PUBLIC POLICY & INFORMATION

Promoting Addiction Prevention, Treatment and Recovery Through Advocacy and Education

NCADD NEW JERSEY

POSITION PAPER
No. 1/212th Legislature (2006-07)

ISSUE:
Revision of health insurance regulations to require coverage for appropriate treatment for addiction and mental illness.

BILL NO.
S-807 (Vitale, Buono)
A-2512 (Gordan, Johnson, Manzo, Burzichelli, Greenstein)

NCADD-NJ POSITION:
NCADD-New Jersey strongly supports S-807/A-2512. The bill holds New Jersey's health insurers accountable for providing coverage for appropriate treatment to the state's privately insured policyholders who are alcohol and/or drug addicted. Under managed care's limits, many of these individuals have had to turn to the public sector for appropriate treatment for their illness.

In December 2005, the Pension and Health Benefits Review Commission endorsed the enactment of identical parity legislation (A-333), citing the cost savings the measure would produce. This endorsement completes a thorough review of parity legislation that has taken place over the past year. These reviews resulted in Gov. Richard Codey's Mental Health Task Force, the Mandated Health Benefits Commission as well as Gov. Jon Corzine's Human Services Transition Policy Group 2006 all recommending enactment of parity legislation.

Ending Cost Shifting to the Public Sector

The Department of Health and Senior Services Substance Abuse Prevention and Treatment Advisory Task Force (DHSSTF) also endorsed the enactment of parity. The task force reported that managed care organizations, by denying or limiting care, have caused many families with private insurance to seek access to publicly funded services as their only alternative. The body cited a national report that found this phenomenon increased costs to federal, state and local governments by as much as 20 percent.

Two decades ago, the cost of providing addiction treatment was split about evenly between private and public payers. Today, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), taxpayers pay for more than three-quarters of all treatment. SAMHSA reported in July of this year that 77.4 percent of treatment in 2003 was paid for by Medicaid, Medicare, and other federal, state and local sources, up from 50.4 percent in 1986.

Meanwhile, the private sector's share of the treatment cost burden slipped from 49.6 percent in 1986 to 22.6 percent in 2003. Private insurers, who paid 29.6 percent of treatment costs in 1986, were only paying 10.1 percent by 2003. Total dollars paid by private insurers for addiction treatment fell from $2.8 billion to $2.1 billion during the same time period.

The private sector has successfully shifted the burden of care to the public sector, exhausting resources that otherwise could have been spent on expanding treatment capacity. This legislation will help to expand alcohol and drug addiction treatment capacity without relying on additional state resources and will ensure that treatment of privately insured people is appropriately covered by the private sector rather than by public-sector funds.

Cost Savings

S-807/A-2512 would not only reduce current cost shifting from the private sector to the public sector but would produce significant cost savings.

A study, Behavioral Health Insurance Parity for Federal Employees, published in the March 30, 2006 issue of the New England Journal of Medicine, evaluated the Federal Employees Health Benefits Program, which has provided insurance parity since 2001. The researchers found that mental health and substance abuse insurance benefits for federal employees have been expanded without increasing costs, yet did result in less out-of-pocket expense. Kaiser, California's largest HMO, provides treatment for addiction and alcoholism based upon medical necessity rather than day or visit limits. They found that 18 months after addiction treatment the expenditures for the treatment were almost entirely recouped in other medical cost savings.

A January 2007 National Conference of State Legislatures report found that a quarter of what states spent on Medicaid went to paying for the consequences of substance abuse. It also found that states reduce their Medicaid burdens by identifying and treating those with substance use problems. The report found annual savings that included $6,480 per person receiving treatment for addiction.

Untreated and under-treated cases of mental health or addiction cost the state and public employers in New Jersey more than $262 million in health care, lost productivity, and absenteeism. A study of nine industries in New Jersey found that they employed 2.1 million people with an alcohol or drug problem. The amount paid out by these industries is more than $3 billion in alcohol and drug-related healthcare, absenteeism and reduced productivity.

Treatment for mental health and addiction drastically reduces these costs and will result in significant savings to the state and public and private employers. Health care costs declined by 40 percent for those treated for their depression. The National Evaluation Data Service found health care costs declined by 23 percent to 55 percent following alcohol or drug treatment, resulting in a savings of $680 million to $1.6 billion for the nine New Jersey industries. For New Jersey's state and public employers, that represents a savings of $56 million to $134 million in alcohol-related health care costs alone.

Creating a More Efficient System

The proposed legislation promotes an appropriate level of treatment for alcohol or drug addiction. The bills ensure that care will be determined by the American Society of Addiction Medicine (ASAM) placement criteria, which is already a practice in the State Health Benefits Plan. ASAM provides patients with a treatment continuum that offers the greatest chance of long-term recovery. This revision to the current statute would result in a system that is both more effective and more economically sound.

One by-product of managed health care's restrictions has been a self-fulfilling prophecy known as "revolving door treatment." The DHSSTF found managed care organizations authorize treatment that is often of insufficient intensity or duration to lead to recovery. The inappropriate level of care afforded by managed care often results in patients undergoing a series of treatment episodes, which in turn are used by critics to dismiss treatment's efficacy.

S-807/A2512, by requiring use of placement, continuing stay, and discharge criteria, will produce a thorough model of care that will ultimately be far more cost-effective than the present system's inadequate methods.

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