



COMMUNITY ADVOCATES
Public Policy Institute

Statement of
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to the
Clinical Advisory Committee on Health and Emerging Technologies (CACHET)
Wisconsin Department of Health Services

August 27, 2009

Thank you for this opportunity to present our views on implementing the federal requirement to provide addiction and mental health services on a parity basis in Wisconsin's BadgerCarePlus Core plan.

We'd like to begin by thanking the Department, Governor Doyle, and the Wisconsin Legislature for creating BadgerCarePlus, and in particular the Core plan, in the first place. This innovative--indeed path-breaking--initiative puts Wisconsin in the forefront of expanding health insurance coverage to those who most urgently need it.

As you know, the recently enacted Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Division C, Title V, Subtitle B, Secs. 511-512 of the Emergency Economic Stabilization Act, H.R. 1424, P.L. 110-343) (Wellstone-Domenici), in concert with pre-existing federal Medicaid law, requires that, if a state's Medicaid program both provides coverage for substance use or mental health disorders and uses Medicaid managed care organizations (HMOs), then the HMOs must provide substance use and mental health disorder services in a way that is no more restrictive than the predominant financial and treatment limitations applied to substantially all medical and surgical services that are provided by the HMOs.

This federal requirement presents a challenge to dozens of Medicaid programs across the country. According to data provided by the Centers for Medicare and Medicaid Services (CMS), over 60% of all Medicaid participants in 2006 were enrolled in Medicaid managed care organizations, i.e., HMOs. In Wisconsin, CMS reports, the 2006 percentage of total Medicaid participants enrolled in HMOs was 47%; but for those enrolled in what we used to call "family" Medicaid—and now call BadgerCarePlus—the percent of enrollees in HMOs in 2006 was already well over 60%. In the three years since 2006, with the huge expansion of enrollment in BadgerCarePlus, the percentage in HMOs in Wisconsin has surely grown much higher.

What this means is that, across the United States as well as in Wisconsin, state Medicaid programs that include a substance use or mental health disorder benefit, and use HMOs, are

grappling with the challenge of how to comply with the Wellstone-Domenici requirement to provide substance use and mental health disorder services on a parity basis. We are not alone. But Wisconsin can be unique. Our challenge is, once again, to lead the nation.

For fiscally understandable reasons, when the Department initially proposed, the Governor and Legislature embraced, and CMS approved the Core plan, they did not include substance use or mental health disorder treatment parity. The program allows all other chronic illnesses to be treated under the supervision of a physician by a wide variety of providers—both doctors and non-doctors. But, the Core plan stipulates that substance use and mental health disorders alone may be treated only by psychiatrists.

Federal law, however, now requires that this unique restriction (which does not apply to either the Standard Plan or the Benchmark Plan—just the Core plan) must change. Wisconsin has three legal options:

- **Wisconsin could, in theory, altogether eliminate substance use and mental health disorder treatment under the Core plan and thus avoid parity.** In other words, Wellstone-Domenici allows Medicaid programs to entirely end substance use and mental health disorder treatment—and then, since there’s no benefit, there’s no need for Medicaid HMOs to provide parity. We assume, however, that no one in this room or this State wishes to *entirely* eliminate substance use or mental health disorder treatment from the Core plan, in which case Wellstone-Domenici applies and its parity requirements must be implemented by HMOs.

- **Alternatively, Wisconsin could stop using HMOs altogether.** Wellstone-Domenici’s parity requirements technically apply to Medicaid programs only to the extent that such programs use “Medicaid managed care organizations.” Wisconsin could abandon its long-standing policy of using HMOs for BadgerCare Plus (in other words, move from over 60% use of HMOs to 0% use of HMOs) and thus escape entirely from the requirements of the parity law. Again, we assume that—however the situation in Milwaukee County is resolved—nobody wants to eliminate *entirely* the Core plan’s use of HMOs, in which case parity is applicable to Core plan enrollees in HMOs.

- **The third option is to fully implement the federal parity requirement.** This means providing substance use and mental health disorder treatment to Core enrollees in HMOs (and, we would argue, to those also in fee-for-service settings) in a way that is no more restrictive than for medical and surgical services provided to, for example, accident victims, asthma patients, diabetes patients, cancer patients, or hypertension patients.

What does such Core plan parity mean? At minimum, it means that (1) the financial requirements, such as deductibles and copayments, and the treatment limitations applied to mental health or substance use disorder benefits under the Core plan be no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical and surgical benefits covered by the plan; and (2) that there are no separate cost sharing or treatment limitation requirements applicable only to mental health or substance use disorder benefits.

But we believe parity should mean more, both as law and policy. When accident victims, asthma patients, diabetes patients, or cancer patients receive treatment, their doctors often issue orders for them to receive—and their HMOs pay for—treatment by non-physician providers, such as physical therapists, rehabilitation therapists, and so forth. **We believe that substance use and mental health disorder parity should mean that when a medical doctor (whether a psychiatrist or otherwise) concludes that a patient’s substance use or mental health disorder also requires treatment by non-physician providers and programs, the patient must also be able to obtain—and the HMO must also pay for—treatment from such non-physician providers and programs.**

In our view, it is not conceivable that the BadgerCarePlus Core plan can move from non-parity to parity, yet still limit patients to receiving care only from psychiatrists.

We recognize that complying with Wellstone-Domenici will increase spending on substance use and mental health disorder services. That, indeed, is one of the *reasons* why Congress enacted the law. Congress *wanted* Medicaid programs that were providing substance use and mental health disorder services through HMOs to spend more on these forms of treatment.

We also recognize that spending more through the Core plan on substance use and mental health disorder treatment creates a fiscal challenge for the State. For that reason, we are not recommending that either one of the Department’s two proposals—the \$31 million proposal or the \$10 million proposal—must be immediately implemented. The \$10 million proposal represents 2/10ths of 1 percent of the entire Medicaid budget. Viewed in that light, it hardly seems like a huge amount. But we recognize that, in today’s fiscal climate, even 2/10ths of 1 percent looks like a lot. We appreciate the need to increase spending under the Core plan for substance use and mental health disorder treatment in a measured way.

However, it is not compatible with Wellstone-Domenici for Wisconsin to move from non-parity to parity, while still providing substance use and mental health disorder treatment *only* through psychiatrists and continue spending exactly the *same* amount for such treatment. **We believe the Core plan must be modified so that, beginning on January 1, 2010, HMOs also begin to provide substance use and mental health disorder services delivered by non-physician providers and by well-managed substance use and mental health disorder programs. This, in turn, will require reasonable increases in Core plan spending for substance use and mental health disorder services.**

We note that DHS and CMS anticipated the possibility of such increased spending when CMS approved the State’s waiver last year. CMS stated that: “After implementation of the demonstration the State may add and/or expand the following services, as recommended by CACHET ... Additional mental health and substance abuse ...” CMS added that: “At implementation, coverage is limited to mental health therapy services provided by a psychiatrist only but coverage may be expanded to include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment, substance abuse treatment and inpatient hospital stays for mental health and substance abuse.” (See Attachment A)

We would also like to emphasize that having the Core plan cover non-physicians, and spend more for substance use and mental health disorder services, does *not* mean increasing *total* Medicaid spending. There is strong evidence that addiction treatment, which we're most familiar with, can greatly reduce total health spending, not to mention spending on incarceration and domestic violence, and increase in tax revenue. (See Attachment B) When addiction is treated effectively, for example, we can avoid millions of dollars in costs due to end-stage liver disease, brain deterioration and early dementia. As with most investments, the "return" on substance use and mental health disorder treatment is not immediate; it may take years to show up; but it is real, and can be accounted for using present value techniques.

Finally, there is another reason for the Core plan to expand coverage for substance use and mental health disorder treatment. One of the Department's recommendations, which we support, is to increase SBIRT expenditures by \$382,000. SBIRT stands for Screening, Brief Intervention, *Referral and Treatment*. It makes little sense to spend money on a program that will surely increase "referral and treatment" for substance use and mental health disorders and yet make zero additional options or resources available to actually provide substance use or mental health disorder treatment.

In conclusion: in advocating that the BadgerCarePlus Core plan comply with federal parity legislation, cover non-physician treatment of substance use and mental health disorders, and increase spending for such treatment, our fundamental message is about saving. Saving lives. Saving families. Saving the logic of SBIRT. And, we believe, saving money.

Thank you.

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**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00242/5

TITLE: Wisconsin BadgerCare Plus Health Insurance for Childless Adults
Section 1115 Demonstration

AWARDEE: Wisconsin Department of Health Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Wisconsin's BadgerCare Plus Health Insurance for Childless Adults section 1115(a) Medicaid Demonstration extension (hereinafter referred to as "Demonstration"). The parties to this agreement are the Wisconsin Department of Health Services ("State") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2009, unless otherwise specified. This Demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of Deliverables for the Demonstration Period.

II. PROGRAM DESCRIPTION

The BadgerCare Plus expansion to low-income childless adults is the second step in a comprehensive strategy to ensure access to affordable health insurance for virtually all Wisconsin residents. Wisconsin is building on the success of the current BadgerCare Plus and is well positioned to lead the Nation both in terms of health insurance access as well as overall health care reform.

The demonstration population consists of the most chronically uninsured population: adults without dependent children, between the ages of 19 and 64 and with incomes that do not exceed 200 percent of the Federal Poverty Level (FPL). The program includes new and innovative features including, 1) centralized eligibility and enrollment functions, 2) requirement for participants to complete a health needs assessment that will be used to match enrollees with health maintenance organizations (HMOs) and providers that meet the individual's specific health care needs, 3) the tiering of health plans based on quality of care indicators, and

- f) Are no longer living.

V. **BENEFITS AND COST SHARING**

25. Core Benefit Plan. Upon implementation, the Childless Adults Population participants will receive a basic benefit package which is referred to as the Core Benefit Plan. The Core Benefit Plan consists of the following benefits. *Attachment A provides a full list of the covered and proposed covered benefits with applicable cost sharing for the childless adults.*

- a) Physician services including primary and preventive care, specialists for surgical and medical services, and chronic disease management;
- b) Diagnostic services including laboratory and radiology;
- c) Inpatient hospital stays and outpatient hospital visits (excluding inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital);
- d) Emergency outpatient services including emergency dental and ambulance transportation service;
- e) Generic drugs; selected over-the-counter drugs, limited brand name drugs and brand name drugs through a Medicaid pharmacy benefit plan (brand name mental health drugs for individuals converting from the GAMP and GA medical programs in December 2008 must be covered, irrespective of any limits otherwise imposed, for as long as such individuals are enrolled in the BadgerCare Plus for Childless Adults waiver program);
- f) Physical, occupational, and speech therapy, limited to 20 visits annually per discipline;
- g) Durable medical equipment limited to \$2,500; and
- h) Disposable medical supplies, including diabetic pens, syringes and disposable medical supplies that is required with use of durable medical equipment (no limit).

26. Modifications to Services in the Core Benefit Plan. After implementation of the demonstration the State may add and/or expand the following services, as recommended by the CACHET and described in Attachment A to the Core Benefit Plan: chiropractic, additional dental, hearing, home care, hospice, additional mental health and substance abuse, podiatry, and vision. The State will be required to provide written notification to CMS related to changes in the initial Core Benefit Plan as described in Attachment A, using the process described below in subparagraphs (a) and (b). Any service changes that are inconsistent with the definition in Attachment A must be submitted to CMS as an amendment to the demonstration as described in paragraph 7.

	potential for limited coverage provided by an audiologist.	included in the benefit, a co-payment up to \$15 per visit, not to exceed \$3 for members under 100% FPL
Home Care Services (Home Health ,Private Duty Nursing and Personal Care	No coverage at implementation, but potential for full coverage of home health services, up to 60 visits per enrollment year.	If coverage is included, a co-payment up to \$15 per visit, not to exceed \$3 for members under 100% FPL
Hospice Services	No coverage at implementation, but potential for full coverage, up to 360 days per lifetime.	If coverage is included, co-payment up to \$2 per day
Inpatient Hospital Services	Full coverage (not including inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital)	\$3 co-payment per day up to \$75 per stay for members under 100% FPL and \$100 co-payment per stay for members between 100% and 200% FPL
Mental Health and Substance Abuse	At implementation, coverage is limited to mental health therapy services provided by a psychiatrist only but coverage may be expanded to include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment, substance abuse treatment and inpatient hospital stays for mental health and substance abuse.	\$.50 to \$15 co-payment per service, not to exceed \$3 for members under 100% FPL
Nursing Home Services	No coverage	
Outpatient Hospital-Emergency Room	Full coverage	No co-payment up to \$60 co-payment per visit, not to exceed \$3 for members under 100% FPL
Outpatient Hospital Services	Full coverage	\$3- \$15 co-payment per visit, not to exceed \$3 for members under 100% FPL
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	Full coverage, limited to 20 visits per therapy discipline per enrollment year	\$.50 to \$15 co-payment per visit., not to exceed \$3 for members under 100% FPL

UNFORESEEN BENEFITS:

Addiction Treatment
Reduces Health Care Costs

**CLOSING THE ADDICTION
TREATMENT GAP**



OPEN SOCIETY INSTITUTE

**EXECUTIVE
SUMMARY**

- ▶ **Improving America's health care system, creating a healthier country, and containing costs will take a range of interdependent solutions. One essential solution involves treating Americans who are addicted to alcohol and drugs.**

Addiction is a pervasive yet treatable chronic health condition. Often it occurs alongside other chronic diseases. If untreated, the addicted person's medical care becomes more costly due to secondary health conditions. When treated, addiction leads to better health care outcomes.

This paper demonstrates how addiction treatment will contribute to containing costs in reforming America's health system. Studies show that addiction treatment significantly reduces emergency room, inpatient and total health care costs.

Addiction treatment will lead to substantial savings to the health system. While the overall cost savings have not been documented, there are clear signs of the potential for savings. **For example:**

- ▶ One out of every 14 hospital stays - 2.3 million stays - was related to substance disorders in 2004, a federal study found.
- ▶ Total medical costs were reduced 26 percent among one group of patients that received addiction treatment.
- ▶ A group of at-risk alcohol users who received brief counseling recorded 20 percent fewer emergency department visits and 37 percent fewer days of hospitalization.



INTRODUCTION ▶

Addiction is pervasive in the United States. An estimated 23 million Americans suffer from alcohol and drug addiction, according to the most recent government survey. Yet only one in 10 of these persons - 2.4 million - get treatment.

Among these and other statistics about addiction, two truths stand out:

- ▶ Addiction is an equal opportunity disease. It is a prevalent and costly chronic disease that disrupts the health care and well-being of individuals in every age, income and ethnic group.
- ▶ Only a small percentage of persons with alcohol and drug addiction get treatment, unlike those suffering from other chronic diseases such as diabetes, hypertension or asthma.

Over the past 20 years, however, signs of hope have emerged. The medical consensus that treatment works was confirmed in a major 2006 federal study, which concluded that "treatment for alcohol and other drug problems and illnesses is effective." A year later, the National Quality Forum issued national standards for treating substance abuse conditions. These consensus standards demonstrate that treatment for addiction is effective.

▶ **ADDICTION TREATMENT YIELDS BETTER HEALTH CARE OUTCOMES**

Addiction affects families and communities as well as individuals. Too often, however, the face of addiction is a person whose addiction is untreated and who is not receiving regular health care. When those characteristics intersect, the result is devastating for the health of individuals and costly for our nation's health care system.

If addictions are untreated, the person's medical care becomes fragmented, inefficient and episodic. It is not just that addiction, by itself, risks health consequences and poor health outcomes. It is also that unrelated and co-existing health issues go unaddressed.

"Persons with addictive disorders suffer from many of the same medical conditions as nonaddicted persons, but addiction can interfere with the disease or its management."

-DR. RICHARD SAITZ

Associate Director and Lead Investigator, Youth Alcohol Prevention Center,
Boston University School of Public Health.

The interrelationship between addiction and general health was noted in a report by the Institute of Medicine, an arm of the National Academy of Sciences. In 2006, an Institute study committee concluded "that improving the nation's general health and resolving the quality problems of the overall health care system will require attending equally to the quality problems" of mental and substance use health care.

Why does addiction treatment improve a person's overall health? Addiction complicates chronic illnesses and other conditions. Many times, substance use may be strongly correlated with difficulty in treating another disease or illness.

► **Addiction contributes directly to many medical conditions.**

Heavy drinking, for example, contributes to illness in each of the top three causes of death: heart disease, cancer and stroke.

► **Addiction frequently worsens or complicates other diseases and illnesses.**

Persons with asthma who use cocaine often find that the cocaine worsens their asthma. Addiction can also lead to misdiagnoses, unexpected side effects from prescribed medications and poor medical outcomes.

► **Health care self-management is poor among people with addiction.**

Finally, many persons with untreated addiction fail to fill a prescription or get laboratory tests, skip a follow-up doctor's appointment or do not follow prescribed care.

"Some of the destructive medical consequences of drug abuse and addiction are temporary – the conditions improve after patients receive treatment and are able to stop their drug use. Other consequences may be more persistent, diminishing the quality of patients' health long after drug use has stopped. Whether short-lived or chronic, the growing list of recognized health consequences of abuse and addiction underscores the fact that drug abuse is not just a brain disease that exists in medical isolation – it manifests itself throughout the body with a broad array of medical consequences."

—FEBRUARY 2004 COLUMN BY DR. NORA VOLKOW
Director, National Institute on Drug Abuse

ADDICTION: A CHRONIC DISEASE.

Another way to analyze addiction to alcohol and drugs is to compare it with other chronic diseases. Research shows that addiction shares many characteristics with other major chronic diseases such as hypertension, diabetes and asthma, for example:

- Genetics play a role
- The medical impact on the body is significant
- Complications develop if the disease is untreated
- Self-care is critical to success
- Medication can help

Addiction also fits the U.S. Centers for Disease Control and Prevention definition for chronic disorders. They are prolonged, lasting for at least three months, do not resolve spontaneously, and are rarely cured completely. Even so, addiction treatment is less available than treatment for other disease.

Researchers say addiction may require lifelong management. In a study published in 2000 called "Drug Dependence, a Chronic Medical Illness," A. Thomas McLellan, who was then at the Treatment Research Institute in Philadelphia, compared addiction with three other chronic diseases: "Hypertension, diabetes and asthma are also chronic diseases, requiring continuing care throughout a patient's life." McLellan and three colleagues concluded, "Treatments for these illnesses are effective but heavily dependent on adherence to the medical regimen for that effectiveness."

TREATING PEOPLE FOR ADDICTION DISORDERS REDUCES EXPENSIVE HEALTH CARE USE

Without question there is a health care justification for treating addiction. But there also is a proven economic justification. Addiction treatment programs result in significant cost-savings for health care systems compared with the cost of not treating addictions. In addition, treating addiction will save money from the reduced costs of treating other general medical and chronic illness conditions.

When addiction is treated, the overall health of patients improves. The cumulative evidence shows that these patients fare better with their other health issues and use fewer costly medical services. Several studies have found that "substance abuse treatment reduces the medical costs of patients with alcohol and drug use disorders, who utilize health care services at a much higher rate than other patients."

The following studies, in particular, lay out evidence that addiction treatment programs are associated with substantial health care cost savings.

California: Savings from Addiction Treatment in Health Care Costs

In 2000 researcher Constance Weisner and others studied the overall medical costs of a group of men at an outpatient Kaiser Permanente addiction treatment program in Sacramento, Calif. They studied the men 18 months before and after they began an outpatient chemical dependency recovery program. The cost savings were startling:

- ▶ **Total medical costs declined 26 percent.**
- ▶ **Inpatient health care costs declined 35 percent.**
- ▶ **Emergency room costs declined 39 percent.**

"As in previous studies on medical offset, we observed that a group of adult, chemical dependency (CD) patients have substantially higher utilization of medical services and medical costs prior to entry in treatment when compared to other, non-CD, members who are similar in terms of age, gender and length of enrollment," the researchers wrote.

"We found that the most significant reductions were observed in inpatient use and likelihood of ER use, but other measures (e.g., inpatient days and number of ER visits) also showed substantial decreases."

Federal Study: Prospects for Reducing Hospital Admissions

In a 2007 report, the U.S. Agency for Healthcare Research and Quality found that one in fourteen stays in U.S. community hospitals in 2004 involved substance related disorders - about 2.3 million hospitalizations. The mean length of each stay was 4.6 days, costing \$4,300 or \$2 billion nationally in 2004. Half of the patients were admitted from the emergency department.

The federal study, which also looked at mental health disorders, carried the clear message that treating addiction earlier would reduce the number of hospital admissions. It concluded:

"Mental health and substance abuse disorders place a substantial burden on individuals, families, the health care system, and the economy. Beyond the personal costs of these conditions, mental illness and

substance abuse result in lost productivity, increased medical expenditures, and other costs including those resulting from law enforcement activities.”

Six States: Medicaid Costs Higher for Those with Addictions

In an article published in 2009, Robin Clark and two other researchers analyzed the impact of substance use disorders on Medicaid health care expenditures in six states. Substance use and dependence, they said, “affect more than one in eight Medicaid beneficiaries, a higher prevalence than in Medicare or privately insured populations.”

They found significantly higher costs among those with addictions. The six states “paid \$104 million more for medical care and \$105.5 million more for behavioral health care delivered to individuals with substance use diagnoses than for care given to persons with other behavioral health disorders but no substance use diagnosis.”

The most surprising finding, Clark said, was that the findings were consistent across the six states. “Left untreated,” he said, “substance abuse or dependence makes it more difficult to manage chronic physical illness.”

Wisconsin: Problem Drinkers Hospitalized Less after Brief Physician Advice

To study the cost and benefits of brief physician counseling for at-risk alcohol users, Michael Fleming and his team at the University of Wisconsin-Madison set up two groups. One group received brief advice from a physician for treatment of problem drinking, which consisted of two physician visits and two nurse follow-up phone calls. The other group did not.

Following up later, the researchers found significant health care cost savings from the brief intervention. Those receiving advice recorded 20 percent fewer emergency department visits and 37 percent fewer days of hospitalization. The intervention saved \$712 per person in medical care costs, they found.

“Dealing equally with health care for mental, substance-use, and general health conditions requires a fundamental change in how we as a society and health care system think about and respond to these problems and illnesses. Mental and substance-use problems and illnesses should not be viewed as separate from and unrelated to overall health and general health care.”

-HARVEY V. FINEBERG, MD, PHD

President, Institute of Medicine

Excerpt from foreword “Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.”

The preceding studies do not present a complete picture of the cost savings from treating people with addiction disorders. But in summary, they point to significant cost savings in three areas:

► **Reduced cost of hospital stays.**

One out of every 14 hospital stays - 2.3 million stays - was related to substance disorders in 2004. With the mean total costs in 2004 of \$2 billion for substance-related disorders, even a fraction of savings through reduced hospital stays will result in billions of dollars over a decade.

► **Reduced emergency room care costs.**

More than 1.7 million emergency department visits a year are associated with drug misuse or abuse, according to the U.S. Department of Health the Human Services Drug Abuse Warning Network study of 2006. A conservative estimate of fewer emergency room visits, like reduced hospital stays, will similarly save billions of dollars over a decade.

► **Reduced total medical costs.**

Another perspective is to look at total medical costs, which includes inpatient, ER and nonemergency outpatient visits. As one example of the potential in savings, the Kaiser Permanente study found treatment reduced total medical costs 26 percent, which also would translate into billions of dollars in the future.

CONCLUSION ►

Effective Addiction Treatment Can Contribute to Improving Quality and Containing Costs in Reforming America's Health System

America has attached a stigma to addiction, treating it as a social problem. By applying the wrong tools, we have made no progress. Addiction is an illness that frequently goes untreated in its early stages. When that happens, it too often leads to other medical problems. It is time to treat addiction as a health issue.

A significant and growing body of knowledge shows that addiction is prevalent, treatable and manageable. From peer-reviewed studies over the past decade, along with the real-life experience of physicians, we know that addiction is a chronic disease. Like other chronic conditions, we also know that it is a treatable chronic disease.

Health care reform presents a unique opportunity.

As part of this national discussion, addiction treatment should not be regarded as a burden on our health care system. Instead, it is a solution - a solution that will help make health reform affordable. Every dimension of health care reform - comparative effectiveness research, information technology infrastructure and coverage of the uninsured - should include addiction treatment to help contain costs and achieve the goals of better quality health care.

By recognizing addiction as a treatable condition, we will encourage people to seek help. Treating addiction within a better health care system will result in better health outcomes. And treating addiction will result in significant cost-savings - estimated at billions of dollars - compared with the cost of not treating persons at all.

► **WWW.TREATMENTGAP.ORG**



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CLOSING THE ADDICTION TREATMENT GAP

Closing the Addiction Treatment Gap is a \$10-million national program of the Open Society Institute. This initiative is designed to create an awareness of—and increase resources to close—an alarming treatment gap: currently, four out of five Americans who need drug and alcohol addiction treatment are unable to get it. The initiative aims to mobilize public support for expanded treatment by increasing public funding, broadening insurance coverage, and achieving greater program efficiency.

For more information, go to www.treatmentgap.org