LEGAL ACTION CENTER

236 Mass. Ave. NE, Suite 510 • Washington, DC 20002 • (202) 544-5478 • FAX: 544-5712

October 18, 1993

Jose Cerda
Senior Policy Analyst
Office of Domestic Policy
The White House
Old Executive Office Building
Room 222
Washington, D.C. 20500

Dear Jose:

I'm writing to provide a copy of the Legal Action Center's Position Paper on the Coverage of Substance Abuse Treatment in the American Health Security Act. After the bill is introduced, we will revise this document, if necessary, and send you the updated version.

You'll notice that we have attached a list of questions to our analysis. We would appreciate answers to these questions so that we can better understand and evaluate the plan. We have sent this document to Secretary Shalala and Peter Edelman as well.

Thank you for responding to our concerns. We look forward to working with you on this most critical issue. Please feel free to contact me if you have any questions.

Sincerely,

Ellen M. Weber
Co-Director of National Policy

153 Waverly Place • New York, NY 10014 • (212) 243-1313 • FAX: (212) 675-0286

LEGAL ACTION CENTER

236 Mass. Ave. NE, Suite 510 • Washington, DC 20002 • (202) 544-5478 • FAX: 544-5712

POSITION PAPER ON THE COVERAGE OF SUBSTANCE ABUSE TREATMENT IN THE AMERICAN HEALTH SECURITY ACT

Introduction

The inclusion of drug and alcohol treatment in the standard benefit package of the American Health Security Act is a milestone in the nation's effort to combat one of our most serious public health problems. The Administration's plan recognizes the critical importance of integrating the current drug and alcohol treatment system into the mainstream health care system, while retaining the unique components of the treatment system that have delivered appropriate, cost-effective care to hundreds of thousands of individuals and families. Specifically, it recognizes the need to retain the community based treatment system and to require that licensed or certified substance abuse counselors provide treatment services. It also recognizes that drug and alcohol problems affect families, not just the addicted individual, and thereby provides coverage for necessary services for family members.

While the Legal Action Center applauds the Administration for its clear understanding of the value and need for treatment services, we have several concerns about the plan as currently outlined.

Most important, the Legal Action Center is very concerned that the Administration's proposed substance abuse benefit will not provide adequate coverage for individuals with the most severe drug and alcohol problems. This includes pregnant addicted women, women with children, the homeless and individuals involved in the criminal justice system, whose untreated addictions impose huge social and health care costs. Depending upon how the Administration has costed out the benefit package and the amount of funds that will be retained in the Substance Abuse Block Grant (and other federal categorical grant programs), the proposed plan may, in fact, cut back the level of services currently available to poor individuals with the most severe drug and alcohol problems.

In addition, while the benefit package on paper may be quite adequate for individuals with less severe problems who are employed and have a stable family life, utilization review/managed care practices could severely limit access to these services. Depending upon how the benefit is managed, individuals could be denied essential services and have no publicly funded "safety net" to rely on for care.

153 Waverly Place • New York, NY 10014 • (212) 243-1313 • FAX: (212) 675-0286

The following outlines the Center's concerns regarding the proposed drug and alcohol benefit, utilization review standards and confidentiality. We have included recommendations for revisions and have attached a list of critical questions about the proposed benefit.

I. Drug and Alcohol Benefit

A. Lack of Adequate Coverage for Individuals Who Need Longer Term Care: The plan does not adequately address (even by the year 2001) the care of individuals, such as pregnant addicted women, the homeless and individuals involved in the criminal justice system, who need longer term residential rehabilitation services. The residential treatment benefit is totally inadequate for individuals who need residential treatment ranging from six months to eighteen months, as is currently provided with federal, state and local funds. In addition, the reshaping of the Substance Abuse Block Grant and maintenance of state effort requirements, as articulated under the plan, will not adequately cover the needs of this population.

Substantial funds will be needed to provide coverage for longer term care. It is very unlikely that sufficient funds will be available through the Substance Abuse Block Grant or state drug and alcohol treatment funds for several reasons.

1. Funds will be backed out of the Substance Abuse Block Grant to the extent the standard package covers a particular level of care. Since the mental health and substance abuse benefit will be merged, dollars will apparently be taken from the Substance Abuse Block Grant to cover some of the cost of mental health care, which is more costly than substance abuse treatment.

2. The Substance Abuse Block Grant is intended to cover the cost of supplemental services that are essential components of care for individuals who need longer term care as well as those whose care is covered under the benefit package. These services include transportation, child care, education, vocational training and assistance in finding housing and linking with other social services. These services will require more funding than the block grant will likely contain.

3. State and local funding currently accounts for about 45% of drug and alcohol treatment services. States invest substantial funds in longer term care. Under the plan, states will be given flexibility to fold their drug and alcohol funds into the health alliances to support integrated systems of care. Accordingly, there is a great likelihood that funds currently spent on drug and alcohol treatment will be diverted to fund other health care and that essential drug and alcohol treatment services will not be funded.

Recommendation: A comprehensive drug and alcohol treatment benefit that provides for a continuum of services, including longer term residential services, should be included in the

standard benefit package. To the extent the benefit package limits covered services, the Substance Abuse Block Grant must be retained at the same funding level to ensure adequate coverage of longer term drug and alcohol treatment, supportive services and "safety net" treatment services for individuals who have exhausted the covered benefits. States must be required to maintain the same level of investment for drug and alcohol treatment while integrating those services and not be permitted to use the base level of drug and alcohol funds to support other health care services.

B. Merged Substance Abuse and Mental Health Benefit: The drug and alcohol benefit will be merged with the mental health benefit under the Administration's plan. This means that individuals who need both substance abuse and mental health services will have access to only one set of benefits.

As a result, dually diagnosed clients, individuals with severe drug and alcohol problems, and individuals with HIV disease who may need mental health counseling as well as drug and alcohol treatment could easily exhaust the benefit and be without care. Because the funds currently available under the Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant (and we would assume other federal categorical grant funds) will be eliminated to the extent a service is included in the standard benefit, it appears that there will be no publicly funded "safety net" for individuals who will need additional care.

There is no other set of illnesses for which the benefit has been merged in this way. It is analogous to saying that a women with heart disease and breast cancer who has been hospitalized for the heart condition cannot get hospital care in that same year for breast cancer because she has exhausted her in-patient benefit.

Moreover, this approach differs from the current care systems. Neither the privately nor publicly funded system merges these benefits. It is only the barebones insurance plans adopted by some states to cut the cost of private insurance that merge these benefits.

Recommendation: The two benefits should be separated and individuals should be eligible for a full complement of both drug and alcohol and mental health services. These benefits have not been given parity in terms of cost-sharing and scope of services. Individuals with these health problems should not be further disadvantaged by having to choose which of their conditions will be treated to the possible exclusion of or inappropriate care for the other.

C. Inconsistencies Between the Outpatient Coverage under the Low Cost Plan and High Cost/Combination Plans: The benefit charts (in the September 7th version) seem to indicate an inconsistency between the outpatient benefit provided in the low cost sharing plan versus that benefit in the high cost or combination cost sharing plans. (This may simply be an oversight in drafting.) The low cost plan describes the outpatient benefit (prior to the year 2001) as "brief office visits for medical

management." The high cost and combination plans describe the outpatient benefit as "all outpatient." The two categories are clearly different. This inconsistency defies the principle that the basic benefit will be the same across health care plans.

In addition, a "medical management" benefit is totally inappropriate for individuals with drug and alcohol problems. Most individuals in drug and alcohol treatment are not on medications. To the extent an individual is on a medication, such as methadone, counseling must always accompany the dispensing and monitoring of medication.

Recommendation: The outpatient benefit in the high cost and combination cost sharing plans must be provided to all individuals regardless of whether they enroll in the low cost or high cost/combination cost sharing plans.

D. Community-Based Treatment Providers as "Essential Providers": While the plan appears to encourage the delivery of substance abuse services by the current system of community based drug and alcohol treatment programs, such programs have not been identified as essential providers. It is essential to retain the community based system because HMOs have a questionable record in delivering these services. Without being designated as an "essential provider," the community-based treatment system may not survive.

Recommendation: Community based drug and alcohol treatment providers should be designated as "essential providers" to ensure that they can continue to compete and provide these services. They should be given the same protections as community health centers and other providers that have been designated under the plan as essential providers.

E. Eligibility Criteria for Youth and Adolescents: The benefit plan requires individuals to have a diagnosable mental or substance abuse disorder that meets the diagnostic criteria specified in the DSM-III-R and poses a significant risk for functional impairment. We are concerned that many youth and adolescents will not be eligible for early intervention counseling and treatment services because they will not meet this criteria.

Young people who are involved in gang activities and violence and are beginning to use drugs and alcohol may not meet the DSM criteria, but are clearly in need of counseling and treatment to prevent more serious and costly problems. Intensive home-based counseling services, family preservation services and school based treatment programs have been very effective in resolving problems early among such youth. But in some states in which similar criteria have been used to determine eligibility, troubled youth -- particularly minority youth -- have been excluded from care.

Recommendation: Develop eligibility criteria that enable youth to get appropriate services at the earliest possible time. Ensure that early intervention and family preservation services can be provided to youth before their problems escalate and become more costly health and criminal justice problems.

F. Cost Sharing: The plan would require cost-sharing for outpatient substance abuse counseling under all three schedules. While the current plan would provide subsidies for deductibles and co-payments to those with incomes below 150% of poverty, the subsidy will only apply for amounts in excess of the "low cost sharing" level. Thus, even the poorest individuals would have to pay $10 for every outpatient counseling session. This cost-sharing requirement will be prohibitive for many individuals who need to attend counseling sessions several times every week (and the many who could not even afford one visit), and, thus, will be a major barrier to obtaining necessary care and preventing relapse.

Recommendation: The outpatient substance abuse counseling service should be treated like the preventive clinic services with no cost-sharing requirement. Drug and alcohol treatment is clearly a preventive health service for HIV/AIDS, fetal alcohol syndrome, and a range of cardio-pulmonary diseases. In addition, because individuals with underlying drug and alcohol problem have increased hospital admissions and longer lengths of stay when obtaining care for other health conditions than individuals who do not have substance abuse problems, treatment will prevent costly complications.

G. Collateral Treatment for Family Members: The plan would provide family members coverage for "medically necessary or appropriately related services in conjunction with the patient." While inclusion of these services is commendable, we have several questions about implementation.

First, it is unclear what the scope of these services is. Second, the definition of "medically necessary" is not provided, and the criteria that will be used to determine whether family counseling or other services are necessary in unclear. Third, will a family member be able to obtain services even if the alcohol or drug dependent person is not in treatment.

H. Managed Care: The day limits that have been placed on the substance abuse benefit will be lifted in the year 2001 and management of the benefit will determine the length of stay. We commend the goal to fully integrate drug and alcohol treatment into the health care system and to provide parity with other illnesses. However, while this will theoretically lead to coverage of longer term residential care, practice has taught that utilization review/managed care often leads to the denial of necessary services and very restricted lengths of stay. If not properly performed and monitored, utilization review could severely limit the benefit rather than expand it.

This same concern applies to the management of the drug and alcohol benefit prior to the year 2001.

Recommendation: The utilization review/managed care system must be closely regulated and monitored to ensure that inappropriate decision are not made in an effort to cut costs. The Legal Action Center has developed a set of principles that should govern the regulation of utilization review. We will provide them upon request. In addition, it is very important that the ombudsperson and the grievance unit within each plan have expertise in drug and alcohol treatment and understand how it differs from treatment for other medical conditions, including mental health care.

II. Miscellaneous Issues

1. Confidentiality: The confidentiality of alcohol and drug patient records is currently protected under strict federal regulations, the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. It is unclear whether the same level of protection would be continued under reform as the plan proposes to establish a single, uniform set of protections. General medical information protections are weaker than the federal drug and alcohol regulations and are inadequate to protect the rights of individuals with drug and alcohol problems.

Recommendation: The protections under the federal drug and alcohol regulations must be maintained and perhaps even extended to cover all other health care records.

2. Grievance Procedure: The grievance procedure under the plan is very vague, and we have grave concerns that individuals may be denied essential services because of inappropriate utilization review decisions.

Recommendation: See recommendation under Managed Care.

3. Accessing Care for Individuals Who Are Not Part of the Primary Health Care System: Many individuals with drug and alcohol problems do not enter treatment through the primary care system. Many are required to attend as a condition of being involved in the criminal justice or social service system. We are concerned that these individuals will not get into treatment unless systems are put in place that ensure that courts and the social service system can continue to divert individuals into treatment and monitor their performance.

Recommendation: To ensure that clients can enter the treatment system at any point, courts and the social service system must continue to be the access point for individuals in need of care. The creation of a centralized assessment and case management unit, such as a treatment alternatives to street crime ("TASC") program for alcohol and drug dependent individuals in the criminal justice system, will facilitate this process.

4. Treatment for Incarcerated Individuals: The Administration's plan does not provide health care coverage for incarcerated individuals. An estimated 70% of these individuals have drug and alcohol problems. If this population is not provided comprehensive treatment services, our Nation will continue to pay health, social services and crime-related costs.

Recommendation: Ensure that the corrections system is required to fund and provide treatment to all who need it.

October 14, 1993

Questions

1. What is the rationale for providing a merged substance abuse and mental health benefit?

2. What amount of funding will remain in the Substance Abuse Block Grant to cover longer term care and supportive services during the transition period?

3. What is the total estimated cost of the substance abuse and mental health benefit? What is the estimated cost of the substance abuse portion and the mental health portion?

4. Will the publicly funded system provide any services to individuals who exhaust their substance abuse benefit? If so, what services will be available?

5. Does the out-patient counseling benefit in the low cost sharing plan differ from that in the high cost and combination plans? If so, why?

6. Will community-based drug and alcohol treatment programs be designated "essential providers"?

7. What family counseling services (collateral services) are included in the plan? What is the definition of "medical necessity" as it applies to this set of services and what criteria will be used to determine "medical necessity? Will a family member be able to obtain services even if the alcohol or drug dependent person is not in treatment?

8. In the year 2001, what happens to the publicly funded treatment system that was retained during the transition period?

9. Who is responsible for funding and providing substance abuse treatment services to incarcerated individuals in both the state and federal systems? Will funds be increased to provide these services?

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

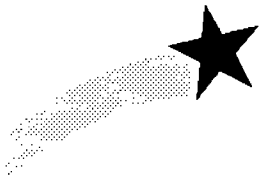
Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

The Health Security Act

Benefits for Business

"The Health Security Act preserves our employer-based, privately-financed system of health care. It will control the costs that are hurting American businesses' ability to compete. And it will help small business owners provide affordable insurance for themselves, their employees, and their families."

– President Bill Clinton



Pre-Publication Offer

Dear Newsletter Subscriber:

IHPP is currently preparing updates to our series of annual reports summarizing state legislative initiatives in the following program areas:

Expanding Access to Health Care
Health Care Provider Availability
Health Planning & Cost Containment
Health Insurance Reform
HIV/AIDS
Long-Term Care
Managed Care
Medicaid
Mental Health
Substance Abuse
Substance Abuse & Mental Health Benefits Under State Health Care Reform

Each report provides summaries of new laws, analysis of major trends and innovations, and abstracts of all the major legislation enacted in the states.

We will also be publishing a compilation volume entitled ***Major Health Legislation in the States: 1993***. This report will include the summaries and analysis sections of each the individual reports discussed above.

Make your pre-publications order by December 31 and pay only $25 for each individual report, and $75 for *Major Health Legislation in the States: 1993*. After December 1, the cost will be $35 for each individual report, and $105 for the compilation volume. Use the order form below, or call IHPP today at (202) 872-1445 and charge your order to Visa or MasterCard.

PRE-PUBLICATION OFFER ORDER FORM

PLEASE ENTER MY ADVANCE ORDER FOR REPORT(S) IN THE FOLLOWING SUBJECT AREAS:

❑ ***Major Health Legislation in the States: 1993***

❑ Expanding Access to Health Care
❑ Health Care Provider Availability
❑ Health Planning & Cost Containment
❑ Health Insurance Reform
❑ HIV/AIDS
❑ Long-Term Care
❑ Managed Care
❑ Medicaid
❑ Mental Health
❑ Substance Abuse
❑ Substance Abuse & Mental Health Benefits Under State Health Care Reform

Orders received before December 31, 1993: pay only $75 for *Major Health Legislation in the States: 1993* and $25 for each report. Take 20% off the total cost for orders of 3 or more publications. Add $5.00 for shipping and handling, unless order is prepaid. Please make check payable to: The George Washington University

NAME: _____ TEL. #: _____
ORGANIZATION: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
AMOUNT ENCLOSED: $ _____ PO ENCLOSED: _____
❑ MasterCard ❑ Visa Card No. _____
Expiration Date: _____ Signature: _____

MAIL OR FAX TO:
Publications, IHPP, 2021 K Street, N.W., Suite 800, Washington, DC 20006
(202) 872-1445 FAX (202) 785-0114

NWS93

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

INTERGOVERNMENTAL HEALTH POLICY PROJECT

STATE ADM REPORT

NOV 5 REC'D

ALCOHOLISM, DRUG ABUSE & MENTAL HEALTH

HEALTH INSURANCE

Mental Health and Substance Abuse Coverage: An Update on Health Care Reform in the States

Reflecting the national debate that has moved center stage with the mid-September release of President Clinton's health reform plan, a growing cadre of State lawmakers have this year argued the need for adequate mental health and substance abuse (MH/SA) coverage in any uniform benefits package. As Mike Hogan, director of **Ohio**'s Department of Mental Health, puts it: "Only time will tell what will happen. What cannot be ignored is that the Clinton health care reform proposal has dramatically shifted the terms of the debate. The question is no longer whether mental health is in or out, 'but how' and 'how much.'"

Indeed, of the more than 70 major reform bills considered this year (in 45 States), 50 (in 27 States) contained language related to mental health and substance abuse coverage. The following article updates activities in those States that have taken the lead on reform: **Minnesota, Oregon, Colorado, Vermont, Washington, Florida, Texas**, and **Montana**. Legislation is still pending in **Wisconsin, Ohio, Pennsylvania,** and **New Jersey**.

Minnesota

The legislature this year amended the State's 1992 health plan for low-income residents—called MinnesotaCare—to 1) clarify that the $10,000 inpatient benefit applies to treatment for mental illness and substance abuse, 2) add medication management by a physician to the list of covered services, and 3) expand the outpatient benefit by adding day treatment and partial hospitalization and removing the 10-hour limit on outpatient treatment for alcohol and drug dependence. The extent and intensity of outpatient treatment will be based on the State's Medicaid managed care guidelines as they relate to the appropriate level of care for a specific diagnosis. Provider, insurer, and cigarette taxes will fund the expanded coverage. A significant feature of the plan is the requirement to reduce the growth rate for all health spending by 10 percent over the next five years.

As of July, the Minnesota Employees Insurance Program for small employers, also adopted in 1992, allows pooled purchasing of coverage (including

"State Reforms" continued on page 2

The George Washington University
WASHINGTON DC

Number 29 October 1993

Lee Dixon, Editorial Director
Linda Demkovich, Editor
Connie Wessner, Assistant Editor
Claire Helf, Mental Health
Jacqueline Morgan, Substance Abuse

This newsletter is supported in part by a contract from the Substance Abuse & Mental Health Services Administration No. 283-91-0004

In This Issue:

GUARANTEED NATIONAL BENEFIT PACKAGE

The health benefits guaranteed to all Americans provide comprehensive coverage, including mental health services, substance-abuse treatment, some dental services and clinical preventive services.

The guaranteed benefit package contains no lifetime limitations on coverage, with the exception of coverage for orthodontia.

MEDICAL SERVICES COVERED

Each health plan must provide coverage for the following categories of services as medically necessary or appropriate with additional limitations and cost-sharing only as specified in the American Health Security Act of 1993 or by the National Health Board. Covered health services are:

- Hospital services
- Emergency services
- Services of physicians and other health professionals
- Clinical preventive services
- Mental health and substance abuse services
- Family planning services
- Pregnancy-related services
- Hospice
- Home health care
- Extended-care services

- Ambulance services
- Outpatient laboratory and diagnostic services
- Outpatient prescription drugs and biologicals
- Outpatient rehabilitation services
- Durable medical equipment, prosthetic and orthotic devices
- Vision and hearing care
- Preventive dental services for children
- Health education classes.

DEFINITION OF SERVICES

Hospital services:

- Inpatient hospital, including bed and board, routine care, therapeutics, laboratory, diagnostic and radiology services and professional services specified by the National Health Board when furnished to inpatients.
- Outpatient hospital services
- 24-hour a day emergency department services
- Definition: A hospital is an institution meeting the requirements of §1861(e) of the Social Security Act.

Services of physician and other health professionals:

- Includes inpatient and outpatient medical and surgical professional services, including consultations, delivered by a health professional in home, office, or other ambulatory care settings, and in institutional settings.

- Definitions

  - A health professional is someone who is licensed or otherwise authorized by the State to deliver health services in the State in which the individual delivers services.

  - Covered services are those that a health professional is legally authorized to perform in that state. No state may, through licensure requirements or other restrictions, limit the practice of any class of health professionals except as justified by the skill or training of such professional.

  The benefit package does not require any plan to reimburse any particular provider or any type or category of provider. However, each plan is expected to provide a sufficient mix of providers and specialties and appropriate locations to provide adequate access to professional services.

Clinical preventive services:

- Specified in Table I.

- Limitation: Must be provided as consistent with the periodicity schedule specified in Table I or as specified by the National Health Board in regulations.

TABLE I -- COVERED CLINICAL PREVENTIVE SERVICES

Age	Immunizations	Tests
0–2	4 DTP, 3 OPV, 3–4 HiB, 1 MMR, 3 HBV	1 Hematocrit, 2 Lead*, 7 Clinician visits***
3–5	1 DTP, 1 OPV, 1 MMR	1 Urinalysis, 2 Clinician visits***
6–19	1 Td	Pap/pelvic** every 3 years after menarche, 5 Clinician visits***
20–39	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic** every 3 years***+
40–49	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic** every 3 years***+
50–64	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic and Mammogram++ every 2 years
65 +	1 Td every 10 years Pneumococcal – once Annual influenza	Cholesterol every 5 years Mammogram++ every 2 years

Preventive coverage includes coverage for women of any age presenting for prenatal care.

Key

* = For children at high risk for lead exposure only.

** = Papanicolaou smears and pelvic exam for females who have reached childbearing age and are at risk of cervical cancer.

*** = Once three annual negative smears have been obtained.

\+ = For females of childbearing age at risk for sexually transmitted disease, an annual Pap smear and screening for chlamydia and gonorrhea.

++ = Females only.

+++ = All visits including immunizations, laboratory tests and other screening tests, including history, blood pressure measurement, risk assessment, and targeted health advice/counseling.

DTP = Diphtheria, tetanus, pertussis vaccine

OPV = Oral polio vaccine

HiB = Haemophilus influenzae type B vaccine
HBV = Hepatitis B vaccine
MMR = Measles, mumps, rubella vaccine
Td = Tetanus diphtheria toxoid

(Continuation of covered services)

Mental health and substance abuse -- inpatient and residential treatment:

- Inpatient hospital, therapeutic family or group homes, residential treatment centers, community residential treatment, community residential treatment and recovery for substance abuse, residential detoxification services, crisis residential services and other residential treatment services.

- Limitations

  - Maximum of 30 days per episode, 60 days annually for all settings in this category. Health plans upon special appeal may grant an exception waiver of only the episode maximum for the limited number of cases in which discharge is not medically appropriate because the patient continues to make or is at serious risk of making an attempt to harm them self or to harm others.

  - Inpatient hospital substance abuse treatment covers only medical detoxification as required for the management of neuropsychiatric or medical complications associated with withdrawal from alcohol or drugs.

  - Inpatient hospital care for mental and substance abuse disorders is available only when less restrictive nonresidential or residential services are ineffective or inappropriate.

- Definitions:

  - A hospital is an institution meeting the requirements of §1861(e) or (f) of the Social Security Act.

  - A residential treatment facility is one which meets criteria for licensure or certification established by the state in which it is located.

- Eligibility

  Persons are eligible for mental health and substance abuse services other than screening and assessment and crisis services if they have, or have had in the past year, a diagnosable mental or substance abuse disorder, which meets diagnostic criteria specified within DSM-III-R, and that resulted in or poses a significant risk for functional impairment in family, work, school, or community activities.

  - These disorders include any mental disorder listed in DSM-III-R or their ICD-9-CM equivalents, or subsequent revisions, with the exception of DSM-III-R "V" codes (conditions not attributable to a mental disorder) unless they co-occur with another diagnosable disorder.

  - Persons who are receiving treatment but without such treatment would meet functional impairment criteria are considered to have a disorder.

  Family members of an eligible participant receiving mental or substance abuse services may receive medically necessary or appropriately related services in conjunction with the patient (so-called collateral treatment).

Mental health and substance abuse -- professional and outpatient treatment services:

- Professional services, diagnosis, medical management, substance abuse counseling and relapse prevention, outpatient psychotherapy.

- Limitations

  - Outpatient coverage is limited to 30 visits except clinical management and substance abuse counseling.

  - Substance abuse and relapse counseling must be provided by licensed/certified substance abuse providers.

- Eligibility criteria specified above for inpatient mental health and substance abuse treatment services apply, except that all persons are eligible for screening and assessment and 24-hour crisis services.

- Definitions for services of physicians and other health professionals apply.

Mental health and substance abuse -- intensive non-residential treatment services:

- Partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, behavioral aide services.

- Limitations

    - 120 days per year for listed services

    - Provided only for the purpose of averting the need for, or as an alternative to, treatment in residential or inpatient settings, or to facilitate the earlier return of individuals receiving inpatient or residential care, or to restore the functioning of individuals with serious mental or substance abuse disorders, or assist individuals to develop the skills and access the supports needed to achieve their maximum level of functioning within the community.

- Eligibility: As specified for inpatient mental health and substance abuse treatment services.

Family planning services

Pregnancy-related services

Hospice care:

- Covered services (as under Medicare):

    - Nursing care provided by or under the supervision of a registered professional nurse.

- Medical social services under the direction of a physician.
- Physicians' services.
- Counseling services for the purposes of training the individual's family or other caregiver to provide care and for the purpose of helping the individual and those caring for him or her to adjust to the individual's death.
- Short-term inpatient care, although respite care is provided only on an occasional basis and may not be provided for more than 5 days.
- Medical supplies and the use of medical appliances for the relief of pain and symptom control related to the individual's terminal illness.
- Home health aide and homemaker services.
- Physical or occupational therapy and speech-language pathology.

- Limitations
  - Only for terminally ill individuals
  - Only as an alternative to continued hospitalization.
- Definition:
  - An individual is considered terminally ill if the individual has a medical prognosis of a life expectancy of 6 months or less if the terminal illness runs its normal course.

Home health care:

- Same services as under the current Medicare program (including skilled nursing, physical, occupational and speech therapy, prescribed social services) with the addition of prescribed home infusion therapy and outpatient prescription drugs and biologicals.

- Limitations

    - Only as an alternative to institutionalization (i.e., inpatient treatment in a hospital, skilled nursing or rehabilitation center) for illness or injury.

    - At the end of each 60 days of treatment, the need for continued therapy is re-evaluated. Additional periods of therapy are covered only if the risk of hospitalization or institutionalization exists.

Extended care services:

- Inpatient services in a skilled nursing or rehabilitation facility.

- Limitations

    - Only after an acute illness or injury as an alternative to continued hospitalization.

    - Maximum of 100 days per calendar year.

Ambulance services:

- Ground transportation by ambulance, including air transportation by an aircraft equipped for transporting an injured or sick individual.

- Limitations

    - Ambulance service is covered only in cases in which the use of an ambulance is indicated by the individual's condition.

- Air transport covered only in cases in which other means of transportation are contra-indicated by the patient's condition.

Outpatient laboratory and diagnostic services:

- Prescribed laboratory and radiology services, including diagnostic services provided to individuals who are not inpatients of a hospital, hospice or extended care facility.

Outpatient prescription drugs and biologicals:

- Drugs, biological products, and insulin.
- Limitation:
  - Must be prescribed for use in an outpatient setting.
  - No frequency or quantity limitations other than reasonable rules for amount to be dispensed and number of refills. Health plans are permitted to establish formularies, drug utilization review, generic substitution, and mail order programs.

Outpatient rehabilitation services:

- Outpatient occupational therapy, outpatient physical therapy, and outpatient speech-pathology services for the purpose of attaining or restoring speech.
- Limitations
  - Coverage only for therapies used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury.

- At the end of each 60 days of treatment, the need for continued therapy is re-evaluated. Additional periods of therapy are covered only if function is improving.

Durable medical equipment, prosthetic and orthotic devices:

- Covered services:
  - Durable medical equipment
  - Prosthetic devices (other than dental) which replace all or part of an internal body organ
  - Leg, arm, back and neck braces
  - Artificial legs, arms and eyes (including replacements if required due to a change in physical condition)
  - Training for use of above items.
- Limitations
  - Items must improve functional abilities or prevent further deterioration in function.
  - Does not include custom devices.

Vision and hearing care:

- Covered services:
  - Routine eye exams, including procedures performed to determine the refractive state of the eyes
  - Diagnosis and treatments for defects in vision

- Routine ear examinations.

- Limitations

  - Eyeglasses and contact lenses limited to children under the age of 18.

  - Routine eye examinations limited to one every 2 years for persons 18 years of age or more.

Preventive dental services for children:

- Treatment for prevention of dental disease and injury, including maintenance of dental health, and emergency dental treatment for injury.

- Limitation: Non-emergency dental services limited to children under age 18.

Health education classes:

Participating health plans are permitted to cover health education or training for patients that encourage the reduction of behavioral risk factors and promote healthy activities. Such courses may include smoking cessation, nutritional counseling, stress management, skin cancer prevention, and physical training classes. Cost sharing is determined by the plan.

INTEGRATION OF PUBLIC AND PRIVATE MENTAL HEALTH CARE SYSTEMS

The benefit package requires the maintenance of the existing public system for mental health and substance abuse. It also requires maintenance of the existing block grant program to the states that supplements their spending on mental and addictive disorder programs.

In order to promote the eventual integration of the public and private systems for treatment of mental and addictive disorders into a single system of care, states are encouraged to use the flexibility allowed under health reform to fold their expenditures for public mental health and substance abuse programs into funding available to regional health alliances to require integrated care for all health needs, including mental and addictive disorders.

States adopting this direction may obtain a waiver from limits in the benefit package and are eligible for federal matching funds to develop integrated service systems.

The Department of Health and Human Services argues for the addition of the following requirements for states to obtain waivers to support the integration of public and private mental health systems:

States may obtain a waiver from the limits in the benefit package and include extended care services after showing that the capacity to deliver, manage and monitor the quality of a more comprehensive mental health and substance abuse benefit through integrated acute and extended care systems is feasible in the state. States also must document that the waiver will not result in additional premium costs and that Medicaid has been integrated. States choosing this approach are allowed greater flexibility in their use of block grant funds to assist in the development o community based systems of care.

EXCLUSIONS

The benefit package does not cover services that are not medically necessary or appropriate, private duty nursing, cosmetic orthodontia and other cosmetic surgery, hearing aids, adult eyeglasses and contact lenses, in vitro fertilization services, sex change surgery and related services, private room accommodations, custodial care, personal comfort services and supplies and investigational treatments, except as described below.

COVERAGE OF INVESTIGATIONAL TREATMENTS

The comprehensive benefit package includes coverage for medically necessary or appropriate medical care provided as part of an investigational treatment during an approved research trial. The intention of this provision is to cover routine medical costs associated with an investigational treatment that would occur even if the investigational treatment were not administered.

- An investigational treatment is a treatment the effectiveness of which has not been determined and which is under clinical investigation as part of an approved research trial.

- An approved research trial is a peer-reviewed and approved research program, as defined by the Secretary of the Department of Health and Human Services, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for that treatment to be medically necessary or appropriate.

  Coverage is automatically available if the research trial is approved by the National Institutes of Health, the FDA, the Department of Veterans Affairs, Department of Defense or a qualified non-governmental research entity as identified in NIH guidelines.

EXPANSION OF BENEFITS

The initial benefit plan provides comprehensive preventive coverage for all patients and focuses comprehensive dental, mental health and substance abuse coverage on priority concerns including preventive dental services for children and treatment for seriously mentally ill adults, seriously emotionally disturbed children and individuals with substance-abuse disorders.

The plan proposes to phase in additional benefits in the year 2000. The National Health Board has discretion to introduce additional benefits earlier if savings from reform and budget resources permit. Additional benefits included in planned expansion include:

Clinical Preventive Services:

- For specific high-risk patients only (as defined by the National Health Board), the following targeted screening tests and vaccinations are covered as preventive services: hemoglobin electrophoresis, tuberculin skin test, rubella antibodies, hearing test, hepatitis B vaccine (for age groups not already covered), pneumococcal vaccine, influenza vaccine, mammogram, colonoscopy.

- Periodic medical examinations: every 3 years for individuals ages 20 to 39, every 2 years for adults ages 40 to 65, and annually for adults ages 65 or more.

Dental Services:

- Preventive dental care extended to adults
- Restorative services
  - Low Cost Sharing -- $20 per visit
  - High Cost Sharing -- 40 percent co-insurance, $50 deductible, and $1500 annual maximum benefit for prevention and restoration
- Orthodontia in cases in which it is necessary to avoid reconstructive surgery
  - Low Cost Sharing -- $20 per visit
  - High Cost Sharing -- 40 percent co-insurance, $50 deductible, and $2,500 lifetime maximum benefit

Mental Health and Substance Abuse:

- Improved inpatient coverage, increasing annual maximum benefit from 60 days to 90 days
- Elimination, in plans with high cost sharing, of the deductible for inpatient care equal to charge for one day
- Elimination of limits on outpatient therapy visits. In plans with high cost sharing, reduction of cost sharing requirement to 20 percent for initial 12 visits and 50 percent for subsequent visits. In plans with low cost sharing, reduction of cost sharing requirement to $10 per visit for initial 12 visits and $25 per visit for subsequent visits.
- Coverage for case management with no cost sharing.

Phasing in additional coverage for mental health benefits allows health plans to develop the skills and capacity to provide a more comprehensive mental health and substance abuse benefit.

COST SHARING

Consumer out-of-pocket costs for health services in the comprehensive benefit package is limited, to ensure financial protection, and standardized to ensure simplicity in choosing among health plans.

Health plans use standard consumer cost sharing requirements. Health plans may offer consumers one of three cost sharing schedules:

- **Low cost sharing:** $10 co-payments for outpatient services; no co-payments for inpatient services.
- **Higher cost sharing:** $200 individual/$400 family deductibles; 20 percent coinsurance; $2000/3000 maximum on out-of-pocket spending.
- **Combination:** Plan provides low cost sharing if participants use preferred providers and higher cost sharing (20 percent coinsurance) if they use out-of-network providers.

LOW COST SHARING

	Cost-sharing	Limitations
Overall - Deductible - Coinsurance - Out-of-pocket max	 None $10 per visit None necessary	
Inpatient Hospital	Full coverage	Private room only when medically necessary
Professional services, outpatient hospital services.	$10 per visit	
Emergency services	$25 per visit	Waived in emergency.
Preventive services, including well-baby, prenatal	Full coverage	Services limited to periodicity in Table 1.
Hospice	Full coverage	As hospital alternative for terminally ill.
Home health care	Full coverage	As inpatient alternative; coverage reassessed at 60 days; added coverage only to prevent institutional care.
Extended care facilities (SNFs, rehab facility)	Full coverage	As hospital alternative; 100 day limit.
Outpatient physical, occupational, speech therapy	$10 per visit	Only to restore function or minimize limitations from illness or injury; reassessment at 60 days; additional coverage only if improving.
DME, outpatient lab, ambulance	Full coverage	
Routine eye and ear exams, eyeglasses	$10 per exam or 1 set glasses	Eyeglasses limited to children only

Dental services -Initial: Prevention -Additions in 2000: Restoration Orthodontia	$10 per visit $20 per visit $20 per visit	For <18 only Remove age limit on prevention Only to avoid reconstructive surgery
Prescription drugs	$5/prescription	
Mental health / substance abuse Initial Inpatient services: Hospital alternatives: All outpatient except psychotherapy: Psychotherapy: 2000 Inpatient services: Hospital alternatives: Outpatient incl. 1-12 psychotherapy visits: 12+ psych visits:	 Full coverage Full coverage $10 per visit $25 per visit Full coverage Full coverage $10 per visit $25 per visit	 30 day/episode; 60 day/year max 120 days maximum no limits 30 visits maximum 30 day/episode; 90 day/year max 120 days maximum no limits no limits

HIGH COST SHARING

	Cost-sharing	Limitations
Overall - Deductible - Coinsurance - Out-of-pocket max Individual Family	 $200/400 indiv/family 20% $2,000 $3,000	
Inpatient Hospital	20% co-ins	Private room only when medically necessary
Professional services, outpatient hospital services including emergency.	20% co-ins	
Preventive services, including well-baby, prenatal	Co-ins and deductible does not apply	Services limited to periodicity in Table 1.
Hospice	20% co-ins	As hospital alternative for terminally ill.
Home health care	20% co-ins	As inpatient alternative; coverage reassessed at 60 days; added coverage only to prevent institutional care.
Extended care facilities (SNFs, rehab facility)	20% co-ins	As hospital alternative; 100 day limit.
Outpatient physical, occupational, speech therapy	20% co-ins	Only to restore function or minimize limitations from illness or injury; reassessment at 60 days; additional coverage only if improving.

DME, outpatient lab, ambulance	20% co-ins	
Routine eye and ear exams, eyeglasses	20% co-ins	Eyeglasses limited to children only
Dental services -Initial: Prevention	20% co-ins	For <18 only
-Additions in 2000:		Remove age limit on prevention
Restoration	$50 deduc + 40% co-ins	$1500 annual max
Orthodontia	40% co-ins	Only to avoid reconstructive surgery; $2500 lifetime max
Prescription drugs	$250/year deduc 20% co-ins oop max applies	

Mental health / substance abuse		
Initial Inpatient services:	1 day deductible 20% co-ins; oop max applies	30 day/episode; 60 day/year max
Hospital alternatives:	1 day deductible 20% co-ins	120 days maximum
All outpatient except psychotherapy:	20% co-ins	no limits
Psychotherapy:	50% cost sharing	30 visits maximum
2000 Inpatient services:	20% co-ins; oop max applies	30 day/episode; 90 day/year max
Hospital alternatives:	20% co-ins	120 days maximum
Outpatient incl. 1-12 psychotherapy visits:	20% co-ins	no limits
12+ psych visits:	50% cost sharing	no limits

COMBINATION COST SHARING

Services (with same limitations as above)	In network	Out of network
Overall - Deductible - Coinsurance - Out-of-pocket max	None $10 per visit None necessary	$200/400 indiv/family 20% $2,000 $3,000
Inpatient Hospital	Full coverage	20% co-ins
Professional services, outpatient hospital services.	$10 per visit	20% co-ins
Emergency services	$25 per visit	20% co-ins
Preventive services, including well-baby, prenatal	Full coverage	Full coverage
Hospice	Full coverage	20% co-ins
Home health care	Full coverage	20% co-ins
Extended care facilities (SNFs, rehab facility)	Full coverage	20% co-ins
Outpatient physical, occupational, speech therapy	$10 per visit	20% co-ins
DME, outpatient lab, ambulance	Full coverage	20% co-ins
Routine eye and ear exams, eyeglasses	$10 per exam or 1 set glasses	20% co-ins

Dental services -Initial: Prevention	$10 per visit	20% co-ins
-Additions in 2000:		
Restoration	$20 per visit	$50 deduc + 40% co-ins
Orthodontia	$20 per visit	40% co-ins
Prescription drugs	$5/prescription	$250/year deduc 20% co-ins oop max applies

Mental health / substance abuse		
Initial		
Inpatient services:	Full coverage	1 day deductible 20% co-ins; oop max applies
Hospital alternatives:	Full coverage	1 day deductible 20% co-ins
All outpatient except psychotherapy:	$10 per visit	20% co-ins
Psychotherapy:	$25 per visit	50% cost sharing
2000		
Inpatient services:	Full coverage	20% co-ins; oop max applies
Hospital alternatives:	Full coverage	20% co-ins
Outpatient incl. 1-12 psychotherapy visits:	$10 per visit	20% co-ins
12+ psych visits:	$25 per visit	50% cost sharing

White House Reduces Drug Abuse Coverage In Health Care Plan

By Michael Isikoff
Washington Post Staff Writer

The White House this week cut back the coverage for drug and alcohol treatment in its health care plan to hold down costs.

Critics charged that this could undermine one of the principal goals of President Clinton's anti-drug strategy.

The reductions are among many "technical corrections" being made in the president's health care bill before it is formally introduced in Congress.

Only last month, the administration released its anti-drug plan, proposing expanded treatment for hard-core cocaine and heroin abusers as its major priority. Although White House drug policy director Lee P. Brown did not announce any new funding for treatment programs, the drug plan promised that the health care reform proposal would provide a "substantial drug treatment benefit so that those who need treatment have the means to get it."

This week, however, White House officials, prodded by actuaries concerned about the cost of treatment, cut in half the length of some substance abuse and mental health treatments in the health care benefit package proposed to Congress last month. Under the new provisions, individuals will receive coverage for 30 days of residential treatment and 120 days for intensive community-based programs, according to an internal White House memo outlining the changes that has been circulating on Capitol Hill.

A residential treatment center is a live-in facility offering intensive therapy and counseling. The Betty Ford Center in California is one of the best-known examples. Community-based treatment is conducted at clinics where addicts receive therapy during the day but return to their homes at night.

Many drug specialists have argued that drug and alcohol abuse is a long-term problem that cannot be

prompted criticism yesterday from six senators who sent a letter of protest to Ira Magaziner, the chief White House advisor on health care. The senators said they were "very concerned" that the revised benefit "will not gain the support of the American people" in part because "it is less than many people now have."

The letter was signed by Sens. Paul D. Wellstone (D-Minn.), Edward M. Kennedy (D-Mass.), Paul Simon (D-Ill.), Daniel K. Inouye (D-Hawaii), Pete V. Domenici (R-N.M.) and Alan K. Simpson (R-Wyo.)

A White House official who asked not to be identified said the changes were prompted by Health Care Financing Administration concerns that the substance abuse and mental health care package in the proposed legislation would cost far more than the $241 per person estimated by the administration.

"This is not something we wanted to do," the official said. "This has been very painful." But the decision to maintain some substance abuse and mental health coverage in the package was still a "historic" move that will for the first time provide such treatment to millions of Americans, according to the official.

The cutbacks are politically sensitive because the Clinton administration has been criticized in recent months for its handling of the drug issue. Although candidate Clinton promised last year to provide "treatment on demand" for all drug abusers and make it a centerpiece of his drug program, administration officials recommended only modest increases in spending for treatment programs in its proposed budget last spring and then acquiesced last summer in reductions made by Congress.

White House officials have argued that the health care package as now written remains an important first step in meeting the anti-drug goals, providing coverage for a broad range of services, including hospitalization for drug and alcohol overdoses, treatment in private res-

THURSDAY, NOVEMBER 18, 1993 THE WASHINGTON POST

In addition, the new changes would require individuals participating in community-based programs to start paying half the costs after 60 days.

"The hard-core drug user that the administration says it was going to reach has been left totally out in the cold," said Ellen Weber, co-director of national policy for the Legal Action Center, a group that lobbies on substance abuse and AIDS issues. "This could very well be a step backward" in the availability of drug treatment because states might reduce their current programs and put the total burden on health care plans.

The proposed changes also idential clinics, and outpatient counseling and relapse prevention services.

But some outside critics have said the health care plan was severely flawed from the start. Long-term treatment in "therapeutic communities," which often require stays of up to a year and have proven to be among the most successful in treating addiction for some groups, would not be covered at all. In addition, the legislation will permit states to cut back funding for treatment programs on the theory that many of their residents would now be covered under the health care plan.

60

THE HEALTH SECURITY ACT OF 1993
Health Care That's Always There

Every Ameican citizen will receive a Health Security Card that guarantees you a comprehensive package of benefits that can never be taken away.

Guaranteeing comprehensive benefits that can never be taken away. Controlling health care costs for consumers, business and our nation. Improving the quality of American health care. Increasing choices for consumers. Reducing paperwork and simplifying the system. Making everyone responsible for health care. These are the principles of the Health Security Act of 1993 and they are not negotiable.

In America, rights and responsibilities go hand-in-hand. We will ask everybody to pay something, even if your contribution is small. Everyone must assume responsibility. No one should get a free ride.

Most important, we're going to offer new opportunities and new incentives for people to stay healthy -- and to treat small problems before they become big ones. Our goal should be to keep people healthy, not treat them after they become sick.

What's Wrong With the Current System

The things that are wrong with our health care system are threatening everything that's right with American health care.

- Over the next two years, one out of four of us will be without health coverage at some point. Change jobs, lose your job, or move -- and your insurance company is currently allowed to drop you.
- Today's system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Then they drop you when you get sick. If you have a pre-existing condition, you usually can't get any insurance at all.
- Insurance companies charge small businesses as much as 35% more than the big guys.
- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.
- Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork -- not patient care.
- Fraud and abuse are exploding, costing us at least $80 billion a year. That's a dime of every dollar we spend on health care.
- Our nation's health costs have nearly quadrupled since 1980. Without reform, by the year 2000, one of every five dollars we spend will go to health care.

Principle #1:
Security: Giving you health care that's always there.

Over the next two years, one of every four of us will lose health coverage for some time. The Clinton plan guarantees that you will never lose your insurance -- no matter what. Here's how the plan guarantees security:

- **Makes it illegal for insurance companies todeny you coverage because of "pre-existing conditions."** The Health Security Act also makes it illegal for insurers to raise your premiums or drop you because you get sick. All health plans will be required to accept anyone who applies -- healthy or sick, young or old.

- **Guarantees coverage if you lose your job.** The proposal guarantees that you will keep your health coverage even if you lose your job, with the employer portion picked up by Federal revenues and savings. Under the current system, if you lose your job, you lose your health insurance.

- **Guarantees coverage if you switch jobs, move or start a small business.** You will always be protected -- no matter what. Today, if you switch jobs, move or start a small business, you can find yourself without health insurance -- and risk bankruptcy.

- **Provides coverage for early retirees.** The health security plan guarantees coverage for early retirees, so they don't have to worry about being without coverage after they retire and before they are covered by Medicare. Today many early retirees are losing their health benefits.

Principle #2:
Comprehensive benefits: Keeping you healthy.

All Americans will receive a Health Security card that guarantees you a benefits package that is as comprehensive as those offered by most Fortune 500 companies...and then some.

Emphasizes preventive care. The comprehensive benefits package goes beyond virtually all current insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations, **at no charge to you.** It puts a new emphasis on helping you stay healthy, rather than waiting until they get sick. Prevention saves money and improves people's health.

Includes prescription drugs. Many insurance companies and Medicare have failed to cover prescription drugs. But drug costs are breaking family budgets, forcing many older Americans to choose between food and medicine. Health insurance should cover prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

- Preventive Care (i.e., screenings, physicals, immunizations, mammograms, prenatal Care; at no cost)
- Doctor Visits
- Prescription Drugs
- Hospital Services
- Emergency/Ambulance Services
- Laboratory and Diagnostic Services
- Mental Health and Substance Abuse Treatment
- Expanded Home Health Care
- Hospice Care/Outpatient Rehabilitation
- Vision and Hearing Care
- Children's Preventive Dental Care

Principle #3:
Savings: Controlling health care costs.

Here's how the Health Security Act will control health care costs:

Limits how much insurance companies can raise your premium. Insurance companies will no longer be able to raise your premiums as they please. Today, insurance companies hike your premiums -- sometimes at several times the rate of inflation -- if you get sick, if someone in your family gets sick, and for any other reason.

Introduces competition to the health care marketplace. The Health Security plan will release the chokehold that in today's system, insurance companies have on all of us -- consumers, nurses, doctors, and businesses. Reform will encourage competition -- forcing costs down as health plans compete by offering high-quality care at an affordable price.

Cracks down on fraud. The health security proposal makes health-care fraud a crime and imposes stiff penalties on those who cheat the system. It prohibits doctors from referring patients to outside facilities, like labs, which they own a piece of. It stops the kickbacks that some laboratories give doctors in an effort to get their business.

Asks the drug companies to hold down prescription drug prices. The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant --certain prescription drugs cost Americans three times more than people pay in other industrialized countries.

Reduces paperwork. All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.

Squeezes the waste out of Medicare and Medicaid. By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to

cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

Principle #4:
Quality: Making the world's best care better.

Emphasizes preventive care. The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. The benefits package fully pays for a wide range of preventive services; the vast majority of today's insurance plans don't cover a penny.

Gives consumers the power to judge the quality of care. Consumers will receive quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will hold health plans accountable for meeting high standards. The National Quality Program will help states share information on health plan performance.

Reforms malpractice. The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality -- doctors ordering extra tests because they fear lawyers looking over their shoulders.

Encourages cooperation in rural and urban areas. Rural residents will have access to the latest technology and emergency services through telecommunications links set up between local doctors and advanced networks of specialists and hospitals. In urban areas, the plan will increase investment in public hospitals and community health centers.

Provides incentives for more family doctors to practice in rural and urban areas. The health security plan will give financial breaks to doctors and nurses who work in underserved rural and urban areas. It will expand the National Health Service Corps. Two of three rural counties today do not have enough doctors and 111 rural counties have no physician at all.

Increases funding for prevention research. The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.

Promotes research on the effectiveness of treatments. Today, a lack of information about the most cost-effective methods of treatment often leads to expensive defensive medicine and wide variation in treatments and costs. The plan's investments in research into what treatments really work will help improve the quality of care.

Principle #5:
Choice: Preserving and increasing what you have today.

Preserves your right to choose your doctor. The proposal ensures that you can follow your doctor and his or her team to any plan they might join. Today, more and more employers are forcing their employees into plans that restrict your choice of doctor. After reform, your boss or insurance company won't choose your doctor or health plan -- you will.

Increases your choice of health plan. You will be able to choose from among all the health plans offered in your area -- no matter where you work. Only one of every three companies with fewer than 500 employees offer any choice of health plan. After reform, every employee will be able to choose a health plan.

Puts consumers in the driver's seat. The Health Security Act brings competition to health care -- unleashing the market forces that will lower costs and improve quality. Giving small businesses and consumers the power to band together in alliances will level the playing field and give them the same bargaining strength as big businesses.

Increases options for long-term care. The President's proposal will make it possible for more Americans to continue to live in their homes and communities while receiving care. Today too many families are split apart when insurance or federal programs only pay for hospital coverage. The plan will help put an end to this situation and give families the options they deserve.

Principle #6:
Simplicity: Reducing paperwork and cutting red tape.

Gives everyone a Health Security Card. The card -- with full protection for privacy and confidentiality -- will allow for electronic billing and the creation of health care information networks. This will reduce paperwork and simplify the system.

Requires insurance companies to use a single claim form. The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.

Eliminates fine print. Everyone will get a comprehensive benefits package -- and what you get will be spelled out in easy-to understand language. If you get sick, insurance companies won't be able to point to fine print and deny you the coverage you've paid for.

Streamlines billing reimbursement for doctors, nurses and hospitals. The comprehensive benefits package, a standard rules and codes for payment, and elimination of excessive government regulations will reduce confusion. Doctors, nurses, and hospitals will have more time to care for patients; and all of us will benefit.

Removes the burden on business of negotiating insurance. Groups of businesses and consumers -- regional health alliances -- will negotiate for high-quality care at affordable prices. This will simplify today's system, where hundreds of thousands of businesses negotiate with more than 1500 insurance companies. The burden of finding insurance will be lifted -- and so will administrative costs -- which can run as high as 40% of total health costs for small business.

HOW THE SYSTEM IS FINANCED

The financing proposal was developed under the most rigorous and conservative forecasting standards. For the first time, representatives from every federal agency involved in fiscal accounting and financial projections have been brought together to work out the numbers. Then teams of actuaries, health economists and other financial analysts from outside the government served as auditors and consultants, checking and rechecking.

The system is financed from five major sources:

1) Employer and employee contributions -- Everyone will pay a portion of health insurance premiums, even if your contribution is small, because everyone must assume responsibility. Today, the overwhelming majority of employers cover their employees, and they'll continue to do so. But the businesses that provide insurance are paying for those who don't. No one should get a free ride.

2) Medicare and Medicaid savings -- Specific savings can be achieved by slowing the rate of growth of these programs. Every penny of these savings will be channeled back into benefits -- prescription drugs and long-term care -- for the people which these programs serve.

3) "Uncompensated care." -- Savings can be achieved from money now paid to hospitals and doctors who care for people who can't afford care but receive it anyway and the uninsured.

4) Sin taxes and other federal revenues -- There will be some new "sin taxes," and other revenues will be added as health care costs slow, less money is spent, and the difference is no longer tax-deductible.

5) Other savings -- Reducing paperwork and administration -- estimated to cost $100 billion or more a year -- will cut bureaucracy and save money. Cracking down on health care fraud -- estimated to be at least $80 billion annually -- and imposing new stiff penalties will also yield savings.

PAYMENT SCENARIOS

As a rule, most individuals and families in which at least one person works will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan -- from among those offered in the area -- will pay a little less than the

20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

Two parent family with children: Two parent families with children -- whether one or both parents work -- pay a maximum of 20% of the family premium offered by the average plan in their area. If both parents work, they choose how to pay their family's share. They can have the share deducted monthly out of either paycheck or write a check to the local alliance.

Couple: Working married couples -- whether one or both spouses work -- pay a maximum of 20 percent of the average plan premium. They can have the share deducted monthly from either paycheck or write a check to the local alliance.

Single-parent family: Working single parents with children pay a maximum of 20 % of the average plan premium for a single parent policy.

Individual: Working single people pay a maximum of 20% of the average premium for an individual policy in their area.

Part-time worker with no unearned income: Part-time workers pay a maximum of 20% of the average plan premium for their policy type in their area.

EXCEPTIONS

Exceptions are provided for: (1) the self-employed and independent contractors; (2) part-time workers who have unearned income; (3) families with incomes below 150% of the poverty level; and (4) seasonal workers.

Self-employed/independent contractors: The self-employed and individual contractors can deduct from their taxes 100% of their health care costs. As with any small business, they pay the employer share. They also pay an individual share. If a firm earns less than $24,000 a year, it is eligible for subsidies.

Part-time workers with unearned income: Part-time workers with unearned income pay a maximum of 20% of the average plan premium for their policy type -- individual, couple, two parent, or single parent family.

The number of hours someone works determines how much of the premium is paid by the employer and how much by the individual. For example, an employer would pay 40% of the premium for someone who works half-time. Payment of the remaining 40% of the premium depends on how much a person makes in unearned income, with subsidies provided on a sliding scale for those whose incomes are below 250% of the poverty level.

Families with incomes below 150% of the poverty level: Families at this level are eligible for discounted premiums and pay a maximum of 20% of the employee's share of

the average plan premium. This applies to individuals making $10,455 annually; couples with incomes of $14,145; families of three earning $17,835; and families of four with incomes of $21,525.

Seasonal workers: Seasonal workers pay a maximum of 20% of the average plan premium in the area where they reside.. Those whose incomes are 150% of the poverty level or below are eligible for discounted premiums. If they have unearned income and are not working, seasonal workers are treated the same as part-time workers.

Unemployed and non-working: Unemployed individuals and heads of household who make less than 150% of the poverty level are eligible for individual subsidies on a sliding scale. Those with unearned income pay all or part of what would normally be the employer's share of the premium.

Those whose incomes are 250% of the poverty level or less -- pensioners, for example -- are eligible for discounts on what would be the employer's share. They are not eligible for individual subsidies, and pay the normal individual share of the health premium.

The Health Security Plan

Every American citizen and legal resident will receive a Health Security Card. Once you get your card, you can ***never*** *lose your health coverage -- no matter what. If you get sick, you're covered. If you change jobs, you're covered. If you lose your job, you're covered. If you move, you're covered. If you have the courage to start a small business, you're covered.*

Your Health Security card guarantees you a comprehensive package of benefits that can never be taken away. *The package is as comprehensive as the ones that many Fortune 500 companies offer their employees. And in critical ways -- like paying for preventive care and prescription drugs -- the package gives you more than big companies provide today.*

You will be able to choose your doctor. *Everyone will have a choice of health plans. You'll be able to follow your doctors and nurses into a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. Your boss or insurance company won't decide how or where or from whom you get your care -- you will.*

Almost everybody will be able to sign up for a health plan at work, like you do today. You'll get brochures that give you easy-to-understand information on several health plans -- which doctors and hospitals are included, an evaluation of the quality of care, a consumer satisfaction survey, and prices. If you're self-employed or unemployed, you can sign up at your area health alliance, which will be run by consumers and businesses and bargain for affordable health care for you.

The federal government will set up a national health board -- a board of directors to set standards and make sure you get the comprehensive benefits and quality care you deserve. State governments will set up health alliances give consumers and small businesses the power to buy affordable care; and the businesses with 5,000 or more employees will be allowed to operate as "corporate alliances."

Insurance companies will be required to use a single claim form to replace the thousands of different forms they have today. So when you get sick, you won't be buried in forms -- and neither will your nurse, your doctor or your hospital.

- **Security for you and your family.**
- **A comprehensive package of benefits.**
- **Health care costs that are under control.**
- **Improved quality of care.**
- **Increased choices for consumers.**
- **Less paperwork and a simpler system.**

That's what the Health Security Act is all about.

SUBSTANCE ABUSE TALKING POINTS

- The structure of the benefit is designed to offer a flexible, continuum of care that allows health plans to tailor treatment programs to an individual's special needs.

PROBLEMS IN THE CURRENT MARKET

- For the first time Americans will have coverage for substance abuse treatment. For example, based on data from the 1991 Bureau of Labor Statistics (BLS), 21% of participants in medium and large health plans had no insurance coverage for substance inpatient rehabilitation or out patient care.

- A large number of insurance policies place severe restrictions on substance abuse coverage. For example, 10% of participants in the BLS survey had lifetime day limits, another 14% had limits on the number of treatments, and 22% had lifetime dollar limitations.

PRESIDENT'S PLAN

- The President's Health Security Act, as presented to Congress, immediately addresses these most discriminatory practices within the current insurance systems. The Health Security Act uses no life time limits or prior existing condition exclusions.

- The initial benefit continues to use day and visit limits similar to current insurance policies. At the same time, the benefit is an improvement over current policies in that it provides coverage for a wider range of services than in typical insurance today, using trades against the inpatient/residential benefit to encourage flexibility, use of lower cost effective alternative, and care management.

- For example, the innovative day treatment program models are included as one of the intensive non-residential treatment settings. Visits for the purpose medication management are treated as any other health visit for the same purpose.

- The substitution provisions of a 4 for 1 trade against the inpatient residential benefit provide for an outpatient substance abuse counseling and relapse prevention benefit that is considerably more generous than available in today's insurance market.

- There is provision for continuing care on an outpatient basis for individuals treated either in residential or intensive non-residential settings.

- Clarifications, changes and corrections have been made to various sections in the draft bill . . .the mental illness and substance abuse benefit has not been singled out. We want to make absolutely sure the language is clear and consistent with out policy goals in every area. When the initial of the mental illness and substance abuse benefit legislative language was made public it became clear that different interpretations were causing confusion about the policy intent. In addition, actuarial review of the benefit was continuing and some changes were made in response to the actuarial findings. The basic benefits are now, in fact, more flexible because of more precise language and clear exceptions.

- The Health Security Act demonstrates the Administration's commitment to making substance abuse coverage part of the nation's comprehensive health coverage. This commitment is demonstrated by proposing a benefit structure which will eliminate all differences in insurance coverage by January 1, 2001.

Center on Addiction
and Substance Abuse
at Columbia University

ATTACHMENT A

March 22, 1993

152 West 57th Street
New York, NY 10019

phone 212 841 5200
fax 212 956 8020

Hillary Rodham Clinton
Office of the First Lady
The White House
1600 Pennsylvania Avenue, N.W.
Room 100-OEOB
Washington, D.C. 20500

Dear Hillary:

Following up on the meeting Betty Ford and I had with you on March 2nd, as promised, I am enclosing the following:

1. A paper describing a proposed substance abuse benefit package, which was developed out of a meeting of experts in the treatment area. The list of experts attending the March 6th and 7th meeting is attached to the paper. If Tipper Gore, Dr. Arons or your staff want to follow up with questions, please have them get in touch with Dr. Herbert Kleber, the Executive Vice President and Medical Director of CASA (212-841-5220) and the host and co-convener of the meeting.

2. A copy of the briefing paper I left with you annotated with the citations you requested.

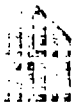
As I indicated, we are ready to help in your important work in any way we can.

Sincerely,

Joseph A. Califano, Jr.

Enclosures

cc: Mrs. Tipper Gore
Dr. Bernard Arons
Mrs. Betty Ford
Dr. Herbert Kleber



Center on Addiction
and Substance Abuse
at Columbia University

RECOMMENDATIONS ON SUBSTANCE ABUSE COVERAGE AND HEALTH CARE REFORM

152 West 57th Street
New York, NY 10019

phone 212 841 5200
fax 212 956 8020

Based On Results Of
A Working Group Convened In
New York City, March 6-7, 1993

Sponsored By:
Center on Addiction and Substance Abuse
at Columbia University (CASA)
In Collaboration With
The Brown University Center
For Alcohol and Addiction Studies (CAAS)

MARCH 22,1993

Substance Abuse Coverage And Health Care Reform

Introduction

On March 6-7, 1993, the Center on Addiction and Substance Abuse at Columbia University (CASA), in collaboration with the Brown University Center for Alcohol and Addiction Studies, convened a group of top national experts in substance abuse treatment and policy to identify what substance abuse/dependency services should be included as part of a comprehensive health care reform package.

Academic, clinical and policy researchers from 19 different institutions made up the group. (For list of members, see Appendix 1). Collectively, the group is familiar with virtually all the scientific research, published and in progress, on substance abuse and dependence treatment and its outcome. No member of the group had a financial interest in any particular treatment approach. For this report, abused substances include alcohol, nicotine, legal psychoactive drugs such as tranquilizers and barbiturates, and illegal psychoactive drugs such as cocaine and heroin.

The Recommended System

The recommendations and their justification reflect the group's consensus, although there was not unanimity on every point. The recommendations are based on the assumption that health care reform will provide universal access to an integrated, managed system of services, with means to refer patients to appropriate levels of care, to assess treatment effectiveness, and to modify treatment methods based on such outcome assessments. In addition, the recommendations assume the availability of a full range of preventive services and strong linkages to the primary care medical system, which serves as an important resource for identifying substance abuse problems, as well as for prevention and treatment.

We believe that the inclusion of a substance abuse treatment benefit is a vital part of true health system reform. Substance abuse and dependence are professionally recognized, clinically diagnosable, and medically treatable conditions. Addictive diseases result in health care and related costs that will reach $140 billion

annually by the end of 1993. These diseases also impose social and economic costs, such as decreased productivity, accidents, crime and family disintegration. All Americans suffer these costs and consequences. A brief list of illustrative health care costs is attached.

The principles of the proposed system are:

--A uniform, comprehensive diagnostic evaluation of every candidate for substance abuse treatment. This standardized evaluation, using well-established criteria, provides the basis for patient/treatment matching and referral to an appropriate level of care. It also, produces baseline data for ongoing management of each case, and permits overall quality assurance and outcomes monitoring.[1]

--Services should be available along a full continuum, from low to high intensity, so that patients can be matched through the initial diagnostic evaluation to the lowest cost level of care appropriate to the severity of the condition and the substance of abuse.

Less expensive outpatient settings have been found by research to be as effective as more expensive in-patient care in the treatment of many individuals with substance abuse problems. The Minnesota State program, for example has demonstrated that an effective, consolidated effort can shift a considerable amount of care to lower cost, outpatient services. However, some individuals require inpatient treatment, and guidelines to identify them have been developed and are being evaluated. It is also important to keep in mind that the intensity of services, (e.g., an inpatient "day" can vary widely in type and quantity of services provided) and the nature of the providers, (e.g. professionally trained psychotherapist vs. counselor) may be a greater determiner of outcome than the setting. In addition, while longer duration of clinical contact is associated with better outcome for the more severely dependent,

---

[1]Health care reform should also address physician and other provider training needs through professional schools, state and national professional organizations and an improved system of in-service training. This training will be needed to enhance the ability of primary care providers, to better assess and refer substance abusing patients in need, and to assist specialists.

relatively brief interventions can be useful for a substantial number of alcohol abusers.

--Treatment needs to be modifiable via periodic evaluation and outcome measures by a care co-ordinator/case manager. Such changes should to be based on practice guidelines and related to clinical findings. This type of ongoing clinical review occurs at present in many areas of medicine.

--The specific services that the substance abuse benefit in any health reform proposal should include are:

a. Evaluation, including diagnosis and referral.
b. Detoxification in a variety of settings.
c. Residential treatment, both short and long-term.
d. Hospitalizations, primarily for medical complications or associated psychiatric problems, e.g. suicidal ideation, major depression.
e. Community outpatient treatment, including services that range from brief counseling to day and evening treatment of varying intensity, as well as family therapy. Such family therapy may be especially critical where children of addicted parents are involved.
f. Pharmacotherapeutic intervention including both short term for acute situations and long-term maintenance such as with methadone or disulfiram (Antabuse).[2]
g. After care, as appropriate.

--Limits should not be set by the number of inpatient days or outpatient visits. Substance abuse and dependency should be treated like other chronic conditions such as diabetes and hypertension. A rigorous initial evaluation and ongoing monitoring of clinical severity, as well as case management, offer the greatest promise of achieving maximum efficiency and effectiveness. There is cost offset data showing that appropriate substance abuse treatment can decrease other health care costs.

A benefit package that prescribes an arbitrary number of inpatient days and/or outpatient visits in order to control costs is most likely to lead to inappropriate utilization in settings and intensity of care, and hinder the flexibility needed to achieve

---

[2]Innovative treatments and technologies will be developed from time to time, so specific provisions should allow for their inclusion once proven effective and efficient through research, as would be the case with any other medical condition.

cost effective outcomes.

If some limit is deemed necessary, we would recommend that a national global dollar cap for coverage of all substance treatment be established, as part of an overall health care budget cap, rather than a cap on individual services. The amount allocated to individual managed health systems, e.g. Accountable Health Plans (AHPs), should be adjusted by risk and geographic location. The average annual size of this cap could be set at approximately $60 per capita.

Many provider groups for other ailments will advocate their inclusion in a national health insurance program. However, the advantages of including substance abuse treatment are unique. Epidemiologic and economic research show that substance abuse is a pervasive risk factor for a wide variety of other health problems which add considerably to morbidity and related health care costs. Substance abuse treatment represents an important weapon in the cost containment arsenal and, over time, can greatly reduce the incidence of other health problems, such as heart disease, cancer, and trauma.

--Substance abuse treatment should be integrated into the mainstream of the health care system and covered as part of a basic package of benefits in any health care reform proposal.

Research on substance abuse treatment has advanced to the point where its inclusion in a universal system of managed care can be designed with confidence that it will work efficiently and effectively.

Addictive diseases as well as the individuals who require treatment for them have long been stigmatized and marginalized. The prejudice, misunderstanding, fear and denial surrounding these problems have affected the behavior of consumers and providers of health care. As a result, many public and private insurers offer no coverage, or coverage that encourages providers to act in a manner that is irrational and needlessly costly. For example: private insurance often covers intensive hospital and inpatient treatment, but limits or fails to cover ambulatory lower cost interventions

which might be more appropriate. Similarly, under Medicaid, all states pay for hospital-based treatment, but few cover long-term residential programs which are often more appropriate. Medicare has no explicit coverage for drug abuse treatment.

Other Key Points

- **Substance abuse treatment, as part of a basic package of health care coverage, is affordable.**

Payers and purchasers have been reluctant to cover substance abuse treatment because, among other reasons, they consider it subject to almost infinite demand. The reality is that although need is substantial, demand is low.

Estimates by the Institute of Medicine and the Department of Health and Human Services suggest that there are 6 million persons in need of treatment primarily for drug abuse (more than 3% of the adolescent and adult population) and approximately 18.5 million persons who need treatment for alcohol abuse (almost 10% of the adolescent and adult population).

But the need for services and actual demand are quite different. 1991 Medstat figures for a number of major U.S. corporations that provided substance abuse coverage indicated that, out of 4.6 million covered lives, approximately 15,000 received inpatient and outpatient treatment. Thus, less than 1% of those eligible for treatment (0.33%) received treatment.

Public sector rates are similar in some states and substantially higher in others. For example, in 1992, of approximately 4.4 million Minnesotans, approximately 46,000 persons were in treatment (33,000 in detoxification), about 1% of the total state population. In 1991, of 18 million New Yorkers, approximately 360,000 were admitted to treatment, roughly 2% of the population. New York is the state often considered to have the worst substance abuse problem in the nation.

The evidence to date suggests that the demand for treatment, even with universal access, would not add dramatically to costs. In order to reap the benefits of diminishing the health and social costs of substance abuse problem, universal access

to these services would cost approximately $60 per American[3], a figure that would actually add little to the cost of a basic benefit package.

There is concrete research evidence that, in general, substance abuse treatment is cost effective, saving the country substantially more in a variety of costs than such treatment itself costs.

A good example is the treatment of nicotine dependence and resulting cost savings in other areas in health care. In the past, it was estimated that of the 50+ million addicted smokers, 18 million would try to quit each year, 90% or more unassisted, and by the end of the year, 93% would have relapsed, leaving 1.3 million successes. With minimal intervention, the success rate would have increased to approximately 2 million.

With the advent of nicotine gum and the nicotine patch, it is estimated that 3 to 4 million individuals per year might be successful in stopping smoking by using these pharmacologic aids and primary care providers. In the past year, 5 million patches or gum were used. The long term quitting rate of individuals receiving this intervention was 2 to 3 times that of the earlier groups. The implications of this for other health costs were striking. In a review presented to the Food and Drug Administration, of 3 million individuals who had received the patch during the 7 month monitoring period, only 33 heart attacks were reported, whereas the expected rate for that group was over 2,000 heart attacks. In spite of these data, many prescription plans refuse to cover these pharmacologic interventions on the grounds that they are prevention (of heart disease or lung cancer) rather than treatment (of nicotine dependence) and the plans do not cover prevention.

While the savings from treatment of alcohol and drug abuse may not have been

---

[3]This estimate is based upon a review of utilization and cost data. It assumes 3.5 million treatment users including an increase for the expanded access to coverage at an average cost per user of $4300. These numbers do not factor in increased use of less costly outpatient services resulting from the likely evaluation assessment, or any savings as a result of decreased health care costs that would be a result of expanded access to treatment.

as precisely calculated, they can be substantial. One study, for example, showed a 24% decrease in health care costs for the group of treated alcoholics in comparison to the untreated group. In another study, one Fortune 100 company looked at the initial savings of their Employee Assistance Program. Medical costs for each employee for the three years prior to their beginning substance abuse treatment averaged $2068 per year. One full year following the initial treatment, average medical cost was $165. When the cost of substance abuse treatment (not a recurring cost) is added in, the company still saved $500 per employee (about 25%). Moreover, absenteeism was drastically reduced.

•Despite the data regarding limited demand for services, we recognize that the managed systems of care, e.g., Accountable Health Plans (AHPs), will have concerns about their exposure resulting from adverse risk and the small segment of the population with persistent, chronic problems. To respond to this concern, three possible approaches to limit an individual provider system exposure were discussed:

-A public reinsurance pool to provide stop loss protection over a predetermined amount of exposure for any AHP. This reinsurance can apply specifically to the substance abuse benefit or be part of a larger reinsurance mechanism.

-The use of a disability rather than indemnity benefit that offers a fixed dollar amount of services for a user based on the level of required treatment. The level of care needed would be determined by the evaluation and resulting plan of care.

-A dollar cap on the overall amount of services available to any individual user, either during a benefit year or on a lifetime basis.

Among the working group, there was general agreement with the first approach, and marked disagreement with the last two unless they were generally applied throughout the system reform.

•Habilitation

While not part of the benefit, needed habilitation and social services should be linked with the treatment services. These should be coordinated by a case manager, but, like other social programs for the needy, financed largely with public funds other than from the health budget.

APPENDIX 1

SUBSTANCE ABUSE COVERAGE AND HEALTH CARE REFORM GROUP MEETING

MARCH 6 AND 7, 1993

CHAIRED BY:

Herbert D. Kleber, M.D. David C. Lewis, M.D.

RAPPORTEUR:

Diana Chapman Walsh, Ph.D.

Listing of Participants

M. Douglas Anglin, Ph.D.
Director, Drug Abuse Research Center
University of California at Los Angeles
School of Medicine
Adjunct Associate Professor

Thomas F. Babor, Ph.D.
Professor of Psychiatry
Scientific Director
Alcohol Research Center
University of Connecticut Health Center

Thomas Badger, Ph.D.
Professor, Department of Pediatrics and
Director of Research
Arkansas Children's Hospital Research Center
University of Arkansas for Medical Science

Lawrence S. Brown, Jr. M.D., M.P.H.
Senior Vice President
Division of Medical Services
Addiction Research Treatment Corporation, New York City
Associate Clinical Professor of Medicine
Harlem Hospital and
Columbia University College of Physicians and Surgeons

Raul Caetano, M.D., Ph.D.
Senior Scientist and Director
Alcohol Research Group, Medical Research Institute
Adjunct Associate Professor, School of Public Health
University of California at Berkeley

Wendy Chavkin, M.D.
Associate Professor of Clinical Public Health
and Obstetrics and Gynecology
School of Public Health
Columbia University

Mary Jane England, M.D.
President
Washington Business Group on Health

Henrick J. Harwood
Health Economist
Lewin - VHI, Inc.

Jack Henningfield, Ph.D.
Chief
Clinical Pharmacology Branch
NIDA
Addiction Research Center
Baltimore, Maryland

Ralph Hingson, Sc.D.
Chairman and Professor,
Social and Behavioral Sciences Department
School of Public Health
Boston University

Constance M. Horgan, Sc.D.
Research Professor and Chair, Department of Substance Abuse
Institute for Health Policy
Heller School
Brandeis University

Herbert D. Kleber, M.D.
Executive Vice President & Medical Director,
Center on Addiction and Substance Abuse
Professor of Psychiatry and Director
Division on Substance Abuse
College of Physicians and Surgeons and
NYS Psychiatric Institute, Columbia University

David C. Lewis, M.D.
Professor of Medicine and Community Health
Director
Center for Alcohol and Addiction Studies
Brown University

Barbara McCrady, Ph.D.
Professor of Psychology and
Clinical Director
Center of Alcohol Studies
Rutgers University

Tom McLellan, Ph.D.
Professor of Psychiatry and
Director
Treatment Research Institute
University of Pennsylvania

Jeffrey C. Merrill
Vice President and Director
of Policy Research and Analysis
Center on Addiction and Substance Abuse, and
Visiting Professorof Health Policy and Management,
Columbia University

Mark V. Pauly, Ph.D.
Bendheim Professor and
Chairman, Health Care Systems Department
Director of Research
at the Leonard Davis Institute of Health Economics
Wharton School
University of Pennsylvania

Cynthia P. Turnure, Ph.D.
Executive Director
Chemical Dependency Programs,
Minnesota Department of Human Services

Diana Chapman Walsh, Ph.D.
Professor and Chair
Department of Health and Social Behavior
Harvard University School of Public Health

Constance M. Weisner. Dr.P.H.
Senior Scientist
Alcohol Research Group, Medical Research Institute
Adjunct Assistant Professor
School of Public Health
University of California at Berkeley

Sarah F. Mullady, CEAP
Employee Assistance Program Consultant
Center on Addiction and Substance Abuse
Former Director, Employee Assistance Program
Champion International Corporation

Eric Wagner, Ph.D.
Post Doctoral Research Fellow
Brown University

Lois B. Morris
Science Writer

Center on Addiction
and Substance Abuse
at Columbia University

152 West 57th Street
New York, NY 10019

March 2, 1993

Briefing Paper

We estimate that, by the end of this year, all substance abuse and addiction--legal and illegal drugs, alcohol and nicotine--will cost the health care system some $140 billion--about one out of every seven of the one trillion dollars we will be spending on health care.

Tobacco:

Cigarettes and other forms of tobacco are responsible for the premature death of some 500,000 people a year.(reference 2)

- Cigarettes cause 18 percent of all coronary heart disease and 30 percent of all fatal cancer--the top two crippling diseases in the United States.(1,10)

- 87 percent of all lung cancer can be traced to cigarettes.(1) As of 1986, lung cancer surpassed breast cancer as the leading terminal cancer among women.(5)

- The EPA recently designated second-hand smoke as a known human carcinogen, along with only ten other compounds. Exposure to parents' smoke causes 150,000 to 300,000 cases annually of lower respiratory infections such as bronchitis and pneumonia in infants and young children.(22)

- Smoking by women during pregnancy retards fetal growth, doubling the risk of delivering a low-birth weight baby; newborns exposed to cigarettes in utero have a 25 to 50 percent increased risk of fetal and infant death.(6)

Estimates for the price we pay in added health care costs for smokers--to say nothing of the health care costs of passive smoking--range from $22 to $50 billion a year.(2,16)

Alcohol:

Alcohol abuse is responsible for at least 100,000 deaths a year.(2)

- Alcohol is the leading cause of chronic liver disease, including cirrhosis. Alcohol abuse can lead to many serious gastrointestinal problems (including esophageal cancer and pancreatitis), nutritional and metabolic disorders, cardiovascular problems and neurologic disorders.(13)

- The AMA estimates that 25 to 40 percent of patients in general hospital beds are being treated for complications of alcoholism.(2)

- Fetal alcohol syndrome is the third most frequent cause of birth defects associated with mental retardation.(21)

- 40 percent of all Americans will be involved in an alcohol-related car accident that requires medical care sometime in their lives.(7)

The estimated cost of health care linked to alcohol abuse is $86 billion a year.(2)

Drugs:

Drug abuse leads to a wide array of diseases, overwhelms emergency rooms, and jeopardizes the health of our children.

- 75 percent of trauma victims test positive for drug use.(19)

- Some 375,000 babies born each year in the U.S. are exposed to illicit drugs in the womb. These babies face higher risk of stroke at birth, physical deformity and mental deficiency.(15)

- Confirmed reports of child abuse or neglect have increased 226 percent over the past decade. More than half of these reports--and 75 percent of reports of child deaths--involve drug abuse by the parents.(19)

- Intravenous drug use is implicated in a third of all AIDS cases found in teenagers and adults. 71 percent of all female AIDS cases are linked to intravenous drug use.(12) (This does not include the significant percentage of AIDS cases due to unprotected sex prompted by non-intravenous drug and alcohol abuse.)

- Drug abuse can lead to endocarditis, cellulitis and hepatitis. Other diseases, including TB, result from a weakening of the immune system and the debilitating life style of many addicts. Drug abuse can cause mental illness, vascular problems and malnutrition.(11,14)

CASA's preliminary estimate is that drug abuse accounts for added health care costs ranging from $20 to $30 billion.(9)

Substance abuse and addiction account for $140 billion of our soon-to-be one trillion dollar annual health care bill.

Compare this to the costs of:

- Excess hospital beds--$6 to $8 billion a year.(3)
- Medical malpractice--$20 to $30 billion annually in legal fees and defensive tests and procedures.(4,18)
- Unnecessary coronary bypasses--about $4 billion a year.(8)
- Excess angiograms--about $1.4 billion a year.(8)
- Unnecessary cesarean sections--about $1 billion a year.(20)

Efforts to eliminate unnecessary administrative costs could result in savings of zero to $25 billion, depending on the bureaucracy required to operate a new system.

Limiting payments to hospitals and doctors to the rate of increase of the consumer price index could result in savings of $19 billion.*

* In 1992, the consumer price index (CPI) was 8.8% for hospitals and 5.7% for physician services. The total CPI (Urban) was 2.9%. Multiplying the 1990 cost of hospital services ($258 billion) by 8.8% yields an increase of $23 billion; multiplying the 1990 cost of physician services ($129 billion) by 5.7% yields an increase of $7 billion. If these costs could be held to the CPIU, the increases would be held to $7 billion and $4 billion respectively--1 $19 billion savings.

References

1. American Cancer Society. (1992). Cancer facts & figures--1992. Atlanta: American Cancer Society.

2. American Medical Association. (1993). Factors contributing to the health care cost problem. Chicago: American Medical Association.

3. Anders, G. (1993, February 22). As outpatient care gains, communities need to trim their excess hospital beds. Wall Street Journal, p. B1.

4. Califano, J. A. Rationing health care: The unnecessary solution. University of Pennsylvania Law Review, 140(5), 1525-1538.

5. Centers for Disease Control. (1989). Reducing the health consequences of smoking: 25 years of progress: A report of the Surgeon General (DHHS Pub. No. (CDC) 89-8411). Rockville, MD: U.S. Department of Health and Human Services.

6. Centers for Disease Control. (1990). The health benefits of smoking cessation: A report of the Surgeon General, 1990 (DHHS Pub. No. (CDC) 90-8416). Rockville, MD: U.S. Department of Health and Human Services.

7. Factors potentially associated with reductions in alcohol-related traffic fatalities--1990 and 1991. (1992). JAMA, 269(2), 202-207.

8. Graboys, T. B., Biegelson, B., Lampert, S., Blatt, C. M., & Lown, B. (1992). Results of a second-opinion trial among patients recommended for coronary angiography. JAMA, 268(18), 2357-2540.

9. Harwood, H. J., Napolitano, D. M., Kristiansen, P., & Collins, J. J. (1984). Economic costs to society of alcohol and drug abuse and mental illness, 1980. Research Triangle Park, NC: Research Triangle Institute.

10. Hauswald, M. (1989). Cost of smoking: An emergency department analysis. American Journal of Emergency Medicine, 7(2), 187-190.

11. Hoffman, R. S., & Goldfrank, L. R. (1990). The impact of drug abuse and addiction on society. Emergency Medical Clinics of North America, 8(3), 467-480.

12. National Commission on Acquired Immune Deficiency Syndrome. (1991). The twin epidemics of substance abuse and HIV: Report. Washington, DC: National Commission on Acquired Immune Deficiency Syndrome.

13. National Institute on Alcohol Abuse and Alcoholism. (1990). Seventh special report to the U.S. Congress on alcohol and health from the Secretary of Health and Human Services (DHHS Pub. No. (ADM) 90-1656). Rockville, MD: U. S. Department of Health and Human Services.

14. National Institute on Drug Abuse. (1991). Drug abuse and drug abuse research: The third triennial report to Congress. Rockville, MD: U.S. Department of Health and Human Services.

15. Pinkney. (1989, October 6). Drugs in pregnancy: A growing crisis with no easy solution. American Medical News, p. 47.

16. Rice, D. P., Hodgson, T. A., Sinsheimer, P., Browner, W., & Kopstein, A. N. The economic costs of the health effects of smoking, 1984. Milbank Quarterly, 64(4), 489-547.

17. Rich, S. (1993, February 3). Defensive medicine changes could save billions, study says. Washington Post, p. A2.

18. Rubin, R. J., & Mandelson, D. N. (1993). Estimating the costs of defensive medicine. Fairfax, VA: Lewin-VHI.

19. Select Committee on Narcotics Abuse and Control. (1992). On the edge of the American dream: A social and economic profile in 1992: A report by the Chairman. Washington, DC: Government Printing Office.

20. Silver, L., & Wolfe, S. M. (1989). Unnecessary cesarean sections: How to cure a national epidemic. Washington, DC: Public Citizens Health Research Group.

21. U.S. Department of Health and Human Services. (1991). Healthy people 2000: National health promotion and disease prevention objectives (Report No. (PHS) 91-50212). Washington, DC: U.S. Government Printing Office.

22. U.S. Environmental Protection Agency. (1992). Respiratory health effects of passive smoking: Lung cancer and other disorders (Report No. EPA/600/6/90/006F). Washington, DC: U.S. Environmental Protection Agency.

Statement of

Joseph A. Califano, Jr.*

before the

Committee on Finance of the United States Senate

March 10, 1994

Mr. Chairman, Members of the Committee:

It is a privilege to be invited to testify before you this morning.

Since the enactment of Kerr-Mills in 1960 and of Medicaid and Medicare in 1965, this Committee has been at the forefront of efforts to make our nation's health care system more just, protect its premier quality and contain its costs.

Your important work continues as you consider President Bill Clinton's proposal to reform the health care system. President Clinton has achieved something none of his predecessors was able to do: He has put the goal of universal coverage on the front burner of the nation's consciousness, and has led the nation toward a general consensus that every American has a right to affordable, quality health care. The challenge is to achieve that goal with sound financing and cost containment. I applaud President Clinton's courage and determination for putting his presidency

---

* Mr. Califano, an attorney, is founding Chairman and President of the Center on Addiction and Substance Abuse at Columbia University and Adjunct Professor of Public Health at Columbia University's Medical School and School of Public Health. He was Secretary of Health, Education and Welfare from 1977 to 1979 and President Lyndon Johnson's top assistant for domestic affairs from 1965 to 1969. His next book, Radical Surgery: Now Comes the Hard Part for American Health Care, will be published next winter by Random House.

behind the drive to achieve universal coverage.

This is no mean task. We have come a long way from the days when a doctor with a little black bag of potions, pills and platitudes made house calls. In 1965, we needed only 60 pages of legislation to enact Medicare and only 10 pages to enact Medicaid. The President's bill weighs in at 1,342 pages, and there are thousands of pages of competing proposals in the legislative hoppers of the Senate and the House. The health industry has mushroomed from a $42 billion-dollar enterprise in 1965 when Medicare was passed into a one trillion-dollar colossus, the nation's biggest business and one of its fastest growing employers.

As a White House aide in the Johnson Administration, as Secretary of Health, Education and Welfare in the late '70s and as chair of the first two board committees on health care of Fortune 500 companies, I have studied and struggled with health policy matters and the administration of the health system for 30 years. I've been surprised and bruised by the unintended consequences of well-intentioned reforms, including several of my own. The following observations on the current drive to reform the health system stem from my experience, and I hope they provide some help to this distinguished Committee.

America's health care system is infernally complex. The health industry employs 11 million Americans, from the highest-skilled neurosurgeons to the lowest-skilled bed pan attendants. The financial stakes in any reform effort are enormous: a trillion-dollar pot of gold for payers and providers to fight over. The

moral and ethical issues become more vexing each day as our scientific genius pushes the envelope of life and death. And though we all want lower costs, nothing is too expensive for me or my spouse, child, parent or sibling when any of them is seriously ill or suffering severe pain.

In this context, devising a system of affordable, quality care for all Americans does not lend itself to solutions that are neatly Republican or Democratic, conservative or liberal, ideologically principled or politically correct. What is needed to fulfill the promise of universal coverage is a pragmatic and careful effort that involves both the public and private sectors, an end to pointing fingers at the other guy, and a willingness in each of us to take more responsibility for our own health. We must be careful to preserve the best of our system as we change it to extend quality care to all our citizens.

The Employer Mandate

You asked me to focus my testimony on universal coverage and cost containment. For historical and practical reasons, I believe an employer mandate is an important component of any reform that aims to fulfill these two goals. Such a mandate would capitalize and build on some of the best elements of our existing system.

Virtually all nations with universal coverage have built on their existing systems. Great Britain's scheme of national health

insurance, enacted in 1946, did not stem from an infatuation with socialist principles. At the time, just after the end of World War II, almost every doctor and nurse in England was in the military and on the government payroll. The government had taken over the nation's voluntary hospitals which had collapsed under the weight of war casualties. After the war ended, the British Parliament simply legislated the status quo. Similarly, Germany's system of universal coverage was built upon worker guilds and sickness funds that performed a role not unlike the role employers and health insurers play in the United States today.

The American link between health benefits and employment dates back 50 years to World War II. The war sparked research that produced wonder drugs like penicillin and dramatic advances in surgery. People no longer went to the hospital just to ease the pain of dying; they went to get cured. Dazzled by the miracles of modern medicine, patients wanted access to them. At the same time, wartime employers scrambled to attract scarce workers. The War Labor Board held the line on pay increases, but it allowed increases in fringe benefits. Health insurance quickly became the premier fringe benefit and employers generously doled it out. The number of Americans in group hospital plans bolted from less than 5 million in 1941 to 26 million by the end of the war.

In 1959, big steel management ended a 116 day strike by agreeing to pay the entire health insurance premium and provide first-dollar coverage for workers, setting the pattern that over the next decade spread through major industries like auto

manufacturing and communications. No one appreciated at the time that this was like giving every worker a credit card to use without ever having to pay a bill, and that management had made itself hostage to a health industry that had no incentive to control costs.

Since then, three American Presidents--Richard Nixon, Jimmy Carter and Bill Clinton--independently concluded that any national scheme of universal coverage should build on the existing American system, in which some 60 percent of Americans, workers and their dependents, receive health insurance through their employment relationship. Each of the presidents' plans would require employers to provide a basic package of health care benefits for their employees--what I call a "Minimum Health Care Bill" similar to the minimum wage bill Congress enacted in the 1930s.

The mandate can be phased in over time. Congress can begin by establishing the mandate among large employers and gradually extend it to smaller businesses, if necessary helping them with subsidies or tax credits to ease their burden and encourage them to form cooperatives to pool their purchasing power. Gradual phasing makes sense not only because of federal budget concerns with respect to any subsidy, but also because of the unpredictability of reform and its effects on the health care system.

The history of the minimum wage provides a telling precedent. In 1938, Franklin D. Roosevelt convinced Congress to enact the minimum wage in the Fair Labor Standards Act. Initially, the law covered only 11 million workers, a fifth of the total labor force

and a third of non-supervisory workers. Of those who were covered, only 300,000--less than three percent--were then earning less than the new minimum wage of 25 cents an hour. Not until 1966, when Lyndon Johnson persuaded the 89th Congress to act, was the law extended to cover all retail and trade employees and, for the first time, agricultural workers.

Congress could follow a similar tack today by phasing in--over a much shorter period, less than 10 years--a minimum health care bill that will assure that every American has a baseline level of health insurance. In a society as mobile as ours where citizens frequently move from state to state, a federally-defined system of minimum benefits makes good sense. With a basic package of insurance, it should be relatively easy to require that insurers have the same claims form for all patients, which would cut administrative costs. Simpler, more uniform administrative procedures would also help the watchdogs ferret out billions now lost in fraud and abuse.

The employer mandate is key to any reform for several reasons. First, it builds on a part of the existing system that, by and large, is working well. Second, it enlists the ingenuity of thousands of businessmen and women to keep health care costs down. Third, it draws a line of clear responsibility that will slow the game of hot potato economics now being played frenetically among those who pay for health care. The feds want to dump the hot potato of costs on the states and private business; the states rush to lay costs on the feds and the private sector. The current

romance of many big businesses with national health insurance plans, which corporate executives once denounced as socialist, evidences their desire to toss the hot potato of costs to the feds.

The employer mandate keeps some costs off the federal budget and puts them into everyday life, throughout our systems of commerce, as part of a fair wage and the purchasing decisions Americans make. And the mandate would end the present lopsided shift of costs to employers with more than 100 workers, who pay at least $15 billion in health care costs for employees at companies with less than 25 workers (who usually have no insurance).

The rhetoric of impassioned opposition to an employer mandate is an echo of earlier battles. Before passage of the Fair Labor Standards Act in 1938, business leaders warned that it would lead the country to a "tyrannical industrial dictatorship." They charged that Franklin Roosevelt's arguments for a mandated minimum wage was, like "the smoke screen of the cuttle fish," a cover for his plot to promote socialist planning of the U.S. economy. Some opponents asked how business could "find any time left to provide jobs if we are to persist in loading upon it these everlasting multiplying government mandates?"

In fact, American business adjusted, just as it did after the passage of the Occupational Safety and Health Act, after the passage of state laws mandating standards of cleanliness in restaurants and smoke-free space in enclosed areas, and after the passage of federal laws mandating safety standards for automobiles and access for the disabled.

We should not underestimate the ingenuity of American business, its ability to comply efficiently with reasonable government mandates and work them into its daily operations. For this reason, I urge you to give employers freedom to bargain for and provide health insurance as they see fit--directly, through managed care plans or fee-for-service doctors, from traditional insurers or new networks of health care providers.

American corporate executives have the agility to bargain more effectively than any government and have become savvy negotiators with a range of providers. They are not inhibited by the political constraints often imposed on government agencies to protect special interests, and they have made progress in making the health care system more efficient. Congress should not restrict their ability to continue doing so.

America's business managers have finally gotten smart about health care. They use their bargaining power to force doctors and hospitals to cut prices, eliminate excess capacity and reduce unnecessary tests and procedures without sacrificing medically-appropriate care. Tight-fisted employers and managed care providers are squeezing deep discounts from pharmaceutical companies. Most large corporate purchasers of health care limit reimbursement for off-patent drugs to the lowest generic price.

The response to these demands is rapidly changing the delivery of health care, independent of any action by the Congress. Hospitals, doctors, HMOs and long-term care facilities are organizing themselves in networks to deal directly and more

efficiently with big corporate purchasers of health care. Large insurers are assembling their own organizations by signing up hospitals and putting doctors on salaries and regular hours.

These competitive churnings in the health care market, combined with generally low inflation and political pressures to rein in costs as the President, the Congress and the 50 states move to revamp health care delivery, have helped slow down the pace of inflation in medical care prices to 5.4 percent in 1993. Though still twice the rate of general inflation, that is the lowest rate of increase since President Nixon's price controls were in effect in 1973.

I believe a government mandate that employers provide a package of benefits to their employees will capitalize on these healthy trends and accelerate the process of making the delivery of health care more efficient. A mandate gives every American employer a stake in making the health care system cost-effective and responsive to the needs of its employees.

Congress can take other steps to complement the mandate and encourage efficiency in the financing and delivery of health care. Congress should require that insurance be portable from job to job, that insurers provide coverage without regard for pre-existing conditions or a person's occupation and that they base their premiums on community ratings, which would motivate insurers to compete to provide the highest quality and least expensive care, rather than to scrap for the healthiest patients.

Substance Abuse and Addiction

Revamping the financing and delivery of sick care is an essential element in making our system more fair and efficient. But it is not the only one. America's health care system is buffeted by over-arching problems that require the attention of Congress if we are to assure that every American has access to affordable, quality care. Substance abuse and addiction, the spread of poverty particularly among young children, violence in every social class, the aging of the population as we become the world's first four-generation society, and the explosion in knowledge and technology that make the scope of what the medical system can treat virtually limitless--all have a tremendous impact on the system and its costs.

Let me illustrate this point with regard to substance abuse and addiction, which has an enormous impact on Medicare and Medicaid, two programs within the jurisdiction of this Committee. For without an all-fronts attack on substance abuse and addiction, efforts to provide every American with all the care he or she needs at reasonable cost are doomed to fail. Substance abuse and addiction is responsible for at least $140 billion--and perhaps as much as $200 billion--of the one trillion dollars we will spend on health care this year:

- Some 54 million Americans are hooked on cigarettes and another 8 million are hooked on smokeless tobacco.
- More than 18 million are addicted to alcohol or abuse it.

- Some 12 million abuse legal drugs, such as tranquilizers, amphetamines and sleeping pills.
- Six million regularly smoke marijuana, and the number of high school students smoking pot is on the rise.
- Two million use cocaine weekly, including at least half a million addicted to crack.
- Up to a million are hooked on heroin, and the number is rising.
- About one million, half of them teenagers, use black-market steroids.
- More and more teens and pre-teens are sniffing everything from propane and glue to gasses in "Reddi wip" cream canisters.

Substance abuse and addiction tax every segment of our health care system. It causes or aggravates more than 70 conditions requiring hospitalization, complicates the treatment of most illnesses, prolongs hospital stays, increases morbidity and sharply raises costs. Half the nation's hospital beds hold victims of violence, auto and home accidents, cancer, heart disease, AIDS, tuberculosis, and liver, kidney and respiratory ailments--all caused or aggravated by the abuse of tobacco, alcohol and drugs. A study at the Medical College of Wisconsin found that more Medicare patients are hospitalized for alcohol-related problems than for heart attacks. Substance abuse and addiction is the largest single cause or exacerbator of cancer, cardiovascular disease and AIDS, and it combines with AIDS and tuberculosis to

roam through inner cities like a modern Cerberus, the vicious three-headed dog guarding the gates of hell.

The nation's elaborate and expensive emergency rooms are largely monuments to alcohol and drug abuse. In 1991, there were more than 401,000 drug-related emergency-room episodes. In the first three months of 1993, record numbers of individuals rushed to hospital emergency rooms with adverse reactions to cocaine and heroin. Many patients ended up in the most expensive domain of the hospital: the intensive care unit. A study at Johns Hopkins University found that substance abuse accounts for more than one third of the spending in its intensive care unit, which costs $3,000 or more a day. Cancer and heart disease victims of cigarette smoking fill intensive care units across the nation.

The Center on Addiction and Substance Abuse at Columbia University (CASA) has found that, in 1991, Medicaid financed nearly 4 million days of hospitalization for disease or trauma related to substance abuse. At least one of every five dollars that Medicaid spends on inpatient hospital bills can be traced to this crippler and killer, at a cost of some $8 billion this year. On average, patients with substance abuse as a secondary diagnosis are hospitalized twice as long as patients who have the same primary diagnosis but do not have a substance abuse problem. I have provided several copies of the CASA study to the Committee and ask that it be entered into the record.

The numbers in the study are low because they do not include the costs of treating innocent victims of alcohol and drug-related

accidents and crimes, or the costs of teen pregnancies that occur because one or both partners are drunk or high. Nor did the study account for under-reporting due to physician concern about confidentiality. Moreover, hospital records give little attention to cigarette smoking or abuse of prescription drugs, so nicotine addiction and abuse of prescription drugs as complicating factors are understated.

Effective health care reform is at best a dicey and unpredictable enterprise, but it is also a hopeless one in the absence of a united and system-wide effort against all substance abuse on all fronts--research, prevention and treatment. I commend the President for including coverage of substance abuse treatment in his reform proposals and urge you to expand that coverage. In this regard, attached to my testimony is a proposal we developed at CASA, working with the best treatment experts in the nation at the request of First Lady Hillary Clinton. I urge you to adopt that package.

Aftercare, as well as treatment, should be included in a basic package of health benefits. Addiction is a chronic disease, more like diabetes and high blood pressure than a broken arm or pneumonia which can be fixed or cured in a single round of therapy. Continuing care is as critical to treating the alcoholic or drug addict as taking insulin is to the diabetic or taking hypertension pills is to the patient with high blood pressure.

Health care reformers worry that covering the costs of treating addiction would be a budget-buster in any national health

plan. But the dollars spent on treatment are only a small part of the health care expense triggered by substance abuse and addiction. The big money--most of the $140 billion in health care costs related to substance abuse--stems from the ailments, accidents and casualties that result from a lack of prevention and treatment.

The proposal to increase the excise tax on cigarettes is an especially important component of reform. Today I am releasing for the first time an analysis by the Center on Addiction and Substance Abuse at Columbia University of data derived from the NIDA (National Institute of Drug Abuse) National Household Survey on Drug Abuse, which reveals the link between cigarette smoking by 12- to 17-year-olds and the use of hard drugs. For too many of these children, cigarettes are a drug of entry into the world of hard drugs.

CASA's analysis, which you will find at Attachment B to my testimony, reveals that 12- to 17-year-olds who smoke cigarettes are:

- 12 times more likely to use heroin than those who have never used cigarettes,
- 51 times more likely to use cocaine,
- 57 times more likely to use crack, and
- 23 times more likely to use marijuana.

Those 12- to 17-year-olds who smoke more than a pack of cigarettes a day are:

- 51 times more likely to use heroin than those who have never used cigarettes,

- 106 times more likely to use cocaine,
- 111 times more likely to use crack, and
- 27 times more likely to use marijuana.

Congress should increase the cigarette tax at least $2 a pack. That would cut the number of smokers by almost 8 million people and, over time, save almost 2 million lives. Most importantly, the higher price would put cigarettes beyond the means and lunch money of most elementary and high-school students. As the Surgeon General recently confirmed, virtually no one starts smoking after they are 21 years of age.

The Food and Drug Administration reported recently that "it is our understanding that manufacturers commonly add nicotine to cigarettes" to make them more addictive. The combined impact of manufacturers spiking their cigarettes with nicotine to calibrate their addictive power and the fact that just about everyone who smokes gets hooked as a teen makes this higher tax not only an immediate revenue raiser, but an essential public health initiative to protect our children from being abused by these companies, as well as a major cost-containment measure.

Other Cost Containment

As the largest single purchaser of care, Congress can also encourage the trend toward consolidation among hospitals and doctors, which is long overdue. At least 250,000 excess hospital

beds cost the nation some $10 billion a year. Even after the elimination of 160,000 beds during the 1980s, only two-thirds of the remaining beds are occupied on a typical day. In many for-profit hospitals, more than half the beds are empty. Some rural hospitals have so few patients that they cannot maintain safe levels of proficiency.

Political reality, however, makes closing a hospital as hard as shutting down a post office or military base. I suggest establishing a federal commission to identify hospitals that should be closed. Such hospitals would then be denied reimbursement from all government programs, including Medicaid and Medicare. A non-partisan, independent panel, similar to the commission that has assumed the task of recommending military closings, could identify low-volume hospitals from which all federal support should be withdrawn.

Malpractice reform could cut as much as $30 billion from the nation's health care bill and help repair the fractured bond between patient and doctor. Doctors, once the trusted providers of care and counselling, have become the villain of choice, an unfair misperception that demoralizes physicians, drives talent from the profession and jeopardizes the prospects for meaningful reform. The stench of mistrust fouls the air between doctors and patients, insurers, nurses and hospital administrators, as lawyers profit, often unconscionably, and push doctors to perform unnecessary tests and treatments.

With the federal government's help, doctors are developing

standards of care to guide them in determining when diagnostic tests and treatments are appropriate. Doctors who follow such standards should be free from malpractice liability; doctors who do not, or who are negligent or willfully improper in their practice, should be held liable. But Congress should limit recovery for pain and suffering in the absence of willful misconduct. Patients should be able to recover their medical costs, loss of income and the costs of accommodating any lingering disabilities. Contingent attorney fees should be limited and decline as the amount of recovery rises.

Conclusion

Universal health insurance will not be achieved by the employer mandate alone. For the poor, the old and the unemployed, the most vulnerable individuals in our society, we must look to the common treasury. Whether through a federal effort, say by expanding Medicare, or by an expansion of the federal-state partnership of Medicaid, or by some other means, the taxpayers who have should pay for the poor who have not.

Mr. Chairman, I believe that the trillion dollars Americans spend on health are more than enough to provide all our people all the care they need. Instead, we waste as much as $250 billion on unnecessary care, administrative waste, excess capacity, untimely care, fraud and abuse. We neglect sound investments in prevention.

Substance abuse and addiction, AIDS, poverty and violence drain the resources of the health system. And the quality of care that Americans receive varies, not so much with their medical needs, as with the thickness of their wallet, the location of their doctor, the generosity of their employer and the power of their union.

Mr. Chairman, you and I have struggled with this problem since the Kennedy administration. We are well-versed in its complexities and have often been confounded by its surprising twists and turns. President Clinton has created a once-in-a-lifetime opportunity to enact comprehensive reform to bring equity and efficiency to American health care. I hope you and your Committee will seize this opportunity to assure that every American can share the extraordinary benefits of the nation's health care system.

And I urge the members of this Committee, as you are pressed on every side by powerful payers, providers and politicians with high financial stakes in the trillion-dollar health care pot, not to lose sight of the patients and to remember that at its core, health care is a ministry, not an industry.

NASADAD
National Association of State Alcohol and Drug Abuse Directors, Inc.

TESTIMONY BEFORE THE HOUSE APPROPRIATIONS

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,

EDUCATION AND RELATED AGENCIES

SUBMITTED BY
JOHN S. GUSTAFSON

EXECUTIVE DIRECTOR
NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS

JANUARY 26, 1995

444 North Capitol Street, N.W. • Suite 642 • Washington, D.C. 20001 • (202) 783-6868 • FAX (202) 783-2704

Chairman Porter and Members of the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, thank you for the opportunity to testify before you today. My name is John S. Gustafson, and I am the Executive Director of the National Association of State Alcohol and Drug Abuse Agencies or NASADAD.

According to the Robert Wood Johnson Foundation, State Alcohol and Drug Agencies are the primary health care system for 2/3 of all alcohol and other drug treatment in this country. In FY'93, State Alcohol and Drug Agencies had admissions of over 1.8 million. Of these admissions, 1.2 million were for alcohol and 703,347 were for drugs. It is important to note that this program is one where States make significant investments of their own - so in this regard it is a true Federal-State partnership. Expenditures through State Alcohol and Drug Agencies were nearly $3.7 billion in FY'93. Of this figure, States provided more than $1.4 billion, or 38.4%, and Federal sources also provided $1.4 billion or 37.3%. The remainder was contributed by local governments, client fees, court-ordered fees, and third party payers.

Need for Treatment

The alcohol and other drug treatment system is under incredible pressure due to recent and proposed Federal legislation as follows:

- Over 630,000 welfare mothers, identified by the Department of Health and Human Services, need AOD treatment to be able to complete education and training programs and get back to work.

- Over 250,000 beneficiaries of the Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) are now required by law to receive treatment and to return to work after a specific time limit.

  According to the Government Accounting Office, here's what the SSI/SSDI numbers look like in the States represented on this Subcommittee. In Illinois, there are 27,723 persons; in California, 34,935; in Florida, 13,728; in Texas 6,833; in Oklahoma 2,369; in Arkansas, 2,074; in Mississippi, 1,547; in Wisconsin, 6,755; in Ohio, 9,086; in Maryland 2,472; and in New York, 15,536.

- Over 100,000 individuals are currently on waiting lists for alcohol and other drug treatment from State Alcohol and Drug Agencies.

  Thus the need for AOD treatment has jumped from 100,000 to 980,000 - a staggering increase.

Substance Abuse as a Public Health Problem

It is important to note that substance abuse is key to many public health concerns. I'd like to quote an unusual source on this point - the American Bar Association. In its report, New Directions for National Substance Abuse Policy, the ABA notes that *"Substance abuse must be recognized as a public health problem that can be prevented and treated. Preventing substance abuse, and treating it at the earliest opportunity for those who already have problems, can reduce the need for more costly interventions measure later on."*

The American Bar Association is backed by a long list of research experts both inside and outside government. Two studies done by the Center on Addiction and Substance Abuse (CASA) at Columbia University provide startling facts on the cost of substance abuse to Medicaid and Medicare. Both of these studies were analyses of the 1991 National Hospital Discharge Survey, which provides the most current data available.

Medicaid

- **$4.2 billion, or 19.2% of the $21.6 billion that Medicaid paid for hospital care in 1991 was attributable to substance abuse. Thus 1 in every 5 dollars that Medicaid spends on hospital care is attributable to substance abuse. And 1 in every 5 hospital days is also attributable to substance abuse.**

- **Substance abuse-related complications of newborns account for a staggering 32.3% of all Medicaid hospital days. The Government Accounting Office estimates that only 11% of pregnant women in need of drug treatment actually receive care.**

- **On average, Medicaid patients with substance abuse as a complicating factor stay twice as long as patients with the same primary diagnosis and no substance abuse problem.**

Medicare

- **In 1991, there were 2.2 million substance abuse-related Medicare admissions that accounted for 20% of all Medicare hospitalizations.**

- **Because substance abuse-related cases tend to be more expensive to treat than the average hospital case, the amount actually paid out by Medicare was even higher accounting for 23% or nearly 1/4th of the total Medicare payments for hospital care.**

- **Based on the CASA analysis, it is estimated that for 1995, substance abuse-related Medicare hospital costs will rise to $20 billion.**

In addition to contributing significantly to the costs of Medicaid and Medicare, substance abuse is a major factor in the transmission of two major health epidemics - TB and its more deadly form of multiple drug-resistant TB (MDR-TB) and HIV/AIDS. Individuals with alcohol and other drug problems are at high risk for contracting and spreading HIV/AIDS, TB, and MDR-TB.

HIV/AIDS

The Centers for Disease Control and Prevention (CDC) report entitled *HIV/AIDS Surveillance Report*, released in July 1993, shows that from 1991 through 1993, over 30 percent of male AIDS cases and 66 percent of female AIDS cases are directly or indirectly attributable to substance abuse.

CDC also reports that 55% of all pediatric AIDS cases were a result of parental alcohol and substance abuse. In addition to the obvious dangers of intravenous drug use in the transmission of AIDS, recent studies have shown that alcohol dependency weakens the immune system, leaving the individual more susceptible to HIV and TB.

Tuberculosis

Along the same lines as HIV/AIDS, substance abusers are at high risk for contracting and spreading tuberculosis and multiple drug-resistant TB. In fact, the Centers for Disease Control and Prevention lists ***alcoholics and intravenous drug users*** as 1 of the 8 "top priority" groups for TB testing. Also in this list are other individuals who are vulnerable to substance abuse including *persons with HIV,* and *low-income populations, including high risk minorities.*

Individuals with substance abuse problems are particularly susceptible to contracting multiple drug-resistant TB because they do not complete their course of medication. This means that the cost of their care can be much more expensive. While treatment costs average about $15,000 for TB, treatment for MDR-TB can range from $95,000 to $250,000.

Clearly the costs of both HIV/AIDS and TB require a heightened emphasis on providing HIV and TB prevention and treatment services to individuals with alcohol and other drug problems. Providing substance abuse treatment will help to reduce the deadly and costly spread of TB and HIV.

Prevention

Prevention services are also part of the continuum of health care provided by State Alcohol and Drug Abuse Agencies. Within the Substance Abuse Block Grant is a mini-block grant that allocates 20% of a State's allocation for alcohol and other drug services for prevention. While these services are for primary prevention and not for treatment, these programs also help to identify individuals in need of intervention or treatment for alcohol and other drug problems.

It is important to note that alcohol and other drug use prevention efforts have been instrumental in the decline of substance abuse over the past 13 year. States have a productive and effective prevention infrastructure in place that mobilizes the resources of community, social, and church leaders. Dollars are needed to strengthen and expand prevention services. Without this commitment, the numbers of individuals needing treatment will surely escalate.

In fact, a recent survey of 8th, 10th, and 12th graders, entitled Monitoring the Future, by the National Institute of Drug Abuse, showed some alarming trends:

- Marijuana use is up for 8th graders for the third year in a row and up for 10th and 12th graders for the second year in a row.

- While the sharpest rise in drug use was for marijuana, other substances showed significant increases as well, including cocaine and hallucinogens.

- Equally important, there was a decrease in perceived harmfulness of 8th, 10th, and 12th graders taking drugs, including LSD.

- Rates of alcohol use among 8th and 10th graders also remained high - 25.5% of 8th graders and 39.2% of 10th graders have tried alcohol in the past month.

- Finally, almost 9% of 8th graders and 20.3% of 10th graders have been drunk in the past month.

Schools present an easy opportunity for researchers to measure youth alcohol and other drug use and attitudes. But State Agencies serve a wide range of ages and populations including: pregnant and parenting women, the elderly, adult children of alcoholics, college and vocational education students, and adults in at-risk environments (high-density drug/alcohol use communities). Other groups that also receive State funded prevention services are: families in poverty or otherwise vulnerable, religious and social institutions, special populations including "at risk" youth, and workplaces, communities, colleges, and schools.

Examples of specific alcohol and other drug prevention programs include:

- Appropriate use of prescription medications by seniors to avoid possible dangerous interactions.

- Educational programs presented at community colleges, universities, and vocational education institutions to help college students deal with alcohol and other drug problems.

- Classes on substance abuse for pregnant and parenting women.

- Alcohol and other drug prevention services for adults in the welfare or correctional system.

- Programs to help offer positive alternatives to individuals and communities to resist substance abuse problems.

State AOD prevention programs are also designed to provide culturally appropriate programs and services to racial and minority groups and to the social organizations that serve them. In addition, AOD prevention experts provide training and expertise to community leaders and community organizations. Without a persistent and targeted prevention effort to address substance abuse problems for people of all ages, the number of people who need treatment will escalate.

Treatment Effectiveness

There are very significant results to report on treatment effectiveness. Last year, Dr. Andrew Mecca, Director of California's Department of Alcohol and Drug Abuse, testified before this Subcommittee and noted that a comprehensive study was soon to be completed on treatment effectiveness. This study was a $2 million investment of research dollars and is the most rigorous one ever conducted on substance abuse.

Here are just two of the results of the study, entitled *" Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment"*:

o The level of **criminal activity** declined by **2/3rds** from before treatment to after treatment. The greater the length of time spent in treatment, the greater the percent reduction in criminal activity.

o Hospitalizations were reduced by **1/3** rd after treatment.

Other States have reported similar cost reductions after alcohol and other drug treatment. Although not all States have research dollars, NASADAD published a report last year, entitled *Invest in Treatment for Alcohol and Other Drug Problems: It Pays*. Here is a sampling of results found in State research efforts:

o Ohio showed a 66% decrease in hospital admissions and a 41% decrease in emergency room utilization. Ohio also showed an 89% decrease in absenteeism and a 57% decrease in on-the-job injury after treatment.

O Texas followed up on clients 12 months after completion of treatment and found that 80% of clients were arrest free.

O Other States had similar results and also showed that individuals who completed training found and kept jobs and made higher wages.

Finally, I want to end on the note that we are aware that the new Congress does not want to continue "business as usual". State Alcohol and Drug Agency Directors are hopeful that the many unfunded mandates in the Substance Abuse Block Grants will be removed and that some of the current demonstration programs will be folded into the block grant. These changes will allow States to more effectively provide alcohol and other drug prevention and treatment services and to develop and maintain a demonstration, research, evaluation and training infra-structures.

As these changes are made, we urge Congress to consider that alcohol and other drug services provided by States are a successful and productive investment in our workforce and families. They are also key to reducing major public health and social programs costs that are now being shouldered by Federal and State government. Thank you for the opportunity to present today.

Number of Addicts by State

State	Grand Totals	Substance Abuse Diagnoses				
			SSI Non-DA&A		DI Non-DA&A	
		SSI DA&As[a]	Primary[b]	Secondary[c]	Primary[b]	Secondary[c]
Alabama	3,953	397	284	1,847	344	1,081
Alaska	345	134	26	85	40	60
Arizona[d]	2,593	672	207	455	429	830
Arkansas	2,074	154	97	1,027	168	628
California[d]	34,935	23,561	3,564	211	3,613	3,986
Colorado	3,306	291	206	1,250	226	1,333
Connecticut	3,715	190	193	918	283	2,131
Delaware	517	26	16	109	26	340
District of Columbia	920	37	50	583	17	233
Florida	13,728	465	430	7,088	544	5,201
Georgia	8,332	484	480	3,387	463	3,518
Hawaii[d]	957	209	30	158	95	465
Idaho	536	98	47	195	54	142
Illinois[d]	27,723	11,643	3,302	2,102	3,705	6,972
Indiana	5,130	957	666	845	901	1,761
Iowa	1,539	195	54	411	118	761
Kansas	1,721	100	84	628	188	721
Kentucky	6,374	912	601	3,029	481	1,351
Louisiana	2,259	189	264	1,228	199	379
Maine	1,815	284	125	225	235	746
Maryland[d]	2,472	604	225	408	300	935
Massachusetts	9,287	1,679	1,270	2,066	1,124	3,148
Michigan[d]	14,524	6,315	662	2,018	1,853	3,676
Minnesota[d]	5,171	1,992	308	552	761	1,558
Mississippi[d]	1,547	177	192	363	188	627
Missouri	3,586	524	115	927	331	1,689
Montana[d]	985	222	46	389	82	246
Nebraska[d]	1,091	107	22	379	73	510
Nevada[d]	1,174	273	73	137	221	470
New Hampshire	719	26	37	182	64	410
New Jersey[d]	4,759	366	442	1,770	418	1,763
New Mexico	1,270	177	121	609	136	227
New York[d]	15,536	2,987	2,456	5,006	1,668	3,519
North Carolina	6,215	388	275	2,493	413	2,646
North Dakota	870	81	9	436	55	289
Ohio[d]	9,086	1,91	968	2,749	1,064	2,396

(continued)

State	Grand Totals	Substance Abuse Diagnoses				
		SSI DA&As[a]	SSI Non-DA&A		DI Non-DA&A	
			Primary[b]	Secondary[c]	Primary[b]	Secondary[c]
Oklahoma	2,369	167	117	1,372	126	587
Oregon	2,799	618	159	573	324	1,125
Pennsylvania[d]	7,857	1,849	713	2,141	742	2,212
Rhode Island	1,290	96	67	499	83	545
South Carolina	2,271	167	137	1,176	201	590
South Dakota	1,220	127	24	751	53	265
Tennessee[d]	4,962	1,593	591	816	798	1,164
Texas	6,833	319	274	3,425	402	2,413
Utah	1,250	87	74	527	89	473
Vermont	608	90	57	127	74	258
Virginia	3,054	516	177	769	382	1,210
Washington[d]	5,003	1,941	312	523	662	1,565
West Virginia	2,108	572	218	386	304	628
Wisconsin[d]	6,755	2,524	390	1,137	928	1,776
Wyoming	458	19	11	252	17	159
Total	249,199	69,419	21,268	60,739	26,065	71,708

[a]SSI DA&A recipients in current payment status as of August 2, 1993.

[b]Number of addicts in current payment status as of August 2, 1993, (SSI) and September 23, 1993 (DI).

[c]Estimated number of addicts based on claims allowed during the years 1989 to 1992 and the relationship between those with primary diagnoses of substance abuse versus those with secondary diagnoses of substance abuse.

[d]States (18) with FMAs as of December 31, 1993.