by 24 percent.

Unfortunately, regulatory barriers limit methadone availability and therefore methadone treatment capacity. To correct this problem, regulatory oversight is undergoing extensive reform. A pilot test of accreditation for methadone treatment programs is underway. If this test proves successful the current regulatory approach will be replaced by an accreditation system. In this system, programs will be subjected to clinically based performance standards that emphasize comprehensive treatment. The accreditation system being developed is consistent with recommendations from recent reviews conducted by the National Academy of Sciences, NIDA, and the General Accounting Office (GAO).

Behavioral Treatment Initiative: Behavioral therapies remain the only available effective treatment approaches to many drug problems, including cocaine addiction, where viable medications do not yet exist. Behavioral interventions are needed, even when pharmacological treatments are being used. An explosion of knowledge in the basic behavioral science field is ready to be translated into new behavioral therapies. NIDA is encouraging research to develop and establish the efficacy of promising behavioral therapies, to determine how and why a particular behavioral intervention is effective; to develop and test behavioral interventions to reduce AIDS risk behaviors, and to disseminate efficacious behavioral interventions to practitioners in the field. More specifically, NIDA's behavioral research initiative will focus on therapies for adolescent drug use, addressing drug addiction treatment as HIV risk reduction, and determining the transportability of behavioral therapies to the community.

National Drug Treatment Clinical Trials Network: Over the past decade, NIDA-supported scientists have made tremendous progress in developing new and improved pharmacological and behavioral treatments for drug addiction. However, most of these newer treatments are not widely used in practice, in large part because they have been studied only in relatively short-term and small-scale studies conducted in academic settings on stringently selected patient populations. To reverse this trend and to dramatically improve treatment throughout this country, NIDA is establishing a National Drug Treatment Clinical Trials Network (CTN) to conduct large, rigorous, statistically powerful, controlled multi-site Stage III and Stage IV treatment studies in community settings using broadly diverse patient populations. The National Drug Treatment Clinical Trials Network will enable rapid, concurrent testing of a wide range of promising science-based behavioral therapies, medications, and their

combined use, across a range of patient populations, treatment settings, and community environments nationwide.
Science-based behavioral therapies that are in queue for testing in the CTN include new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, and new, manualized approaches to individual and group drug counseling. Medications to be studied include naltrexone, LAAM, buprenorphine for heroin addiction, and those currently being developed by NIDA for cocaine.

Center for Substance Abuse Treatment (SAMHSA/CSAT) :
Effective rehabilitation programs characteristically differentiate by substances, cause addicts to change lifestyles, and provide follow-up services. However, all treatment programs are not equally effective. That is why efforts are underway to raise the standards of practice in treatment to ensure consistency with research findings. ONDCP, NIDA and SAMHSA/CSAT have focused on treatment in national conferences on marijuana, methamphetamine, heroin, cocaine and crack. Additional conferences on treatment modalities and treatment in the criminal-justice system were held during the spring of 1998. SAMHSA/CSAT continues to develop Treatment Improvement Protocols (TIPS), which provide research-based guidance for a wide range of programs. SAMHSA/CSAT also supports thirteen university-based Addiction Technology Transfer Centers, which cover forty states and Puerto Rico. These centers train substance-abuse counselors and other health, social service, and criminal-justice professionals. In addition, SAMHSA/CSAT have several programs in their portfolios that are intended to move research into the field and establish an epidemiological measurement system.

4. Reduce Infectious Disease Among Injecting Drug Users

Illegal drug users and people with whom they have sexual contact run higher risks of contracting gonorrhea, syphilis, hepatitis, and tuberculosis. Chronic users are particularly susceptible to infectious diseases and are considered "core transmitters." The prevalence of HIV infection in Injecting Drug Users (IDUs) and their sexual partners and children is high in the United States, and is on the rise in many other parts of the world as well. Not only is the AIDS/HIV epidemic a problem in this country, the reemergence of tuberculosis (TB) is also something which should be taken notice of when working on programs for injecting drug users. These populations, especially drug users who are dually infected with HIV and TB and who congregate in poorly ventilated areas, are suspected to be the source of TB infection for non-HIV infected crack smokers. This epidemic has continued to grow, especially among women on welfare. Many times, these women have infected their children, further adding to the medical costs borne out by society. Both hepatitis B and

hepatitis-C continue to be an infectious disease problem associated with drug abuse.

Interventions for HIV/AIDS: The National Institute on Drug Abuse (NIDA) is continuing research programs on the enhancement and further development of behavioral therapies focusing on AIDS risk reduction. NIDA research has determined specific factors that should be present in intervention programs aimed at reducing the spread of HIV, especially among youth. It will identify the most effective types of interventions appropriate for different groups and communities, as well as the effect of abused drugs on the progression of AIDS. Drug abuse prevention and treatment significantly reduce drug use, improve social and psychological functioning, decease related criminality and violence, and reduce the spread of AIDS, TB and other diseases.

SAMHSA continues to support early intervention services for HIV through the Substance Abuse Prevention and Treatment (SAPT) Block Grant in 38 States. In addition SAMHSA is developing a strategic plan to address HIV/AIDS with an emphasis on minority communities. Planned activities include funding the National Minority AIDS Council (NMAC) for $100,000 to define the gaps in HIV/AIDS activities and substance abuse treatment and prevention and mental health services for women in minority communities. A cooperative project, among the CDC; the National Association of State and Territorial AIDS Directors (NASTAD); and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), has been started to define the barriers to collaboration of state and local HIV and substance abuse and mental health programs in minority communities. In addition, SAMHSA/CSAT targets funds to support comprehensive treatment for women and their children, substance abuse treatment programs that include an HIV component for men and youth, and prevention and substance abuse prevention services for African American and Hispanic youths.

The Centers for Disease Control (CDC) provides funding for AIDS drug counseling and drug-related HIV prevention activities. The Substance Abuse and Mental Health Services Administration (SAMHSA) also provides HIV/AIDS activities in support of this initiative. The program studies the efficacy, outcomes, recidivism, and HIV risk behaviors (needle use and sex) among injecting drug users.

5. Training for Substance Abuse Professionals

The recognition of substance abuse is the first step in treatment. Unfortunately, although most medical students are required to have some background in mental health training, they receive little education regarding substance abuse. If physicians and other

primary-care managers were more attuned to drug related problems, abuse could be identified and treated earlier. In 1997, ONDCP and SAMHSA/CSAP co-hosted a conference for leaders of health-care organizations to address this issue. In addition, SAMHSA/CSAT published a Treatment Improvement Protocol: *A Guide to Substance Abuse Services for Primary Care Clinicians*.

A related problem is that many competent community-based treatment personnel lack professional certification. The administration supports a flexible system that would respect the experience of treatment providers while they earn professional credentials. *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*, a SAMHSA/CSAT publication, will help provide criteria with which to certify practitioners.

Educational Materials for Substance Abuse Professionals: This initiative is intended to develop educational materials for substance abuse professionals using information such as SAMHSA's Laboratory Certification Program Standards and other national professional, accreditation, and certification organizations materials. It also provides the resources necessary to develop performance and educational materials for substance abuse professionals. Funding will also be used to conduct training for substance abuse prevention and treatment professionals, and for employee assistance professionals employed by programs receiving federal funds.

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Mrs. MINK. And in response to your inquiry, which I think is very critical, in this report it says that the studies show that the average premium increase is only 0.2 percent, so it is very minimal. So I don't think that it is a cost factor. There is some hang-up someplace else.

Senator WELLSTONE. I think, Congresswoman Mink, and I leave on this, and you will find this in the hearing today and many of you already know it, you have this disconnect or lag between the scientific evidence, the data, and the perceptions that people have, both about what we are talking about, also about the nature of this disease and also about the treatment and the cost of it. The consequences are really tragic of our not trying to end this discrimination and getting some coverage for people.

Thank you very much.

Mr. MICA. Thank you, Senator, and we will let you scoot.

I would like to now recognize our champion on this issue, someone who is really the leading force in our conducting this hearing today, who has been just tireless in trying to bring this issue before Congress. As we all know, this is a tough venue, but there are individuals among us who will take an issue and just hammer away and work at it, and Jim Ramstad, who has himself had problems and is a survivor from chemical dependency, I have heard him talk about it, has turned a difficult personal experience into something very positive for himself and also for our country and has been the leader since he came to Congress on this issue.

He is also on the Ways and Means Committee and on the Health and Trade Subcommittees and House Law Enforcement Caucus and Medical Technology Caucus, and he is in the author in the 105th Congress of the Substance Abuse Treatment Parity Act of 1997 and sponsor of the Substance Abuse Parity Act of 1999 in the 106th Congress. And, again, just an untiring champion. And we thank you for your persistence and are pleased now to recognize you.

STATEMENT OF HON. JIM RAMSTAD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. RAMSTAD. Thank you very much, Mr. Chairman, Ranking Member Mink, and members of the distinguished panel. I appreciate your leadership and in particular, Mr. Chairman, your kind words. Also, I want to thank Sharon, Mason, and Steve from your staff for helping put this hearing together, as well as Megan from my staff.

Mr. Chairman, members, we are talking about the epidemic of addiction in America, dealing with an epidemic, and I use that term advisedly because 26 million Americans are presently addicted to drugs and/or alcohol. Of these addicted, 16 million people are covered by health insurance plans, but only 2 percent of these 16 million, as the chairman pointed out, can access effective treatment.

That is because of, as Senator Wellstone explained, discriminatory caps, artificially high deductibles, limited treatment stays and copayments that don't apply to any other diseases. In short, only 2 percent of alcoholics and addicts covered by health plans are ac-

cessing treatment because of discrimination, discrimination against people with addiction.

Now every day we all hear talk around here of the goal of a "drug-free America." But we will never even come close to a drug-free America until we knock down these barriers of discrimination, these barriers to chemical dependency treatment. We can build all of the fences on our borders, all of the prison cells that money can buy, hire border guards, other drug enforcement officers, but simply dealing with the supply side of the drug problem will never solve it.

Mr. Chairman, your words in your opening statement were very refreshing. You recognized the need to deal with the demand side, to deal with treatment as well as the supply side.

The American Medical Association first recognized in 1956 that chemical addiction is a disease, and it is a fatal disease if not treated properly. If we are serious about reducing illegal drug use in America, we must address the disease of addiction by putting chemical dependency treatment on par with treatment for other diseases. If you believe what the American Medical Association told the Congress and the country in 1956, then you can't justify the discrimination. And that is why Senator Wellstone and I introduced the Substance Abuse Treatment Parity Act named after Harold Hughes in the Senate and Bill Emerson in the House with whom many of us served. Their recoveries from addiction certainly inspired thousands of chemically dependent people, including myself. We now have 50 co-sponsors in the House for this legislation.

And this the bill that we are bringing forward would enable 16 million Americans to receive treatment without significantly increasing health care premiums. It is the right thing for Congress to do, and it is clearly the cost effective thing to do.

I am a recovering alcoholic, and I know that the treatment works, and I know firsthand the value of treatment. I have been in recovery for over 18 years, and I am absolutely alarmed by the dwindling access to treatment in America. Over the last 10 years, over 50 percent of the treatment beds are gone. Even more alarming is the fact that 60 percent of the adolescent treatment beds in America have disappeared in the last 10 years.

Why do we have youth violence? Why do we have so many problems with juvenile crime? Let's look and treat the underlying cause—addiction. Any police officer will tell you that 80 percent of it is related directly to addiction. Now, over half of the treatment beds are gone for adults, 60 percent for adolescents. Why? Because only 2 percent of the alcoholics and addicts covered by health plans are able to access treatments.

It is time, Mr. Chairman and members of this panel, to reverse this alarming trend. It is time to end the discrimination against people with alcoholism and drug dependency. It is time to provide access to treatment by prohibiting the discriminatory caps, the high deductibles, the copayments that don't apply to any other disease.

We have all of the empirical data, including actuarial studies, to prove that parity for chemical dependency treatment will save billions of dollars nationally while not raising premiums, as you explained, more than two-tenths of 1 percent in the worst-case sce-

nario. Dr. Roland Sturm is here, the senior economist with the RAND Corp., to testify on the cost savings from parity for treatment. Because that is the first question I asked when I was approached by people with addiction and others from my district to champion this legislation. The first thing I asked, what is it going to cost in terms of increased premiums?

In addition to savings billions of dollars, every dollar spent for treatment saves $7 in health care costs, criminal justice costs, lost productivity, injury, sub par work performance, and so forth. A number of studies have shown that health care costs alone are 100 percent higher for untreated alcoholics and addicts compared to people like me who have had the benefit of treatment. Think of that. Health care costs for these 26 million untreated alcoholics and addicts today in America are 100 percent higher than they are for people like me and Ms. Rook, who will testify shortly, who have had the value of treatment.

Mr. Chairman, I would like to address one last point which has been raised in opposition to this critical legislation, and that is the argument that it imposes a mandate. H.R. 1977, the Substance Abuse Treatment Parity Act, does not require insurance companies or health plans to cover anyone for treatment of chemical dependency. It simply bans discrimination by saying that addiction must be treated like any other disease. Plus there is an exemption option. If the sky fell in and for some reason health care costs increased 1 percent or greater, then the parity requirement is off. No parity. And of course businesses with 50 employees or fewer are exempted under this legislation.

Let me just say in closing, Mr. Chairman and Members, that I truly do appreciate this hearing today. The fact that you accommodated my requests for many of the witnesses here today, you are going to hear from some incredible people, and I hope many of you can hear their testimony. They are vital stakeholders in the battle against drugs and alcohol addiction, recovering physicians and people, employers and insurance company representatives. They know, like the American Medical Association told us in 1956, that we are dealing with a disease. If you believe that, if you accept that, then there is no way that we can justify the continued discrimination against people with addiction. We cannot justify discrimination against this disease.

We also know and I know firsthand that this disease, if not treated, is fatal. It is a fatal disease we are dealing with. And I am very grateful as a recovering alcoholic, because I know, Mr. Chairman, without any doubt at all if it weren't for treatment, I would be dead. I would not be here because of the quantities of alcohol that I was consuming over a 12-year period of time.

I didn't want to be an alcoholic. I had two uncles who died of this addiction. One was a doctor who did very well on my mother's side of the family. The other was a very successful businessperson, my uncle George in Alaska, who died after making millions of dollars in the construction business, who died on Skid Row in Anchorage drinking wine out of a brown paper bag.

I didn't want to be an alcoholic. Nobody chooses to be an alcoholic. There are various components to this disease, and I trust that this panel understands the disease nature of addiction.

I truly hope that each one of you will work hard with me, with Mark Souder, with others who are championing this legislation because, believe me, it is not my battle alone. We have 50 cosponsors bridging the ideology gap in the House, from some of the most conservative friends and Members on the far right to some of our most liberal friends on the far left, and a lot of us who are more centrist.

This is not a political issue. It should not be partisan. It is a human issue, a life-or-death issue.

And, Mr. Chairman, again, let me express my gratitude to all of you for holding this hearing today and working together in a bipartisan, common-sense, pragmatic way to move this legislation forward. Thank you.

Mr. MICA. Jim, I thank you for your very compelling testimony and, again, your leadership on this issue. You do so I think from the heart and from personal experience in trying to bring some hope and resolution to the great personal problem that you have had and so many others have experienced.

[The prepared statement of Hon. Jim Ramstad follows:]

STATEMENT BY REP. JIM RAMSTAD
BEFORE THE CRIMINAL JUSTICE, DRUG POLICY AND
HUMAN RESOURCES SUBCOMMITTEE
OCTOBER 21, 1999

HEARING ON SUBSTANCE ABUSE TREATMENT PARITY: A VIABLE SOLUTION TO THE NATION'S EPIDEMIC OF ADDICTION?

Mr. Chairman, Ms. Mink, thank you very much for holding this important hearing today on substance abuse treatment and its critical role in dealing with the epidemic of addiction in America.

I use the term "addiction" advisedly because 26 million Americans are presently addicted to drugs and/or alcohol. 16 million of these addicted people are covered by health insurance plans for chemical dependency treatment, but cannot, in fact, access effective treatment.

Every day, politicians talk about the goal of a "drug-free America." But we will never even come close to a drug-free America until we knock down the barriers to chemical dependency treatment for the 26 million alcoholics and addicts in the U.S.

We can build all the fences on our borders and all the prison cells money can buy. We can hire thousands of additional border guards and other drug enforcement officers. But simply dealing with the supply side of the drug problem will never solve it.

Last Congress, many members of this Committee worked hard as members of the Speaker's Drug Task Force to put together a drug interdiction package. While I supported that package, there was one section of the legislation that I believed could have been stronger – the demand reduction provisions.

If we are really serious about reducing illegal drug use in America, we must address the disease of addiction by putting chemical dependency treatment on par with treatment for other diseases. That's why I introduced H.R. 1977, the "Harold Hughes, Bill Emerson Substance Abuse Treatment Parity Act," named after two departed friends and colleagues whose recoveries from addiction inspired thousands of chemically dependent people, including myself.

This important legislation will enable 16 million Americans to receive treatment without significantly increasing health care premiums. It's the right thing for Congress to do, and it's the cost-effective thing to do.

Providing access to treatment will not only address the epidemic of addiction; it will save health care dollars, reduce crime and mend shattered lives and broken families.

As a recovering alcoholic myself, I know firsthand the value of treatment.

As a recovering person of almost 18 years, I am absolutely alarmed by the dwindling access to treatment for chemically dependent people.

(over, please)

Over half of the treatment beds that were available 10 years ago are gone. Even more alarming, 60% of the adolescent treatment beds are gone.

The bottom line is that only 2% of alcoholics and addicts covered by health plans are receiving adequate treatment. It's time to reverse this alarming trend.

It's time to end the discrimination against people with alcoholism and drug dependency.

It's time to provide access to treatment by prohibiting discriminatory caps and artificially high deductibles and copayments that don't apply to other diseases.

It's time to end the limited treatment stays and other restrictions on chemical dependency treatment that don't exist for other diseases.

Members from both sides of the aisle, including Reps. Gilman, Shays, Souder, Cummings and Blagojevich, have cosponsored this legislation. As of today, the bill has 50 sponsors and continues to gain support.

My colleagues, I must tell you, the American people – our constituents – cannot afford to wait any longer.

Alcohol and drug addiction, in economic terms, cost the American people $246 billion last year. American taxpayers paid over $150 billion for drug-related criminal and medical costs alone in 1997 – more than they spent on education, transportation, agriculture, energy, space and foreign aid combined.

We have all the empirical data, including actuarial studies, to prove that parity for chemical dependency treatment will save billions of dollars nationally while not raising premiums more than one-half of one percent, in the worst case scenario! In fact, the recent Rand Corporation study found that removing an annual limit of $10,000 per year on substance abuse care is estimated to increase insurance payments by only 6 cents per member per year. Removing a limit of $1,000 increases payments by only $3.40 per year, or 29 cents per month.

It's well-documented that every dollar spent for treatment saves $7 in health care costs, criminal justice costs and lost productivity from job absenteeism, injuries and sub-par work performance. A number of studies have shown that health care costs, alone, are 100 percent higher for untreated alcoholics and addicts compared to recovering people who have received treatment.

Mr. Chairman, I would like to address one last point that has been raised in opposition to this critical legislation – the bogus argument that it imposes a mandate. H.R. 1977 does not require insurance companies to cover anyone for treatment of chemical dependency. It simply bans discrimination against addicts and alcoholics and says addiction must be treated like any other disease.

You will now hear from a number of important people who are important stakeholders in the fight against drugs – recovering people, physicians, employers, and insurance company representatives.

Thank you again, Mr. Chairman, for holding this important hearing on the need for parity in substance abuse treatment. I urge all of my colleagues to support this life-saving legislation.

Mr. MICA. I would like to see if you have any questions, any questions from our side? Go ahead, Mr. Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman.

I want to express my appreciation to Representative Ramstad for his compelling testimony and personal experiences he shared. I doubt that there are many Members of Congress who do not have some family member somewhere who has been impacted by this.

In my life, I have had a nephew, and I have very close family members that have had substance abuse problems, and it can be fatal. For my nephew, it was not a matter of access to a treatment facility, it was a matter of it not being successful, and he ultimately committed suicide.

I am certainly struck by your testimony. There has been a decline in adolescent treatment beds, and I would like for you to elaborate why you see that is the case. Is it simply a lack of resources and people cannot afford these beds? And then what obstacles are you running into getting this legislation through?

Mr. RAMSTAD. Thank you for the comments and for sharing your own family experience.

Each week on the average I get two to three calls from people, mostly in Minnesota, but sometimes elsewhere, recently in Oklahoma, Florida, from people with sons or daughters, families who are suffering the ravages of addiction. Virtually all of these people, most of them, although the one in Oklahoma didn't, most are covered by insurance plans. One or two of the parents are gainfully employed and covered for substance abuse treatment. But because of the limitations placed on the plans, they are not able to access treatment.

I wish I had all day, and I would like to share with you a couple of those statements.

A family in Eden Prairie, a family in a town in Oklahoma and a family in Florida who have been absolutely devastated, and at least two of those families had insurance, but the main problem is only 2 percent of the 16 million people covered under health plans are able to access treatment because of the limited treatment stays, on the average from 2 to 7 days.

Dr. Smith, a Navy Captain, is going to testify later today. He is the expert. He knows more about addiction than anyone in this country. He will tell you that no one can get meaningful treatment in 2 to 7 days. The artificially high copayments and the caps that don't apply to any other disease are what we are trying to overcome and eliminate.

Mr. HUTCHINSON. This is a disease, but it is related to behavior as well. Is there a comparison where other diseases that are impacted by behavior is covered, but for this there are all of these caps?

Mr. RAMSTAD. I am not sure that I understand your question. Another disease that is caused by——

Mr. HUTCHINSON. For example, I can see people objecting saying—and I think it is perhaps through a lack of understanding—that substance abuse relates to behavior. You start with a weakness, it leads to a disease, and so why should everyone who is on a health plan subsidize someone else's poor behavior habits. I am thinking this through in my own mind. You have heart disease,

also, but that is related to behavior because you have not—perhaps not eaten correctly.

Mr. RAMSTAD. A good example is lung cancer caused by smoking. We were told by the AMA about the direct link, the cause-effect link, causal relationship between smoking and lung cancer, but we don't discriminate against lung cancer patients like we do alcohols or addicts.

I think the American Medical Association, based on the chromosome research—and there are experts following me in the testimony today who can testify as to the disease concept, but I think they would question—I don't think that I am a weak person. I never thought of myself as a weak person. But when I had a beer or a glass of wine I responded differently from my nonaddicted mother and sister, from other friends who are not alcoholics or addicts. It is partly physical and partly psychological and partly emotional.

Mr. HUTCHINSON. I yield back the balance of my time.

Mr. MICA. We only have 4½ minutes before this vote.

Mrs. MINK. Yes, I just want to say that I am certainly impressed by your testimony, and if I am not already a cosponsor, I will become one.

Mr. RAMSTAD. You are and thank you. Thank you for your cosponsorship. I should have pointed that out.

Mr. MICA. Mr. Tierney.

Mr. TIERNEY. The cutoff point at 50 employees or less, how many people does that leave out and was that strictly a decision over what you could gather support with?

Mr. RAMSTAD. That was the pragmatic part of the bill, and we made some other changes too.

Many changes we have made are positive. One provision addressing faith-based treatment centers is appropriate. I am close to a faith-based treatment center sponsored by an Assembly of God Church in south Minneapolis, and I go there frequently and share my story and listen to the kids' stories, and their results are about the same as Hazelden or Fairview Recovery Services or Turning Point or any of the other programs that I am familiar with.

Mr. TIERNEY. Would that add a significant cost or is there just the perspective of people that would add a cost that makes you back off that on the bill?

Covering employees of 50 or less, would that add to the cost of this whole operation, or is it just that people perceive that so you want to stay away from it politically?

Mr. RAMSTAD. In working with the various groups in putting this bill together and getting last year 98 cosponsors and this year 50 already, we had to give and take a little bit. I would just as soon not see that exemption, but to get the bill moving and to bring in conservatives and others, we compromised.

Mr. MICA. We are down to about 3 minutes. If you want to come back, Jim.

Mr. RAMSTAD. I would be happy to come back.

Mr. MICA. We will come back. In 15 minutes we will be back here.

[Recess.]

Mr. MICA. We will call the subcommittee meeting back to order here. I did not have a chance to ask questions and will do so at this time.

Mr. Ramstad, one of the concerns is that, again, the potential cost, increasing costs. I asked Senator Wellstone about this, and you did tell me that you have a trigger in your Substance Abuse Parity Act. That 1 percent premium increase would allow companies to, I guess, exempt themselves from this. Could you tell us how that would work, specifically?

Mr. RAMSTAD. How the exemption option would be utilized?

Mr. MICA. Right.

Mr. RAMSTAD. It is simply an option on the part of business.

Mr. MICA. They have to experience a 1 percent, and then it is triggered?

Mr. RAMSTAD. Exactly. Then the option is up to them.

Mr. MICA. All right. What about ERISA plans. Are they covered?

Mr. RAMSTAD. ERISA plans, yes, similarly.

Mr. MICA. All right. And, as I mentioned, we have eight States that have now adopted some type of parity provision, somewhat similar in requirements. Why do you believe the Federal Government should get into this particularly mandated requirement, as opposed to allowing each State to pursue its own legislative remedy?

Mr. RAMSTAD. Well, for several reasons. I reviewed my good friend Chip Kahn's testimony last night. Chip is not supporting this legislation on behalf of the Health Insurance Association of North America, but he will after we educate him as to the cost effectiveness. I haven't spent enough time with Chip yet.

But as Chip's testimony pointed out, Mr. Chairman, even he recognizes that the State laws are inconsistent and incomplete. In his statement he notes that among the States with substance abuse parity laws, quoting from his testimony, requirements vary as to who is eligible for the expansion of benefits and what benefit levels are required to be covered. Because of those inconsistencies, we are not realizing the full cost savings.

To complete the answer to the question that you posed to Senator Wellstone and he deferred to me, and there will be more extensive testimony from the representative of RAND Corp., but let me put it this way so everybody can understand. For less than the price of a cup of coffee per month, we can treat 16 million addicts in America. That is the bottom line. For less than the cost of a cup of coffee per month, increase in premiums, two-tenths of 1 percent, we can treat 16 million Americans addicted to drugs and/or alcohol today.

The RAND Corp. study found that removing the annual limit of $10,000 per year on substance abuse treatment is estimated to increase insurance payments by 6 cents per member per year. The RAND Corp. study also found removing a limit of $1,000 increases payments by $3.40 per year, or 29 cents per month. I don't know any coffee you can buy for 29 cents.

Mr. MICA. Thank you.

Let me see, Mr. Barr was here and was about to ask a question. Then we will go to Ms. Schakowsky. Mr. Barr.

Mr. BARR. Thank you, Mr. Chairman. Starbucks' coffee costs considerably more, which is what I drink.

Mr. RAMSTAD. It sure does.

Mr. BARR. But I guess you get what you pay for.

Jim, you used a lot of statistics this morning, and one that I am not sure that I caught correctly was one you mentioned, in talking about law enforcement, 80 percent is related to addiction. Is that the figure—I have heard the figure from a lot of law enforcement people that 80 percent of the crime they see is drug-related, which is not to me necessarily the same as addiction. A lot of that is drug trafficking, money laundering, sales, so-called recreational use and so forth.

Is that what you meant by the 80 percent, or is there something——

Mr. RAMSTAD. I was alluding to the Columbia University—the recent 10-year comprehensive study of crime in America conducted by the Institute of Criminal Justice at Columbia University in New York City, and their finding, exhaustive research, is that 80 percent of all criminal activity in America is related directly or indirectly to drugs and/or alcohol addiction, to drugs and/or alcohol.

Mr. BARR. I think I would be a little bit suspect with that.

Mr. RAMSTAD. I can also show you six other studies that corroborate the Columbia University study. More importantly, or just, I think, Bob, as importantly, come and ride with me in north Minneapolis or south Minneapolis or St. Paul or my district, certain parts, and any police officer will tell you—and I spent 1,600 hours riding in squads since 1984 and chronicled every hour—every cop tells you the same thing.

Mr. BARR. I am not saying 80 percent of the crime is drug related—it's not. I understand that. That was pretty much the figure when I was the prosecutor and so forth. I don't accept the fact that it is addiction-related. I think it is drug-related. It may be how broadly one defines "addiction." I may not agree with how they conducted their studies using the term addiction.

But to me somebody that sells a joint of marijuana is violating the law, and that is a crime that is related to drugs. It is not necessarily a crime related to addiction. I don't think that everybody that uses drugs is addicted to them. I think a lot of people choose to use drugs, and the same as a lot of people, I understand that some people—I think a lot of people choose to use alcohol. If one says that people can't choose not to be—don't choose to be an addict or an alcoholic, one also has to accept the fact that a lot of people, even those who grow up in families with a history of alcoholism, choose not to become alcoholics.

So it plays both ways. I think we have to be very careful in the use of some of these statistics. I am not saying you are not being careful, but one really has to look at the terms on which these studies are based. I think it might very well be valid to say that 80 percent of crime is drug related. To me, that is not necessarily if we simply took care of those who are suffering true addiction, the crime problem would go away. I don't think that would happen.

Mr. RAMSTAD. Certainly you believe the statistics from the American Medical Association, and they have been corroborated as well by other studies, by 10 or 12 studies that I have seen, that there

are approximately 26 million—obviously you can't quantify it to the person, but approximately 26 million people in America today addicted to drugs and/or alcohol. That is a fact. One out of 10 Americans is addicted to drugs and/or alcohol. Nobody disputes that, that I know of.

Mr. BARR. There are an awful lot of people, far too many people, that use drugs and alcohol.

Mr. RAMSTAD. I am talking about those addicted. You are right, there are recreational users, I hate that term, but that is what everybody understands, that aren't chemically dependent people. I know a lot of people. Most of my friends will have a beer or glass of wine. They don't have disastrous consequences. They are not chemically dependent. They can stop after one glass of wine or two, or a beer or two. They are not addicts, chemically dependent.

I didn't choose to be chemically dependent. I wish I weren't. I would love to have a beer after running my 3 miles. Of course, that would defeat the run, but playing tennis or whatever. I didn't choose to be chemically dependent, any more than I choose to be a male versus a female. It is not something I chose.

I think if you look at the research and the report to the Nation, to the Congress, in 1956 by the American Medical Association that explains the disease nature, and then look at the followup research that has been done, the Bill Moyer series last year on public television that went to identifying the genes and the chromosomes that are different from people like me, who are chemically dependent, and people like my sister, the commissioner of corrections in Minnesota, who is not.

Mr. BARR. Thank you.

Mr. RAMSTAD. Thank you for your question.

Mr. MICA. Thank you.

The gentlelady from Illinois.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Mr. Ramstad, I am proud to be a cosponsor of your legislation and couldn't agree more on whether we want to dispute some dollars. It seems to me everyone, all experts in the field, are in agreement that it is the most cost-effective way to deal with this issue, is through treatment and prevention.

I wanted to ask you a question about the 1 percent waiver. Is that in our bill because you are confident that most won't achieve that 1 percent? We certainly don't want to set barriers that are going to——

Mr. RAMSTAD. You know, when I talk to small businessmen and women back home, most of them realize, who have programs that cover chemically dependent employees, they realize the value in this. They would be willing to pay increased premiums to have their people treated. They realize that absenteeism drops markedly when people are treated; productivity increases dramatically when people are treated who are chemically dependent.

The empirical reason for that—I explained the political reason to get the bill moving. The empirical reason for that is some small employers are having trouble getting insurance, as we all know, and we don't want to put another burden. We want to give the employers the option if costs for, let's say, I said before, if the roof fell

in and costs did increase more than 1 percent because of parity, we want to give them that option to be exempted.

Ms. SCHAKOWSKY. When we say premiums have increased because of parity, in your discussions with the insurance industry has there ever been clear documentation or justification or explanation of why insurance premiums go up? It is kind of a mystery I think in many cases.

Mr. RAMSTAD. That is why Mr. Kahn is here today, to answer that question. I hope you ask it, because that is a fair question and one that needs to be answered.

I think there is a certain shroud of mystery surrounding the increases. Some of the costs are certainly justified and easily quantifiable and understandable, and others I don't think are. But the most compelling evidence and the most I think compelling justification for this legislation from a cost standpoint came from the Family Research Council.

Listen to this. The Family Research Council—a very credible organization and credible study—found that, "Alcohol and drug addiction in economic terms cost the American people $246 billion last year. American taxpayers paid over $150 billion for drug-related criminal and health care costs alone."

$150 billion for criminal justice and health care costs alone. That is more than we spent on education, transportation, agriculture, energy space and foreign aid combined. Think of that. And that is what the insurance companies need to realize, need to understand. That is what most small business people understand, the cost if they don't do it is much greater than any 29 cent increase per premium if they provide help.

Ms. SCHAKOWSKY. Add in some of that foreign aid, because we are right now discussing a very substantial amount, several billion dollars to Colombia possibly to fight the drug war, and yet it seems to me that this is a more cost-effective way to address the problem. I am not necessarily posing it as an either or.

Mr. RAMSTAD. I don't think there is any question, we need both. We need to emphasize the supply side and the demand side. If you look over the last 12 years in America, two-thirds on the average of the resources have gone to the supply side, one-third to the other side. As General McCaffrey explained not long ago, this single-step parity for substance abuse treatment would do more than any other measure to cut down on the drug problem in America.

We have got to treat the people already addicted. We are emphasizing the supply side and new Border Patrol agents and keeping the drugs out. What about the 26 million Americans right now living and working, as the chairman pointed out, who are already hooked, who are already addicted? We have got to deal with them, because those numbers are increasing. If we don't deal with the problem of addiction, if we don't treat these people already addicted, we are never going to see an improvement in this situation.

Ms. SCHAKOWSKY. Let me ask you a more specific question.

Many private insurers that currently cover substance abuse treatment only cover expenses associated with detoxification but don't cover expenses associated with ongoing support services. How would your bill respond to the need for ongoing support services?

Mr. RAMSTAD. Well, again, a person who is a diabetic or who has heart disease or lung disease, much of that is up to the providers, the diagnosis, the evaluation. For some people, long-term treatment is necessary and is desirable. For others—I spent 28 days in St. Mary's, it was then called St. Mary's Rehabilitation Center in Minneapolis, undergoing treatment for alcoholism. Then I went to recovery groups. I have been going to recovery groups every week for 18 years. Others go to 6-month programs and halfway houses. That is pretty much a decision that needs to be made by the professionals, the chemical dependency, chemical treatment professionals.

Ms. SCHAKOWSKY. Thank you.

Mr. RAMSTAD. Thank you for your cosponsorship and help on this bill.

Mr. MICA. I would like to recognize the gentleman from Indiana, Mr. Souder.

Mr. SOUDER. It is good to see you here this morning. I don't have a lot of questions, but I am pleased we have been able to work together on this bill.

I commend you for your persistence and your leadership. Clearly, in keeping the bill moving forward, had you not been willing to speak in conference, work with the leadership, continue to push for hearings in many places and try to hear the different concerns that people had, this legislation would not be getting a hearing today. We would not be continuing to gain cosponsors in the House. I want to congratulate you for that, first off.

I also think you have accommodated a number of concerns that are most frequently raised, which I am sure we will hear today and which have come through in the testimony, about the costs and about accountability. We all know that unless people are accountable with this, they can easily burn up a lot of dollars through drug and alcohol treatment when it is not a personal decision to go. I think everybody is concerned about that. You may want to make a few additional comments on that. I am sorry I missed the first part.

I also think that, as we work through drug-free schools, which is a prevention program over in the Education Committee, as we work with the question of Colombia, because if we don't address the amount of supply of illegal narcotics then the price will go down, which means people use it more. We have all those different things. But we also can't neglect the treatment side. Because, ultimately, if our prevention works and if our interdiction works, you still have a large pool of not only those addicted to cocaine and heroin but to alcohol who are not being reached, and ultimately a lot of the problems, whether it is work productivity or crime in our society, are related to those two things.

I mostly wanted to commend you at this point and thank you for your work. If you wanted to comment on any of those points further——

Mr. RAMSTAD. Thank you, Mr. Chairman. Thank you, Mark.

You know, you have truly been a leader here, and your efforts in putting this bill together have been very, very appreciated. We wouldn't have had 98 cosponsors last year if it weren't for your

leadership. We wouldn't have 50 cosponsors this year if it weren't for your leadership. I appreciate working together with you.

I want to work with all of you. We think we have enough caveats, regulations here, so there aren't going to be abuses. We don't want abuse. We don't want money wasted. This is about saving money and saving lives.

Certainly some of the things you brought into the bill have been very important in that regard. John Kasich, a cosponsor of this bill with me, who has been very helpful from the dollar and cents standpoint, John Kasich understands this problem, and certainly you understand it and other members of this committee. That is very refreshing.

Many of you have heard me say this many times in conference, I wish we could turn Congress into one big AA meeting where people say what they mean and mean what they say. I think this panel does that. That is why I am confident that, working together, we can get this done.

Mr. MICA. Thank you.

Mr. Kucinich.

Mr. KUCINICH. Thank you, Mr. Mica.

To Mr. Ramstad, I want to add my voice to those of you on the committee who are thanking you for the work you have done. People ask me, Mr. Chairman, about serving in the House of Representatives and about the people I serve with, and what I have found in the 3 years now that I have been here is that we are very fortunate to be serving with each other. We have people here of depth and of character, people who are willing to share their deepest experiences, not with just us but with the Nation. And, through you, people all over this country are going to be given an opportunity to transcend themselves, to become bigger and better than they are and through their experience to help a Nation lift itself up.

So, I think all of us owe you a debt of gratitude for your courage, for your willingness to make your story parts of America's story and to help the Nation recover. So I thank you. I look forward to working with you on this.

Mr. RAMSTAD. Thank you, Dennis.

Mr. MICA. Mr. Ose.

Mr. OSE. No questions.

Mr. MICA. We certainly thank our colleague again for his leadership, for his testimony today, and for his hard work in bringing this very troubling issue before the Congress and the American people. We thank you. We will excuse you at this time. Thank you, Mr. Ramstad.

Mr. RAMSTAD. Thank you again.

Mr. MICA. We will move forward with the hearing. Our second panel today is one individual who is going to offer her personal testimony, and I will call forward as the witness Susan Rook.

Susan Rook is a media consultant. Susan has covered most of the breaking news stories of the last decade. She joined CNN in January 1987 and became a nationally prominent news anchor while coanchoring crime news with Bernard Shaw. She was chosen to pioneer the network's daily interactive town meeting, a show that we know as Talk Back Life.

On Talk Back Life, Susan became the first journalist to juggle both a live studio audience, newsmaker guests and a nationwide high-tech audience into a quick-based interview and discussion program.

She lives now in Washington, DC, and she has been willing to come forward today and share with us some of her personal experience with addiction and treatment.

I must say, first of all, that we welcome you. This is an investigations and oversight subcommittee of Congress. We had congressional Members. We don't swear them in. We will swear you in and ask you at this time if you would stand, please, raise your right hand.

[Witness sworn.]

Mr. MICA. The witness answered in the affirmative.

We are pleased to have you join us. We look forward to your testimony, and you are recognized.

STATEMENT OF SUSAN ROOK, MEDIA CONSULTANT

Ms. ROOK. Thank you, Mr. Chairman. Thank you, all of you, for the privilege and the opportunity to speak to you today.

You mentioned my work on CNN. As a journalist, I have always looked for stories that needed to be told. For two decades I have reported on the so-called war on drugs. Well, today I am here to give you a live report from the lines. I am an alcoholic and an addict. I am in recovery. I am alive today because I was able to get access to the medical treatment that was required to treat my disease.

An overdose landed me in the emergency room. Without access to drugs and alcohol, I started the withdrawal process. I turned to this nurse that was there and I said, "Why can't I hold a glass of water without spilling it? Why do I feel so sick?" and I really was very physically sick. I asked her what was going on.

She looked at me with a mixture of disgust and pity on her face, and she said "Because you are a drunk and a junkie. You are detoxing. What do you think is happening to you?"

Until that moment, I did not know.

I thought I knew what drunks and junkies looked like, and I certainly didn't fit that picture.

I am here today because I may not fit your picture of what a drunk and a junkie looks like. I want you to see the face of addiction, and I want you to see the face of recovery.

Until the comment from that nurse, I didn't know that I had crossed the line from being a social drinker to being an addict. Current scientific evidence shows that there is a line that people with chemical dependency cross. Certainly that initial use is voluntary, but that use triggers a biological reaction that changes my biology, making it unable for me to stop.

The right to have the choice of whether to have a drink or not drink, or have just one drink, disappears. The obsession and compulsion are the most powerful things I have ever seen or experienced. I could not moderate my use of drugs and alcohol, and I could not stop.

Treatment interrupted that compulsion, and it gave me the opportunity for sobriety.

Top management came to the hospital, and they gave me a choice. I could either stay in the hospital for the 72 hours required for what was listed as a suicide attempt and go back to work, or I could immediately go into alcohol and drug treatment. I chose treatment.

Shaken by the look of pity by that nurse and armed with the knowledge that I have a disease for which there is no cure but there is the possibility of recovery, I went off to treatment.

About a week into treatment insurance ran out. I was scared. Physically, I was still very sick. Trying to negotiate the maze of the insurance company, that familiar hopelessness reappeared.

CNN management and an effective and committed employee assistance program coordinator stepped in and told me if I was willing to complete the entire 28-day treatment program, CNN would pay for anything that insurance did not cover. I stayed in treatment and have been abstinent from drugs and alcohol ever since.

Two things made the difference for me. I was lucky enough to work for a company that treated my disease as a disease and gave me access to the same kind of medical care that they would give anyone who has another brain disease, like Parkinson's.

CNN did that. The insurance company did not. According to the Hay Group study, substance abuse benefits have decreased 75 percent in the last 10 years. I called where I went to treatment, Ridgeview, outside of Atlanta. I called Ridgeview yesterday and I said, say, do you guys still offer that 28-day treatment program? They said, no, managed care won't allow it. We don't even have it.

If I got into treatment today, I couldn't go and get the comprehensive medical care, even fully paying for it myself or my company paying for it, because it is not there.

As you go into your business today, I ask you to look around you. Studies show that 7 out of 10 people are affected by this disease, 1 in 10 people have it. I want you to wonder how many people are living a double life, as I did when I was giving you the news and when you watched me and when I was doing all the things that you mentioned in the bio. I was drinking and using illegal drugs, and chances are you certainly didn't know it, and nobody else did.

As you go in your cars to go home and go about your business, I want you to look around you and wonder, who is in that car next to me? This is the face of addiction.

I applaud your efforts to reduce the supply of drugs coming into this country. I think that is a very important component of this, and I urge you to put greater emphasis on demand reduction techniques like treatment and prevention.

Mr. Chairman, you have the power to lead this country in moving the conversation of alcoholism and drug addiction from a moral arena to a medical arena where it belongs, and I ask you to use that power to do that.

Please make treatment a visible component of our Nation's drug policy. This is the face of addiction. Can you afford to ignore it? This is the face of recovery.

Thank you for seeing it.

Mr. MICA. Thank you for your testimony and your coming forward and giving us your difficult experience.

[The prepared statement of Ms. Rook follows:]

Testimony of Susan Rook
September 21, 1999

Thank you for the privilege and opportunity to speak to you.
Some of you remember my work on CNN. It is as a public figure and a journalist that I am here. For two decades I've reported many stories on the war on drugs. Today, I'm here to give you a report from the front lines.
I am an alcoholic and a drug addict. I am in recovery.
I am alive today because I had access to the comprehensive medical care required to treat my disease.
An overdose landed me in the emergency room. Without access to drugs and alcohol I started detoxing. I asked a nurse why my hands were shaking so badly I couldn't hold a glass of water without spilling it. I asked her why I was so sick. She looked at me with a mixture of disgust and pity and said, "You're a drunk and a junkie, you're detoxing, what do you think is happening to you?" Until that moment I did not know.
I thought I knew what drunks and junkies looked like and I didn't fit that picture. I am here today because I may not fit your picture of an alcoholic and addict. I want you to see the face of addiction and the face of recovery.
Until the comment from that nurse I did not know I had crossed the line from being a hard living journalist to being an addict. Current scientific evidence shows there is a line that people with chemical dependency cross. Initial use is voluntary but that use alters my biological ability to stop using. The right to the choice of whether to drink, or have just one drink, disappears. The obsession and compulsion are the most powerful things I have ever seen or experienced. I could not moderate my use of drugs and alcohol and I could not stop.
Treatment interrupted that compulsion and gave me the opportunity for sobriety. Top management at CNN came to the hospital and gave me a choice. I could stay in the hospital for the 72 hours required for what was listed as a suicide attempt and go back to work or I could go immediately into alcohol and drug treatment. Shaken by the look of pity on the face of that nurse and armed with the news that I had a disease for which there is no cure, but there is the possibility of recovery, I choose treatment.
About a week into treatment, insurance ran out. I was scared. Physically I was still very sick. Trying to negotiate the maze of the insurance company, that familiar hopelessness returned. CNN management and an effective and committed employee assistance program coordinator stepped in and told me if I was willing to complete the entire 28-day treatment program, CNN would pay for anything insurance didn't cover. I stayed in treatment and have been abstinent from drugs and alcohol ever since.
Two things made the difference for me. I was lucky enough to work for a company that treated my disease as a disease and gave me the same opportunity to health care as with any other brain disease like Parkinson's or physical trauma to the brain. CNN did that; the insurance company did not. Second, I got the comprehensive care in treatment that gave me the tools to do what I need to do to stay in recovery.
As you go about your business today, look around you. According to conservative estimates 1 in 10 people have this disease; I want you to wonder how many people are living a double life, as I did when I was giving you the news. As you get into your cars to go home I want you to look around and ask yourself how many people don't fit your picture of an alcoholic or addict. Who is in the car next to you? This is the face of addiction. Can you afford to ignore it?

I applaud your efforts to shut down the supply side and I urge you to look at the demand side. Mr. Chairman, you have the power to take the lead in moving alcoholism and drug addiction from the moral arena to the medical arena. Please make treatment a visible component in our nations drug policy.

This is the face of recovery. Thank you for seeing it.

Mr. MICA. I want all the Members—also, I have heard her saying that I have the power to change this. As chairman, I want you to vote in lockstep with me.

Mrs. MINK. Yes, sir. Yes, sir.

Mr. MICA. I wish it was that easy. Sometimes I feel like I am drowning in a sea trying to get—and failing—in trying to get the attention of the Congress and the American people, and it is a tremendous drain on our society. The cost is just unbelievable, not only in dollars and cents, but in human tragedies, as you have cited.

One of the difficulties we have is trying to sort out how we can do things that will be most effective, and the question before us today is do we mandate insurance coverage for substance abuse and chemical dependency. When I say mandate, bring the Federal Government into the arena. And then there is the question of the effectiveness of what is done.

You almost sort of presented a dream case today because most of the cases—you are very fortunate. It sounds like you went into a treatment plan, you had 7 days' coverage and then, through the largesse of your employer, they went on and covered you, and you have since maintained recovery.

But the unfortunate story we hear is so many of the treatment programs are not working. You feel, though, that the 7 days—you went on to 28 days—were adequate at least for you. If you had stopped at 7, what do you think the outcome would have been?

Ms. ROOK. I don't think I would be sober today if I had simply detoxed. The obsession and compulsion are incredibly powerful. When I was talking to the insurance company, and I really thought that I was going to have to leave, I was scared. I was scared. But that 28—what that 28 days bought me was a little bit of time and distance, a little bit of foundation, of security and safety. That was completely invaluable. I mean, I can't even measure that.

Mr. MICA. Mrs. Mink.

Mrs. MINK. Yes, thank you very much for your very compelling testimony.

In reference to the 28 day treatment, if we at least did that in terms of our insurance coverage, do you feel that that would be an adequate first step, if we weren't able to move to a more comprehensive type of coverage?

Ms. ROOK. First, let me address the issue of mandating health care. The parity legislation is actually about being straight with people who are getting health care. A $10,000 cap does nothing. What I would really love to see is insurance companies look at people and say, you know what, we are actually pretending to give you insurance coverage, but here is the deal: We are not.

So if you are going to use this coverage, you need to be aware of it. I would like honesty in the advertising. I wonder how many companies are paying for something that they are actually not getting?

I was lucky enough to work for a company that stepped in and said we will do the difference. But I wonder how many companies and business people out there think, I am looking out for my employees, and then bump up against that cap?

I am not a proponent of Federal mandates. I don't want the Federal Government to step in and say everyone who is an addict or alcoholic, you need to trot into treatment for 28 days. I don't want the Federal Government messing in lives like that. I didn't want—I would not want it messing in mine. So I am not advocating that.

I am advocating, one, truth in advertising; two, an opportunity and a commitment on the Federal level to have treatment as an available option for the people who want it; and, third, it is cost effective. When you put somebody in jail—so a 28-day program at Hazelden, for example, is about $15,000. When I went through, it was about $20,000. So for a month it is $39,000 to keep someone in prison.

Now, when they get out of prison, do you want them making their decisions drunk or sober? The decision to go in and check with the parole officer, the decision of whether or not to really go look for a job or, hmm, let's just boost that car and toss the kid out who is in the back seat. How do you want people to make their decisions?

That is actually what my request is. Not a blanket Federal mandate of going in and actually doing things, but a commitment on the Federal level that when treatment is available and people can get into it, it works.

Mrs. MINK. Thank you very much.

Mr. MICA. Mr. Barr, our vice chairman.

Mr. BARR. Thank you, Mr. Chairman.

I appreciate the hearing; and I appreciate, Ms. Rook, your being here and our colleagues before you and the witnesses that will come after. The only thing I would caution would be I guess it all depends on what mandate means. I mean, the legislation—and I am not saying I am for or against the legislation, because I need to look at it a great deal more carefully. But to say that it doesn't include mandates is simply, I think, inaccurate, unless one uses a very unusual definition of mandates, because it does mandate that group health plans shall do certain things and cannot do other things. So there are mandates in it.

I think we need to look at it, to weigh the mandates. Obviously, there are a lot of laws that provide for a lot of mandates, but it does contain some mandates. What we have to weigh up here is the policy, the cost, and the policy decisions. Do we want to remove any flexibility that insurance companies might have for making sometimes legitimate perhaps economic decisions? They may have a legitimate reason to treat certain types of coverage somewhat different than others, based on history.

I do think that saying we should remove this, the moral component, completely may not be the best way to cast this argument, because we do want to send a message to people that alcohol is bad and the use of drugs is bad, and not to say, well, it is OK and we can't have any stigma at all attached to it.

So I think, from my standpoint, I just stay away from saying we ought to remove any moral component. I think it is important to have a moral-ethical component. That should be reflected in the policies that Congress sends. That is just my reaction.

I do appreciate your being here and appreciate your work in the media very much. Thank you.

Ms. ROOK. Thank you, sir.

You mentioned legitimate economic decisions. I am very compassionate to the insurance companies looking and saying we don't want to increase costs. I am compassionate to the employers who look and worry and say I don't want to increase costs. But here is the deal: If people aren't sober, the insurance cost that isn't going up over here comes over here. So you are going to have to go back to your voters and explain why you are going to have to build more prisons, and they are going to have to pay for it.

Mr. BARR. Well, I certainly try to and think I succeed fairly well at listening to my constituents, and they are a compassionate constituency. They believe in fairness. They also believe in tough law enforcement. They don't like drugs. They don't like alcoholism either. They want to strike a balance, and that is what I try and do, also. Because there are some very good reasons for what you are saying. But to me it isn't simply that, well, we have alcoholics and drug addicts out there. Therefore, we must mandate that they be taken care of.

I think it is a little more complex than that. We need to weigh in a lot of different factors. The economics of it, you are right, may in the great cosmic scheme of things, everything we do irons out in the end. We save some money here, we cause further problems over here. But we still have to make those decisions.

I will look very carefully, Mr. Chairman, at this legislation. I think it is important. I appreciate it coming up, and I appreciate your being here.

Ms. ROOK. Thank you, sir.

Mr. MICA. The gentleman from Arkansas, Mr. Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman.

I do not have any questions. I just want to express my appreciation for your testimony today and for sharing your story with us. Let me thank the chairman also, just for having this hearing, because I had not focused on the legislation, and this allows us to do so. I look forward to doing that and hopefully moving this forward. Thank you for your testimony today.

Ms. ROOK. You are welcome.

Mr. MICA. Mr. Ose, the gentleman from California.

Mr. OSE. Ms. Rook, thank you for coming. I appreciate it.

I want to explore a little bit the insurance side of the thing, because we have a lot of debate going on here in the House about access and availability and what have you.

Clearly, CNN offers a health insurance program for its employees. Do they give you a choice, or is it just kind of this is the program, period?

Ms. ROOK. I don't know what they do now. I left CNN 2 years ago.

Mr. OSE. When you were there.

Ms. ROOK. When I was there, we got a choice. Employees could look and say, I want this plan, this plan or this plan. I don't know what they are doing now. I would imagine it is the same. They have got a really good commitment to quality of life for their employees.

Mr. OSE. So CNN gave you a choice, and the final decision, the employee would pick which of those programs best suited their needs.

Ms. ROOK. Yes.

Mr. OSE. It wasn't crammed down, if you will——

Ms. ROOK. No.

Mr. OSE. And then the amount of cost, if you will, the premium reflected the services or the benefits that were in each of the programs I imagine.

Ms. ROOK. Yes. I had the Cadillac deluxe plan. I don't remember what it was or what the insurance company was, but I checked the one that said, yes, you get everything covered, whatever you want.

Mr. OSE. OK.

Ms. ROOK. And substance abuse coverage was $10,000.

Mr. OSE. Was capped at $10,000.

Ms. ROOK. Yes.

Mr. OSE. And if I understand your point today, it is that, No. 1, the cap is too low, and, secondarily, businesses should be offering the substance abuse treatment because from your perspective it is a disease over which you don't have any control.

Ms. ROOK. Yes.

Mr. OSE. I am accurate on that?

Ms. ROOK. Yes. Not just the cap is too low, but let's be straight about it. People think they are buying insurance, and they are not. It would be like if I have breast cancer and I go in and they say you can get treated for your breast cancer, but only $10,000, which will not cover much. Just be straight about what you are offering the people. That is not insurance. That is a double bind.

Mr. OSE. That is the part—I don't mean to be argumentative, but that is the part I don't quite understand. You are able to cite the provisions very clearly today, and from where I sit $10,000 worth of coverage is better than zero coverage, even though it doesn't address the problem in its entirety. But the ultimate decision as to which of those programs—I presume some of the other programs had zero for substance abuse treatment. The ultimate decision for that, which plan you chose, was left by CNN in the lap of the employee, if I understand you correctly.

Ms. ROOK. Yes, correct.

Mr. OSE. Thank you, Mr. Chairman.

Mr. MICA. The gentleman from Indiana, Mr. Souder.

Mr. SOUDER. I wanted to followup, too, because our legislation doesn't mandate any particular line of coverage, and while 28 days may have been essential for you, a smaller program may have been enough for other people, and, in fact, some people can go through three or four programs. Part of the goal of this legislation is to make sure there is at least a minimal option.

Could you describe—you said you have been drug and alcohol free. Could you explain to us a little bit—because many people stumble. When you are battling it, it is not easy just to go cold turkey, even if it is 28 days, and suddenly not be tempted by the sin and the same problems you had before. Could you explain a little bit about how you felt previous, why you went into this treatment, and what gave you the strength to then be free after 28 days? That is a pretty amazing story.

Ms. ROOK. I didn't go in willingly. I went in because I overdosed and ended up in the hospital. I didn't think that I had a problem. Everybody that I knew drank and did drugs. My social life, my private life, was very—was completely separate from the life on CNN, completely separate.

I did not know that I had an option of not drinking or not doing drugs. I didn't know that that was even possible.

Treatment interrupted that and made me see, oh, look, sobriety is even possible. It never occurred to me that other people didn't live like I lived. It just didn't occur to me.

What I got in treatment was a group of medical professionals skilled in what they do who were suggesting things for me to do in my recovery in the 28-day program and my recovery when I left treatment, when I actually left the facility. They made the decisions. They made the suggestions. And I guess that is one of the things that I am requesting that you look at, who is actually making the decision. Is it a clerk at an insurance company who is saying what is best or is it a professional? And you are absolutely right. Not everybody needs 28 days. You can do it in less. If something else works, great. Explore all of those options. But a trained professional making that is, to my mind, the way to go, instead of like a clerk.

Mr. SOUDER. Are you part of an accountability group and did your company do anything that further held you accountable that if you did not change—tell me a little bit about that. It is still dramatic. Most people who go through programs struggle and often they make some progress each time they go through, but it is a real battle.

Ms. ROOK. I think Hazelden has a study that 50 percent of people who go to treatment are abstinent for their first year, and 80 percent are sober their first year, with one slip in between. I will tell you, if you had those kind of results with heart disease, adult onset diabetes and asthma, you would be doing pretty good.

Personally, I do a personal program of recovery. I am not going to talk about that in front of the cameras. I will be glad to talk about that with any of you in private.

I learned what I need to do to stay sober in treatment, and I do it. I am really clear. I did a lot of drugs. I drank a lot. I am really clear. I pick up, I am dead.

Mr. SOUDER. Thank you.

Mr. RAMSTAD. If the gentleman would yield very briefly.

Mr. MICA. You are recognized, Mr. Ramstad.

Mr. RAMSTAD. Susan is right; and Mr. Mike Conley, who is chairman of the Board of Trustees of Hazelden, will be able to elaborate on that, I am sure. Recidivism, as the American Medical Association studies have shown for chemical addiction, it is amazingly the same as for diabetes. The amount of recovery or recidivism, depending on whether you want to look at the glass half full or empty, is about the same as it is for diabetes. Recovery rates after treatment for addiction compare very favorably to most other diseases, are about the same as for diabetes, as was said.

Mr. MICA. Thank you, Ms. Rook. Thank you for coming forward and providing us with your personal testimony today. Mrs. Mink and I said that you are very fortunate to be in recovery and

through a treatment program that has been so successful for you personally. Unfortunately, we had over 15,200 who died from drug-induced deaths last year, and we have millions who are not covered, who are hopeless and a tremendous burden on their families, destroying their lives and not success stories. We are pleased that you would come forward and tell a little bit about your personal experience and maybe give some hope to those other individuals out there.

We do have a vote in progress and just a few minutes left. We are going to excuse you and thank you again for your testimony.

The subcommittee will stand in recess until 12:15. We will call our third panel at that time.

[Recess.]

Mr. MICA. I would like to call the subcommittee back to order.

I would like to call at this time our third panel. The witnesses on that panel consist of Mr. Michael Conley, who is chairman of the Board of Trustees of the Hazelden Foundation; Dr. Michael Schoenbaum, who is an economist with the RAND Corp.; Mr. Kenny Hall, who is an addiction specialist with Kaiser Permanente; Captain Ronald Smith, M.D. and Ph.D., who is vice chairman of the Department of Psychiatry at the National Naval Medical Center; Mr. Peter Ferrara, general counsel and chief economist for the Americans for Tax Reform; and Mr. Charles N. Kahn III, who is president of the Health Insurance Association of America.

I would like to welcome all of our witnesses. As I mentioned to our previous panel witness, this is an investigations and oversight subcommittee of Congress, and we do swear in our witnesses. If you would all stand, please, to be sworn.

[Witnesses sworn.]

Mr. MICA. The witnesses answered in the affirmative, and we are pleased to have each of you with us this afternoon looking at this question of substance abuse treatment parity. We will start right off with Mr. Michael Conley, who is chairman of the Board of Trustees of the Hazelden Foundation.

Now since we have a large number of panelists, we are going to run the light and try to stick to it. It is 5 minutes for an oral presentation. If you have a lengthy statement or additional report or information you would like to be made part of the record, it will be included in the record by unanimous consent request. So we just ask your compliance with that set of time limits. We will put those complete documents in the record.

With that, let's recognize Mr. Michael Conley, chairman of the Board of Trustees of the Hazelden Foundation.

STATEMENTS OF MICHAEL CONLEY, CHAIRMAN OF THE BOARD OF TRUSTEES, THE HAZELDEN FOUNDATION; MICHAEL SCHOENBAUM, ECONOMIST, RAND CORP.; KENNY HALL, ADDICTION SPECIALIST, KAISER PERMANENTE; CAPT. RONALD SMITH, M.D., PH.D., VICE-CHAIRMAN, DEPARTMENT OF PSYCHIATRY, NATIONAL NAVAL MEDICAL CENTER; PETER FERRARA, GENERAL COUNSEL AND CHIEF ECONOMIST, AMERICANS FOR TAX REFORM; AND CHARLES N. KAHN III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. CONLEY. Thank you, Mr. Chairman and members of the subcommittee.

Good afternoon. My name is Mike Conley. I am here today as chairman of the Board of the Hazelden Foundation, as a retired health insurance executive, profoundly concerned with the negative trends that I see in the chemical dependency reimbursement systems, and as a grateful recovering alcoholic. I would like to thank you for the opportunity to testify before your subcommittee and would like to request that my entire written statement be included in the record.

Mr. MICA. Without objection, so ordered.

Mr. CONLEY. Thank you.

I am testifying on behalf of the Partnership for Recovery, a coalition of nonprofit alcohol and drug treatment providers that include four of the Nation's leading treatment centers, the Betty Ford Center, Caron Foundation, Hazelden Foundation, and Valley Hope Association, collectively representing 250,000 individuals who completed treatment for alcohol or drug addiction.

Today I would like to focus my remarks on three key areas: one, that addiction is a treatable disease; two, that good treatment is a cost-saving tool in the workplace; and, three, that H.R. 1977, the Substance Abuse Treatment Parity Act, is an important first step toward fully utilizing treatment benefits to society.

My testimony reflects the strong need for a balanced approach between demand and the supply side strategies, including treatment, prevention, interdiction and criminal justice measures.

Mr. Chairman, as a former businessman and health insurance executive, I know that good substance abuse treatment is a cost-saving tool in the workplace. A significant number of American workers abuse substances, and some of them—some of this occurs at work. Most current drug users age 18 and older are employed—in fact, 73 percent. The costs of alcohol and illicit drug abuse in the workplace, including lost productivity, medical claims and accidents, is estimated to be as high as $140 billion a year. Moreover, the societal costs are staggering. Fortunately, the tools for addressing the problem are available, as many enlightened employers have discovered.

A couple of examples, Chevron Corp. found that for every $1 spent on treatment, nearly $10 is saved. Northrup Corp. saw productively increase 43 percent in the first 100 employees to enter an alcohol treatment program. After 3 years of sobriety, savings per rehabilitated employee approached $20,000. Oldsmobile's Lansing, MI, plant saw the following results 1 year after employees with alcoholism problems received treatment: Lost man-hours declined by

49 percent, health care benefit costs by 29 percent, absences by 56 percent.

Despite the significant efforts of this subcommittee as well as others to improve the outlook for drug-free workplaces, small businesses unfortunately fall far behind when it comes to addressing substance abuse. The data is clear. Most small businesses will at some point be faced with an employee who has a substance abuse problem. Given that small businesses represent a large majority of employers, the work site is one of the most effective places to reach Americans. In short, good treatment and recovery policies are sound business investments for large and small employers alike.

We believe that H.R. 1977 is the landmark legislation that takes an important first step toward giving people suffering from the disease of alcoholism and drug addiction increased access to treatment. This legislation does not mandate that health insurers offer substance abuse treatment benefits. It does prohibit health plans from placing discriminatory caps, financial requirements or other restrictions on treatment that are different from other medical and surgical services. H.R. 1977 will help eliminate barriers to treatment without significantly increasing health care premiums, and you will hear about it in a minute, but the RAND study did show that this could be made available to employees for $5.11 a year or 43 cents a month.

Mr. Chairman, my statement details what the Partnership believes are some of the key ingredients for a public policy that effectively addresses the essence of the addition problem: Acceptance of the disease as a critical public health issue and a public policy with a balanced emphasis on treatment and prevention as well as interdiction and criminal justice.

Our Federal drug policy should also recognize that all persons, regardless of their illness, should be treated with human dignity. H.R. 1977 goes right to the heart of the need for fair and equitable treatment for people suffering from this disease, and we believe it is a step in the right direction.

And if I can just speak strictly for myself as a recovering alcoholic, it breaks my heart to know that so many people out there who need help are not getting help because of the system. They are not statistics. They are living, breathing people like me, a recovering alcoholic, with a potential of being important contributors to their families, workplaces and communities. You folks have the power to help get this back on track, and I sincerely appreciate your letting me share this with you today. Thank you.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Conley follows:]

TESTIMONY

OF

R. MICHAEL CONLEY
CHAIRMAN OF THE BOARD OF TRUSTEES
HAZELDEN FOUNDATION

ON BEHALF OF THE

PARTNERSHIP FOR RECOVERY

BEFORE THE

HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY and HUMAN RESOURCES

October 21, 1999

Mr. Chairman and members of the subcommittee, good morning. My name is Mike Conley. I am a former health insurance executive and Chairman of the Board of the Hazelden Foundation, an organization that has been providing a continuum of services for people suffering from chemical dependency and their families for the past 50 years. I am also a grateful recovering alcoholic.

I would like to thank you for the opportunity to testify before your subcommittee. Chemical dependency is a public health problem that affects millions of people and imposes enormous financial and social burdens on society. It destroys families, victimizes individuals and communities, and suffocates the educational, criminal justice, and social services systems. It is a disease that can affect anyone regardless of age, cultural background, or profession.

I am testifying today on behalf of the Partnership for Recovery, a coalition of non-profit alcohol and drug treatment providers that includes four of the nation's leading treatment centers: the Betty Ford Center, Caron Foundation, Hazelden Foundation and Valley Hope Association, collectively representing 250,000 individuals who completed treatment for alcohol or drug addictions.

The Partnership is dedicated to improving access to professional treatment for all Americans suffering from the disease of addiction. Addiction is a chronic, relapsing brain disease that is treatable. We are committed to the pursuit of equitable and non-discriminatory treatment for those individuals and/or family members with the disease of chemical dependency.

Members of the Partnership for Recovery hope to broaden the public's understanding of the disease and create an awareness of the value of professional treatment. We share a common philosophy and more than 100 years of treatment experience based on the 12-Step model with an emphasis on family involvement and individual recovery.

As leaders in the field, the Partnership for Recovery believes that we have an obligation to provide information on the 12-Step model, the most effective model of treatment for our patients. The 12-Step or "Minnesota Model" is characterized by the use of the 12-Step philosophy of Alcoholics Anonymous as a foundation for therapeutic change in peoples' lives. The treatment goal is total abstinence from mood-altering substances and improved quality of life. While this model was developed for residential settings, we believe it can be easily adopted in community, correctional, or outpatient settings.

At our Centers, we often see success rates (that is abstinence from alcohol and other drugs for one year after treatment) ranging from 51-75 percent using this model of treatment. It is important to note that no one model of treatment is appropriate for all patients. We believe that an individualized continuum of care is an important factor in making recovery last for the addicted person.

Key Components of the 12-Step Model Include:

1. Assessment;
2. Development of a individualized plan of care;
3. Execution of the treatment plan;

4. Specific continuing care plan (including halfway house, group, or individual therapy and AA or NA attendance; and
5. Post treatment services.

Post treatment services or continuing care, increase the quality of recovery by helping to prevent relapse. Based on variability of severity, continuing care options are individually prescribed. One-to-one counseling and referral to a 12-Step self-help support group is frequently recommended for those individuals with supportive family and social environments, employment, and relatively successful treatment response.

The data is also compelling that longer lengths of stay yield better outcomes. For example, a 1993 study published by McLellan, Grisson, Brill, Durell, Metzger and O'Brien reported outcomes of patients from four private treatment centers, two inpatient and two outpatient. While the programs varied somewhat in program characteristics, all four programs were based on the 12 Steps of Alcoholics Anonymous, had a goal of abstinence, and utilized a multidisciplinary team to deliver services. Two inpatient programs yielded an average abstinence rate of 71 percent, while the two outpatient programs averaged an abstinence rate of 48 percent.

H.R. 1977: A Cost Savings Tool in the Workplace

Addiction is treatable and the treatment does work. There are numerous national studies whose data chronicle the effectiveness of treatment, the cost savings it affords the workplace, and the life saving and transforming potential it offers individuals and family members. There are literally millions of people living new lives in recovery across the United States today.

As a former businessman, I feel strongly that substance abuse treatment is a cost savings tool in the workplace. A significant number of American workers abuse substances, and some of this use occurs at work. Most current drug users age 18 and older are employed -- in fact, 73 percent work, including 6.7 million full-time and 1.6 million part-time workers, according to the 1997 *National Household Survey on Drug Abuse*. In addition, the costs of alcohol and illicit drug use in the workplace, including lost productivity, medical claims and accidents, is estimated to be as high as $140 billion per year. (*Drug Strategies, 1996*) I ask you to consider the following:

- 70% of people with drug and alcohol problems are employed and the health care costs of untreated alcoholics and addicts are 100% higher than treated ones. (*National Household Survey on Drug Abuse, 1994 and Rutgers University study, 1994*)

- 60% of employees know someone who has gone to work under the influence of alcohol or drugs. (*Hazelden Foundation, 1996*)

- 65% of emergency room visits are caused by an underlying drug or alcohol problem. *(American Medical Association, 1996)*

- 38% to 50% of all workers' compensation claims are related to substance abuse in the workplace. (*National Council on Compensation Insurance, 1993*)

A Chevron Corporation study found that for every $1.00 spent on treatment, nearly $10.00 is saved. As I said, the tools are there. Simply put: addiction is a disease; it's treatable; and study after study has shown it's effective. Indeed, comparatively, treatment is a far less expensive alternative than retraining new workers.

The costs and benefits of workplace policies are primary considerations for businesses--no single solution will work for every organization. However, understanding various approaches to substance abuse treatment will help employers make the right decisions for their businesses.

The Corporate Impact of Drug and Alcohol Addiction

Many corporations have already taken steps to address the issue of illicit drug use in the workplace by establishing employee assistance programs (EAPs). EAPs are designed to assist employees with problems that affect their job performance, such as alcohol and drug abuse, as well as stress, marital difficulties, financial trouble, and legal problems. Most EAPs offer a range of services, including employee education, individual and organizational assessment, counseling, and referrals to treatment. Whichever way a company chooses to address the issue of addiction among employees, research has shown that substance abuse treatment results in a significant reduction in medical claims, absenteeism, and disability; an increase in productivity; and a healthier and safer environment for all employees. For example:

- General Motors Corporation's EAP saves the company $37 million per year in lost productivity - $3,700 for each of the 10,000 employees enrolled in the program. (American Society for Industrial Security, *Substance Abuse: A Guide to Workplace Issues*, 1990)

- United Airlines estimates that it has a $16.95 return in the form of higher productivity for every dollar invested in employee assistance. (American Society for Industrial Security, *Substance Abuse: A Guide to Workplace Issues*, 1990)

- Northrop Corporation saw productivity increase 43 percent in the first 100 employees to enter an alcohol treatment program. After 3 years of sobriety, savings per rehabilitated employee approached $20,000. (Campbell D. and Graham M. *Drugs and Alcohol in the Workplace: A Guide for Managers*, 1988)

- Oldsmobile's Lansing, Michigan, plant saw the following results one year after employees with alcoholism problems received treatment: lost man-hours declined by 49 percent, health care benefit costs by 29 percent, absences by 56 percent, grievances by 78 percent, disciplinary problems by 63 percent, and accidents by 82 percent. (Campbell D. and Graham M. *Drugs and Alcohol in the Workplace: A Guide for Managers*, 1988)

In 1995, the average annual costs of EAP services per eligible employee nationwide was $26.59 for internal programs staffed by company employees and $21.47 for programs provided by an outside contractor. (French, M.T., Zarkin, G.A., Bray, J.W., *Costs of Employee Assistance Programs: Findings from a National Durvey, 1995*) These costs compare favorable with the

expense of recruiting and training replacements for employees terminated because of substance abuse problems - about $50,000 per employee at corporations such as IBM. (Falco M. *The Making of a Drug-Free America: Programs That Work*, 1992)

The Impact of Alcohol and Drug Addiction on Small Business

America's 23.3 million non-farm small businesses (firms with fewer than 500 employees) employed more than 50 percent of the private non-farm workforce in 1996. And the number of small businesses is growing; between 1982 and 1996, the number of small businesses increased by 57 percent. (Office of Economic Research. *The Facts About Small Business*, 1997)

Despite the significant efforts of this subcommittee as well as others to improve the outlook for drug-free workplaces in the small business community, these companies fall far behind when it comes to addressing substance abuse in the workplace. About one-half of coworkers aged 18 to 49 employed in establishments with fewer than 25 employees reported in 1994 that their employer offered information or has a written policy on alcohol and/or drug use, compared with more than 80 percent of workers from medium and large workplaces. In addition, a study breaking down work establishments by size found that in 1994, 11 percent of workers aged 18 to 49 in the smallest firms (fewer than 25 employees) reported current illicit drug use, a rate significantly higher than that for workers in two larger employment categories (25-499 employees, and 500 and more, both of which reported rates of 5.4 percent. In 1994, 12.2 percent of 18 to 25 year old workers, 8.6 percent of 26 to 34 year old workers, and 5.2 percent of 35 to 49 year old workers reported current illicit drug use. (Hoffman JP, Larison C, Sanderson A. *An Analysis of Worker Drug Use and Workplace Policies and Programs*. SAMHSA, 1997)

The data is clear - most small businesses will at some point be faced with an employee who has a substance abuse problem. Given that small businesses represent 99 percent of all employers, (Office of Economic Research. *The Facts About Small Business*, 1997) the work site is one of the most effective places to reach Americans with information about the success of substance abuse treatment.

Treatment and recovery are a sound business investment. Implementing a substance abuse program enables a small business to stand out among its competitors as a company that cares about employees and families in the community by taking steps to ensure that its employees are free from alcohol and drug addiction. Consider the following:

- A study of 700 hospitality industry employees who were abusing substances and remained on the job after receiving treatment produced the following results: job-related injuries declined from 9 percent to 5 percent; tardiness decreased from 39 percent to 7 percent; absenteeism dropped from 42 percent to 5 percent; job errors declined from 32 percent to 6 percent; and failure to complete assigned tasks dropped from 23 percent to 5 percent. (U.S. Department of Labor. *Working Partners: Substance Abuse in the Workplace*, 1997)

Effectiveness of Treatment

Alcoholism and drug addiction are painful, private struggles with staggering public costs. Assuring access to treatment will not only combat this insidious disease -- it will save health care

dollars in the long run. Treatment also helps people remain outside the criminal justice system thereby reducing federal government expenditures.

- In a major before-and-after drug abuse treatment study of 4,411 people in federally funded treatment, the prevalence of illicit drug abuse was cut by about one-half for each illicit substance (i.e., cocaine, marijuana, crack or heroin), and the number of those troubled by alcohol abuse dropped by more than two-thirds 5 to 16 months after treatment. (Gerstein DR, Datta RA, Ingels JS, and others. *Final Report: National Treatment Improvement Evaluation Survey*. Center for Substance Abuse Treatment, SAMHSA, 1997)

- The percentage of people selling drugs, shoplifting, or beating someone up in the past year dropped by almost 80 percent 5 to 16 months after treatment. In addition, the percentage of clients receiving welfare declined from 40 percent to 35 percent - an almost 11 percent overall decrease. (Gerstein DR, Datta RA, Ingels JS, and others. *Final Report: National Treatment Improvement Evaluation Survey*. Center for Substance Abuse Treatment, SAMHSA, 1997)

Substance Abuse Treatment Parity Is an Important First Step

Once the federal government moves toward a national drug policy that treats addiction as a disease that has devastating public health and economic consequences, the case for providing treatment for the disease becomes evident. We believe that the Substance Abuse Treatment Parity Act (H.R.1977) is landmark legislation that takes an important first-step towards giving people suffering from the disease of alcoholism and drug addiction increased access to treatment. This legislation does not mandate that health insurers offer substance abuse treatment benefits. It does prohibit health plans from placing discriminatory caps, financial requirements or other restrictions on treatment that are different from other medical and surgical services.

H.R. 1977 will help eliminate barriers to treatment -- without significantly increasing health care premiums. An April 19, 1999 RAND study found that substance abuse treatment services could be made available to employees for $5.11 a year, or 43 cents per month.

Unfortunately, the stigma associated with this disease is subtle and often difficult to document. Recently, a survey by Peter Hart and Associates captured the essence of the stigma. While over 50 percent of the people surveyed said they believed addiction is a disease, 52-68 percent said that if addicts really wanted to, they could stop using on their own.

A March 1999 Substance Abuse and Mental Health Services Administration (SAMHSA) study reported substantial progress in closing the gap in group health benefits for physical illness and for mental disorders following enactment of the Mental health Parity Act of 1996, without unduly raising premiums.

Under the Mental Health Parity Act that went into effect in January 1998, group health plans providing both medical/surgical and mental health benefits may not impose a lifetime or annual dollar limit on mental health benefits that is less that that applied to medical/surgical benefits. According to the report, *Background Report: Effects of the Mental Health Parity Act of 1996*, the majority of those employers who made changes to comply with the Act stated that it

did not increase their costs or require major changes to other benefits provisions. In addition, about half of those employers affected were already in compliance prior to the law becoming effective in January in 1998.

Conclusion

Mr. Chairman, my statement details what the Partnership believes are some of the key ingredients necessary for the formulation of public policy that effectively addresses the essence of the addiction problem: acceptance of the disease as a critical pubic health issue, public policy that has a balanced emphasis on treatment and prevention as well as interdiction and criminal justice. Federal policy must recognize that inclusion of demand reduction strategies like treatment doesn't result in policy that is soft on crime. Last but not least, recognition that all persons, regardless of their illness should be treated with human dignity. The bill before you today goes right to the heart of the need for fair and equitable treatment of people suffering from the disease of chemical dependency.

Mr. Chairman, momentum is building for our leaders to include a public health/demand reduction component in our nations drug policy. We hope this will include a greater emphasis on treatment. We know that H.R. 1977 is a step in the right direction. Congress has the opportunity to take this first step, and move legislation forward to solve this public health crisis before another generation is lost to the disease of drug and alcohol addiction. We ask you to join us in the **Fight for Fairness** and incorporate meaningful treatment provisions into our nation's drug policy.

Mr. MICA. We will hear all of the witnesses and then go through for questions.

I recognize next Dr. Michael Schoenbaum, who is an economist with RAND Corp. Welcome, and you are recognized, sir.

Mr. SCHOENBAUM. Thank you.

I am an economist at RAND. I am here today in place of my colleague at RAND, Roland Sturm, who ruptured his Achilles tendon and was unable to come. He has prepared a written statement, and I would ask that be entered into the record.

Mr. MICA. Without objection, so ordered.

Mr. SCHOENBAUM. Thank you.

[The prepared statement of Mr. Sturm follows:]

Effects of Substance Abuse Parity in Private Insurance Plans Under Managed Care

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I am a senior economist at RAND and director of economic and policy research in the UCLA/RAND Center on Managed Care. RAND is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. This statement is based on research funded by the Robert Wood Johnson Foundation and the National Institute on Drug Abuse. The opinions and conclusions expressed are mine and do not necessarily reflect those of RAND or the research sponsors.

My research has focused on costs and utilization patterns for substance abuse treatment in today's health care environment. New data are needed to inform policy decisions about substance abuse treatment because the health care delivery system has changed dramatically. For most privately insured Americans, behavioral health (which includes mental health and substance abuse care) is now managed by specialized managed care companies. Treatment patterns have changed dramatically, and patterns criticized in the past as excessively costly, such as automatic 28-day inpatient stays, are almost nonexistent.

These changes in how substance abuse treatment is delivered mean that legislation will have different consequences today than it would have had 20 years ago. However, estimates of the cost consequences of proposed legislation, including reports by the Congressional Research Service[1,2] or the Substance Abuse and Mental Health Services Administration[2,3], were based primarily on actuarial assumptions, which reflect

utilization patterns from the 1970s and 1980s. Many of those do not reflect today's mental health or substance abuse treatment system in the private sector[4-6].

The results that I present here are based on a study published in the Journal of Behavioral Health Services and Research[7]. We examined the use and costs of substance abuse treatment in 25 managed care plans that currently offer unlimited substance abuse benefits with minimal co-payments ("parity" level benefit) to their enrollees in 38 states. However, care is managed and services must be preauthorized and received through a network provider to be fully covered, a typical service arrangement in employer-sponsored plans.

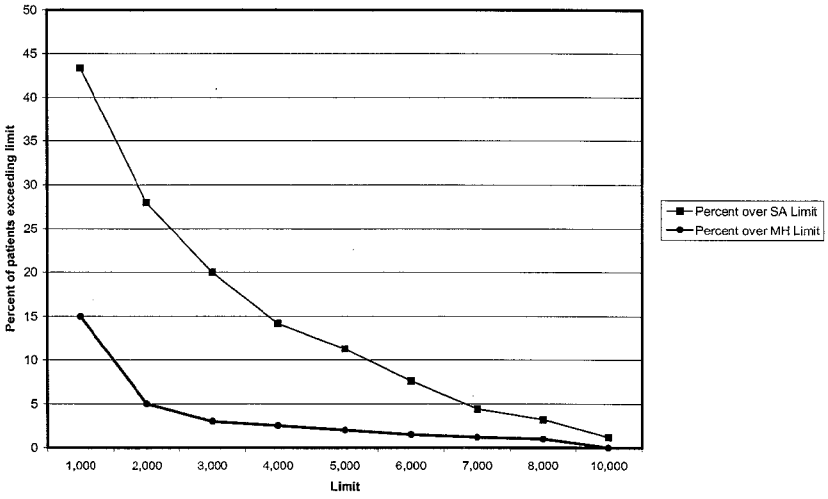
Providing unlimited substance abuse benefits in these plans costs employers slightly more than $5.00 per plan member per year in insurance premiums paid to providers. Employees account for the largest costs, child dependents the smallest; thus limits on substance abuse care have the most substantial cost consequences for employees. In terms of benefit limits, a $10,000 annual cap on benefits would reduce the cost of unlimited benefits by only 6 cents. A $5,000 annual cap would reduce the cost to $4.33 per member per year.

Based on a sample of several hundred employer-sponsored plans that were active in 1997, we estimate that about three-quarters of plans have caps for substance abuse of $10,000 or less. Changes in copayments or deductibles have cost reduction effects similar to the caps,, but the resulting payments to providers are always lower than the costs of providing the parity benefit (about $5 dollars per member per year).

To put these numbers into perspective, the additional costs of adding full parity benefits for substance abuse treatment to a plan that previously offered *no substance abuse* benefits is in the order of 0.3 percent, based on a total annual health maintenance organization insurance premium of $1,500 per member. Expanding *existing substance abuse* benefits in a plan would have a correspondingly smaller effect. Note that the numbers reflect payments to providers (the part counted as the medical loss ratio); administrative fees or insurance profits are in addition.

We find no evidence that substance abuse mandates or parity could lead to health premium increases in the order of several percentage points in managed care plans. We also concluded that limiting substance abuse benefits saves very little in managed behavioral health care plans, but affects a substantial number of patients who need additional care (see the figure). Substance abuse patients are quite costly, on average twice as costly as typical mental health care users; thus the same limits affect relatively more substance abuse patients than mental health patients, leaving the former at risk for a large part of their treatment costs. However, overall plan costs are small because substance abuse patients are rare in privately insured populations.

Figure 1: Percentage of Mental Health and Substance Abuse Users Exceeding $ Limit



In the private sector, individuals with substance abuse problems are much more likely to become ineligible for insurance. Employees, who account for a relatively larger share of substance abuse benefits than other type of members, are the most likely to lose coverage[8]. Patients who exceed benefits and lose insurance coverage are likely to end treatment prematurely, thereby reducing both their chance of recovery and the probability of maintaining employment. Parity legislation by itself will probably not remedy this problem.

Cost and use data from comprehensively managed plans currently offering unlimited parity-level substance abuse treatment provide no support for excluding substance abuse from parity efforts because of cost reasons. It is unclear how decoupling mental health and substance abuse care in terms of benefits can save much money. However, decoupling is likely to create difficulties in coordinating treatment and lead to less efficient care. Since a high proportion of individuals have both MH and SA problems, poor coordination of care is a significant concern.

Our results suggest that parity for substance abuse treatment in employer-sponsored health plans is not very costly under comprehensively managed care, which is the standard arrangement in today's marketplace. However, this result does not apply to unmanaged indemnity plans and may only hold for large employers, but not for individuals or for small groups buying insurance. Our data also reflect a fairly "typical" employed population. Some industries may attract higher than average rates of substance abusers, resulting in somewhat larger treatment costs. Of course, providing comprehensive substance abuse treatment benefits in those industries would also have the largest social impact on reducing consumption and lowering the indirect social costs of substance abuse.

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Mr. SCHOENBAUM. RAND is a nonprofit institution which helps improve policy and decisionmaking through research and analysis. This statement is based on research funded by the Robert Wood Johnson Foundation and the National Institute on Drug Abuse. The opinions and opinions expressed are mine and do not necessarily reflect those of RAND or of the research sponsors.

As we have heard today, substance abuse imposes major economic burdens to society, and empirical studies document that some treatment programs can be effective. However, largely because of cost concerns, treatment for substance abuse has been excluded from recent Federal and State legislation mandating parity, equal coverage for mental health and other medical conditions. These concerns stem from assumptions that do not reflect current treatment delivery systems under managed care.

We examined—in the research that I am going to present, we examined the use and costs of substance abuse treatment in 25 managed care plans that currently offer unlimited substance abuse benefits with minimal copayments—parity level benefits—to their enrollees. However, in those plans, care is managed and services must be preauthorized and received through a network provider to be fully covered. I will note that the plans in our study did cover a comprehensive range of substance abuse treatment services.

Our research indicated that providing unlimited substance abuse benefits in these plans cost employers slightly more than $5 per plan member per year. The actual number is $5.11 per member per year.

A $10,000 annual cap on substance abuse benefits reduces the cost of providing substance abuse treatment coverage by only 6 cents per member per year. A $5,000 annual cap reduces the cost by 78 cents per member per year, compared with the cost of providing unlimited managed substance abuse treatment benefits.

To put these numbers in perspective, if we assume that a typical group health insurance premium is approximately $1,500 per member per year, substance abuse benefits under unlimited coverage represent three-tenths of 1 percent of this cost. Furthermore, the potential savings associated with benefit limits is even smaller relative to unlimited but managed benefits. A $5,000 benefit limit, for instance, reduces the overall cost of providing health insurance by less than $1 per member per year.

We conclude in this study that limiting benefits saves very little but can affect a substantial number of patients who do need additional care. Patients who lose insurance coverage are likely to end treatment prematurely or switch to public sector coverage which may increase costs in other areas.

In sum, parity for substance abuse treatment in employer-sponsored health plans is not very costly under comprehensively managed care, which is the standard arrangement in today's marketplace. However, I do want to note for the record that the results of our study do not apply to unmanaged indemnity plans, and also the employers in our study were relatively large employers, so the results may not hold for individuals or for smaller groups buying insurance.

Thank you.

Mr. MICA. Thank you.

We will now recognize Mr. Kenny Hall, who is an addiction specialist with Kaiser Permanente.

Mr. HALL. Mr. Chairman, I would like to thank you and your committee for allowing me to speak on a matter that is very dear to my heart, and that is adequate treatment for individuals seeking treatment for chemical dependency.

Before I go on, I have to apologize to the committee. I have a 2 flight that I must take back to California. I am really committed to my clients to be there tomorrow, so I actually apologize——

Mr. MICA. Are you leaving from National?

Mr. HALL. Yes.

Mr. MICA. No problem. Go right ahead.

Mr. HALL. What I am going to present this afternoon is a study from a pilot project that was conducted by Kaiser Permanente in California in 1994 in offering treatment to Medicaid clients and the results of that particular pilot project.

For the last 3 years, I have been blessed to be part of an organization which I believe has become a pioneer and innovator in the arena of chemical dependency treatment and recovery. That organization, I am proud to say, is Kaiser Permanente in California. I am part of an incredible team of professionals with the Kaiser Vallejo Chemical Dependency Recovery Program which is on the northern end of San Francisco Bay in Solano County.

Kaiser Permanente is the oldest health maintenance organization in the country, a pioneer in the concept of prepaid, capitated health care over 50 years ago. Kaiser Permanente is also the Nation's largest nonprofit HMO, with almost 9 million members, 6 million members within the California division.

Kaiser Permanente is a staff group model HMO with all Permanente Medical Group physicians and other health care professionals providing services exclusively to Kaiser members within Kaiser's own hospitals and outpatient clinics. This greatly enhances their ability to operate in an integrated and cooperative manner, which significantly improves the overall quality of care offered.

Kaiser Permanente's California Division is also distinguished from many other managed care organizations in that it provides a very comprehensive chemical dependency treatment benefit which is part of the basic health plan benefit for all members. Chemical dependency services are provided within the integrated organizations, not by a carve-out company. The benefit includes various levels of care, from inpatient detoxification through day treatment, which is partial hospitalization, and intensive outpatient programming to long-term follow through treatment. It also includes family and codependency treatment, as well as adolescent treatment program. These services are provided at multiple sites and are generally accessible for initial evaluation and treatment within 24 hours. Services are well integrated with other hospital and outpatient medical services, and efforts are made to assist all primary care physicians within Kaiser Permanente to identify and refer chemically dependent patients and their family members in a timely and effective manner.

In 1989, the county's public hospital closed and since that time the county health department had been involved in discussions

with the private hospitals in the county over reimbursement for publicly funded and indigent health care.

The largest of those hospitals is a part of Kaiser Permanente. Other private hospitals and large physician groups as well as a number of previously unaffiliated private physicians were also participants in these discussions and planning processes. As the California Department of Health Services became more encouraging of public-private partnerships and managed care arrangements, the Solano Partnership Health Plan was created.

SPHP, which began operations in 1994, was a Partnership of all public and private health care providers in the county and was constituted as an independent health authority. SPHP contracted with the State government to provide a capitated health plan for all—approximately 40,000—Medicaid recipients within the county. Based on negotiations to determine "fair shares" of recipients, 10,000 of those clients were assigned to Kaiser Permanente and enrolled as members.

When the agreement was reached to enroll 10 Medicaid recipients as Kaiser members, concerns were raised by Kaiser physicians about the exclusion of chemical dependency benefits in the agreement. Kaiser physicians had come to rely on the services of their own chemical dependency program and were loathe to give up the prerogative to utilize it with this group of patients.

I want to highlight the result of this study. After 2 years, we had gained sufficient data in working with this particular population, and there was a striking result. The results indicated a 50 percent reduction in hospital days utilized, from 117 days during the 6 months before treatment to 58 days during the post-treatment period. What that meant, in the beginning, our Medicaid clients utilized the services at a much larger proportion than our commercial users did, but after a couple of years it leveled out to the same level. There was this pent-up urge for treatment, and these clients were able to utilize these services that were denied to them for so long. As a consequence, the medical savings that Kaiser experienced was very, very significant.

In closing, I would like to say it must be reiterated that the strongest arguments for the provision of high quality, universally accessible chemical dependency treatment services is a personal benefit of the recipients of these services. After spending 20 years addicted to heroin and traveling the path that addiction leads one down, I can personally attest to the influence that chemical dependency can have on one's life. It has been 15 years since my last shot of heroin. The protracted suffering produced by chemical dependency can be eliminated by successful treatment enhancing the health and quality of life of patients, families and society.

Thank you very much, Mr. Chairman.

Mr. MICA. Thank you.

[The prepared statement of Mr. Hall follows:]

TESTIMONY

OF

KENNY HALL
ADDICTION SPECIALIST
KAISER PERMANENTE

BEFORE THE

HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY and HUMAN RESOURCES

October 21, 1999

Mr. Chairman, I would like to take this opportunity to thank you and the members of your committee for allowing me to speak on a matter that is dear to my heart: adequate treatment for individuals seeking help from chemical dependency.

For the last three years I have been blessed to be part of an organization that I believe, has become a pioneer and innovator in the arena of chemical dependency treatment and recovery. That organization I am proud to say is Kaiser Permanente in California. I am part of an incredible team of professionals with the Kaiser Vallejo Chemical Dependency Recovery Program, California, which is on the northern end of San Francisco Bay in Solano County.

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In 1989 the county's public hospital closed and since that time the county health department had been involved in discussions with the private hospitals in the county over reimbursement for publicly funded and indigent health care.

The largest of those hospitals is a part of Kaiser Permanente, and in fact Kaiser has been the major health service provider in Solano County for over fifty years. Other private hospitals and a large physicians group, as well as a number of previously unaffiliated private physicians, were also participants in these discussions and planning processes. As the California Department of Health Services became more encouraging of public-private partnerships and managed care arrangements, the Solano Partnership Health Plan (SPHP) was created.

SPHP, which began operations in 1994, was a partnership of all public and private health care providers in the county, and was constituted as an independent health authority. SPHP contracted with the state government to provide a capitated health plan for all (approx. 40,000) Medicaid recipients within the county. Based on negotiations to determine "fair shares" of recipients, 10,000 of these were assigned to Kaiser Permanente and enrolled as members.

When the agreement was reached to enroll 10,000 Medicaid recipients as Kaiser members, concerns were raised by Kaiser physicians about the exclusion of chemical dependency benefits in the agreement. Kaiser physicians had come to rely on the services of their own chemical dependency program, and were loath to give up the prerogative to utilize it with this group of patients. They perceived (correctly) that the capacity of the available county chemical dependency services was overwhelmed and that lengthy waiting lists for treatment were the norm. The breadth of available services was less than that within Kaiser, and the easy flow of patients between Kaiser services would be greatly encumbered by the necessary process for referrals the to outside agencies.

Finally, the physicians lacked the confidence born of familiarity that they had with their own services.

Kaiser's chemical dependency staff as well as other planners within the organization were also arguing that probable cost-savings could be achieved within medical services if ready access to comprehensive chemical dependency treatment were available.

The final result of extensive discussions within Kaiser Permanente was the decision to include the standard chemical dependency benefits provided to commercial members within the benefit package for Medicaid recipients. Although there would be no funding from the State for adding this benefit the potential overall advantages of including these services were compelling.

During the initial year of operation, Kaiser's Medicaid members utilized the chemical dependency services at about twice the frequency of the commercial members. Specifically, 13 per 1000 Medicaid members utilized these services, compared to 5.6 per 1000 commercial members.

Some saw this as evidence that Medicaid members had a much higher incidence of chemical dependency and substance abuse problems than did commercial members. However, an alternative explanation was that the Medicaid group had a pent-up demand for these services due to the difficulty of obtaining them under the previous system, and that this demand was now being relived by the easy access they had to services within Kaiser.

Data from the following year supported the explanation of pent-up demand. Utilization among Medicaid members decreased to 8.5 per 1000 while utilization among commercial members, which had been increasing since the chemical dependency benefit was expanded, continued to increase so that it was also 8.5 per 1000. Since that time, there has been no significant difference noted in utilization of chemical dependency services between the Medicaid and commercial populations.

Reduction in medical utilization:

> After two years, sufficient data was available to develop a preliminary report on medical utilization by Medicaid members who had been treated in the chemical dependency services.
>
> Medical utilization during the six months prior to treatment was compared to utilization during the period six months post treatment. The results indicated a striking 50%

reduction in hospital days utilized, from 117 days during the six months before treatment to 58 days during the post treatment period.

Probably the most far-reaching consequence of this experience has been a major policy decision by the Solano Partnership Health Plan (now called Partnership Healthplan of California) to expand their chemical dependency benefits for the entire Medicaid population.

Kaiser's results have also attracted national attention from health care policy makers and major health care purchasers. Financial arguments are of course extremely important in policy decisions, and the results cited here are strong support for the inclusion of chemical dependency benefits in all health care coverage, public and private.

Finally, it must be reiterated that the strongest arguments for the provision of high quality, universally, accessible chemical dependency treatment services is the personal benefit to the recipients of these services.

After spending 20 years addicted to heroin and traveling the path that addiction leads one down, I can personally attest to the tremendous influence that chemical dependency treatment can have on one's life. It has been 15 years since my last shot of heroin.

The protracted suffering produced by chemical dependency can be eliminated by successful treatment enhancing the health and quality of life of patients, families, and society.

Thank you.

Fast Facts

Nation's Largest HMO: Kaiser Permanente is America's leading health care organization. Founded in 1945, it is a nonprofit, group-practice health maintenance organization (HMO) with headquarters in Oakland, California. Kaiser Permanente serves the health care needs of members in 18 states and the District of Columbia. Today, it encompasses Kaiser Foundation Health Plan, Inc., and subsidiaries; Kaiser Foundation Hospitals; the Permanente Medical Groups; Group Health Cooperative of Washington; and Community Health Plan of New York. Nationwide, Kaiser Permanente has more than 90,000 technical, administrative, and clerical employees, and 10,000 group-practice physicians representing all specialties. Kaiser Permanente aspires to be the world leader in improving health through high-quality, affordable, integrated health care. We will be distinguished by our strong social purpose, physician responsibility for clinical care, and an enduring partnership between our Health Plan and our medical groups.

Membership (as of 1/99): There are 8.6 million voluntarily enrolled members, most of whom join through their employer, who pay part or all of the monthly dues. Qualified individuals who do not have access to the plan through their employer also may join. The percent of the Division 's general population enrolled in Kaiser Permanente ranges from a high of 40 percent in Northern California to less than 5 percent in several of the developing Kaiser Permanente markets. Enrollment in Kaiser Permanente includes 4 percent education, 9 percent federal government, 59 percent private-sector employer groups, 18 percent state/local government, 10 percent individual enrollment.

Membership by Division: California 5.8 million; Central East 734,000; Hawaii 212,000; Northeast 617,000 (includes Community Health Plan); Northwest 440,000 (Group Health Cooperative 657,000); Rocky Mountain 433,000; Southeast 372,000.

States: California, Colorado, Connecticut, Georgia, Hawaii, Kansas, Maryland, Massachusetts, Missouri, New York, North Carolina, South Carolina, Ohio, Oregon, Vermont, Virginia, Washington, and the District of Columbia.

Local markets: Northeast Division: Massachusetts, Vermont, central New York, eastern New York, Connecticut; Central East Division:

Cleveland, Akron, Washington, D.C./suburban Maryland/Northern Virginia, Baltimore; Southeast Division: Atlanta, Raleigh/Durham, Charlotte, Rock Hill, South Carolina; Rocky Mountain Division: Denver/Boulder, Colorado Springs, Kansas City; Northwest Division: Portland (includes Salem/Longview); California Division:

East Bay, Fresno, Golden Gate, North East Bay, South Bay, Stanislaus County, Valley, Coachella Valley, Inland Empire, Kern County, Metropolitan Los Angeles/West Los Angeles, Orange County, San Diego County, The Valleys, Tri-Central, Western Ventura County; Hawaii (Oahu, Hawaii, Kauai, Maui).

Medical Centers: 30 **Medical Offices:** 361

Physicians: 10,000 representing all specialties; 57 percent are primary care.

Non-Physician Employees: 90,000 professional, technical, administrative.

History: Kaiser Permanente evolved from industrial health care programs for construction, shipyard, and steel-mill workers for the Kaiser industrial companies during the late 1930s and 1940s. It was opened to public enrollment in October 1945.

Divisional Structure: Kaiser Permanente's six Divisions, and Hawaii, are comprised of separate but closely cooperating organizations. These organizations are:

- Kaiser Foundation Health Plans: Nonprofit, public-benefit corporations that contract with individuals and groups to arrange comprehensive medical and hospital services. Health Plans contract with Kaiser Foundation Hospitals and medical groups to provide services.
- Kaiser Foundation Hospitals: A nonprofit, public-benefit corporation that owns and operates community hospitals in California, Oregon, and Hawaii; owns outpatient facilities in several states; provides or arranges hospital services; and sponsors charitable, educational, and research activities.
- Permanente Medical Groups: Partnerships or professional corporations of physicians--one or more in each Kaiser Permanente Division. The full responsibility for providing and arranging necessary medical care is assumed in each Division by the Permanente Medical Groups.

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Mr. MICA. We will now recognize Captain Ronald Smith, vice chairman of the Department of Psychiatry with the National Naval Medical Center.

Dr. SMITH. Thank you.

My name is Ronald Earl Smith. My remarks do not represent necessarily the Navy's position. They are my opinion as a physician, and some of this is the Navy's position.

I am a Navy captain and doctor of medicine. I am currently a consultant in psychiatry, addictions, and psychanalysis at the National Naval Medical Center, the Pentagon and the U.S. Congress. I teach and supervise residents, interns and medical students at the Uniformed Services University. I am certified by the American Board of Internal Medicine, the American Board of Emergency Medicine, the American Board of Psychiatry and the American Society of Addiction Medicine. I have a doctorate in the philosophy of psychoanalysis.

It has been my honor, pleasure and pain to work in the field of addiction for about 27 years. This work has been in academic centers, in emergency rooms, critical care units, psychiatry wards and addiction units. I have worked in private practice, in the military, the Federal and State systems.

Over these years, it has been my sad experience to watch our culture decrease money for active primary treatment in addiction and mental illness. The limited funds remaining after budget cuts have been moved to other forms of institutionalizations, primarily jails and prisons. Instead of hospital beds for treatment, our culture builds prison beds. The bulk of the homeless population within 5 miles of this Capitol are there because of inadequately treated substance abuse and mental illness.

I have watched mental health units close in my private hospital in Newport Beach, CA. It closed 35 beds for mental health because the funds were not there. Five years ago in the national capital area—and this is in our own military system—we had three inpatient units, one at Walter Reed, one at Bethesda and one at Andrews. We now have two outpatient units, and this is a result of money being cut back.

We know that treatment works. The Navy—I will ask that my statement be submitted for the record, but I want to talk just candidly about my experience. We know that treatment works. The Navy is not exactly in the humanitarian business, and we wanted sober pilots in our planes on carrier decks, and we got in the treatment business for that reason. The submariners, we wanted them to be sober and clear-headed, and 85 percent of those pilots who later go on to fly for Northwest and American and fly you in and out of this town are sober because of the treatment programs in the Navy. The pilots actually do the best.

We treated 220 physicians over the time that I was there in Long Beach, and 80 plus percent of those remain sober. And we wanted sober doctors in the Navy taking care of the pilots, and we insist on that.

These diseases—sooner or later, the Federal Government picks up the tab. Sooner or later, it goes up in Social Security, it goes up in Social Security disability, it goes up in prison beds. Sooner or later, people within a culture which believes that we ought to

take care of one another, and we do, and ultimately the bill is passed onto the Federal system.

Now why ask private insurance for help with this? Simply because they can do it pretty well. But I think in my experience they kind of need a nudge to say go ahead and do it. I do believe that the health care—that they do it well, but in my private practice in Newport Beach it became harder and harder to get care. Plans which promised 50 outpatient beds, you had to beg for 4 and 10, particularly in the matters of substance abuse. The reality was that the funds were withdrawn.

All of us are responsible—the Navy for decreased units, the Federal Government for decreased funding in Social Security for healthcare. It is very hard to get someone treated in an inpatient unit through the Social Security system.

Private industry I don't think is any more responsible than all of us in this room. But this is a culture with a paradigm shift that is, in the age of deinstitutionalization of the mentally ill and substance addicted, to homelessness or to lock them up. We are doing the reverse of what was done in the enlightenment when we began to take better care of one another, and we need to notice that. This committee needs to notice that. Private industry needs to notice that.

Now, the reality is that it is treatable. The reality is that an alcoholic affects seven people really. It is the most important thing since Social Security. Because you treat 16 million alcoholics, you treat 100 million Americans. The children get off Ritalin for ADD. The work compensation goes down. The prison beds empty out. The courtrooms empty out. It is just efficient, and it is humane, and it is kind of wonderful, and it is a hell of a lot of fun to treat it in the early stages.

But, as a critical care physician, an 18-year-old paraplegic because he was drunk on a motorcycle is probably as expensive a way to burn dollars as we can do it. AIDS is a terribly expensive way to die. There is probably no more expensive way to die, and this is preventable stuff.

All we are asking the private insurance industry to do is help us out. The Southern Bell study was not quoted. They opened the door for treatment for mental health and substance abuse, and that portion goes up a little bit, but guess what happens to the total health bill? It goes way down, and it takes a while to realize that. Wall Street shows real immediate response and when you have to show profit on Wall Street you sometimes won't take that long delay. It takes 3 or 4 years to go down, but it does.

Thanks for letting me speak.

Mr. MICA. Thank you. Without objection, the balance of your statement will be made a part of the record.

[The prepared statement of Dr. Smith follows:]

TESTIMONY OF RONALD SMITH
VICE-CHAIRMAN, DEPARTMENT OF PSYCHIATRY
NATIONAL NAVAL MEDICAL CENTER
OCTOBER 21, 1999

My name is RONALD EARL SMITH. I am a Navy Captain and Doctor of Medicine. I am currently a consultant in psychiatry, addictions and psychoanalysis at the National Naval Medical Center, the Pentagon, and the United States Congress. I teach and supervise residents, interns and medical students at the Uniformed Services University for the Health Sciences on a daily basis. I am certified by the American Board of Internal Medicine, the American Board of Emergency Medicine, American Board of The Psychiatry and American Board of Addiction Medicine. I hold a Doctorate in the Philosophy of Psychoanalysis.

It has been my honor, pleasure and pain to work in the field of addiction medicine and treat alcoholics and addicts for 27 years. This work has been primarily in academic centers- in the emergency rooms, critical care units, psychiatry wards, and addiction units. I have worked in private practice, the military and the federal and state systems.

Over these years it has been my sad experience to watch our culture decrease money for active primary treatment of addiction and mental illness. The limited funds remaining after budget cuts have been moved to other forms of institutionalizations, primarily jails and prisons. Instead of hospital beds for treatment, our culture builds prison beds. The bulk of the homeless population is there because of substance abuse and mental illness. As Chairman of the Department Of Psychiatry in a prominent west coast hospital, I watched the mental health unit close because of funding problems. Five years ago, in the National Capital Area, there were three excellent military inpatient treatment units, one each at the National Naval Medical Center at Bethesda, Walter Read Army Hospital in the District, and Andrews Air Force Base in Maryland. Today, as a result of decreased funding, there remains one outpatient treatment unit at Andrews Air Force Base.

Treatment works. Indeed alcoholism and addiction are the two illnesses/behaviors which are quite fatal and completely treatable. The average alcoholic affects the lives and psychological and physical health of five other people. The California and Oregon studies show clearly the monetary return to the state of dollars spent for treatment. To the best of my knowledge this seven for one return of dollars invested in treatment did not include the more subtle and hard to measure- but very real payoff in reduced learning disabilities, attention deficit disorders, and divorce rates. These conditions are so common in the family dysfunction induced by addiction that they are seldom measured. The complications of alcoholism and drug addiction remain the most expensive diseases in medicine and include HIV, AIDS, brain trauma, paraplegias, cardiovascular disease, diabetes, complex infectious diseases including TB, Klebsiella pneumonia, and HEPATITIS C, fetal alcohol syndromes and severe psychological problems resulting in life long dysfunction for many family members. As a physician working and teaching long and wonderful hours in intensive care units and emergency rooms, I continue today in wonder--Why will private and public insurers pay willingly for Delirium Tremens, respiratory arrests due to Heroin overdose, strokes due to Cocaine, life long paralysis due to driving under the influence, severe gastrointestinal bleeding, and liver transplants while continuing to decline adequate primary treatment for the very addictions which cause these

vicious complications. Why not treat the earlier stages- ***parity for addiction treatment***- when it is much less expensive, more interesting, and a lot more rewarding for all concerned.
The Honorable Jim Ramstad knows treatment works. He also knows that addicts and alcoholics, probably because of denial, will not demand good treatment benefits when they initially review their health plans, and that private insurers because of price/earnings ratios and stock price indices will not write adequate coverage because of the ***possible, very minor, short term increase*** in premiums. In an ideal world the federal legislation for parity in substance abuse would not be an issue. The health care crisis in this country is far from ideal. Ultimately the federal government picks up the cost of addictions by funding prisons, courts, special education, and health care for the uninsured in the form of Social Security Disability, Medicare and Medicaid. Why not ask and demand help from private industry, the very group that claims to treat disease better and more efficiently than a federal health care system. Why not treat addictions like other fatal and less treatable illnesses by providing parity.
I know treatment works. The United States Navy knows treatment works. The United States Navy wants sober pilots in fighter planes and sober physicians taking care of these pilots and provides excellent treatment because treatment is cost effective, efficient and the right thing to do. The recovery rate for pilots treated in the Alcohol Recovery Service at Naval Hospital Long Beach was 85 per cent. The recovery rate for 220 physicians treated there was 80 percent. The overall recovery rate in the Navy has remained about 70 percent.
The Betty Ford Center in Rancho Mirage, California was built and designed utilizing the model of treatment developed at the Naval Hospital Long Beach. The Betty Ford Center in one of the more successful treatment centers in the world and the Betty Ford Center knows treatment works. President and Mrs. Gerald Ford know treatment works. President Carter and his family know treatment works.
The evidence that funding for treatment is inadequate and ineffective can be seen today within steps of this Capitol in the ever increasing homeless population. The growing number of expensive jail and prison beds reflect a culture that is all to willing to treat severe end stage complications of alcoholism and addiction rather than treat the illnesses primarily, when it is cheaper and more effective for all concerned. Private insurance companies are no more to blame than myself, all of us sitting in this room, the federal and state governments, and/or the paradigm shift in medicine and health care. But private insurers with the help of this legislation can lead the way in treatment and do it cost effectively.
The Ramstad bill provides a capacity to begin the shift in dollars from prison beds to hospital beds, from homelessness to homes and work.
PASS THIS LEGISLATION NOW!

RONALD EARL SMITH MD PH D
CAPTAIN, MEDICAL CORPS, UNITED STATES NAVY

Mr. MICA. I would like to recognize Mr. Peter Ferrara, who is the general counsel and chief economist with Americans for Tax Reform.

Mr. FERRARA. Thank you, Mr. Chairman.

Americans for Tax Reform strongly opposes any government mandate requiring health insurers to cover substance abuse treatment. There are several reasons for this position.

First, the American people ought to be free to decide what they want in their health policy coverage. If they want substance abuse treatment coverage in their health policies, they can buy it in the marketplace. Insurers will be more than happy to provide the coverage the market demands. But if they don't want the coverage or don't want to pay the cost, the government should not force them to buy it.

Let us think about this for a minute. Is this any way to decide what is in people's health insurance policies? You have these committees in Washington and you have these various interests that come before them, and then this small committee decides for every American in the country this is what benefits you will have in your health policy, and these are the benefits you will pay for, and you will learn to like it.

I would submit that a central planning approach is neither efficient nor does it have the proper respect for the freedom of choice that the American people should have.

We have heard a lot of testimony today about how efficient and cost effective this kind of coverage is. Well, let me submit that those who buy the health insurance in America don't agree with that position. They are the ones who should be deciding.

Now, all this discussion about how efficient and cost effective it is should be submitted to the insurance companies and should be submitted to the employers and should be submitted to the purchasers of health insurance across the country, and maybe they will change their minds and they will buy it, but that is the way that the system ought to work. We should not have a group in Washington dictating to the American people what the benefits are in their health insurance policies.

Second, if the government mandates the inclusion of this coverage in health insurance policies, that will raise the cost of health insurance. This additional cost burden on working people is objectionable in itself. Indeed, in our view, this cost increase is quite analogous to a tax increase to fund increased government spending for substance abuse treatment.

Of course, there is one difference with the tax increase. You can avoid the increase by just refusing to buy health insurance at all, and that is what many people will do if you impose this type of mandate on health insurance policies. More working people will decide they don't want to buy it, more small businesses will decide that they are going to drop it, and the result is an increase in the number of uninsured.

The decision of how much to tax the American people for substance abuse treatment programs should be made in the regular budget process. It should not be made by this committee through a back door health insurance mandate. If it is so cost effective, then you should do it openly and directly. And maybe you should have

more government programs for substance abuse treatment and maybe you should cut some other government spending to pay for it, but then we can judge this openly as part of the general political process and we can hold people accountable for their taxing and spending policies. And if it is so cost effective, then it is not going to cost you anything, and we have heard all this testimony about how much it is going to save you. Well, you investigate that and find out if that is true, and that then is part of your budget control policy.

But as a matter of health policy, what you should be doing in health policy is quite the opposite of what you are considering here today. One of the few helpful things that Congress could do with health policy is to enact legislation removing all government mandates on what benefits are included in health insurance policies. This would reduce the cost of health insurance, and it would enable more people to buy the essential health coverage that they really need. It would reduce the number of uninsured, and so it would go a great ways toward helping to address that problem and expand the freedom of choice for the American people.

Thank you very much.

Mr. MICA. Thank you.

[The prepared statement of Mr. Ferrara follows:]

Testimony of

Peter J. Ferrara
General Counsel and Chief Economist
Americans for Tax Reform

before the

Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Committee on Government Reform
U.S. House of Representatives

October 21, 1999

Americans for Tax Reform strongly opposes any government mandate requiring health insurers to cover substance abuse treatment. There are several reasons for this position.

First, the American people ought to be free to decide what they want in their health policy coverage. If they want substance abuse treatment coverage in their health policies, they can buy it in the marketplace. Insurers will be more than happy to provide the coverage the market demands. But if they don't want the coverage or don't want to pay the cost, the government should not force them to buy it.

This committee should not be in the position of making this decision for every American across the country. In a free country, people should have the freedom to choose whether to include such coverage in their health insurance policies or not.

Secondly, if the government mandates the inclusion of such coverage in health insurance policies, that will raise the cost of health insurance. This additional cost burden on working people is objectionable in itself. Indeed, this cost increase is quite analogous to a tax increase to fund increased government spending for substance abuse treatment.

Of course, the one difference with a tax increase is that people can avoid the increase by refusing to buy health insurance at all. But that, of course, is another problem. With increased costs for health insurance, more people will choose not to buy any health insurance. More working people will not be able to afford it. More employers, particularly small employers, will drop health coverage altogether. The result will be an increase in the number of uninsured.

The decision of how much to tax the American people for substance abuse treatment programs should be made in the regular budget process. It should not be made by this committee through a back door health insurance mandate.

Quite to the contrary, one of the few helpful things Congress could do in health policy is to enact legislation removing all government mandates on health insurance. The American people will then be free to decide for themselves what their health coverage should be. Lower

cost basic policies with the essential coverage would then be available for those most concerned about costs. The result would be more people buying health coverage, either directly or effectively through their employers. The number of uninsured would then go down while freedom and prosperity increases.

Americans for Tax Reform receives no government funding of any sort.

Mr. MICA. I would like to recognize Charles Kahn, and he is president of the Health Insurance Association of America. Welcome, and you are recognized.

Mr. KAHN. Thank you, Mr. Chairman and Mr. Ramstad.

I am Charles N. Kahn III, president of the Health Insurance Association of America [HIAA]. Our members provide health, long-term care, disability, dental and supplemental coverage to more than 123 million Americans.

I am pleased to be able to address your committee today on this issue of parity for substance abuse in health coverage. The costs of addiction and substance abuse are enormous, but they are costs of mandated benefits, and I think that the argument has been made today, and a very compelling one, that services to help those overcome substance abuse work, are essential and provide a societal good as well as an economic good.

My issue with this matter is not substance abuse. It is a question of health policy and insurance—and Federal policy toward insurance. An increasingly persuasive body of evidence shows beyond any reasonable doubt that mandated coverage for treatment or services not historically covered in other major medical plans do increase costs and that these costs are passed on to consumers in the form of higher premiums, increased cost sharing or both. And these higher costs resulting from benefit mandates lead directly to more uninsured Americans.

I think this is very important to make the point that many employers provide coverage for services like those provided today. Others don't.

I think if we go back to Ms. Rook's testimony, I think—I don't want to be a victim here, but in some ways her characterizations of insurance were unfortunate. The fact is that CNN purchases her health insurance, probably pays the whole price for it. They made the choice as to what the benefits were. The insurer offers a product to—or a set of products to CNN, and they decide how much they want to spend for their employees.

Second, under the law, under the ERISA law there are requirements for CNN to make the benefits available, a description of those benefits available to employees. And for those of you who are going through open season in FEHBP right now, if you look at the book, it tells you how many days you get under substance abuse.

I have sympathy, and who cannot empathize with her situation, but on the other hand the company made a decision about the health plans, and the company probably made a very sound decision for an important employee with an employee assistance program, but that was not necessarily—but I guess I am a bit taken aback that necessarily the insurer is held responsible for what is an employer decision.

Let me make a few points about that.

First, we have a voluntary health insurance program in this country. In a voluntary system, costs do matter. Employers are not required to offer coverage to their workers, and individuals are not required to sign up for coverage. Yet the private employer-based system in this country provides coverage to nearly 160 million Americans, and another 13 million buy their insurance privately.

We all know that health insurance costs are continuing to climb, and that is driving up premiums to both employers and consumers, and each year employers must decide whether or not it will still be economical to provide any health insurance coverage. And I make the point any health insurance coverage, whether it is for substance abuse or basic med-surg coverage, and that their employees must decide whether they want to continue to enroll.

A recent study showed that, of the uninsured, 20 percent of them have access to employer-based coverage and because of cost sharing have chosen not to take that coverage.

A recent study by Doctors Gail Jensen and Michael Morrisey showed that the number of State mandates has increased 25 fold during the last two decades, making health insurance disproportionately more expensive for small businesses and causing as many as one in four Americans to lose their insurance.

According to Jensen and Morrisey, chemical dependency alone increased insurance premiums by 9 percent on average. I am not arguing against coverage for chemical dependency. If that is what the employer or the premium payer wants to purchase, then they ought to purchase it. But the mandate for this cannot be isolated.

First, there are many mandates. The Federal Government has begun to adopt more mandates and, as time proceeds, I can envision the cumulative effect being very great on the total cost of health insurance.

The second point I would like to make is that the RAND study, which I am sure represents the value of these types of services as well as the services provided by Kaiser Permanente, are in a managed care environment. And going back to my cumulative—my concern about the cumulative effect of mandates, we also have with—and I will call it the assault from our standpoint by Congress on this—the Nation's health insurance system with the patient protection legislation. The State legislatures are doing the same, and what the trial attorneys are about to do in class action suits against the insurance industry and the managed care industry, they are basically dismantling managed care.

And so the techniques and opportunities managed care offers I would argue are not necessarily going to be around, and the costs of mandates are clearly higher for small business and others who tend to buy plans with more choice, PPO plans and other kinds of plans where you don't have the tight control of managed care.

Mr. Chairman, my time has expired, and I will conclude with just a thought that, in isolation, who can argue against coverage for substance abuse? I am not making that argument. I am making the argument that public policy that leads to mandating coverage is in a sense nothing more than a tax, as Peter described. And at the end of the day it is not going to help us get more Americans covered, which we see generally as a public good and something that we all ought to be seeking. We need to provide other kinds of ways of providing these services, and hopefully those can be found through other public policy.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Kahn follows:]

Health Insurance Association of America

Statement of

Charles N. Kahn III
President

Health Insurance Association of America

on

Substance Abuse Parity: Promoting Treatment Options

Before the

Subcommittee on Criminal Justice,
Drug Policy, and Human Resources

House Committee on Government Reform

United States House of Representatives

October 21, 1999

555 13th Street, NW - Suite 600 East, Washington, D.C. 20004-1109 202/824-1600

Mr. Chairman and members of this distinguished committee, I am Charles N. Kahn III, president of the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its members provide health, long-term care, disability, dental, and supplemental coverage to more than 123 million Americans.

I am pleased to be able to address your committee today on the issue of parity for substance abuse in health coverage.

We are all too aware of the problem of drug abuse and addiction in our country and the problems that substance abuse causes in the workforce, in families, and in our communities. A 1998 report by the General Accounting Office (GAO) estimated that the total annual cost of illicit drug use to society is estimated at nearly $70 billion.

Treatment Options Raise a Host of Complex Issues

The issue of parity for substance abuse coverage is complex. On the one hand, advocates believe coverage for treatment of substance abuse should be equal with other areas of coverage. On the other hand, the issue of parity is difficult because substance abuse involves a long list of conditions and, for many of these conditions, there is not always a defined list of proven "cures" nor any assurance of effective treatment. I do not mean to imply that treatments are wasteful or ineffective in all cases. However, I am aware that the issue of repeated courses of treatment is not uncommon with many cases of addiction.

The health insurance industry has come a long way in offering coverage for both mental health as well as substance abuse (although mental health coverage is somewhat more widespread than substance abuse coverage). This is due in large part to the fact that unlimited substance abuse coverage can be quite costly for consumers. We are aware of only half a dozen states that have mandated comprehensive substance abuse parity laws. Among these laws, requirements vary as to who is eligible for the expansion in benefits and what benefit levels are required to be covered.

The industry is also continuing to recognize that mental health and substance abuse are two separate and distinct areas. Mental health treatment may not involve substance abuse treatment, although treatment of substance abuse often involves the need for mental health services. Also detoxification is sometimes paid for under "medical" benefits, not "substance abuse" benefits. After detoxification, however, comes rehabilitation and the question of whether rehabilitation should be done on an outpatient basis, or through a long-term residential program, or through community based programs, and so on is debated among experts in addiction treatment. Treating substance abuse is complex, varied, and often involves the patient's family.

Current State of Coverage Among Private Firms

According to the Employee Benefit Research Institute, coverage for substance abuse benefits for private employers is roughly equivalent to that provided by public employers, such as state and local governments. While small employers typically offer somewhat less comprehensive coverage, these differences are marginal. Nearly all large, medium, and small firms offer coverage for inpatient detoxification; over 80 percent offer coverage for inpatient rehabilitation; and about 84 percent offer coverage for outpatient drug and alcohol treatment, according to the latest available data.

Large employers have moved in the past decade to organize benefits for mental health and substance abuse into more specialized settings. It is estimated that almost 150 million people are served by behavioral health programs, organized or sponsored by their employers. Some of these managed behavioral health organizations actually are subsidiaries of major health insurers and are organized as "carve outs" or specialty organizations that are designed to bring concentrated services and care management skills to the benefits and services provided to employees and family members of employer-sponsored plans.

While treatment helps many, it is not always effective. Parity in benefit coverage would mandate coverage for repeated treatments. Whether this is an effective approach is not my call. However, we need to be cognizant of the cost factors and of who will pay for repeated treatments. There is no doubt it will be the purchasers of coverage—employers and consumers.

Substance abuse treatment has predictable high costs and those costs would have to be shared by employers and individual consumers. In 1997, the National Center for Policy Analysis estimated that a benefit mandate for treatment of alcoholism, a condition far narrower than the general area of substance abuse, would raise the annual cost of a $3,500 standard family insurance policy by up to 3 percent. And all too often we are reminded of the fact that the higher the costs of health coverage, the more consumers elect not to have coverage. Substance abuse parity would have the unintended consequence of making health care coverage more available to those who need coverage for these services but less available for the hundreds of thousands, or even millions, who pay in general for health coverage.

To quote R. Lucia Riddle, vice president for Government Relations of The Principal Financial Group, in a recent Milbank Memorial Fund study on mental health parity, "Each mandate is discussed as though it is being proposed in a vacuum—that it will increase premiums only 1 percent or 2 percent. But we get hit with a number of mandates, and those costs do add up." Ms. Riddle also states that "… one recent study estimated that about 30 percent of every premium dollar in state regulated plans is attributable to mandates." I should add that this 30 percent is not just benefit mandates, but other administrative requirements that may be imposed on health plans.

HIAA is opposed to federal legislation that mandates benefit coverage. While we recognize that not all of the needs of any given patient may be taken care of by his or her health plan, we also need to have benefits determined by the purchaser. Health plans, whether they are health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) options, managed indemnity options, or fee-for-service plans need to offer the benefits and services that meet the needs of their purchasers in terms of coverage as well as cost. The industry strives for a balance in cost and coverage so that the largest number of persons may have meaningful health coverage at an affordable price. In the case of parity for substance abuse, the costs would almost certainly tip that balance and result in declining overall coverage.

In a voluntary marketplace for health coverage, the consumer is the driving force behind change and innovation. We would not have some of the products and services in the market today if it were not for the flexibility and innovation that is allowed in the private health care system—products such as point-of-service options, "open access" HMOs, and even PPOs. Adding benefit mandates, whether at the federal or state level, will add to the cost of coverage. Each group, no matter how well intended, that advances one level of benefits may fail to see the effects of its advocacy for extended coverage as it relates to the efforts of other groups.

Mandates can impose significant burdens on health insurance carriers and drive up costs for consumers. A recent (1999) study by Gail A. Jensen, Ph.D., and Michael A. Morrisey, Ph.D., showed that the number of state mandates has increased 25-fold during the last two decades, making health insurance disproportionately more expensive for small companies and causing as many as one in four Americans to be uninsured. According to Jensen and Morrisey, mandates accounted for 21 percent of health insurance claims in Virginia, 11 to 22 percent of claims in Maryland, and 13 percent of claims costs in Massachusetts.

Several benefits are particularly expensive. According to Jensen and Morrisey, chemical dependency treatment coverage increases insurance premiums by 9 percent on average; coverage

increases premiums by 12 percent; and coverage for routine dental services raised premiums by 15 percent. A 1998 study by William Custer, Ph.D, showed that people living in states with mandated mental health coverage were nearly 6 percent more likely to be uninsured than people in states without this mandated benefit. Copies of both the Jensen-Morrisey study and the Custer study are attached to my testimony and I would like to ask that they be made part of the record.

It is important to note that mandates also can affect health care plans differently depending on their organizational structure. In a tightly controlled managed care setting, such as an HMO, substance abuse parity would be subject to utilization review mechanisms that would allow for appropriate treatments after application of clinical guidelines to the patient's care. In a PPO option or traditional fee-for-service plan, the care may be "less managed" and therefore could tend to result in benefit mandates having a higher cost impact than on an HMO. Recent studies show that mental health parity in tightly managed plans can be less expensive than in PPO or fee-for-service plans. Yet, in the current legislative debate, cost containment features of many managed care plans have been under criticism. Often, policy makers want to undermine the very managed care components that are designed to assure the appropriateness of the services provided. So on the one hand Congress wants more coverage, yet, with private health care plans, there is always the lingering criticism when plans take steps necessary to manage benefit coverage.

Benefit Mandates and Federal Government Programs

It is surprising to me that Congress continues to propose certain mandated benefits and then excludes the mandates from some of the programs for which Congress is responsible - Medicare, Medicaid, the Federal Employees Health Benefits Program, and so on. Let's look at the Federal Employees Health Benefits Program (FEHBP), which currently is viewed as a model health benefits program. FEHBP provides benefits and services to more than nine million federal employees, annuitants, and their family members. There is no mandate for these plans to offer substance abuse benefits on the same level as benefits for other medical conditions. Although the

substance abuse services, there has been no mandate for parity in substance abuse. The same holds true for Medicare, which has different benefit and cost-sharing levels for substance abuse and mental health services levels than for services for other medical conditions (as well as different caps for psychiatric hospital stays). This is also true within the Department of Defense Health System. Why, then, should the private health care market become a target for increased coverage when federally sponsored programs are treated differently? The answer most likely is cost—costs to federal employees, costs to the Medicare and Medicaid programs, costs to DOD, etc.

Even when President Clinton proposed extensive health care reform in 1993 and subsequently introduced his "Health Security Act," the actual legislative language had some 15 pages devoted to mental health and substance abuse benefit descriptions with inpatient or residential treatment limitations (30 days) and aggregate annual limits (60 days). Inpatient hospital treatment for substance abuse was limited to detoxification only. Limits were also placed on group therapy visits for substance abuse counseling and relapse prevention (30 visits).

There is a perception that private health care plans have unlimited dollars for coverage, and therefore, expansions of benefit plans are an acceptable way to bring more services to insured persons. However, we must understand that not everyone has the high level of employer contributions that federal employees enjoy, nor do businesses have unlimited dollars for the health benefits programs that they voluntarily offer to their employees, nor does the paying consumer have unlimited dollars for health care coverage given other demands on their dollar, especially those in lower to middle income categories.

And let me add one additional note on the issue of mandated benefits. All too often when a mandated benefit is proposed, the benefit mandated can become far more extensive in scope than originally intended. Take the current discussions in both houses of Congress on the issue of emergency room services. The original intent of many legislative proposals was to guarantee insured persons the right to payment for their emergency care services if their condition, or their

talk about mandates on emergency care, we include payments for post-stabilization services as well as maintenance. All too often legislative proposals dictate not only the benefit required but the terms of the service, how it must be provided, whether it can be exempt from any utilization review or plan oversight, and so on. Benefit mandates can end up doing more than just providing a new service.

Mr. Chairman, I understand the problems with substance abuse as it affects patients, their families, their employers, and our society. However, extending benefits for such a complex area of care can only drive up the costs of coverage without, at this point, known quantifiable results being derived from those increased expenditures. We must exercise responsibility and not impose requirements on private health care plans that will only lead to more uninsured persons. We must work together to continue to bring affordable coverage to as many consumers as possible. Benefit mandates work against that objective.

Thank you.

Mr. MICA. Mr. Hall, you are going to have to leave, so we have 2 or 3 minutes here before we excuse you. I will ask a couple of questions, and then we will let you scoot and catch that plane.

You had indicated that when your coverage, I guess Kaiser Permanente, had gotten into offering some of this treatment, that there was sort of a pent-up demand and that quite a few folks took advantage of that. Were there substantial increases in that first year or two from this increased usage? Was that reflected in cost, premium costs?

Mr. HALL. I am trying to understand your question. When you say substantial usage——

Mr. MICA. You testified—you said when you first got into this coverage, I thought you said that there was some pent-up demand or there were some more people taking advantage.

Mr. HALL. A particular population utilizing it at a higher rate.

Mr. MICA. Right. Was there—were there substantial costs involved in that?

Mr. HALL. No. Because part of our program has a cap on what everyone pays when they come into our treatment facility which is like a $5 cap.

Mr. MICA. You testified that there was this pent-up demand, and people were taking advantage of it. And then it leveled out?

Mr. HALL. Yes.

Mr. MICA. With that demand with the treatment, how were the costs covered? Who absorbed that?

Mr. HALL. Kaiser Permanente did. We weren't reimbursed by the State.

Mr. MICA. But you did say that, after a period of time, there was a reduction, I think you said 50 percent of hospital days. Can you clarify that?

Mr. HALL. Medical utilization during the 6 months prior to treatment was compared to utilization during the period 6 months post-treatment. And the results indicated a 50 percent reduction in hospital beds—in other words, hospitalization.

Mr. MICA. Well, those are my major questions to you.

Mr. Ramstad, did you have any questions for Mr. Hall at this time?

Mr. RAMSTAD. No, I just want to thank you, Kenny, for coming all of the way from California for this hearing today and all of your important work in this area. You have been a key leader nationally in this area, and I appreciate all of your efforts.

Mr. HALL. Thank you. Congressman Ramstad, I thank you for your courage also in this area.

Mr. MICA. We may have additional questions for all panelists. I am going to excuse you. Did you have a final comment that you wanted to make?

Mr. HALL. If I can get permission from the committee, I promised a young lady who was part of that initial pilot program that I would read a letter that she would like me to read for the record.

Mr. MICA. Read it or submit it for the record.

Mr. HALL. I would like to read it.

Hello, my name is Diana. I participated in the Valleho Chemical Recovery Program in November, 1996. As of November 10, 1999, I will have 3 years drug free. I could never express my gratitude on a piece of paper. There are so many wonder-

ful aspects of this program. The qualified and dedicated staff are the best. This program is the best thing that ever happened to me. And through this program comes the most important aspect, my children have their mother back. I owe this to Kaiser's chemical dependency recovery program and its irreplaceable staff. Forever gratitude, Diana D.

Mr. MICA. Thank you. We will excuse you at this time. Thank you again for your participation.

Some of our other witnesses, I have heard so much about Hazelden treatment and you also said that you represent, sir, several other very prominent treatment facilities, Betty Ford and others, Mr. Conley?

Mr. CONLEY. Yes.

Mr. MICA. And I guess you have a pretty good success rate. What is your success rate?

Mr. CONLEY. Collectively, as a group, we look at a success rate varying from 51 to 75 percent abstinence from alcohol and drugs after 1 year.

Mr. MICA. You also have a pretty hefty price tag. These clinics that were cited or treatment centers are some of the highest in the Nation; is that correct?

Mr. CONLEY. Well, I don't know if I can comment on the others. I can comment on Hazelden. The going retail rate if you are in for 28 days of treatment, $15,000. The net effect of the cost is somewhat lower because we do get patient aid out for those that don't have the insurance and so forth to handle it.

Mr. MICA. What is your average treatment cost for your patients? Could you give us a range?

Mr. CONLEY. The average for the full 28 days would be right around the $15,000 range. But after we factor in on the average the patient aid we give out, I would guess—and I won't swear to it—I guess it would be around $11,500, $12,000, or something like that.

Mr. MICA. Of the patients that you see, what percentage would you say have insurance coverage that covers all or part of that?

Mr. CONLEY. I think it would depend on what part of Hazelden they went to, if they went to the primary care for adults or adolescents. I believe we are reimbursed 30 to 50 percent of the patients go through and get some reimbursement. I can get you those numbers. I don't have it.

Mr. MICA. I think we would like to have those for the record, and maybe alcohol and also drug dependency if they are broken out in that fashion.

[The information referred to follows:]

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Equal Opportunity Employer

November 12, 1999

The Honorable John L. Mica
Chairman
Criminal Justice, Human Resources and
Drug Policy Subcommittee of the
House Committee on Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20514

Dear Chairman Mica:

In response to your questions at the October 21, 1999 Criminal Justice, Human Resources and Drug Policy Subcommittee hearing on "Substance Abuse Treatment Parity: A Viable Solution to the Nation's Epidemic of Addiction?" regarding Hazelden's outcomes and its experience with insurance coverage of their patients, I consulted with the appropriate clinical and research staff to obtain the requested information.

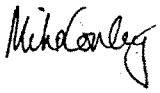
I am pleased to report that after studying outcomes data for more than 20 years, Hazelden continues to consistently seek ways to improve our patients' ability to be clean and sober. According to Hazelden's follow-up data, 77% of those we followed-up on, report that they were clean and sober one year after treatment. Does this mean that all of these people had a perfect year? No. But 54% were totally abstinent from all drugs and alcohol for the entire year. Just 23% used once after treatment, but stopped and were currently clean and sober. Only 5% reported using as much or more than before treatment. How accurate are these results? All of the data is based on follow-up interviews with about 71% of our patients and their families; the others could not be located.

On the insurance coverage issue, none of our patients have had insurance that covers 100% of an average 21-28 day stay in the last decade. In fact, Hazelden has extended $10 million in patient aid over the past three years alone, and most of that went to employed people with health insurance. Many of these people came to Hazelden expecting and needing their insurance to cover treatment. But what they find once they arrive is that it isn't enough either to get them in the door or stay here long enough to get well. In addition, Hazelden has contracts

with insurance companies, but those are at a deep discount as compared to what it costs us to treat these patients.

I would like to thank you again for the opportunity to participate in your hearing last month and for your continued interest in this important issue that affects millions of Americans and their families. If I may be of further assistance, please do not hesitate to contact me at (651) 213-4000.

Sincerely,



Michael Conley
Chairman of the Board of Trustees

Mr. MICA. You heard some testimony from our last two witnesses that felt that this coverage should be left as an option and it does result in an indirect tax increase or fee increase for everyone when it is imposed or mandated. How would you respond to that criticism if we were to adopt a Federal parity requirement?

Mr. CONLEY. Well, I used to be in that end of the business, and my company was a member of HIAA at one time, so I have a certain amount of sympathy for that position. But I guess the question I really have to say is we haven't had these mandates, and as I look at society now, I see a $146 million price tag to the work site. I see prisons full. I just see this as something that has to be done. I respectfully disagree, I guess, with their position.

Mr. MICA. We heard the gentleman from Americans for Tax Reform oppose this as an additional mandate which would, in fact, increase costs, which would also diminish the number of people who have health care coverage. As the cost goes up, we have *X* number of people, 43, 44 million now, uninsured now with no coverage. We would have actually fewer people covered because of the increased costs mandated.

Mr. CONLEY. Uh-huh.

Mr. MICA. What do you think about that?

Mr. CONLEY. I would make two comments to that.

No. 1, the incremental cost of this benefit, if the RAND study is right, isn't going to be so high that it is going to drive people out. That is my first reaction.

My second reaction, and I would invite HIAA members to think about this, is the cost shift to employers in other areas. For instance, if people were treated effectively, the productivity, the absenteeism, the workers comp claims, the liability, the risk exposure, would be less. So what you are doing, in effect, is you are robbing Peter or cutting back on the treatment end, but that cost is being shifted to employers. And I think it would be a fascinating study to see what happened after a year or two if the macro health costs would go up and drive people out of the market. I don't think that is the case.

Mr. MICA. Your people under treatment are all there voluntarily?

Mr. CONLEY. Pretty much, although some are through interventions from employers or families. So when I say voluntarily, they may not be jumping for joy that they are going to Hazelden.

Mr. MICA. One of the problems, Captain Smith, we adopted a policy of deinstitutionalization of mentally ill or people who have substance abuse problems. Many were forced into treatment and actually almost incarcerated into some of these programs some years ago against their will. And today we—that is not allowed. It is not permitted.

And we do have—you can—just as you said, you can walk blocks from here and you will see otherwise healthy human beings who have been victimized by chemical dependency and substance abuse, and we have no way to get them off the streets, no way to get them into these programs, and they will not voluntarily go. That is the bulk of our homeless population right now. What do we do?

Dr. SMITH. That is a superb question. Whenever human rights and individual choices interface with government control and the very Constitution, those are significant questions. Do we round up

everybody and make them take lithium? No. But treated in the early stages—and this is my astonishment. My colleagues never complain about paying the bill for a paraplegic from a motorcycle accident or about AIDS bills. They don't complain about liver transplants.

When you are treating that stage, the ball game is gone. But you can treat it early and so efficiently, and I think $15,000—do you have any idea how long it takes to spend $15,000 in an intensive care unit? I was an internist. I was there. Half of the people in ICU are there because of drugs or alcohol at the wrong time. And we can run through $15,000 in about 12 hours.

And you can treat—this is the reason that the Navy got into the business. You have $2.5 million in a pilot, and our pilots like to drink, and you train him that much, you get a return on investment that is significant. It is the same for IBM or the insurance companies. They train these executives. These are good people.

All we are saying is, let's shift the money to an earlier stage. Let's let industry help us with this. If these guys would open up their doors to chemical dependency and mental health, the total budget would go down. It has been done too many times by Kaiser, Northrup, Southern Bell, but they are not saying come in and we will treat you. And if they were we would not be having these hearings.

What is the responsibility of the Federal Government to say hey, help, it is not working? And if you want to know it is not working, look at the largest mental health hospital in this country today is the L.A. County jail.

The prison beds I don't need to tell you that the decline in substance abuse beds, adolescent beds comes like this, the jail cells go up like that. They cross right there. Where do we want to turn it around? I think this is a wonderful way because I think these guys can do it well, but I do think that you have to say help us in the early stages. Once it gets to homelessness and the liver is gone, it is a done deal.

Mr. MICA. I heard some conflicting testimony today on the costs. One of our witnesses and a Member of Congress and some others testified to a less than 1 percent cost increase were projected. I believe the last witness, Mr. Kahn, talked about a 9 percent increase. Could you explain what that was for?

Mr. KAHN. The researchers that I was quoting looked at State legislation that had been put in place and made comparisons between States that did and didn't have such legislation, and that is the difference that they came up with. That was directly attributable to that benefit requirement.

Mr. MICA. It was.

Mr. RAMSTAD. Would the gentleman yield?

Mr. MICA. Go ahead.

Mr. RAMSTAD. Those studies reflected mental health parity cost, not substance abuse treatment parity.

Mr. KAHN. That——

Mr. MICA. This gentleman in the back in the audience is not sworn. If you want to comment, we will be glad to have you be sworn and comment.

If you want to provide the testimony, Mr. Kahn, you are recognized.

Mr. KAHN. The study is included, and I can make it for the record. It refers to the amount and explains the methodology and——

Mr. MICA. Specifically substance abuse and parity legislation.

Mr. KAHN. Yes, and that is explained in here.

Mr. MICA. Can you identify the title?

Mr. KAHN. It is the Mandated Benefit Laws and Employer-Sponsored Health Insurance.

Mr. MICA. Without objection, that report will be made a part of the record.

[NOTE.—The report entitled, "Mandated Benefit Laws and Employer-Sponsored Health Insurances," may be found in subcommittee files.]

Mr. RAMSTAD. Who commissioned that study?

Mr. KAHN. We commissioned the study, but it was done by a professor at Wayne State and the University of Alabama at Birmingham.

Mr. RAMSTAD. It flies in the face of the RAND Corp. study, the California study, the Rutgers study, the Columbia University study, the Minnesota study, States that I am familiar with, so I would truly like to sit down and talk to you about that because I have some serious questions about that study.

Mr. KAHN. I would not necessarily argue that this study is in contradiction to the other studies. This study is looking broadly at all types of coverage in given States. If you look at very specific types of coverage, you can find that there are savings or the cost is marginal. Our problem is that when you do a one-size-fits-all mandate, are you mandating that on fee-for-service coverage, on PPO coverage as well as on managed care coverage? That might be sort of tightly controlled and that makes a difference.

The amount of flexibility that an insurer has in determining what—under what circumstances benefits will be provided is critical to the cost, and I think even in the testimony on the RAND study there was precertification and other hurdles that had to be overcome for someone to get the treatment.

Mr. RAMSTAD. If I may just ask, I didn't support Dingell-Norwood, and this is not Dingell-Norwood, and I am usually with the groups represented by the last two witnesses, and I have a lot of respect for them. But per your definition, every bill is a mandate. Every bill in Congress from the beginning required someone to do something or not to do something.

I want to point out that this bill does not mandate an employer-plan-covered substance abuse treatment. As Susan put it so well, if you say you cover it, cover it.

And to answer your question, and Susan is not here so I would take the liberty of answering the question, Chip, that you raised. CNN was totally unaware of the cap until Susan was in that detox center. They were told and they thought they bought the Cadillac package, the whole package. And treatment, if it were as available as most plans say, we wouldn't be here today.

Let me ask you a question. Why do most plans offer chemical dependency treatment but not make it accessible? Why not tell people what the definition of medically necessary care is?

Mr. KAHN. It is hard for me to imagine, although I am sure if you say it is the case it's the case, but a major corporation in this country that I am sure has a staff of more than 10 or 15 people in their human resources department that are overseeing health benefits, and I assume that they are self-insured, so probably the carrier was in a sense administering the benefit, and for them to say that they didn't understand their benefits, I don't think that is the insurer's problem, I think that is CNN's problem. And I would argue that they were probably in violation of the ERISA laws if they were not making clear what those restrictions were to their employees from the git-go when those employees made an annual choice as to their plan.

Second, I can't sit here and argue against the success of this kind of treatment. I wouldn't sit here and argue against the success of drug treatment for cholesterol and the effect that has on heart disease.

I take Pravachol and watch my diet so I know in terms of my heart disease that there are treatments that deal with that. I am not going to argue about that. But I would be concerned——

It is fine to say, let's mandate this. We could have a hearing at which I could make the same argument that drug coverage ought to be mandated because every person with heart disease ought to have through their insurance coverage access to Pravachol or other kinds of cholesterol drugs which are high-cost drugs. I could make the same argument, and we can come here and show all of the cost-saving value of people taking cholesterol drugs rather than at the end stage needing whatever they get—bypass or whatever.

I am not arguing the utility of it, but the fact is that if you go down this road of requiring it here, before you know it you are going to have to require drug benefits and you are going to have to require other things. Because all of the compelling arguments that are being made here can be made about many of the things that are offered in our wonderful health care system.

Mr. RAMSTAD. I know Captain Smith is anxious to respond.

Dr. SMITH. The response I had—and I love so much of what Mr. Kahn said, but what the bill is asking, as I understand it, is if you have a myocardial infarction, you are going to have to pay 10 percent of what the care is. If you get in a crisis with drugs, they will ask you to pay at least 50 percent of the cost. The bill is asking for parity. I have a much better success rate with substance abuse than your cardiologist does with cardiovascular disease because I have been in both businesses.

What the bill is asking, look, just treat this one the same. The reason that people don't demand high levels for substance abuse treatment is the denial. If someone has alcoholism, he doesn't have the disease so he doesn't care what the number is. It is one of those few instances because of denial inherent in the disease—that is what treatment does. It breaks through the denial.

You are asking a sick brain to decide how much we need to treat it. How much money is needed to treat it? And nobody is going to sit there—and particularly an alcoholic. His spouse may read it

carefully, but the alcoholic is not going to care how much money there is in the policy for alcohol treatment because he doesn't have it because of the denial.

And those are the points that I would make.

Mr. MICA. Mr. Ferrara wanted to comment.

Mr. FERRARA. Mr. Chairman, you have heard testimony today about it is going to cost less than 1 percent, cost 9 percent increase in costs. And you know what? You don't know. I know you don't know. You know you don't know. You are not going to know because that is the wrong question to ask. That is a central planning question we are never going to know.

That is why the decision needs to be left up to the marketplace where, A, you have people putting out their own money directly and have to be convinced directly of the benefits that they are going to get back and they will very carefully evaluate and make their own choice; and, B, different people can make different choices so some people might try it. Wow, it reduced our costs or General Motor's costs and Kaiser Permanente's costs. And then other people do it, and that is the right way to do this. You don't try to have a committee in Washington make the decision for everybody.

I am not making an argument for or against a particular kind of treatment or for or against a kind of bill. I am making an argument on process. This decision needs to be left up to the people buying the health insurance. If there are some effects on the government and the government budget, maybe this is a decision that you need to make explicitly in the budget process. But don't engage in these activities where you shift the cost off budget onto other people and then you hide it from accountability.

And in the situation where quite—I don't mean this negatively—you don't know what you are doing because in this kind of model you don't know, sitting here in Washington. This needs to be made on a decentralized basis by people across the country who are putting their own money on the table and will do so when they are clear they are going to get the benefit back.

Mr. MICA. Dr. Schoenbaum.

Mr. SCHOENBAUM. Yes, I would like to respectfully disagree with what Mr. Ferrara just opened with, that we don't know and can never know what the costs are of legislation such as this. Respectfully, we do know, at least on average and under some assumptions that we can articulate and that seem fairly reasonable, approximately what the costs are that we can expect from legislation like this.

In the RAND study we looked at data from behavioral—from the third largest behavioral carve-out insurance carrier in the country, I assume a member of HIAA. Of people with private insurance in this country, 75 percent received their coverage for substance abuse and mental health services through a carve-out company.

RAND has negotiated an agreement with United Behavioral Health, the third largest behavioral carve-out company in the country, for unrestricted access to their claims and utilization data. Those are the data that we based our study on. We identified the plans in that study that provide unrestricted, although managed, substance abuse treatment benefits. That I would argue is the

standard of care, the standard of practice that is currently prevailing in this country—managed carve-out health insurance.

Under those circumstances, across the range of employers that we looked at, which were in a number of different industries, had employees in 38 different States, we were quite clear about the cost of providing unlimited substance abuse treatment benefits. Three-tenths of 1 percent of members in an employed population use any substance abuse treatment benefits in a year. Of those, the number who use—the fraction who used a fairly high amount in a given year is yet smaller.

So it stands to reason that, under practice patterns like that, we are not talking about enormous amounts of money for providing the benefit. The issue is that managing services, utilization review, the practices, the technologies that the carve-out companies have developed for targeting services to the people who need them are a more effective way of allocating care than benefit limits which have the unfortunate feature that they affect the people who need the largest amount of services.

Mr. MICA. Let's see. Has everyone had a shot at this?

Mr. FERRARA. Do I get to respond briefly?

Mr. MICA. Captain Smith, did you want to respond? And then we will go back to Mr. Ferrara.

Dr. SMITH. I would just say to Mr. Ferrara, these are the best people in the world, but it has been left to the marketplace to solve this problem. That is why the beds are gone. That is why your beds are now in prison. That is why you have homelessness all over this country. The marketplace has had its shot at it, and by my value system it has failed miserably.

Now are they going to spontaneously open the doors? No, I don't think that they are. I think Congress has to say, hey, help us, open up the doors. They have no problems asking us to build more prison beds. They have no problem when someone is fired and becomes homeless. That is a high consumer of health care cost to the private insurer, and ultimately it is the Federal system that picks up the tab. You are saying, help us when this disease is treatable cheaply.

Thank you.

Mr. FERRARA. Captain Smith says this is a great deal, and it works out wonderfully, and I tried to explain it, and they are not buying it, so please Mr. Smart Federal Government, you force them to do it, tell all of these people they are wrong. If Mr. Schoenbaum is right and Captain Smith is right, go make the case to the employers and to the insurance companies and tell them about all the great money that they are going to save, and if they think you are right, they will risk their money on it. The point is, who is going to make this decision, not who is right or wrong, and the decision needs to be made by the people buying the health insurance.

Mr. MICA. Their point is that they are not saving the money by instituting this. Or if it is not required by the Federal Government for coverage, what happens is that the rest of us are picking it up as taxpayers in some more costly fashion.

Mr. FERRARA. If that is the case, you need to examine your substance abuse health treatment programs and deal with it in the context of the Federal budget. If there are government savings and

government effects or broad or societal effects, then deal with it explicitly in the budget process where you consider it overall against all of the considerations of how much taxes you are going to raise and other demands in the budget, and then you make your priorities. That is where it needs to be decided. Don't hide it by saying we are going to make someone else pay for it. They ought to be able to decide what is in their health insurance policy and what is not.

If you are convinced after doing a thorough investigation, gee, this is extremely cost effective and the employers don't take into account all of the costs that accrue to them and insurance companies don't take into account all the costs that are going to accrue to them, that is when you have a government program to do it.

Mr. MICA. Mr. Ramstad, do you have additional questions?

Mr. RAMSTAD. I don't, Mr. Chairman.

Mr. MICA. Well, we haven't solved the problem of parity for those afflicted with substance abuse or what are our national legislative direction will be on this issue today, but we have aired some opinions and heard some good testimony I think from a number of folks and hopefully moved the debate a little bit forward and possibly a legislative resolution.

We will keep the record open for 10 additional days for additional statements. We may have some additional questions for some of those who have testified before us today.

If there is no further business to come before the subcommittee—Mr. Ramstad——

Mr. RAMSTAD. Just one last word, Mr. Chairman. I want to thank all six witnesses on this panel, including the two who vehemently disagree with my legislation, because this is the way that the process should work. Thank you for coming forward and being part of this discourse.

Mr. MICA. In conclusion, I did want to thank each of the witnesses who are on this panel and the other witnesses and Members of Congress who testified today. I appreciate again your helping us make the process work.

As I said, there being no further business to come before the subcommittee this afternoon, this meeting is adjourned.

[Whereupon, at 1:20 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

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

PLNDP Consensus Statement

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

Policy Recommendations

- *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

Background and References

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.[24] No equivalent federal bill has been passed for substance abuse benefits, however.

[24] 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.

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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.[25] 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.[26]

The primary argument against providing substance abuse parity is the fear that the cost to third-party payers will be too high.[27] 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.[28]

The Cost of Full Parity for Substance Abuse Treatment

Average Premium Increase 0.2%

Annual Insurance Cost Increase: $5.11 yearly or 43¢ monthly per insured individual

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).

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[25] 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.

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

[27] 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).

[28] 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).

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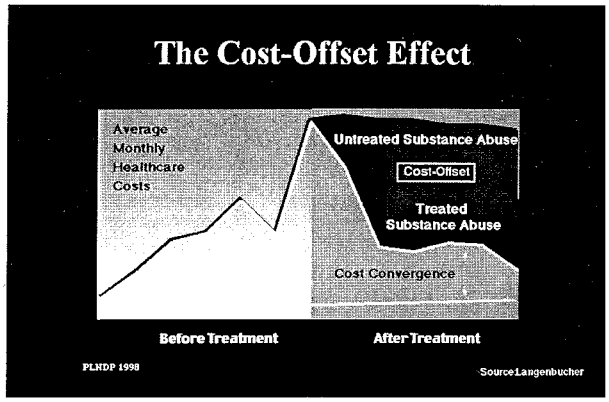
The study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that offering full parity for substance abuse treatment would increase insurance premiums by only 0.2% (see table on page 15). A more recent parity study, by the RAND Corporation, concluded that the cost for large corporations and HMOs to provide complete substance abuse benefits would be $5.11 annually per employee, or about 43¢ per month.[29] 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 & Robertson Inc. found the additional cost for drug abuse treatment to be less than 1%.[30]



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).

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.[31]

One study, which followed 161 methadone patients, found that nearly half had at least one comorbid medical condition that required immediate treatment.[32] Eighteen percent required

[29] 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).
[30] Milliman & Robertson, Inc. (National Center for Policy Analysis), Estimated Additional Costs for Certain Benefits (March 18, 1997).
[31] The President's Commission on Model State Drug Laws (The White House), *Socioeconomic Evaluations of Addictions Treatment* (December 1993).
[32] 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).

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.[33] 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.[34]

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.[35]

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.[36]

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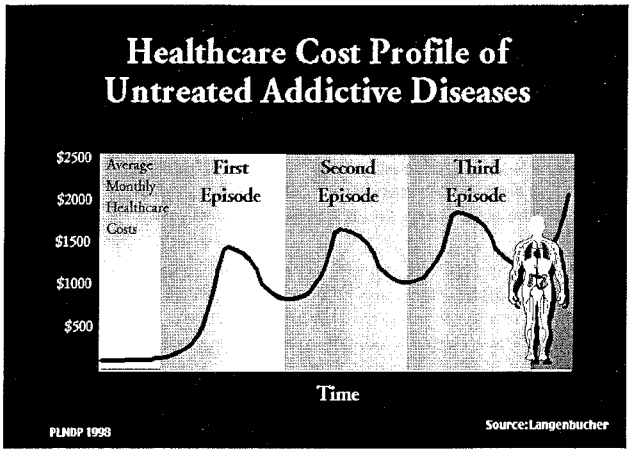
[33] Tengs T, Adams M, Pliskin J, Safran D, Siegel J, Weinstein M, Graham J, Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness, *Risk Analysis* 15(3): 369-90 (1995).
[34] Hanson K, Public Opinion and the Mental Health Parity Debate, *Psychiatric Services* 49(8): 1059-1066 (1998).
[35] 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.
[36] 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).

A recently published study of the costs and benefits of publicly-funded outpatient treatment services in the city of Philadelphia found similar results.[37] 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.



Escalating costs of repeated relapse episodes of untreated drug addiction. Chart compiled by James Langenbucher, PhD 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* (NY: Springer-Verlag, 1990).

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.[38]

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).[39]

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[37] French M, Salome HJJ, Sindelar J, McLellan AT, Benefit-Cost 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).

[38] Office of National Drug Control Policy (Executive Office of the President), Statement on Parity for Substance Abuse Treatment (January 22, 1999).

[39] 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

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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 Administration details the implementation of the Act, measures taken to ensure compliance, comparisons between treatment conditions, and estimated impact on health insurance costs.[40] 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 percent - 3 percent 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 so far 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.[41] 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

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Addiction Recovery Act of 1999) (July 27, 1999); American Academy of Addiction Psychiatry, Letter Formally Endorsing the PLNDP Consensus 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 Coverage: 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).

[40] 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).

[41] Information on corporate healthcare databases was provided by Robert Hunter, MD, Corporate Medical Director, Shell Oil Company.

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).