

## COALITION FOR WHOLE HEALTH

On behalf of the Coalition for Whole Health, we appreciate the opportunity to share our comments with members of the Senate Finance Committee on *America's Healthy Future Act*. We commend the Committee's commitment to providing universal coverage and access to necessary care, and to utilizing evidence-based strategies to improve public health and reduce costs.

We applaud the Committee for including mental health and substance use disorder services as a required benefit for small and non-group plans. Medical experts universally agree that substance use disorders and serious mental illness are chronic diseases that are prevented and treated effectively. Fully and equitably including mental health and substance use disorder prevention, treatment, rehabilitation and recovery support services in healthcare reform will improve the quality of life for millions of Americans and dramatically reduce healthcare costs.

As the *America's Healthy Future Act* moves forward in the legislative process, to ensure that mental health and substance use disorder services are fully and equitably included in national healthcare reform and strong state parity laws are not preempted, we ask the Committee to:

### **APPLY THE REQUIREMENTS OF THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT TO SMALL AND NON-GROUP PLANS**

National health insurance reform offers a timely opportunity to significantly improve access to care and achieve cost savings by universally applying the principles and requirements of the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (P.L. 110-343).

However, we are concerned that excluding small and non-group plans from the parity mandate will undermine the significant advances made last year when Congress enacted the Wellstone Domenici Act. The Wellstone Domenici Act was intended to stop plans from offering benefits in name only.

Moreover, many state parity laws, including Montana, West Virginia, Arkansas, Massachusetts, New Mexico, Oregon, Washington, Maine, New York, New Jersey and Delaware require that state parity laws apply to the small and/or individual markets. We are concerned that requiring parity only in the large group market may put these stronger state parity laws at risk.

Applying parity uniformly will improve the health of millions of Americans and will result in considerable cost savings to the healthcare system. Alcohol, nicotine, and other drug dependencies are primary diseases which produce serious secondary physical and psychiatric complications. Untreated alcohol and other drug addiction costs the U.S. \$400 billion annually. Persons with severe mental illnesses alone accounted for \$193 billion in lost earnings in 2002 - more than the gross revenue of every Fortune 500 company except Wal-Mart. Conversely, treating addiction and mental health confers significant cost savings on physical medical expenditures.

For patients with substance use disorder-related medical conditions, integrating medical and addiction treatment services results in decreases in hospital readmissions, fewer days of inpatient treatment, and fewer emergency room visits. One dollar spent on addiction treatment has consistently produced returns of over \$3 in health care savings to states that have done these studies - and often as much as \$7 when

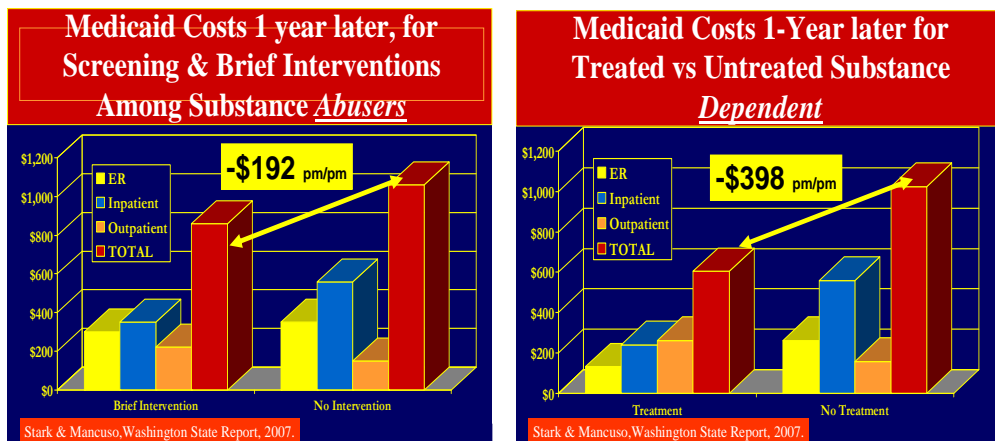
these states have added in the benefits to public safety (arrests, incarceration and welfare/child welfare costs). States that have increased access to addiction treatment in Medicaid have reduced Medicaid costs by 11% within 2 years; and 18% within 4 years of implementation.

It has been well documented by AHRQ, the National Institutes of Health, and others that individuals who received mental health treatment had lower subsequent medical costs and a reduced risk of death compared to individuals diagnosed with mental illness who did not receive mental health treatment. A 2003 Washington State study found that costs for disabled Medicaid beneficiaries receiving outpatient mental health treatment were lowered by about \$105 per member per month in the first follow-up year and \$126 per member per month in the second year, compared to clients with mental illness who did not receive mental health treatment.

**INCLUDE MENTAL HEALTH AND SUBSTANCE USE DISORDERS BENEFITS AT FULL ACTUARIAL VALUE IN THE BENCHMARK BENEFIT AFFORDED TO THE NEW GROUP OF NON-ELDERLY, CHILDLESS ADULTS WHO ARE AT OR BELOW 133% OF THE FEDERAL POVERTY LEVEL**

The Coalition for Whole Health applauds the Committee for creating a new Medicaid eligibility category for non-elderly, childless adults who are at or below 133% of the federal poverty level (FPL). The benefit package these newly eligible individuals would receive is tied to the benefit package included in Section 1937 of the Deficit Reduction Act (DRA). Unfortunately, mental health services are included only in the ancillary or “additional services” states *may* provide and substance use disorder services are not included in Section benchmark benefit additional or ancillary services. This would restrict or severely limit access to life-saving substance use disorder and mental health care for this population.

Medicaid programs can and do achieve savings when mental health and addiction benefits are equitably provided to Medicaid populations. The charts below show that increasing the treatment penetration rates among Medicaid **has reduced Medicaid costs by 11% within 2 years; and 18% within 4 years of implementation.** Examples below are from Washington: for Brief Interventions & for Full Treatment.



A recent Kaiser Family Foundation study (May, 2009) documents that 1 in 5 individuals in what would be the newly eligible Medicaid population has a severe mental health or addictive disorder. Not

providing this population with access to benefits on the same basis as medical and surgical benefits is discriminatory and will limit cost savings that can be achieved in state Medicaid programs. Numerous studies have shown that cost savings on the medical side cannot be achieved if the mental health and addictive disorders remain minimally or entirely untreated. Moreover, given that the benefit package will only cover 65% of the actuarial value of costs, it is critical that every benefit provided to this newly eligible population contribute to the overall costs savings of providing the benefit – savings that providing access to effective addiction and mental health services will produce; both to federal and state budgets.

**EXPLICITLY STATE THAT STATE LAWS WHICH PROVIDE BETTER COVERAGE, RIGHTS, METHODS OF ACCESS TO HEALTH CARE SERVICES AND CONSUMER PROTECTIONS ARE NOT PREEMPTED BY THE FEDERAL LAW**

The Coalition for Whole Health is hopeful that federal health reform legislation will include coverage, rights, methods of access to healthcare services, and consumer protections that are at least as strong as those found in all State laws. However, in the event they are not, and/or to allow States in the future to improve upon federal health reform legislation, stronger State laws should not be preempted.

States across the country have enacted consumer protections that should not be undone by the draft legislation. Examples of state consumer protection laws:

- Connecticut state law mandates the provision of mental health services
- Pennsylvania Act 106 requires all group health plans to provide coverage for a continuum of addiction-related treatment and a certification and referral from a licensed physician or licensed psychologist is the only lawful prerequisite to addiction treatment
- Article 44 of New York State Public Health Law guarantees rights to enrollees of managed care organizations such as:
  - Consumer has the right to know what steps he or she can take if the plan will not cover a service
  - Consumer is entitled to know how much in a plan year the plan will pay doctors and health providers who contract with the plan
  - Consumer has the right to see a doctor outside of the plan if the plan does not have a provider who meets the consumer's health needs ([http://www.health.state.ny.us/health\\_care/managed\\_care/billofrights/bill.htm](http://www.health.state.ny.us/health_care/managed_care/billofrights/bill.htm))

**ENSURE “SUBSTANCE USE DISORDER” WORKFORCE CAPACITY IS ONE OF THE HIGH-PRIORITY TOPICS TO BE REPORTED ON BY THE WORKFORCE ADVISORY COMMITTEE**

The Coalition for Whole Health thanks the Committee for including mental health and behavioral health as top priorities to be considered by the Workforce Advisory Committee. However, we are concerned that because the definition of “behavioral health services” in the Public Health Services Act does not include substance use disorder services, the substance use disorder workforce will be excluded as a Workforce Advisory Committee priority.

Substance use disorder professionals are a critical—and distinct—component of the nation’s health care workforce. There are over 60,000 health care professionals who hold state or national certification,

licensure or other qualifications in substance use disorder prevention, treatment and recovery support. These credentials reflect specialty education, training and experience in providing care for substance use disorders. Each state has certification, licensure or other qualifications to meet before providing substance use disorder services, and there are nationally recognized credentials as well. Like many other health professions, the substance use disorder workforce faces serious challenges including low pay, high turnover, “graying,” and a lack of cultural and linguistic diversity.

## **ENSURE THAT SUBSTANCE USE DISORDER AND MENTAL HEALTH PREVENTIVE SERVICES ARE INCLUDED**

We applaud the Committee for working to remove barriers to obtaining preventive care, to promote wellness, and to prevent chronic disease.

The bill uses findings of the U.S. Preventive Task Force ratings for screenings as the baseline for inclusion for being reimbursed in Title II, Subtitle A of the bill. In order for preventive services to be covered under the legislation, they must be items or services that have an A or B rating in the current recommendations of the United States Preventive Services Task Force.

To date, the Task Force has found insufficient evidence to rate screening for illicit drug use as an A or a B. However, screening for drugs and suicide ideations have been used for a number of years and have been effective tools to help identify many youth and adults in need of services. Under the Task Force’s criteria, those screening procedures would not be funded. Recent research clearly demonstrates that rapid, economical screening and brief interventions reduce substance use and significantly reduce health care costs.

Given the low risk and low cost of screening for substance use and mental illness, and the current state of knowledge about the consequences of untreated addiction and mental illness, the harms associated with not screening are too severe to be ignored. Therefore, screening for both mental illness and substance use disorders should be considered for reimbursement in the Committee’s bill.

In addition, we are pleased that the bill seeks to support wellness initiatives such as tobacco cessation programming. Addiction to alcohol and other drugs is a developmental disorder that begins in adolescence, sometimes as early as childhood, for which effective prevention is critical. Addiction is a complex chronic disease and is influenced by a number of factors, including genetics, environment and age of first use. According to studies by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, the younger a person first uses drugs or alcohol, the greater the likelihood that they will become dependent and/or addicted to drugs and alcohol as an adult. It is critical that attention to and funding for substance use disorders be included in all of the authorized funds, programs and benefits that address general prevention and wellness as well as chronic disease prevention in the draft bill.

For the above reasons, we ask the Committee to include language in the draft legislation to include substance use disorder prevention on par with nutrition, smoking and tobacco cessation issues within any fund, program or benefit that addresses general prevention and wellness as well as chronic disease prevention. In this context, substance use disorder prevention would include underage drinking, illegal drug use, and the abuse and misuse of over-the-counter and prescription drugs.

## **INCLUDE THERAPEUTIC FOSTER CARE SERVICE AS A DEFINED MEDICAID SERVICE CATEGORY**

Therapeutic foster care provides medically necessary, evidence-based intensive services in the least restrictive community-based environment for children with severe mental and substance use disorder needs. Currently, States rely on a patchwork of sources to fund therapeutic foster care services.

Creating a medical assistance category within Medicaid for therapeutic foster care would ensure a more stable source of funding and would improve access to these critically important services for children with severe mental illness and substance use disorder needs. In addition, the quality of care for these children and youth would be improved by offering a streamlined, transparent system of reimbursement.