



SUBSTANCE ABUSE INSURANCE PARITY

A Guide for Advocates

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This document provides background information and negotiation strategies for advocates who are working to achieve substance abuse parity. In some states, obtaining parity for substance abuse/addiction coverage will entail advocating for additional legislation to complement existing mental health parity laws. In other states without mental health parity, this information is designed to support advocacy efforts for comprehensive mental health and substance abuse parity, or separate substance abuse parity legislation.

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National Mental Health Association

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I. OVERVIEW

Comprehensive Mental Health and Substance Abuse Parity

In most parts of the country, healthcare plans cover mental disorders, but they contain significantly more restrictions on the scope and type of services covered when compared to physical health disorders. For substance abuse/addiction, insurance companies are less likely to provide coverage and are more likely to not cover it at all. Insurance policies typically impose higher copayments, deductibles and more restrictive day and visit limits for mental health and substance abuse/addiction coverage than they do for physical healthcare.ⁱ

Parity legislation is intended to end practices that unfairly limit mental and substance abuse benefits. **Comprehensive parity** requires insurance companies, employers and other payors to provide the same level of mental health and substance abuse/addiction coverage that is offered for physical healthcare needs.

Comprehensive parity mandates that insurance companies provide these types of benefits, and does not include any exemptions or limitations.ⁱⁱ The ideal solution to the problem of insurance discrimination would be to enact comprehensive parity on the federal level without any exemptions or loopholes. However, this solution has not yet become a reality, and states have been forced to protect their own citizens in the interim. Connecticut, Maryland, Minnesota and Vermont have passed comprehensive parity legislation and can be used as models for other states.ⁱⁱⁱ

The National Mental Health Association (NMHA) strongly supports the passage of comprehensive parity, or separate substance abuse parity legislation to supplement already existing mental health parity laws. NMHA argues that parity must apply to all Americans and not just to a discrete population with specific diagnoses, or to those with private health insurance and full-time employment. The lack of parity for substance abuse/addiction treatment discriminates against individuals who have co-occurring mental health and substance abuse disorders.^{iv} It creates barriers to all substance abuse AND mental health treatment for those with substance abuse/addiction problems, and increases their risks for relapse and treatment failure. On a separate note, comprehensive parity must also be addressed in public healthcare systems.^v

Federal Parity

The Mental Health Parity Act of 1996 (MHPA) began the federal effort to establish parity for mental illness, but it specifically excluded treatment for alcoholism and drug addiction. The Act was also very limited in scope, addressing only lifetime and annual spending limits. In 1999, President Clinton took a major step forward with his landmark decision to offer mental health parity for the nine million federal workers and their dependents covered through the Federal Employees Health Benefits Program. Although it excludes substance abuse disorders, this first

test of “full” mental health parity at the federal level has proven to work well. It has resulted in a less than one percent increase in costs.

In 2001, Congress came very close to passing an improved mental health parity bill. Senators Domenici and Wellstone introduced SB 543, the Mental Health Parity Act. This bill would have required insurance companies that offer mental health services to provide parity in day and visit limits, deductibles, as well as lifetime and annual spending limits. In August, it passed the Senate Health and Human services committee unanimously. It was then attached as an amendment to the Health and Human Services Budget. It was hoped that House conference committee members, who had failed to address parity despite numerous opportunities, would pass the bill with the parity amendment. Unfortunately, they did not, and the 1996 Mental Health Parity Act was renewed until December 31, 2002.

Despite its near passage, the SB 543 did not include substance abuse coverage. There have been many substance abuse parity bills introduced on the federal level, but the political realities make it unlikely for any of these bills to be considered in the near future. States must set an example and pass substance abuse parity and create a groundswell of support from the states.

Substance Abuse Parity in the States

Currently only nine states include substance abuse in their parity laws: Connecticut, Maryland, Minnesota, Vermont (which all have comprehensive parity), and Delaware, Virginia, Kentucky, and Rhode Island. Indiana, South Carolina and North Carolina include substance abuse parity in their state insurance plans.

In May 2000, Massachusetts (S 2036) enacted limited parity for substance abuse/addiction treatment when it co-occurs with a mental illness. The law prohibits discrimination in annual or lifetime dollar limits and unit of service limits for severe mental illnesses and co-occurring disorders.^{vi} It also provides a minimum mandated benefit of 60 inpatient days and 24 outpatient visits for people with only substance abuse disorders. While certainly not ideal, Massachusetts provides an example of compromise legislation for people advocating for substance abuse parity. It also begins to address the complicating factors of dual diagnoses.

Accepting Limited Parity

As mentioned previously, few states have passed comprehensive parity legislation. For a variety of reasons, many states have focused on more limited types of legislation with a limited list of diagnoses covered. This approach, often referred to as *severe mental illness* (SMI) legislation, makes inherent judgments about what is and what is not “worthy” of coverage – judgments that are not similarly made on the physical health side. Moreover, the list approach stresses a person’s diagnosis, rather than his or her level of functioning.^{vii} Lastly, SMI bills/laws often do not encompass substance abuse disorders.^{viii} However, in 2001, Delaware passed a parity law that expanded their list to include substance abuse disorders.

Prior to the 1999 legislative session, states that compromised and accepted more limited parity bills were left with little recourse to improve their laws. However, states like Indiana, Delaware, Rhode Island and Connecticut have given advocates new hope. Connecticut expanded its law from one that only covered certain diagnoses, an SMI law, to a comprehensive parity law. A prior Indiana law expanded from parity for only state and local employees to a full parity approach for all of its citizens with mental health treatment needs, although still allowing insurance discrimination for those with substance abuse disorders. Most recently Indiana expanded to comprehensive parity for state employees, including substance abuse. For the first time, legislators have listened when constituents have gone back to their legislatures to amend their parity laws to be more broad-based, thereby proving that comprehensive parity can be achieved incrementally.

Obstacles to Parity

Ongoing discrimination caused by stigma, misinformation and misunderstanding continue to create substantial barriers to fair treatment of people with substance abuse/addiction treatment needs. In spite of years of official acceptance of addiction as a treatable illness by the medical, psychiatric and psychological communities, there are some advocates, legislators and providers who still believe that alcohol and drug abuse represent behavioral problems or lifestyle choices. They inaccurately argue that treatment for substance abuse/addiction is undefined and ineffective and that precious healthcare dollars should not be spent here. In effect, the chief obstacle to enacting parity for substance abuse is misperception.

II. DEFINITIONS AND PREVALENCE OF ALCOHOL AND DRUG ABUSE AND ADDICTION

Alcoholism and drug addiction are recognized as primary, progressive, chronic, relapsing and treatable diseases, with clear diagnostic classifications in the American Psychiatric Association's Diagnostic and Statistical Manual – Fourth Edition (DSM-IV) and with research based treatment principles and protocols. Dr. Alan Leshner, director of the National Institute on Drug Abuse, defines addiction as “a brain disease shaped by behavior and social context.” NMHA has adopted the term substance abuse/addiction to comprehensively address issues related to a wide array of issues and problems associated with alcohol or drug abuse, including addiction.

Incidence and prevalence of alcohol and other drug abuse and addiction are pervasive throughout the population of American youth and adults. The findings of the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) 1999 National Household Survey on Drug Abuse (NHSDA) show that in 1999, 105 million people in the United States over the age of 12 reported current use (use within the 30 days prior to the survey) of alcohol, 10.4 million of whom are under the age of 21. Of those, 8.2 million people were estimated to be alcoholic, or addicted to alcohol. While 14.8 million persons reported current use (use within 30 days prior to the survey) of an illicit drug in the 1999, 3.6 million were dependent on an illicit drug. Overall, an estimated 10.3 million Americans were dependent on either alcohol or illicit drugs. Only 27 percent, or an estimated 2.8 million had received treatment or counseling for their alcoholism and/or drug abuse.^{ix}

Alcohol and other drug abuse and addiction are rarely limited to the abuse of just alcohol or one drug alone. The 1999 NHSDA showed that of heavy drinkers, 30.5 percent (3.8 million people) were current illicit drug users. Among the binge (but not heavy) drinkers, 14.8 percent (4.8 million) were illicit drug users.^x The inter- and intra-personal consequences of poly-drug abuse or addiction are more complex, and treatment for it takes longer and costs more than treatment for a single drug addiction.

A 1999 report from SAMHSA indicates that in any twelve-month period, an estimated 10 million people in this country will have a combination of at least one mental health and one substance abuse disorder. The prevalence of substance abuse disorders in people with severe mental illness is higher than in the general population. The National Comorbidity Survey found that 56 percent of all persons aged 15-54 years with a mental or addictive disorder have at least one other co-occurring disorder.^{xi}

III. COSTS OF ADDICTION

Estimates of the total economic cost of untreated alcohol and other drug addiction and its related effects – including costs for healthcare, substance abuse prevention, treatment for addiction, costs of substance abuse related crimes, and lost resources from reduced work productivity and accidental and drug related deaths – in 1995 was \$276.3 billion (\$166.5 billion for alcohol addiction, and \$109.8 billion for other drug addiction).^{xii} These costs are passed on to all Americans through higher taxes and increased consumer prices, such as higher premiums on health and auto insurance. The economic, productivity and human costs of substance abuse, the abuse of alcohol and other drugs by persons who may not meet the diagnostic criteria for addiction, are also significant.

The financial costs only begin to tell the story of pain and isolation substance abuse causes to children and families. According to the National Association for Children of Alcoholics, children with alcohol- and other drug-addicted parents are at highest risk for developing their own substance abuse and related behavioral and emotional problems.^{xiii} Studies of family violence frequently document high rates of alcohol and other drug involvement. Fear, shame, isolation and stigma are the legacies of persons living with one or more addicted family members.

Fear of Rising Costs is Unfounded

Early fears about skyrocketing costs for insurance coverage that included substance abuse and mental health benefits prove to be unfounded. A study conducted by the RAND Corporation demonstrated that the costs of parity for alcoholism and drug addiction alone (without mental health) would rise minimally, perhaps as little as 0.7 percent. This is because high level users of substance abuse services tend to be found in the public rather than private sector. In addition, SAMHSA has estimated that comprehensive parity would increase costs by only 3.6 percent or about five dollars per employee per month.^{xiv} In 2000, the Hay Group reduced this estimate to say that parity would increase premiums by only 1.4 to 1.6 percent, and warned that this estimate may still be too high.^{xv}

Co-Occurring Disorders and Parity

In any given year, there are estimated to be over ten million persons in the United States with at least one co-occurring mental health and substance abuse disorder.^{xvi} NMHA advocates for, and research supports the benefits of, integrated treatment models for addressing the complex needs of persons with co-occurring disorders. Effective delivery of integrated services is difficult to achieve because of disparate funding streams, differences in treatment philosophy between mental health and substance abuse providers, and lack of cross-discipline trained providers. These barriers are exacerbated when public or private benefits are unavailable for some populations or for some types of treatment providers.

The costs to the consumer and community that result from a fragmented service delivery system go far beyond financial ones. In many ways the system further stigmatizes a population already struggling with enormous shame in the community. Individuals with co-occurring disorders, whose illnesses can cause significant social impairment, are often left to navigate between disconnected service delivery systems on their own when basic needs such as transportation, employment or housing are not being addressed. When the needs of persons with co-occurring disorders cannot be addressed in a comprehensive treatment approach, social service, hospital and corrections systems become providers by default, at increased cost to the community, and increased risk to the consumer.

Effective Treatment Delivers Cost Offsets

The indirect costs for substance abuse-related medical issues for people who do not receive appropriate treatment are significant.

- Alcohol and/or other drug (AOD) abuse and addiction cost American businesses nearly \$100 billion in increased medical claims, medical disability, injuries and decreased productivity.
- According to a report from the National Association of Alcohol and Drug Addictions Counselors, 70 percent of those using illicit drugs, and 75 percent of alcoholics hold down regular jobs.^{xvii}
- In the workplace, turnover, low and inconsistent employee performance, and alcohol or drug related illnesses hurt productivity; it is estimated that alcoholism alone causes 500 million lost workdays a year.^{xviii}
- Healthcare costs of untreated persons who suffer from alcoholism and drug addiction are 100 percent higher than those who receive treatment.^{xix}
- Thirty-five to 50 percent of all workers compensation claims and 65 percent of emergency room visits are AOD related.^{xx}

The connections between substance abuse/addiction and crime are well established in the literature. Fifty-one percent of prisoners reported use of alcohol or drugs while committing their crime, 83 percent of state prisoners report past drug use, and 57 percent were using drugs in the month before their offense.^{xxi} When treatment is not available in the community, jails and prisons become de facto treatment centers, often with ineffective, if any, treatment programs.

IV. SUBSTANCE ABUSE TREATMENT WORKS!

According to reports by the National Institute on Drug Abuse, scientific research and clinical practice over the past three decades have yielded a variety of effective approaches to drug and alcohol addiction treatment. Extensive data document that drug addiction treatment is as effective as are treatments for most other similarly chronic medical conditions. However, because addiction is a chronic disorder, the ultimate goal of long-term abstinence and recovery can require sustained and repeated treatment episodes.

Recent research confirms that substance abuse treatment works. In a longitudinal study, the Center for Substance Abuse Treatment found that there was a 21 percent reduction in illicit drug use and 14 percent drop in alcohol use five years after treatment, in spite of the fact that 44 percent had been in treatment less than one month, and criminal behavior by alcoholics and drug users dropped by between 23 and 28 percent.^{xxii}

In a recent article in the Journal of American Medical Association, McLellan, et al. argued that too often drug treatment fails because “drug dependence has been treated as if it were an acute illness. Review results suggest that long-term strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated and evaluated like other chronic illnesses.”^{xxiii}

V. STRATEGIES FOR ADVOCATES

The voice of the mental health community is critical to the enactment of comprehensive and/or incremental mental health and substance abuse parity legislation in states across the country. Below are useful strategies for advocates to use in moving parity forward in state legislatures.

- ❑ **Expand, organize and energize your coalition!** Strive for a balanced representation from substance abuse and mental health prevention and treatment communities. A few national substance abuse organizations with local affiliates are listed at the end of this document. Find parents, teachers and faith community leaders who are committed to substance abuse prevention and treatment, especially for youth, and invite them to coalition meetings.
- ❑ **Provide the coalition members with accurate information and resources.** Emphasize cost-offsets by showing how untreated substance abuse/addiction increases costs to the community in other areas, such as automobile accidents, prosecuting Driving Under the Influence offenses, healthcare costs of related medical problems and costs resulting from drug- and alcohol-related crime. Use the statistics reported in this document to clear up old myths and misconceptions about substance abuse and to demonstrate that traditional limits on mental health and substance abuse benefits are economically and socially self-defeating.
- ❑ **Anticipate compromise.** Make sure your coalition agrees about *when* to compromise and *what* compromises are acceptable *before* negotiations begin. When compromises are suggested, carefully examine the status of the legislation before making any decisions.
- ❑ **Increase public and political awareness.** Fighting for substance abuse parity is the only way to adequately address the needs of persons with co-occurring disorders. Without it, these individuals can be denied necessary treatment for basic substance abuse services, and/or have their treatment for their mental health issues disrupted by relapse of substance abuse-related problems. Those with substance abuse as their primary diagnosis are often required to resolve their substance abuse problem first. Without adequate benefits for substance abuse treatment, which are ensured by substance abuse parity, in effect that person is denied both substance abuse and mental health treatment. The weaker the benefit structure, the wider the gap into which persons with co-occurring disorders can fall.
- ❑ **Work with the media.** When you promote programs to screen for mental health and substance abuse problems and address stigma issues in public education campaigns, emphasize the need for substance abuse parity. Watch for occasions to submit *Letters to the Editor* or *Op-Ed* pieces to local print media. Prepare members of your coalition to appear on local radio and TV talk shows and pitch specific topics related to parity to the program directors. Find out how to use community cable access airtime to present information on healthcare reform, specifically comprehensive and substance abuse parity.
- ❑ **Recruit members of the business community.** Recommend they provide testimony for parity legislation. Ask them to attest to the cost savings and economic value of providing comprehensive mental health and substance abuse benefits. Also invite them to become members of your coalition.

VI. ADDITIONAL RESOURCES

This publication should provide a solid foundation to support state substance abuse parity advocacy efforts. However, state campaigns will vary according to the structure of the coalitions and the political composition of the legislature.

To help state and local coalitions throughout the process, NMHA provides ongoing technical assistance to mental health associations, individual advocates, and other interested parties. For technical assistance around strategies for state parity campaigns, contact NMHA's Healthcare Reform Advocacy Center at 1-800-969-NMHA, or e-mail at shcrinfo@nmha.org. Mental health advocates can rely on the Advocacy Resource Center to:

- Respond to requests for information and research;
- Produce informative publications on managed care & state healthcare reform topics; and
- Identify experts on specific healthcare reform issues.

Other NMHA publications that will help you with your parity campaign include:

- *National Mental Health Association Advocacy Primer*;
- *Coalition Building: The Foundation of Advocacy*; and
- *Lobbying Primer: A Guidebook on How to Influence your State Legislature*.

For more information about specific mental illnesses, please contact NMHA's Information Center at 1-800-969-NMHA. Other resources include:

- The National Council on Alcoholism and Drug Dependence at 800-NCA-CALL or www.ncadd.org or look in the local yellow pages under Alcoholism or Drug Addiction Council;
- The Community Anti-Drug Coalitions of America, with over five thousand community substance abuse prevention coalitions across the United States, at 1-800-54-CADCA or www.cadca.org; and
- Join Together, a project of the Boston University School of Public Health, a national resource for communities fighting substance abuse and gun violence, at 617-437-1500 or www.jointogether.org.

VII. ENDNOTES

ⁱ Insurance companies also typically imposed lower annual and lifetime aggregate limits for mental health and substance abuse treatment than for physical illness. However, this practice was banned by the federal Mental Health Parity Act of 1996.

ⁱⁱ Full parity refers to parity that is not quite comprehensive, due to certain exemptions and/or limitations. Limited parity refers to legislation that only applies to select groups, such as those with severe mental illness or state and local government employees. For more information, please see NMHA's Parity Chart entitled, "*What Have States Done to Pass Health Insurance Parity?*" See also, NMHA's "*Strategies for Negotiating Comprehensive Parity.*"

ⁱⁱⁱ States like Georgia and Kentucky have full parity laws that do incorporate substance abuse. Indiana and New Mexico, the other two states with full parity, do not.

^{iv} People with "co-occurring disorders" have both a substance abuse disorder and a diagnosed mental illness. Thus, a person may be forced to receive substance abuse treatment before he or she can access mental health services. This approach is costly, ineffective, and unnecessary.

^v Parity has traditionally referred to private insurance only. Unless specifically included, public insurance is not within the scope of a typical parity bill. However, this is not because there is no need for it. For example, the federal Medicaid program does not provide an adequate array of services to treat substance abuse disorders. In fact, most Medicaid programs only cover detoxification services, thereby missing what appropriate prevention and treatment services can offer. In addition, the federal State Children's Health Insurance Program does not require that states provide substance abuse benefits. Although every state except for Pennsylvania does, the benefit packages run the gamut. States like Indiana and Texas have led the way in trying to achieve parity in their Children's Health Insurance Programs. Indiana has been successful.

^{vi} The language in the law does not clearly define "unit of service," but we have interpreted this to mean the prohibition of visit limits.

^{vii} Other laws that address persons with disabilities, such as the Americans with Disabilities Act, use language that focuses on a person's ability to function when defining the disability. For example, a qualifying mental disorder could be defined as a functional impairment that substantially interferes with or limits one or more major life activities.

^{viii} Virginia is the only state to have included substance abuse in their SMI law.

^{ix} Substance Abuse and Mental Health Services Administration (SAMHSA). *National Household Survey on Drug Abuse – Main Findings 1999*. Rockville, MD: SAMHSA. 2000.

^x Ibid.

^{xi} Kessler, R.C., McGonagle, K.A., Zhao, S., et al. "Lifetime and 12-Month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey." *Arch. Gen. Psychiatry*, 51, 1996: 8-19.

^{xii} National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (NIDA & NIAAA). *The Economic Cost of Alcohol and Drug Addiction in the United States-1992*. Executive Summary. Bethesda, MD: NIDA & NIAAA. 1995.

^{xiii} National Association for Children of Alcoholics (NACA). *Children of Alcoholics: Important Facts*. Rockville, MD: NACA. 1998.

^{xiv} Sturm, R., Zhang, W., & M. Schoenbaum. "How Expensive Are Unlimited Substance Abuse Benefits Under Managed Care?" *Journal of Behavioral Health Services and Research*, 26(2), 1999: 203-210.

^{xv} Kirschstein, R. L. *Insurance Parity for Mental Health: Cost, Access, and Quality: Final Report to Congress by the National Advisory Mental Health Council*. Rockville, MD: Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. June 2000.

^{xvi} Substance Abuse and Mental Health Services Administration (SAMHSA). *Advisory Council Report*. Rockville, MD: SAMHSA. 1997.

^{xvii} NAADAC. "Frequently Asked Questions." Website: www.naadac.org/faq.htm.

^{xviii} National Association of Treatment Providers (NATP). *Treatment is the Answer: A White Paper on the Cost-Effectiveness of Alcoholism and Drug Dependency Treatment*. Laguna Hills, CA: NATP. March, 1991.

^{xix} Conley, M. "Testimony before House Committee on Government Reform." Center City, MN: Hazelden Foundation. October 21, 1999.

^{xx} Ibid.

^{xxi} Mumola, C. J. *Substance Abuse and Treatment, State and Federal Prisoners, 1997*. Washington, DC: Department of Justice, Bureau of Justice Statistics. January 1999

^{xxii} Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment, *National Treatment Improvement Evaluation Study*. Rockville, MD: SAMHSA. 1998.

^{xxiii} McLellan, A.T., Lewis, D.C., O'Brien, C.P., and H.D. Kleber. "Drug Dependence: A Chronic Medical Illness: Implications for Treatment, Insurance and Outcome Evaluations." *JAMA*, V284N13, 2000, 1689-1695.