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State Medical Society of Wisconsin
Working together, advancing the health of the people of Wisconsin

TO: Senator Rod Moen, Chair
Members of Senate Health Utilities Veterans and Military Affairs

FROM: Michael M. Miller, M.D., F.A.S.A.M.
President, Dane County Medical Society
Past Chair, Commission on Addictive Diseases, State Medical Society
Secretary, American Society of Addiction Medicine
Chair, Public Policy Committee, American Society of Addiction Medicine

DATE: September 19, 2001

RE: In Support of SB 157

I am a practicing addiction medicine physician from Madison, Wisconsin. I am board-certified in general psychiatry and addiction psychiatry, but my practice is focused on addiction medicine.

I stand before you today representing the State Medical Society of Wisconsin; the Coalition for Fairness in Health Insurance, of which the Medical Society is a member; and the American Society of Addiction Medicine, the largest medical specialty society in the nation devoted to the needs of patients with addiction.

I am here to discuss:

- Fairness
- Science
- Discrimination
- Savings

Parity is clearly an issue of FAIRNESS.

- It is unfair to patients to pay for health conditions which affect their hearts and not those which affect their brains.
- It is unfair to patients to pay for health conditions which involve one area of their brains and not those which involve another area of their brains.

- It is unfair to families to have to self-pay for treatment for conditions excluded based on arbitrary distinctions.
- It is unfair to employers who want a level playing field for benefits and insurers who want a level playing field.
- It is unfair to practicing physicians, who must contort and jump through hoops to respond to the unfairness in the current system.
  - ✓ This is NOT an issue 'of the advocates', i.e., providers of mental health and addiction treatment.
  - ✓ This is an issue that doctors from a broad range of specialties embrace.

Parity is an issue based in SCIENCE.

- Affective disorders, schizophrenic disorders, and particularly organic mental disorders such as Alzheimer's disease and other dementias, are diseases of the brain.
- Addictive disorders as well as drug intoxication states and drug withdrawal states are diseases of the brain.
- Treatments are biologically based.
- Yes, there are effective drug-therapies (pharmacological treatments) for drug addictions (to alcohol, to nicotine, to opiate analgesics).

The current situation in which parity is not fully implemented, is based on STIGMA, which leads to DISCRIMINATION.

- There is definitely stigma against the mentally ill
- There is definitely stigma against the chemically dependen.
  - …due to an inability to make clear distinctions between substance use and substance addiction
  - …due to an inability to make clear distinctions between criminality and illness
  - …due to an inability to accept that behavioral aberrations can have a basis in brain dysfunction
  - …due to an inability to move past belief systems which moralize mental illness and addiction
  - …due to an inability to view persons with psychosis or addiction as persons 'like me'
  - …due to an inability to separate actuarial science from political beliefs

Parity is about SAVINGS.

- Yes, it is about spending money: a 1% increase in premium.
- More than that, it is about SAVING MONEY due to early intervention, effective chronic disease management, appropriate treatment, and the stabilization of conditions that can lead to extensive further medical utilization.
- We spend about 10 times as much on the health care costs of treatment of conditions caused by addiction, than we do on the treatment of addiction. The former face few limits; the latter is limited unless parity provisions remove limits.
- The most effective way to reduce Medicare and Medicaid costs and all health care costs is to treat addiction effectively, early, and for the duration.

Summary of Socioeconomic Findings

- Substance abusers are among the highest cost users of medical care in the country.
- Only 5-10% of these are due to addiction treatment.
- Treatment results in marked reduction in health care utilization, by alcoholics, addicts, and the families.

Medical Problem

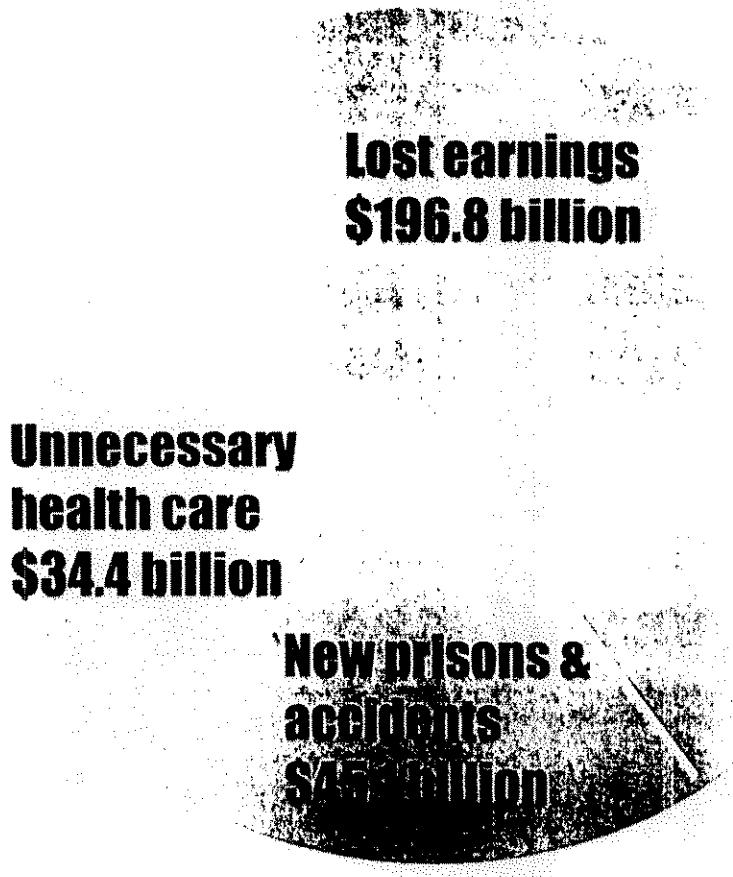
1. Alcohol and drug addiction is essentially a brain-chemistry disorder.

2. Genetic, inheritable elements predispose some individuals and families to addiction.

3. Research shows that addiction is as treatable as other comparable chronic illnesses like diabetes, heart disease and asthma.

Public Health Problem

Untreated addiction costs $276.3 billion a year



ADDICTION TREATMENT WORKS—IT IS EFFECTIVE.

ADDICTION TREATMENT ISN'T EXPENSIVE.

ADDICTION TREATMENT IS A VALUABLE PURCHASE.

THE MOST EXPENSIVE PUBLIC POLICY DECISION IS TO <u>NOT TREAT ADDICTION</u>
AND TO NOT TREAT ADDICTION <u>AS A CHRONIC DISEASE</u>

So if alcohol and drug addiction is a medical and public health problem, do we treat it like one?

Date: February 26, 2001

To: Members, National Coalition to Increase Access and Parity for Addiction Treatment

From: James F. Callahan, DPA, Chair
Coalition Work Group on "Parity Legislation Core Principles"

Subject: "Core Principles" For Parity Legislation

CORE PRINCIPLES FOR LEGISLATION

ON ACCESS TO TREATMENT AND PARITY

FOR TREATMENT OF ALCOHOLISM AND OTHER DRUG DEPENDENCIES

The Origin of the Coalition and the Core Principles: The National Coalition to Increase Access and Parity for Addiction Treatment began at a Strategic Planning Meeting of the Physician Leadership for National Drug Policy (PLNDP) at Brown University Medical School on February 17, 2000. At that meeting, the PLNDP, JoinTogether and the American Society of Addiction Medicine (ASAM) agreed to form a Coalition to work in the states to increase access to addiction treatment and promote parity. They also agreed to invite national organizations with state-based constituent groups to attend an organizing meeting to be hosted by the Center for Substance Abuse Treatment (CSAT).

At the CSAT meeting the groups formed three work groups on Core Principles for parity legislation, States' Inventory, and Advocates' Tool Kit. Several drafts of the Core Principles were developed and reviewed by the Coalition members; they were accepted at the Coalition's February 26, 2001 meeting.

Sources from which the Principles were derived:

1. Vermont's Mental Health and Substance Abuse Parity Law, and *Fighting for Parity In An Age of Incremental Health Care Reform* (K. Libertoff) (January 1999).

2. Physician Leadership for National Drug Policy (PLNDP) Consensus Statement.

3. Join Together National Policy Panel for Addiction Treatment and Recovery.

4. American Society of Addiction Medicine (ASAM) Policy Statements:

a. "Core Benefit for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence" (April 1993).

b. "Parity in Benefit Coverage: A Joint Statement by the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association" (October 1997).

5. "GAO Report: Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited" (May 2000).

6. "The White House President's Commission on Model State Drug Laws" (December, 1993)

7. National Coalition member recommendations.

Assumptions:

1. Assume full parity with other physical illnesses for coverage for mental illness and addictive disorders.

1. The parity law must be stronger than any existing state mandated benefit.

Core Principles:

1. Definitions:

a. Terminology: Use the term "alcoholism, and other substance-use disorders "(DSM, ICD and ASAM Criteria*); not "behavioral disorders" (ICD).

* The DSM are diagnostic criteria; the ASAM Criteria are guidelines to determine appropriate level of care.

a. Primary Disease: Alcohol and other substance-use disorders are primary diseases that produce serious secondary physical and psychiatric complications.

c. Parity: Coverage for alcohol and other substance-use disorders shall be non-discriminatory on the same basis as any other medical care. Health Insurance plans shall provide coverage for the treatment of substance-use disorders that are listed for this condition in the current edition of the International Classification of Diseases (ICD).

Plans shall cover the continuum of clinically effective and

appropriate services, and continuing treatment provided in a licensed, certified or state approved facility, or by a licensed and certified physician, appropriately credentialed addictions counselor, or other qualified professional; care shall include emergency, primary care and specialty services.

Coverage and funding shall be the same as benefits, including medications, covering other chronic, physical illnesses, with the same cost-sharing provisions, deductibles, appropriate caps or limits on numbers of outpatient visits, residential or inpatient treatment days; payments; lifetime benefits and catastrophic coverage.

1. Eligibility: Eligibility shall be based on diagnosis of substance-use disorders by use of objective criteria such as the current edition of the ICD 10, and on medical necessity which should be determined by objective public criteria (such as the ASAM Criteria) with quality care assured by appropriate qualified and licensed clinical peer review.

1. Covered Participants:

    a. Adults, adolescents, children, families covered in

    b. Group and individual plans in

    c. Private insurers

    d. Under:

        i. Fee-for-service
        ii. Managed Indemnity
        i. PPO and POS
        ii. HMO and Gatekeeper programs
        iii. Public sector payers

2. Consumer Protections:

    a. Use and disclosure of diagnostic and continuing stay criteria.

    b. Gatekeepers trained and knowledgeable in addiction.

    c. Appeal or grievance process that is time-sensitive, conflict of interest free, credentialed and expeditious.

    a. Toll free numbers to the appropriate state office for consumer appeals, such as the state's attorney general's office, or the state's

insurance commissioner's office.

c. Disclosure and accountability provisions similar to those in the *Managed Care Consumer Protection Act of the National Alliance for Model State Drug Laws.*

a. Definition of "medical necessity" as both acute and chronic care.

b. Confidentiality of medical records.

3. Evaluation and Case Management:

   a. Ongoing treatment evaluation, case management, cost benefit and outcome studies should be an integral part of the ongoing evaluation of all substance use disorders services.

   b. Treatment for substance use disorders must be monitored by independent treatment managers with no vested financial interest, to insure ongoing treatment effectiveness.

1. Cost estimates should be based on State-specific actuarial figures.

February 26, 2001

1. What Are Alcoholism and Drug Addiction?

Defining Alcoholism and Drug Addiction

Two commonly and widely recognized criteria are used by clinicians and researchers to diagnose alcoholism and drug addiction. The first is the American Psychiatric Association's *Diagnostic and Statistics Manual of Mental Disorders*; the most current is the fourth edition, commonly referred to as the DSM-IV. The other is the World Health Organization's *International Classification of Diseases* (ICD-9). Both are used to help identify and classify substance abuse disorders. The codes contained in them also are used in patient medical records and for claims and billing purposes.

As years pass, the terms and definitions associated with alcoholism and drug addiction have changed. Although the terms change, the fundamental problems associated with these disorders remain constant. However, before these problems are examined, it is important to understand how the disorders are defined.

The most common tool used in the United States for diagnosing substance use disorders is the DSM-IV. The ICD-9 is most often used as an international tool for diagnosing causes of death and disability. The DSM-IV classifies alcoholism and drug addiction as substance dependence, substance abuse and substance-induced disorders. Substance dependence is a pattern of substance abuse that leads to impairment or distress; substance abuse is related to the repeated use of substances; and a substance-induced disorder is a specific syndrome, such as a mood change that is related to ingesting the substance.[1]

Alcoholism and Alcohol Abuse

According to the National Institutes of Health, nearly 14 million adult Americans—1 of every 13—meet the diagnostic criteria for alcohol dependence or alcohol abuse. About 50 percent of adults have or have had a close family relative with one of those disorders. In addition, more than 70 percent of individuals who consume alcohol exceed moderate drinking guidelines (up to two drinks per day for men and one drink per day for women and older people). More than 50 percent of college students who drink alcohol say that they drink to "get drunk."[2]

Experts use the following two terms to identify an individual with an alcohol-related problem.

- **Alcohol Abuse**—is defined as a heavy and frequent alcohol problem, which involves the continued use of alcohol-despite social, occupational, psychological or physical problems-in addition to recurrent alcohol use in physically hazardous situations.

- **Alcohol Dependence**—also termed "alcoholism" or "alcohol dependence syndrome" is distinguished by cognitive, behavioral, and physiologic symptoms, which indicate that a person continues to drink despite significant alcohol-related problems. These alcohol-related problems do not necessarily involve heavy drinking.[3]

Although alcohol is not an illegal substance for adults, the abuse of alcohol has become a serious problem in the United States. Approximately 12.8 percent of men and women experience symptoms of alcohol dependence sometime in their lives. Of those individuals, approximately 700,000 are treated annually.[4]

Drug Addiction

The diagnostic criteria used to identify drug addiction are similar to the ones used for alcoholism and are classified in three ways: use, abuse and dependence.

Use, abuse and dependence are the three diagnostic criteria used to identify drug addiction.

- **Use**—characterized by low or infrequent doses and can be considered experimental, occasional or social; damaging consequences are rare and minor.

- **Abuse**—describes higher doses or frequencies that are usually sporadically heavy and intensive; effects are unpredictable and sometimes severe.

- **Dependence**—defines the addiction to drugs and is associated with high or frequent doses, compulsion, craving and withdrawal; severe consequences are likely.[5]

Understanding the scope and scale of drug use, abuse and addiction in the United States, determining its prevalence among various populations, and learning about the many health and social consequences are critical to solving this complex problem. Using epidemiological research is one way used to identify and examine trends in both drug use and the attitudes that Americans have toward drug use. Many epidemiological studies, including a variety of surveys, experimental studies, and field investigations, are conducted on a continuing basis. These studies provide long-term data trends that can help measure the nation's success in preventing and treating drug use.[6, 7]

AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement
on
The Definition of Alcoholism

Alcoholism is a **primary,** chronic **disease** with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is **often progressive and fatal.** It is characterized by continuous or periodic: **impaired control** over drinking, preoccupation with the drug alcohol, use of alcohol despite **adverse consequences,** and distortions in thinking, most notably **denial**.

- **Primary** refers to the nature of alcoholism as a disease entity in addition to separate from other pathophysiologic states which may be associated with it. **Primary** suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state.

- **Disease** means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specified common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage.

- **Often progressive and fatal** means that the disease persists over time and that physical, emotional, and social changes are often cumulative and may progress as drinking continues. Alcoholism causes premature death through overdose, organic complications involving the brain, liver, heart and many other organs, and by contributing to suicide, homicide, motor vehicle crashes, and other traumatic events.

- **Impaired control** means the inability to limit alcohol use or to consistently limit on any drinking occasion the duration of the episode, the quantity consumed, and/or the behavioral consequences of drinking.

- **Preoccupation** in association with alcohol use indicates excessive, focused attention given to the drug alcohol, its effects, and/or its use. The relative value thus assigned to alcohol by the individual often leads to a diversion of energies away from important life concerns.

- **Adverse consequences** are alcohol-related problems or impairments in such areas as: physical health (e.g. alcohol withdrawal syndromes, liver disease, gastritis, anemia, neurological disorders); psychological functioning (e.g. impairments in cognition, changes in mood and behavior); interpersonal functioning (e.g. marital problems and child abuse, impaired social relationships); occupational functioning (e.g. scholastic or job problems); and legal, financial, or spiritual problems.

- **Denial** is used here not only in the psychoanalytic sense of a single psychological defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers designed to reduce awareness of the fact that alcohol use is the cause of an individual's problems rather than a solution to those problems. **Denial** becomes an integral part of the disease and a major obstacle to recovery.

Approved by NCADD 2/3/90
Approved by ASAM Board of Directors 2/25/90

AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement
on
Core Benefit
for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence

PREFACE

Statement of the Problem

Alcohol, nicotine and other drug dependencies are widespread primary chronic diseases [1,2,3,4]. A study of nearly 20,000 adult Americans in the general public, found a 13.5% lifetime prevalence of alcohol abuse or dependence, and a 6.1% lifetime prevalence of other drug abuse or dependence, exclusive of nicotine [5]. The prevalence rates of substance use disorders for children are also significant. Additionally, about 17% of American adults are dependent on the nicotine in tobacco [6]. Alcoholism is associated with 25% of all general hospital admissions [7] and alcohol abuse and dependence cause an estimated 100,000 deaths annually. Smoking of tobacco is responsible for 434,000 deaths per year [8].

The health costs, exclusive of tobacco costs, are estimated at $140 billion per year [9]. Substance use disorders lead to a wide variety of long term disabling diseases such as hepatic cirrhosis, cancer, cardiovascular diseases, cerebral atrophy, and fetal alcohol syndrome, and to an increased incidence of HIV/AIDS and antibiotic resistant tuberculosis. In society as a whole, substance use disorders also adversely affect family members [10], increase absenteeism and poor job and school performance, and are associated with crime, violence and accidents.

Cost Benefits of Treatment

The cost benefit of treatment has been demonstrated [11,12,13]. Studies also demonstrate cost offsets for alcoholism treatment within the healthcare system [14,15], including a 1993 report [16]. Additional cost offsets are produced by decreased vehicle crashes, family violence, work and school absenteeism, and industrial accidents [17].

Objective Basis for Determining Need, Level and Continuum of Care

The need for and level of treatment must be a clinical judgment based on objective guidelines derived from research literature and clinical consensus such as the guidelines in the *ASAM Patient Placement Criteria For The Treatment of Substance-Related Disorders: Second Edition (ASAM PPC-2)* [18]. The goals of objective criteria are to match intensity of service to severity of illness in a continuum of care, prescribe a treatment level that can accomplish the objectives safely, and provide a framework in which clinical outcomes and cost benefit may be assessed. These goals and concepts have been widely accepted. The *ASAM PPC-2* contains separate criteria for adults and children.

Principles

Alcohol, nicotine, and other drug dependencies are primary diseases which produce serious secondary physical and psychiatric complications. Principles that govern the development and implementation of the Core Benefit are:

A. Primary care and specialty treatment for substance use disorders should be specifically included in any basic health benefit, rather than be subsumed under some other category, such as mental health.

B. Coverage should include a continuum of primary care and specialty services that provide effective treatment for substance use disorders.

C. Provision should be made for simultaneous treatment of substance use disorders and their physical and psychiatric comorbidity, wherever indicated.

D. Ongoing treatment evaluation, case management, cost benefit and outcome studies should be an integral part of the ongoing evaluation of all substance use disorder services.

E. Eligibility should be based on competent diagnosis of substance use disorders by use of objective criteria such as the DSM IV or ICD 10, and on medical necessity.

F. Patient placement should be based on objective criteria with quality of care assured by appropriate review.

G. Where specialized substance use disorder services are provided, these services must be linked to the rest of the health care system.

H. Medicine must work closely with other professional providers and self-help groups, and all must avail themselves of the broad network of community services to address the long-term vocational, education, and other needs of people with substance use disorders.

I. Linkage between medical institutions and nonmedical rehabilitative services should be assured by requiring such institutions to be licensed and accredited (e.g., state licensing boards, JCAHO and CARF).

J. Coverage for alcohol, nicotine and other drug dependencies should be nondiscriminatory on the same basis as any other medical care.

K. Caps or limits on numbers of treatment visits, days or payments should be applied in the same manner as with any chronic disease.

L. Treatment should be financed from the same source as any other primary disease. Additional revenue could come from taxes on alcohol and tobacco products, but the budget for substance use disorder treatment should not be contingent on sales of these products.

CORE BENEFIT

The Core Benefit is a statement of the minimum services that must be available to an individual and his/her family. The Benefit is:

1. Prevention Through Patient Education

- on the harmful effects of the use of alcohol, tobacco, and other drugs
- on the risk factors for the development of drug dependency.

These services are offered to patients and their families in a health care setting and are analogous to dietary and exercise counseling for patients at risk for myocardial infarction or diabetes mellitus.

2. ***Assessment and Treatment***

- history
- physical examination
- mental status examination
- screening and diagnosis
- provision of treatment as is required of any chronic disease.
- management of acute exacerbations and relapse
- detoxification at appropriate levels of care

SCOPE OF BENEFIT

Treatment should be provided in the most appropriate and cost beneficial setting. Inpatient treatment should be used when justified by illness severity; e.g., when the illness meets the criteria for Level III or IV placement according to the *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders: Second Edition (ASAM PPC-2).*

When significant social problems are the major factor determining the need for inpatient care, such care would preferably take place in residential settings, with appropriate cost sharing between the health care and social service systems.

Patients with physical or psychiatric comorbidity may need additional care or consultation from other disciplines. Some patients with severe physical or psychiatric comorbidity may require treatment in or referral to appropriate settings.

Linkages among all service systems should be maintained and monitored.

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Adopted by the ASAM Board of Directors 04/28/93

AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

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

The American Managed Behavioral Healthcare Association (AMBHA) and the American Society of Addiction Medicine (ASAM) join together in advocating that

> **Health Plan Coverage For The Treatment Of Alcohol, Nicotine, And Other Drug Dependencies Should Be Non-Discriminatory**

Two key phrases in this statement are "drug dependencies"[1] and "non-discriminatory."

By non-discriminatory we mean "coverage on the same basis as any other medical care."

In a May 30, 1997 joint statement,[2] AMBHA and ASAM observed: "Addictive disorders are primary

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1 The American Psychiatric Association's DSM-IV, "Substance Dependence" observes that "the essential feature of substance dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior." [DSM-IV, p.176]

Further, the Institute of Medicine states: "As a consequence of its compulsive nature, involving the loss of control over drug use, dependence (or addiction) is typically a chronically relapsing disorder.... [IOM, p.19] ...addiction...[is] a brain disease similar to other chronic and relapsing conditions such as hypertension, diabetes, and asthma...." [IOM, p.20] [Institute of Medicine (IOM), National Academy of Sciences 1996 publication, *Pathways of Addiction: Opportunities in Drug Research*.]

To further clarify the IOM and DSM-IV definitions we cite E.M. Steindler, "Addiction Terminology," from N.S. Miller, editor, *Principles of Addiction Medicine* (Chevy Chase, MD: ASAM, 1994):

> **Addiction**: A disease process characterized by the continued use of a specific psychoactive substance, despite physical, psychological or social harm.
>
> **Dependence**: Used in three different ways: a) physical dependence, a physiological state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by readministration of the substance; b) psychological dependence, a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence; c) one category of psychoactive substance use disorder.

disorders which require their own unique and specialized treatment. By addictive disorders we mean alcohol, nicotine and other drug dependencies. Individuals with addictive disorders may also experience mental illness and may also experience primary health problems."

The Nature of the Problem

As America continues to confront unprecedented problems from the widespread prevalence of alcoholism and other drug dependencies and the annual direct and indirect costs these problems create, access to treatment for addictive diseases is becoming increasingly important. Many persons in need of such treatment are covered for their overall health care by a variety of public and private third-party payment plans that severely restrict or exclude addiction treatment services, thereby denying patients access to quality care. These patients face limits on duration of treatment and on total dollar benefits that are far narrower than the limits placed on other medical care they receive.

AMBHA and ASAM have joined together in acknowledging that a disparity between health benefit coverage for drug dependencies and other medical care exists, to declare our opposition to such discriminatory benefit design, and to emphasize that treatment of drug dependencies is cost effective.

Recent Legislative Responses

On September 26, 1996 President Clinton signed into law the "Mental Health Parity Act of 1996" (Title VII of P.L. 104-204). For the first time, the federal government prohibited some health plan discrimination against mental illness. Specifically, the federal government prohibits the use by health plans of annual and lifetime financial caps which are different from mental illness and other physical illnesses. Addictive disorders are expressly not covered by federal legislation.

Recently state legislatures have enacted health benefit parity requirements - Arkansas, Colorado, Connecticut, Indiana, Maryland, Maine, Minnesota, New Hampshire, North Carolina, Rhode Island, Texas, and Vermont have enacted such laws. Indiana, North Carolina, and Texas laws apply only to health insurance for state employees. Of these 12 state parity laws, only Maryland, Minnesota, North Carolina, and Vermont cover both mental illness and drug dependency.

The Logic of Current Practice

Purchasers and public policy makers should consider the following logic and current state of practice:

1. health insurance provides financial coverage for diagnosis, treatment, and prevention of acute and chronic diseases

2. addiction medicine is involved in the diagnosis, treatment, and prevention of substance related disorders, which are acute or chronic diseases

3. addiction is a complex neurobehavioral disorder, involving biochemical abnormalities of the brain that involve reinforcement and reward systems of the central nervous system; addiction is manifested by aberrant behaviors that can compulsively persist despite adverse consequences

[2] AMBHA and ASAM, "Effective Treatment of Addictive Disorders: A Basis for an AMBHA-ASAM Dialogue," May 30, 1997.

from those behaviors; addiction is not a character weakness.

4. addiction diagnosis is objective, standardized, and scientific, no less so than for other chronic diseases
5. addiction treatment is effective[3] [4] [5] [6] [7]

6. barriers to effectiveness of addiction treatment are the same as barriers to effectiveness of treatment interventions for other chronic diseases: patient compliance and readiness to change, socioeconomic complications to care -delivery and management, and co-morbid emotional-behavioral conditions all adversely impact treatment success for substance addiction and for other chronic illnesses. There is nothing intrinsic to addiction treatment that should generate pessimism about treatment efficacy rates, and such pessimism is not supported by clinical research or experience.

7. relapse is inherent in addictive disease, but also inherent in virtually all chronic disease; relapse is usually a sign of chronicity, not a sign of treatment failure. By relapse, we mean a return to the signs and symptoms meeting criteria for a substance use disorder, not a return to use per se.

8. insurance benefits for addiction treatment should be equivalent to benefits for the treatment of other chronic diseases

9. treatment for the disease of addiction is cost-effective, and can be cost-saving for the health care system overall[8]

10. because of medical cost offsets, to NOT treat the disease of addiction is costly - economically as

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[3] National Treatment Improvement Evaluation Study (NTIES), 1996: The use of heroin by methadone maintenance treatment patients declined by 51%.

[4] California Drug and Alcohol Treatment Assessment (CALDATA), 1992: Compared with pretreatment rates, patients participating in methadone maintenance treatment experienced a 67% decrease in the use of substances.

[5] Comprehensive Assessment and Treatment Outcome Research (CATOR), 1992: Estimated one-year abstinence rates were 60% for inpatients and 68% for outpatients who were available to follow-up.

[6] NTIES: Between the pretreatment and follow-up period, of non-methadone outpatients, marijuana declined 42%, crack cocaine by 52%, heroin use by 41%, and the use of any drug by 41%. Alcohol related problems declined 62%.

[7] CATOR: Following treatment, 70% of patients who attended AA regularly, 70% of patients who participated in continuing care, and 90% of patients who both attended AA regularly and participated in continuing care for the entire year maintained their abstinence.

[8] California Drug and Alcohol Treatment Assessment (CALDATA), 1992: Compared with pretreatment rates, patients participating in methadone maintenance treatment experienced a 39% decrease in hospitalizations.

well as socially;[9] [10] benefit structures should not create barriers to effective intervention to diagnose and treat addiction.

Advocacy Position

AMBHA and ASAM support and advocate:

Benefit plans for the treatment of addictive disorders, in both the public and private sectors, shall be comprehensive; i.e., they shall cover the entire continuum of clinically effective and appropriate services provided by competent licensed professionals, and should provide identical coverage and funding to those benefits covering physical illness, with the same provisions, lifetime benefits, and catastrophic coverage.

Next Steps:

A national dialogue must take place among consumers, family members, professions, managed care organizations, employers, and state and federal government addressing the following critical issues:

1. In an environment of global competition, increasing health care needs, an aging population, and constraints on tax revenues, we need to identify best practices that demonstrate comprehensive coverage and its affordability, and we need to encourage the adoption of these best practices in public and private benefit plans.

2. We need to reduce the amount of variability between states regarding the interpretation of parity legislation, increase the consistency between various state laws on this issue, and prevent legislation on federal and state levels that inhibit the adoption of the best practices we have identified.

3. It is necessary to achieve consensus on what it means for a service to be "medically or clinically necessary", "appropriate" and a legitimate use of a benefit plan for behavioral health problems and services.

Adopted by the ASAM Board of Directors October 1997
Adopted by the AMBHA Membership October 1997

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[9] California Drug and Alcohol Treatment Assessment (CALDATA), 1992: Compared to pretreatment rates, patients participating in methadone maintenance treatment experienced an 84% decrease in criminal behavior.

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AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement
on
Relationship Between Treatment and Self Help:
A Joint Statement of the American Society of Addiction Medicine, Inc., the American Academy of Addiction Psychiatry, and the American Psychiatric Association

Background

For many years, physicians and other treatment professionals have recognized the value of self help groups as a valuable resource to patients in addiction treatment and their family members. (See, for example, American Society of Addiction Medicine's [ASAM] 1979 resolution on self help groups; the ASAM Patient Placement Criteria (Second Edition), and the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids). Addiction professionals and programs routinely recommend such groups to their patients and help them understand and accept the value of becoming an active participant.

It is important to distinguish between professional treatment and self help. Treatment involves, at minimum, the following elements:

a. *A qualified professional is in charge of, and shares professional responsibility for, the overall care of the patient;*

b. *A thorough evaluation is performed, including diagnosis, determination of the stage and severity of illness and an assessment of accompanying medical, psychiatric, interpersonal and social problems;*

c. *A treatment plan is developed, based on both the initial assessment and response to treatment over time. Such treatment is guided by professionally accepted practice guidelines and patient placement criteria;*

d. *The professional or program responsible and accountable for treatment is also responsible for offering or referring the patient for additional services that may be required as a supplement to addiction treatment;*

e. *The professional or program currently treating the patient continues therapeutic contact, whenever possible, until stable recovery has been attained.*

Self help groups, although helpful at every stage of treatment and as a long-term social and spiritual aid to recovery, do not meet the above criteria and should not be confused with or substituted for professional treatment.

In some instances, utilization review and medical necessity guidelines used by insurers and other managed care entities have sought to substitute self help attendance for professional treatment in patients who have

not reached stable remission from their alcohol or other drug dependence.

Recommendations

ASAM, AAAP and APA recommend that:

1. **Patients in need of treatment for alcohol or other drug-related disorders should be treated by qualified professionals in a manner consonant with professionally accepted practice guidelines and patient placement criteria;**

2. **Self help groups should be recognized as valuable community resources for many patients in addiction treatment and their families. Addiction treatment professionals and programs should develop cooperative relationships with self help groups;**

3. **Insurers, managed care organizations and others should be aware of the difference between self help fellowships and treatment;**

4. **Self help should not be substituted for professional treatment, but should be considered a compliment to treatment directed by professionals. Professional treatment should not be denied to patients or families in need of care.**

Adopted by the ASAM and the AAAP Boards of Directors October 1997
Adopted by the APA Board of Trustees December 1997

AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement
on
Treatment For Alcoholism and Other Drug Dependencies

I. ***General Definition of Treatment***

Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism, and other drug dependence, designed to enable the affected individual to achieve and maintain sobriety, physical and mental health, and a maximum functional ability.

II. ***Components of Treatment***

Treatment should include all or a combination of the following:

1. A thorough physical and psychosocial evaluation;

2. Detoxification: that is, the achievement of a state free of both alcohol and any other addicting drug. Detoxification may be accomplished on an inpatient or outpatient basis, and with or without the use of psychoactive drugs, depending on the physical, psychological and social needs of the patient.

3. Counseling, including education on: the nature of alcoholism and drug dependence as diseases; the need for long term abstinence; the need for a program of rehabilitation, including family involvement; the dangers of switching addictions and other related issues.

4. Medical treatment of the physical concomitant and complications of addictive illness including attention to nutritional needs.

5. Psychological assistance, for the patient and family through psychotherapy and /or counseling, along with involvement in self-help groups, depending on the needs and characteristics of the patient and the family. This assistance is aimed at sustaining motivation for sobriety, and helping the patient find alternative healthier ways of coping with personal, work, family and social problems without dependence on alcohol or other drugs. It is aimed at helping the family develop healthier, more satisfying patterns of interaction which will in turn facilitate and reinforce the patient's abstinence. This includes help for the children of patients with these disorders aimed also at prevention of the disease in this high-risk group.

   The prescription of a deterrent drug (e.g. disulfiram, naltrexone) or aversive counter-conditioning may accompany this phase of treatment as a motivational aid.

6. Treatment of any psychiatric illness which may accompany the alcohol or other drug dependence, such as affective disorders, anxiety disorders, personality disorders, etc.

7. Referral for help with social, legal, child care, vocational, spiritual or other associated problems to appropriate community resources.

8. Long term follow-up. Since alcoholism and other drug dependencies are chronic terminal diseases, treatment is generally conducted as a planned program with a prolonged follow-up, or on an open ended basis.

9. Opioid maintenance therapy may be used in selected opiate dependent patients.

III. *Length of Treatment*

Depending on the age of the patient, the stage of illness, the degree of associated physical and psychiatric disability, and the extent of social, family, vocational and legal problems, the length of the treatment and rehabilitation process will vary widely from case to case. In all cases, however, long term availability of social supports and medical supervision are needed because of the severe nature of the illnesses and potential for relapse.

IV. *Self-Help Groups*

Self-help groups for persons suffering from these disorders and for their families have been and remain a vital source of help in recovery. They represent a long term and ongoing source of psychological, social, and spiritual intervention and support, and are recommended as part of the plan of treatment wherever possible.

Adopted By ASAM Board of Directors 5/4/80
Revised By ASAM Board of Directors 9/21/86
Revised by ASAM Board of Directors 10/5/97

AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Effective Treatment of Addictive Disorders: A Basis for a Dialogue Between the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association

Sharing an interest in the delivery of high quality, cost-effective treatments of addictive disorders, the American Managed Behavioral Healthcare Association (AMBHA) and the American Society of Addiction Medicine (ASAM) have entered into an ongoing dialogue and, as a beginning, make the following observations:

1) Substance related problems span a range from problems associated with use, misuse and addiction. Patients may present requesting care at any time during this spectrum.

2) We accept the need to match the severity of patients' disorders with appropriate interventions for that intensity of problem.

3) Some individuals experience single or isolated episodes of illness; others experience periodic recurrences in their lifetimes; others have severe and persistent addictive disorders. For some persons with addictive disorders, especially those with severe and persistent disorders, there is a need for ongoing management and periodic acute treatment interventions to appropriately respond to situations of relapse.

4) Addictive disorders are primary disorders which require their own unique and specialized treatment. Individuals with addictive disorders may also experience mental illness and may also experience primary health problems.

5) A purpose of managed behavioral health care is to deliver clinically effective and cost-efficient services within the constraints of finite resources. This involves using the least intensive available treatment setting, appropriate to the needs of the patient, while maintaining patient safety. As for all chronic medical conditions, payers/purchasers of addiction services have limited resources. Effectiveness requires provider accountability for clinical outcomes that improve patients' health and provide acceptable consumer satisfaction.

6) The history of addiction expenditures is one characterized by stigma, prejudices, and biases which have led to inadequate treatment resources and a misallocation of resource use.

7) Managed behavioral health care is attempting to build organized and integrated delivery systems targeted to a population-based approach. But treatment must also be individualized and tailored to each individual's unique situation and needs.

8) To successfully assess and treat individuals with addictive disorders, providers must possess a core set of knowledge and experience. There are multiple and many professional providers of addiction services; each must demonstrate that he/she individually possesses a core set of knowledge and experience. AMBHA and ASAM have a shared interest in articulating what a minimum and standardized set of knowledge and experience should be.

9) All providers should deliver treatment that is effective, efficient, and has value. This will require sophisticated screening, assessing and tracking systems for measurement of outcomes and agreement on common screening tools, diagnostic criteria and nomenclature. There is increasing awareness that health plans, networks and individual providers must be more publicly accountable for the clinical outcomes they deliver.

10) Quality should be measured. Standardized data sets, including administrative, clinical, and performance, should be developed. AMBHA and ASAM will strive to articulate possible data set guidelines. AMBHA and ASAM share the goal of seeing that guidelines are produced to oversee the development, articulation and application of data sets and data accumulation processes.

Adopted by the ASAM Board of Directors, April 1997
Adopted by the AMBHA Membership, April 1997

Western Journal of Medicine
174:375-377. 2001.

Op-Ed: Why health insurers should pay for addiction treatment: Treatment works and would lead to net societal benefits

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Addiction is a chronic, relapsing-and-remitting disease that has profound effects on thought, emotions, and behavior. As an illness, it places a huge burden on health care services. All primary care physicians will encounter patients with the varied and episodic syndromes of intoxication, withdrawal, and craving. They will also encounter illnesses and injuries that are associated with both the drugs of addiction and the risky behaviors of addicted patients. These include treatment-resistant hypertension, liver and pancreatic diseases, industrial and recreational injury, sleep disorders, and family dysfunction and abuse. Medical specialists and tertiary treatment facilities see huge numbers of patients with illnesses that might have been prevented, such as hepatitis C, fetal alcohol syndromes, traumatic spinal cord and brain injuries, and end-stage psychiatric syndromes. What can be done to reduce this enormous burden?

The simple answer is that we can reject the therapeutic nihilism that surrounds addiction and start to provide comprehensive treatment to our addicted patients. Treatment of addiction works as well as, or better than, most other therapies for chronic, incurable diseases, especially those that require patients' compliance with lifestyle changes.1 Therapy works best if the addiction-and associated medical and psychiatric illnesses-is diagnosed early, before permanent damage occurs to cognitive processes that are essential in the struggle for sobriety. Ideally, treatment should begin while patients' family lives and careers are still intact.2 Not only does it work, but also addiction treatment is cost-effective.

The problem is that patients with addiction depend on coverage by their health insurers for treatment. Unfortunately, such coverage is rare. Insurers are, in a sense, preventing primary care physicians from being able to use an important therapeutic tool that could curb this "epidemic." Only wealthy patients who can afford to pay for treatment out of their own pockets are able to access comprehensive addiction treatment. This denial of payment for addiction treatment is part of a trend of declining coverage of psychiatric and behavioral treatments. The Hay Group found that employer-provided health benefit values for such treatments have declined annually.4 From 1988 to 1998, the value fell by 54.7% for psychiatric care and 76% for treating substance abuse.

Denying coverage of addiction treatment makes little financial sense. In 1999, the estimated medical expenditure in the United States to treat outcomes associated with addiction was $300 billion.5 Offering treatment nationally would cut these health costs. In the California Alcohol and Drug Treatment Assessment (CALDATA) study, the cost of treating approximately 150,000 substance users was $209 million, but the savings during treatment and in the first year afterward amounted to

$1.5 billion.6 The largest savings were related to reductions in crime. Health during and after treatment improved significantly, with corresponding reductions in use of health services. Emergency room admissions, for example, were reduced by one third after treatment.

Treatment is highly beneficial to taxpayers-the CALDATA study found that the cost benefit averages $7 return for every dollar invested.6 The Rand Corporation found that providing unlimited substance abuse benefits in employer-sponsored health plans costs employers only $5.11 per plan member per year.7 It 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."7 California is now leading the way for a change in how we treat people with addictive illnesses, with 2 new pieces of legislation. First, in November of 2000, 61% of California voters approved Proposition 36, the Substance Abuse and Crime Prevention Act of 2000 (www.prop36.org). With enactment of this new drug policy, offenders with addictions will be diverted from the California correction system and into community-based addiction treatment programs. The California Legislative Analyst's office estimates that the act will lead to a net state savings of $100 million to $150 million.8 Therapy for the addicted felon will be beneficial for society. Proper implementation of Proposition 36, even though it covers only a small percentage of people with addictions, is expected to overwhelm existing public and private treatment services; clearly, these will need to be expanded. Second, California State Senator Wes Chesbro is introducing a comprehensive drug treatment parity bill (Senate Bill 599 was passed out of the Senate Insurance Committee on April 18, 2001) that would require that health care service plan contracts provide coverage for treating alcohol and drug addiction.9 The bill stops discrimination in health insurance benefits, making lifetime addiction treatment available to all insured citizens. Passage of the bill would signal a public health approach to treating addiction and would enable physicians to provide or initiate treatment. It will reduce the number of people using addictive drugs as well as the prevalence of illnesses that are related to drug misuse.10 Insurers will undoubtedly fight passage of the bill, denying that parity is affordable and cost-effective for them.

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Parity legislation has gained support from, among others, the California Medical Association, the California Society of Addiction Medicine, and the California Society of Public Health Officers. Rather unexpectedly, support for parity has even come from the recently departed commanding general of the failed "War on Drugs." In January 2001, Barry MacCaffrey was asked, "What's the one big thing you've not done?" To this, he replied: "I'd say, `Get access to insurance for drug abuse and mental health'-it's a no-brainer."11 Society stands to benefit if insurers listen to his words and finally provide the comprehensive coverage for addiction treatment that patients deserve.

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Op-Ed Piece

Addiction Parity:

Saves Money, Stops Discrimination, Promotes Personal Responsibility

Donald J. Kurth, M.D.

Californians of every ethnic, social, and economic group are not receiving the health insurance benefits that they thought they had purchased. Health insurance companies have cut benefits for addiction treatment to less than a fourth of what benefits were ten years ago. These short sighted insurance companies are trying to save a few pennies but are actually costing the public treasury billions of dollars each year. They are discriminating against those among us with the disease of addiction and alcoholism. And, they are denying people the right to be responsible for their own healthcare.

Most employers do not realize that chemical dependency coverage has been excluded from their employees' policies. Nationwide, only one third of those who need treatment for addiction receive that treatment. If you are fortunate enough to have health insurance, you probably will not know that these benefits have been excluded from your policy until you or a family member is in need of treatment and that coverage is not available.

James F. Callahan, Executive Vice President of The American Society of Addiction Medicine, points out that 70% of Americans are insured by private health plans. But, few Americans receive chemical dependency benefits for treatment on par with those provided for other diseases because their health plans employ a number of discriminatory practices. These include:

- Annual and lifetime caps that are more restrictive than those imposed on other diseases.
- More stringent limits on days of inpatient care and number of outpatient visits than are imposed on other diseases.
- Higher co-pays and deductibles required for employees and their families who seek treatment for addiction.
- Arbitrary and often undisclosed criteria used by insurers and employers to determine whether treatment services are "medically necessary."

Often, health insurance companies will list addiction and alcoholism treatment as a covered benefit but fail to inform the insured that the coverage is woefully inadequate to pay for even the

most minimal treatment currently available. Sometimes, when the family member presents for treatment, he is informed that the insurer or HMO has decided that treatment for addiction or alcoholism is "not medically indicated" and that the individual should simply stop drinking on his own. This is not only medically unsafe but also unrealistic. Certainly, this may be good advice for the "whoopee drinker" or experimenting adolescent, but in the case of the addicted person or alcoholic there is no alternative but medical treatment.

Addiction and alcoholism is a fatal illness. It is a chronic, relapsing-and-remitting disease that profoundly affects thought, emotions, and behavior. The Robert Wood Johnson Foundation documents that addiction is the number one health problem in America today. No other disease costs society more. In the June 2001 issue of The Western Journal of Medicine, Dr. David Breithaupt, a member of the Public Policy Committee of the California Society of Addiction Medicine, points out that as an illness the cost of addiction to the health care system can be staggering, but not as a result of treatment. The real cost results from failure to treat. Every year our society spends billions of dollars on the treatment of drug and alcohol related hypertension, liver and pancreatic disorders, industrial and recreational injury, sleep disorders, and family dysfunction and abuse. University medical centers see huge numbers of preventable disorders such as hepatitis C, fetal alcohol syndrome, traumatic spinal cord and brain injuries, and end stage psychiatric syndromes. Columbia University has estimated that in 1999 in the United States, medical expenditures resulting from failure to treat the underlying addiction at its source cost 300 billion dollars.

The Physician Leadership on National Drug Policy (PLNDP) at Brown University recently reported that untreated addiction costs the nation six times more than heart disease, six times more than diabetes, and four times more than cancer. This is a non-partisan issue and warrants the support of Democrats and Republicans alike. A recent Congressional hearing in Washington, D.C., convened by Senator Orin Hatch (R-UT), resolved unanimously to make addiction treatment one of the primary focuses of U.S. drug policy. On Capital Hill, The Fairness in Treatment: Drug and Alcohol Recovery Act of 2001 (S. 595/H.R. 1194) is attempting to address these issues against stiff opposition from the big insurance companies and HMOs.

Treatment of addictive disease is not free, but denial of coverage for addiction treatment makes little financial sense. The California Alcohol and Drug Treatment Assessment (CALDATA) study found that treatment of 150,000 substance users cost $209 million. However, savings during treatment, and in only the first year following treatment, amounted to $1.5 billion. That means seven dollars are saved for every dollar spent on addiction treatment.

Not all HMOs oppose addiction treatment. Dr. Gary Jaeger, incoming President of the California Society of Addiction Medicine, points out that Kaiser, California's largest HMO, provides essentially unlimited treatment for addiction and alcoholism. Why would Kaiser do such a thing? The answer is simple: because it saves Kaiser money. Kaiser has found that by 18 months following addiction treatment, the medical costs of that treatment have been almost totally recouped in cost savings for that population of patients. In fact, the Rand Corporation found that providing unlimited substance abuse benefits in employer sponsored health plans costs employers only $5.11 per member per year. That is only 43 cents per month for unlimited addiction coverage. The Rand study concluded, "Limiting substance abuse benefits saves very

little in managed behavioral health care plans, but affects a substantial number of patients who need additional care."

Where do Californians stand on these issues? Clearly, the voters of California recognize the need for treatment of addictive disease. Just last November, the voters approved Proposition 36 by a confident 61% majority. Beginning July 1, 2001, offenders with addictions will be diverted from the correctional system into community based addiction treatment programs. This dramatic shift in public policy reflects a dynamic change in public opinion. The voters of California realize that treating a disease as a crime does not help to cure the disease. We must apply the same principles that have been successful with other diseases to the disease of addiction. Only then will we begin to make progress in eradicating that disease.

So why isn't treatment for addictive disease available? Actually, it is. If you are wealthy and can afford to pay cash for your medical care, treatment will always be available. Also, if you are arrested for a drug charge in California, under Proposition 36, treatment will be available. Judge Manley of California's Drug Court recently testified in favor of addiction parity before the California Senate. He suggested that Californians have found themselves in an unusual situation. If you are arrested for a drug charge, treatment will be provided. However, if you are a working-class person, going to work each day, trying to pay your bills and being responsible for your own health care problems, you probably have little or no coverage for you or your family to help pay for addiction or alcohol problems. Not only is this is a crisis in health care coverage; this is a crisis in personal responsibility that must be addressed.

The California legislature is addressing this issue as you read this article. California State Senator Wes Chesbro has introduced S.B. 599, a comprehensive drug treatment parity bill. The California Senate recently passed S.B. 599 by a sound majority and the bill has gone on to the State Assembly for approval. S.B. 599 requires health insurers to stop discrimination against Californians suffering from the disease of addiction. Passage of this bill would signal a legislative acknowledgement of a public health approach to addiction. Addiction Parity Bill S.B. 599 will reduce the number of people using addictive drugs as well as the prevalence of other illnesses related to drug abuse.

Big profit insurance and shortsighted HMOs have taken a stand against this bill and are spending big money to lobby your Assembly Member to vote against S.B. 599. Fortunately, many groups are in support. Among many others, support has come from the California Medical Association, The California Society of Addiction Medicine, and the California Society of Public Health Officers. Even former Director of the Office National Drug Control Policy, Executive Office of the President, Barry MacCaffrey, has come out in support of greater insurance benefits for drug and alcohol treatment. When asked, "What is the one big thing you have not done?" MacCaffrey's response was clear. "I'd say, 'Get access to insurance for drug abuse and mental health—it's a no-brainer.'"

We all stand to benefit if our California Assembly Members listen to these words and protect Californians' access to addiction treatment. We stand now at the turning point of public policy. The eyes of the nation are upon us. We can stop discrimination against those among us suffering from the disease of addiction and alcoholism. We can help California employers provide their

workers with the best medical coverage available. We can establish fiscally responsible policy and help Californians to be responsible for their own medical care. Big insurance has already visited your legislator to let him know how he can best look out for their financial interests. Now, it is your turn call or write your State Assembly Member today to let him or her know how you feel. Support passage of the Addiction Parity Bill S.B. 599.

Donald J. Kurth, M.D. is the incoming Chairperson of the Public Policy Committee of the California Society of Addiction Medicine and a Fellow of the American Society of Addiction Medicine.

Testimony before the SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES by
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SUBSTANCE ABUSE: THE SCIENCE OF ADDICTION AND OPTIONS FOR TREATMENT

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
July 28, 1998

Thank you, Senator Jeffords, for this opportunity to appear before the committee to describe the effectiveness and cost-effectiveness of addiction treatment and to explain the nature of addiction as a chronic disease which should have parity of access to treatment and parity of benefits for treatment comparable to other chronic diseases.

My written testimony first describes an overview of the problem we face taken from a chapter that I wrote for primary care physicians in the Medical Clinics of North America. Then I will describe the background and activities of Physician Leadership on National Drug Policy (PLNDP), whose work is relevant to the subject of these hearings. Finally I present selections from a research report about addiction and addiction treatment compiled recently by the PLNDP.

Overview

Of the 1,060,000 annual deaths in the U.S. attributed to lifestyle and behavior, about 50% are caused by substance misuse—419,000 from tobacco use, 100,000 from alcohol use, and 20,000 from illicit drugs. Substance abuse disorders severely affect the non-abusing population as well.

The financial toll of substance abuse is staggering. The total economic cost of tobacco, alcohol and other drug abuse on the U.S. economy exceeds $238 billion per year, with alcohol abuse accounting for $98.6 billion per year, tobacco for $72.0 billion, and other drugs for $66.9 billion. Fifteen percent of the entire national health care budget—about $140 billion dollars annually—is spent treating conditions and complications related to tobacco, alcohol and other drug abuse.

The morbidity and complications data for the risks attributable to alcohol, tobacco and other drugs are equally daunting. For example, among the following sources of morbidity, 13% of breast cancer, 72% of chronic pancreatitis, 74% of cirrhosis and 49% of all fatal automobile crashes are alcohol related. Smoking causes 87% of cheek and gum cancer, 53% of male bladder cancer, and 43% of placenta previa. Eighty percent of esophageal cancer is attributable to alcohol and smoking. Furthermore, various studies estimate that 17 to 53% of falls are alcohol related and 40 to 64% of people dying in fires have a blood alcohol level indicating intoxication. Illicit drug use presents a whole dimension of problems related to the criminal justice system and crime, but particularly pressing for the generalist is the increasing percentage of AIDS caused by injection drug use. It approaches 50% overall, with 71% of all female AIDS cases linked to intravenous drug use. These and other negative consequences from the harmful use of alcohol, tobacco and other drugs present a compelling reason for early intervention.

PLNDP

On July 8, 1997, a group of physician leaders convened at the NY Academy of Medicine to reach consensus on their view of national drug policy. A list of PLNDP members and their affiliations along with the list of financial supporters for the organization appears at the end of the written testimony. The PLNDP Consensus Statement is as follows:

"Addiction to illegal drugs is a major national problem that creates impaired health, harmful behaviors, and major economic and social burdens. Addiction to illegal drugs is a chronic illness. Addiction treatment requires continuity of care, including acute and follow-up care strategies, management of any relapses, and satisfactory outcome measurements.

"We are impressed by the growing body of evidence that enhanced medical and public health approaches are the most effective method of reducing harmful use of illegal drugs. These approaches offer great opportunities to decrease the burden on individuals and communities, particularly when they are integrated into multidisciplinary and collaborative approaches. The current emphasis — on use of the criminal justice system and interdiction to reduce illegal drug use and the harmful effects of illegal drugs — is not adequate to address these problems.

"The abuse of tobacco and alcohol is also a critically important national problem. We strongly support efforts to reduce tobacco use, including changes in the regulatory environment and tax policy. Abuse of alcohol causes a substantial burden of disease and antisocial behavior which requires vigorous, widely accessible treatment and prevention programs. Despite the gravity of problems caused by tobacco and alcohol, we are focusing our attention on illicit drugs because of the need for fundamental shift in policy.

"As physicians, we believe that:

· "It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention, utilizing criminal justice procedures which are shown to be effective in reducing supply and demand, and reducing the disabling regulation of addiction treatment programs.

· "Concerted efforts to eliminate the stigma associated with the diagnosis and treatment of drug problems are essential. Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned.

· "Physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area.

· "Community-based health partnerships are essential to solve these problems.

· "New research opportunities produced by advances in the understanding of the biological and behavioral aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training."

The PLNDP has received an extraordinary and positive reception in response to its initial July 8, 1997, Consensus Statement and to the release of its first research report on addiction treatment. This response has come from national professional societies in medicine, in the addiction field, in corrections and law enforcement, and from policy makers at both state and federal levels. PLNDP has

struck a responsive chord that crosses partisan lines and has garnered supporters covering the entire spectrum of ideologies, from very liberal to very conservative.

One of PLNDP's major activities is to bring scientific research to bear on this field. They have requested that several research reviews be assembled. The first research review on the nature of addiction and the nature of addiction treatment was presented in March, 1998.

Summary of the First Research Report on Drug Addiction and Addiction Treatment Presented to the Physician Leadership on National Drug Policy

This report on drug addiction and addiction treatment represented an integrated effort by researchers to provide a sound scientific foundation upon which to base drug policy alternatives. By revealing the similarities of drug addiction to other chronic illness, this report presented a challenge to physicians and other health professionals to review their role in addressing drug addiction and its consequences. The report also provided compelling information that merits attention by policy makers at all levels of government. The report consisted of five components:

Prevalence and costs of addictions relative to other chronic diseases: Using prevalence and economic data, drug addiction is compared with other common chronic medical conditions.

The combined prevalence of alcohol and drug dependence is about as great as that of heart disease, but addiction accounts for more lost productivity than heart disease and diabetes combined. In addition, the total annual cost per affected person for drug addiction is greater than either stroke, diabetes, or heart disease.

Drug addiction is not unique insofar as its manifestations are greatly influenced by behavior. Diet, exercise, and other health related behaviors, such as taking medications appropriately, affect the natural progression and treatment success for many chronic diseases.

Effective treatment of addiction can have a significant impact on reducing the prevalence and medical costs of a range of other illnesses. Improvements in employment status and in work productivity, in addition to medical savings, far outweigh the costs of drug treatment.

(Principal Researcher: Henrick Harwood, The Lewin Group)

Cost-effectiveness of treatment: Addiction treatment was compared with other life saving interventions and data presented on how to enhance treatment effectiveness at a reasonable cost.

In addition to considerable savings in short and long term medical costs, addiction treatment leads to major savings to the individual and society resulting from significant drops in interpersonal conflicts, various types of accidents, and crime, and increased work productivity.

A Harvard study (by Tengs *et al* from Harvard School of Public Health), showed that addiction treatment ranks among the top ten percent of the most effective health and life saving measures from among a list of over 500 medical and safety interventions. This section examined how the quantity of initial care, the frequency of self-help support group attendance, and the duration of maintenance care services influence the cost-effectiveness of treatment. Compared to other chronic conditions, additional professional services to enhance maintenance of recovery were among the most cost-effective forms of treatment.

(Principal Researcher: Donald Shepard, Ph.D., Brandeis University)

Returns on the drug addiction treatment investment: What are the cost benefits of addiction treatment?

Alcohol and drug addiction make a major contribution to the incidence and severity of a wide range of medical conditions such as certain forms of cancer, pancreatitis, endocarditis, injury, and AIDS. Although addicted persons are among the highest users of medical care, only 5% to 10% of these costs are due to addiction treatment. The rest is attributed to medical problems that are most often the result of, or triggered by, the addiction. For more than a decade, studies have demonstrated that addiction treatment marked reductions in medical care utilization and costs.

As impressive as the impacts and potential benefits are in the area of health care, other areas provide even greater potentials for financial returns on the treatment investment. The most dramatic return is the effectiveness of drug addiction treatment in reducing the occurrence and costs related to crime.

(Principal Researcher, James W. Langenbucher, Ph.D., Rutgers University)

Is drug dependence a treatable medical illness? Addiction treatment is compared with the treatments of other chronic medical conditions such as hypertension, diabetes, and asthma.

An extensive review of the literature showed that drug dependence meets the criteria for a treatable, chronic medical condition and is as consistently diagnosable as other illnesses. As important, addiction treatment has outcomes comparable to other chronic conditions. The heritability, or estimate of genetic contribution, for addiction is comparable to that of hypertension, diabetes and asthma. Although the treatment of addiction, like other chronic conditions, is far from perfect, positive outcomes are typically achieved, particularly with adequate and sustained treatment.

A key issue with chronic conditions is compliance with the prescribed treatment plan. Comparisons of medication and behavioral compliance reveal that addicted patients have compliance rates comparable to patients receiving treatment for diabetes, asthma and hypertension. In fact, the likelihood of requiring additional treatment within a 12 month period is slightly higher for diabetes, hypertension and asthma than for drug addiction.

(Principal Researchers: Thomas McLellan, Ph.D., University of Pennsylvania; Charles O'Brien, M.D., Ph.D., University of Pennsylvania; Norman Hoffmann, Ph.D., Brown University; Herbert Kleber, M.D., Columbia University)

Below are excerpts from the report by McLellan, O'Brien, Hoffmann, and Kleber:

On comparison with other chronic illness

"We found some areas of difference between drug dependence and the other chronic illnesses but primarily there were marked similarities in terms of:

1) the important role of personal choice, family, culture and environmental factors in the etiology and course of all these disorders,

2) genetic heritability

3) reliable, valid and easily measured symptomatic presentation enabling physicians to differentiate the pathological from the non-pathological condition and

4) evidence of pathophysiological changes at the cellular and system levels that underlie the expression of the behavioral manifestations of all these disorders"

On the nature of addiction, and cost savings of treatment

> "Although science has made great progress over the past several years, we cannot yet fully account for the physiological and psychological processes that transform controlled, voluntary "use" of alcohol and/or other drugs into uncontrolled, involuntary "dependence" on these substances. However, genetic research indicates that dependence is in part heritable. Neuropharmacological and neuroimaging research indicates that there is a predictable physiological course to dependence. Finally, research indicates that dependence can be reliably and validly differentiated from even heavy drug "use." In considering these factors associated with the onset, course and clinical presentation of drug dependence, the similarity with other well characterized, chronic, medical illnesses is clear. Four well controlled clinical trials compared treated and untreated samples of drug dependent individuals. Each trial showed clear evidence of broad and significant gains to both the patients and to society from these treatments. There was ample evidence of cost offset effects from the provision of drug dependence treatment, with major social and criminal justice costs being avoided among the treated individuals. We conclude that drug and alcohol dependence are medical illnesses, and that that drug and alcohol dependence are treatable medical illnesses."

PLNDP Research Report: Graphic Presentation

In the following section of the report, several graphics are presented. Most of them are copies of materials that were presented to the PLNDP panel.

I call your attention first to a series of three graphics prepared by Henrick Harwood of Lewin Associates for the PLNDP. Figure 1 shows the prevalence of several chronic conditions. You can see where alcohol, smoking, and drug addiction fall on this chart. Figure 2 deals with loss of productivity where alcoholism tops the list. Figure 3 assesses the costs of these chronic conditions by adding up three factors: health costs, the costs of decreased productivity and "other costs". By this reckoning we pay the highest price for drug addiction where the "other costs" are primarily the costs of crime.

There is a real economic value in reducing the crime costs and this can be done by providing medical treatment for addicts. Figure 4 shows that if in the first year you invest from about $2,900 to $8,900 in one or another treatment modality, you recoup approximately $19,000 in saved costs from reduced crime costs in year two.

Figure 5 shows the comparative costs of various treatment approaches along with the average cost of incarceration and makes the obvious point about varying costs of varying policy options. *(Prepared by PLNDP national office.)*

Figure 6 summarizes some information comparing addictive disease with other chronic diseases and, in particular, abstinence oriented addiction treatment. The compliance with medication and diet is comparable to the attendance compliance in addiction treatment. Patients with diabetes and hypertension who return for treatment to adjust their medications occur in even greater numbers than people returning for addiction treatment once their addiction is under control. *(Prepared by Dr. McLellan of the University of Pennsylvania.)*

Finally, Figure 7 reinforces the points that I have made about the reduction in health care costs and the decrease in crime from increased funding for addiction treatment. The State of Minnesota invested $50 million in increased treatment and recovered about $40 million in offsetting cost benefits in the first year. *(Prepared by Cynthia Turnure, Minnesota Dept. of Human Services)*

Additional Reports

In addition to the six hundred research studies surveyed in order to compile the PLNDP research report , many of our conclusions are also shared by other reports, including a recent report of Join Together's policy panel on treatment and recovery, which is chaired by former AMA President Robert E. McAfee, and entitled Treatment for Addiction: Advancing the Common Good. Also, there are two reports from the Institute of Medicine entitled Broadening the Base of Treatment for Alcohol Problems ,and Treating Drug Problems.

Summary

1) Treatment for substance abuse is effective, and particularly so if compared with absence of treatment or with treatment outcomes of other chronic diseases.

2) Cost offsets from addiction treatment are impressive, ranging in various studies from three to seven times the treatment investment. The cost savings are profound in three areas: reduced health care costs, increased productivity, and reduced crime.

3) Promising basic biomedical and behavioral research will enhance our understanding of addiction and improve the outcomes of addiction treatment. What works now for addiction treatment can only get better by the application of new scientific findings.

Membership of the Physician Leadership on National Drug Policy

June E. Osborn, MD (Chair)	Sixth President of the Josiah Macy, Jr. Foundation. Former Chair of the U.S. National Commission on AIDS. Former Dean, University of Michigan, School of Public Health.
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	Addiction Studies.
(Project Director)	
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Physician Leadership on National Drug Policy

Consensus Statement

Physician Leadership on National Drug Policy July 9, 1997

- Addiction to illegal drugs is a major national problem that creates impaired health, harmful behaviors, and major economic and social burdens. Addiction to illegal drugs is a chronic illness. Addiction treatment requires continuity of care, including acute and follow-up care strategies, management of any relapses, and satisfactory outcome measurements.

- We are impressed by the growing body of evidence that enhanced medical and public health approaches are the most effective method of reducing harmful use of illegal drugs. These approaches offer great opportunities to decrease the burden on individuals and communities, particularly when they are integrated into multidisciplinary and collaborative approaches. The current emphasis -- on use of the criminal justice system and interdiction to reduce illegal drug use and the harmful effects of illegal drugs -- is not adequate to address these problems.

- The abuse of tobacco and alcohol is also a critically important national problem. We strongly support efforts to reduce tobacco use, including changes in the regulatory environment and tax policy. Abuse of alcohol causes a substantial burden of disease and antisocial behavior which requires vigorous, widely accessible treatment and prevention programs. Despite the gravity of problems caused by tobacco and alcohol, we are focusing our attention on illicit drugs because of the need for fundamental shift in policy.

As physicians, we believe that:

- It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention, utilizing criminal justice procedures which are shown to be effective in reducing supply and demand, and reducing the disabling

regulation of addiction treatment programs.

- Concerted efforts to eliminate the stigma associated with the diagnosis and treatment of drug problems are essential. Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned.
- Physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area.
- Community-based health partnerships are essential to solve these problems.
- New research opportunities produced by advances in the understanding of the biological and behavioral aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training.

Over the next year, Physician Leadership on National Drug Policy will review the evidence to identify and recommend medical and public health approaches that are likely to be more cost-effective, in both human and economic terms. We shall also encourage our respective professional organizations to endorse and implement these policies.

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Annual Total Deaths for Major Chronic Behavioral Health Problems

- The mortality toll from heart disease, diabetes, and stroke (as well as smoking) are all much higher than the loss of life from alcohol and drug disorders. Of course, one of the palpable concerns with respect to alcohol and drug abuse is that a minority of deaths is of innocent victims (non-users of alcohol or drugs) through accidents and violence.
- Valuable perspective is provided on this by McGinnis and Foege (1993), who found that diet and activity patterns were responsible for about 300,000 deaths per year (this cuts across heart disease, stroke, diabetes, and other disorders) versus about 400,000 from smoking, 100,000 from alcohol abuse, and 20,000 from drug abuse.
- Heart disease and diabetes have total health expenditures many times greater than alcohol and drug disorders, while annual stroke and smoking health expenditures are only somewhat greater than alcohol and drug costs. Medically necessary health services for these other health behavior related disorders are routinely covered under private insurance as well as Medicare and Medicaid, as are health problems cause by smoking (prominently including heart disease and stroke).
- Source: National Institutes of Health (1997). Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update. Department of Health and Human Services.

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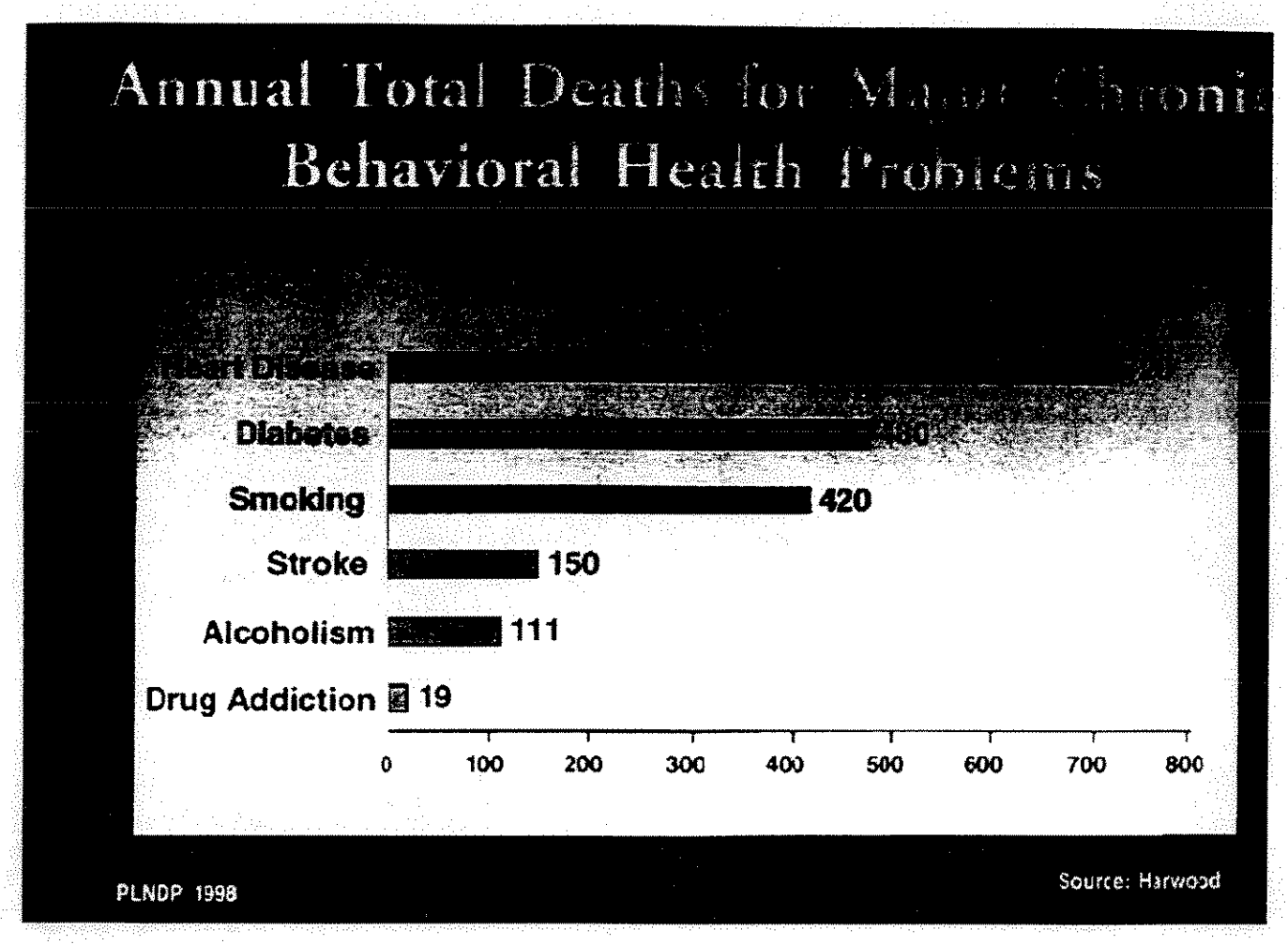
Annual Total Deaths for Major Chronic
Behavioral Health Problems
Heart Disease
Diabetes
Smoking
420
Stroke
150
Alcoholism
111
Drug Addiction
19
0
100
200
300
400
500
600
700
800
PLNDP 1998
Source: Harwood

Annual Expenditures on Major Chronic Behavioral Health Problems

Heart disease and diabetes have total health expenditures many times greater than alcohol and drug disorders, while annual stroke and smoking health expenditures are only somewhat greater than alcohol and drug costs. Medically necessary health services for these other health behavior related disorders are routinely covered under private insurance as well as Medicare and Medicaid, as are health problems caused by smoking (prominently including heart disease and stroke).

Source: National Institutes of Health (1997). Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Update. Department of Health and Human Services.

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