

Parity of Medicare Benefits for Persons with Mental and Substance Use Conditions

March 27, 2007

Statement of
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Before the
Subcommittee on Health
Committee on Ways and Means
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Chairman Stark, Congressman Camp, distinguished Subcommittee members. I am Eric Goplerud, research professor in mental health and substance use policy in the Department of Health Policy at George Washington University Medical Center (GWU). I am pleased to be here this morning to discuss the research evidence supporting parity between the treatment of mental and substance use conditions treatment of other illnesses.

For the last five years, I have directed a research program at GWU, Ensuring Solutions to Alcohol Problems, whose mission is to improve access to effective, affordable treatment for people with alcohol use disorders. We assist employers, government officials, health plans, and health care professionals to use effective, science-based strategies to change policies and practices that inhibit access to alcohol treatment. Previously, I served as Associate Administrator for Policy and Planning at the Substance Abuse and Mental Health Services Administration (SAMHSA), and directed quality improvement, finance and performance metrics programs at SAMHSA.

Thank you for the opportunity to participate in this important discussion of Medicare parity. The proposed Medicare parity legislation would resolve crucial problems caused by the existing Medicare benefit design, especially the much higher co-payment requirements for outpatient treatment of mental and substance use conditions. HR 1424, the subject of the first panel's discussion this morning, would resolve critical problems in commercial insurance coverage of mental and addictive disorders. In particular, HR 1424 would extend coverage to all of the mental disorders defined by the professional standard, the American Psychiatric Associations Diagnostic and Statistical Manual (DSM); health plans will have to make their criteria for determining medical necessity available to beneficiaries and providers; it requires out-of-network options if necessary treatment is not available in network; and it does not pre-empt state laws that have stronger benefits.

In my remarks today, I would like to highlight several key points:

- Parity is the right thing to do.
- Now is time to eliminate disparities in Medicare coverage.
- Parity will fix problems in service use and provider payment.
- Parity will lead to better healthier seniors.
- The benefits of parity outweigh the slight increase in initial cost.

In addition, I would like to address specific issues related to parity coverage for persons with alcohol and other drug use disorders.

Parity is the right thing to do.

In 1965, when Medicare was established, its benefit closely mirrored the typical commercial health insurance product at the time. In 1965, most health insurance offered very limited coverage for treatment of mental and substance use conditions. Most singled out mental health for more restricted benefits because of concerns that diagnosis was subjective and imprecise, treatments were of questionable effectiveness and outcomes difficult to measure. There was a concern (perhaps justifiable) that equitable coverage would lead to overuse and uncontrolled costs. Given this environment, Medicare followed conventional wisdom.

The result: Medicare requires 50 percent co-payments for outpatient treatment of mental and substance use conditions, but only 20 percent for outpatient treatment of other illnesses. Medicare limits lifetime inpatient days in psychiatric hospitals, but has no limits for inpatient treatment of other illnesses.

Although an inequitable benefit design may have been the right decision more than forty years ago, advances in the diagnosis and treatment of mental illness and addiction require us to reevaluate those old assumptions. The biochemical, genetic and neurological bases of many mental illnesses and addictions are far better understood now. Diagnosis is more precise and predictive. Psychological treatments are more specific and effective. Medications and psychotherapy now help millions of people to live fulfilling lives in with families, jobs and friends.

In 1999, I led the team in HHS that negotiated with the Office of Personnel Management for full and comprehensive parity for 9 million beneficiaries in the Federal Employees Health Benefit Program. We now have six years' experience with FEHBP parity and a high-quality evaluation of the program demonstrates that equitable coverage of mental and substance use treatment improves access to care without significantly increasing costs.

There are now 42 states that mandate mental health and substance abuse coverage requirements for group health insurance products. Most are substantially more equitable than the present Medicare benefit. Employers, state Medicaid programs, and Medicare through Medicare Advantage have used managed care techniques that have dramatically changed mental health and substance use treatment patterns, dropping hospital lengths of stays, increasing use of intensive outpatient and psychosocial rehabilitation services, and

increasing access to outpatient treatment from mental health and substance use treatment specialists. The availability of powerful, safer, and more easily managed psychotropic medications (coupled with physician counseling) has rapidly expanded the role of primary care physicians and other health care professionals. These changes make re-examination of the unequal outpatient co-payment in Medicare Part B, the limitations on psychiatric inpatient days in Part A, and the extension of coverage for intensive outpatient services the right thing to do.

Now is the right time to eliminate disparities in coverage:

In creating the New Freedom Commission in 2002, President Bush stated:

“Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve our excellent care. They deserve a health care system that treats their illness with the same urgency as a physical illness. Health plans should not be allowed to apply unfair treatment limitations or financial requirements on mental health benefits. I’ll work with the Senator [Dominici]. I will work with the Speaker. I will work with their House and Senate colleagues to reach an agreement on mental health parity.” (April 29, 2002)

Surgeon General Satcher, in his Report on Mental Health and Mental Illness, found:

“...formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down.” ("Mental Health: A Report of the Surgeon General," 1999)

Public opinion polls consistently show overwhelming support for health insurance to handle mental illnesses and addictions like other illnesses in. A November 2006 poll conducted for Mental Health America found that most Americans support cover mental health treatment, support parity in coverage, and this support is bipartisan:

- Nearly all Americans (96 percent) think health insurance should include coverage of mental health care.
- 89 percent assert that insurance plans should cover mental health treatments at the same level as treatments for general health problems.
- A large majority (74 percent) believe that insurance plans should cover substance abuse treatments at the same levels as treatments for general health issues.

- Public demand for mental health equity is bipartisan: 83 percent of Republicans and 92 percent of Democrats want equitable health insurance.

A Michigan poll conducted in 2000 found that 88 percent of Americans feel that a person's health insurance should pay the cost of treatment for mental illness to the same extent that it pays for the cost of treating other illnesses. A 2004 poll by Peter Hart and Coldwater Associates found that 76 percent of likely voters are more likely to vote for a candidate favoring legislation requiring health insurance to handle addictions the same as other medical conditions. In California, 54 percent of voters in 2004 supported Proposition 63 to impose a tax to cover expanded treatment for mentally ill adults and children.

In 2002, the Medicare Payment Advisory Committee (MedPAC) recommended that the outpatient mental health limitation be eliminated, finding that the modest increase in program costs likely to result from parity (\$500 million in 2002) is justified in light of the improvement in access to treatment and cost-sharing simplifications that would be the result. (MedPAC, 2002, p. 65).

Parity will fix problems in service use and provider payment

Later, Dr. Manderscheid will discuss his research on how the 50 percent co-payment for outpatient mental and substance use treatment disrupts good community care, contributing to over-utilization of emergency and inpatient services, hinders continuity of care when patients are discharged from the hospital, and creates barriers to integrated outpatient care by physicians and other health care providers who are managing the many co-occurring physical and mental illnesses of Medicare beneficiaries. I would like to point to two consequences that Dr. Manderscheid will not address:

- **Continuity of care is undermined by the current Medicare coverage disparity.** Standard quality measures developed by the National Committee for Quality Assurance (NCQA) include measures of the proportion of patients with mental or substance use conditions discharged from a psychiatric hospital who start outpatient treatment within 7 and within 30 days. Medicare lags far behind private insurance.
 - For commercially insured patients, 56 percent get outpatient care within 7 days and 76 percent within 30 days. For Medicare patients, only 39 percent are seen within 7 days and 57 percent within 30 days. Apparently, Medicare benefit restrictions create financial barriers for patients and health care professionals that account for this almost 20 percent quality gap.
 - In Medicare, only 2 patients out of 1,000 beneficiaries are identified as having a substance use problem – even though 3.2 percent of persons 65 years or older drink heavily, and 0.7 percent intentionally misuse prescription drugs. Of those identified, fewer than one in twenty receives a minimum of three services in the next 45 days. In

commercial insurance, three times as many patients receive this level of care.

- **Distortions and inconsistencies in payment will be corrected with Medicare parity.** The DHHS Office of the Inspector General (OIG) recently found that Medicare fiscal intermediaries have adopted inconsistent policies regarding the application of the outpatient limitation. In a study of 57 carriers, nine different policies for the application of the limitation were identified. In over one-half of the service areas, carriers incorrectly subjected evaluation and management services for patients with Alzheimer’s disease to the 50 percent co-pay. Other CMS and OIG studies have found widespread confusion among MH/SA treatment providers and carriers, protracted reimbursement adjudication processes and high rates of claims denials (up to 20 percent of medication management and 50 percent of group therapy claims are denied).

Parity will lead to healthier seniors:

From almost every authoritative source, a consistent message can be seen supporting integrated care. For example, the fundamental finding in the Institute of Medicine’s report, “Improving Health Care for Mental and Substance Use Conditions” (2005) is that “Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.” The committee recommended “removal of barriers to and restrictions on effective and appropriate treatment that may be created by co-payments, service exclusions, benefit limits, and other coverage policies” (IOM, 2005, p. 12). In three places the IOM report points to Medicare’s 50 percent co-payment for outpatient treatment as an example of financial barriers to effective care.

Establishing Medicare parity is consistent with at least 29 authoritative, research-based clinical practice standards from professional medical societies, independent quality improvement organizations and the VA/DOD. These guidelines direct clinicians to provide integrated health and behavioral health care (especially for the chronic, disabling conditions that afflict older adults). Several of these guidelines are listed in the appendix.

Clinical practice standards for heart disease, type II diabetes, chronic pain and stroke all direct clinicians to screen for depression, anxiety and alcohol use, and to actively manage these commonly co-occurring conditions. The Veterans Administration and Department of Defense have created a number of joint evidence-based clinical practice guidelines for common health and behavioral health conditions affecting elderly and disabled veterans. Their guidelines for depression, substance use disorder, post-traumatic stress disorder, and other mental illnesses recommend primary care screening and ongoing management, with referral to mental and substance use treatment specialists for severe or complicated problems.

In 2005, Medicare initiated the “Welcome to Medicare” preventive physical and screening examination. The preventive assessment explicitly includes screening for

depression, alcohol and drug use. The one-time Welcome examination is covered as a regular outpatient visit, subject to the 20 percent co-payment. The inclusion of depression and alcohol screening is consistent with the recommendations of the US Preventive Services Task Force (USPSTF). The USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. It recommends:

- Screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.
- Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.

Without Medicare parity, primary care clinicians who follow CMS recommendations for the Welcome to Medicare preventive evaluation face the dilemma of finding patients with possible depression or alcohol problems who will not be able to afford the copay to get necessary treatment.

The benefits of parity will outweigh the slight increase in initial cost.

Studies on the impact of parity have found that access improves while service costs barely increase. For example the evaluation of the Federal Employees Health Benefit Program parity found that costs increased by less than 1 percent (0.94 percent), at the same time that utilization increased by 15 percent. More people used mental health and substance use treatment services because parity makes treatment more affordable. At the same time, health plan costs barely increase as plans and patients have more flexibility in benefit usage, less expensive alternatives to inpatient care are emphasized, and early intervention and preventive care services are promoted. SAMHSA's report on actual state experiences with parity found that "state parity laws have had a small effect on premiums. Cost increases have been lowest in systems with tightly managed care and generous benefits. Most insurers in Maryland, Minnesota, New Hampshire, and Rhode Island reported small increases in total premium due to MH/SA parity laws.

Parity for Treatment of Alcohol and Other Substance Use Disorders

Before I conclude, I would like to briefly discuss the integration of alcohol and drug use treatment under parity.

Alcohol use disorders are the predominant substance use conditions affecting Americans – no matter what age or income level. This chart shows that alcohol use disorders share all of the characteristics of other chronic illnesses, except one – health insurance coverage is not equitable:

Comparisons Among Alcohol-Related Problems, Including Alcoholism, And Other Chronic Diseases

	ALCOHOL-RELATED PROBLEMS	ASTHMA	DIABETES	HIGH BLOOD PRESSURE
Prevalence	13.8 million (includes 8.1 people with alcoholism)	17.6 million	10 million	50 million
Total Economic Costs	\$185 billion	\$11 billion	\$98.1 billion	\$40 billion
Health Care Costs (including medical complications and treatment)	\$26.3 billion	\$7.5 billion	\$44.1 billion	\$29 billion
Other Medical Complications	YES (heart & liver disease, cancer, depression, fetal alcohol syndrome)	NO	YES (heart disease, adult blindness, kidney failure, lower limb amputation)	YES (heart disease, kidney disease, stroke)
CAUSES				
Controllable Risk Factors	YES ▶ limit drinking	YES ▶ limit exposure to allergens	YES ▶ limit food intake ▶ exercise regularly	YES ▶ limit food and fat intake ▶ limit salt intake ▶ exercise regularly
Uncontrollable Risk Factors	YES	YES	YES	YES
Estimated Genetic Influence	50 60%	36 70%	30 55% type I 80% type II	25 50%
TREATMENT				
Cure	NO	NO	NO	NO
Clear Diagnostic Criteria	YES	YES	YES	YES
Research-based Treatment Guidelines and Protocols	YES	YES	YES	YES
Effective Patient and Family Education	YES	YES	YES	YES
Percent of Patients Who Follow Treatment Regimens Faithfully	40 60%	30%	30%	30%
Percent of Patients Who Relapse Within a Year	40 60%	50 70%	30 50%	50 70%
HEALTH INSURANCE				
Equality (Parity) With Other Medical Conditions	NO	YES	YES	YES

Sources: National Institute on Alcohol Abuse and Alcoholism (1994, 2000a, 2000b); Centers for Disease Control and Prevention (1999); National Center for Health Statistics (no date: a, b, c); McLellan et al (2000); American Lung Association (no date); American Heart Association and National Pharmaceutical Council (2000).

The Cost of Substance Use Parity

An extensive George Washington University Medical Center analysis of 11 state studies on SA parity shows that the cost of parity to employers is negligible – *raising annual premiums just 0.2 percent.* ("Improving Private Insurance Alcohol Treatment Benefits Can Save States Money," Ensuring Solutions)

“The cost of parity is comparatively small when compared to overall health expenditures and when spread out over all enrolled members,” concluded California's State Legislative Analyst's Office after reviewing health insurance coverage of substance abuse treatment. (California State Legislature, unpublished review) Mandating parity would not place an undue burden on businesses that offer health insurance to their employees. My analysis shows that:

- Equitable coverage reduces pressure on states budgets (and the tax burden on citizens and employers). Oregon, for example, found the state saves \$5.62 in tax-supported health, corrections and welfare costs for every state dollar spent on people who complete treatment. (Oregon Taskforce Report, 2000)
- Parity increases the number of people who receive treatment, thereby reducing their long-term cost to the state. In addition, more get treatment as outpatients and inpatients, while the length of (more expensive) hospital stays is sharply reduced.
- The benefits of mandatory employment-based insurance parity are substantial. A North Carolina legislative report concludes: “Studies from several states have consistently shown that appropriate treatment of chemical dependency results in a significant reduction in medical claims, absenteeism, and disability; an increase in productivity; and a healthier and safer environment for all employees. (North Carolina Legislative report, 2000)
- According to a PricewaterhouseCoopers actuarial analysis, the cost of parity to individual businesses goes down sharply when all or most businesses in a state are required to have equal coverage. (Bachman, 2002)

In recent years, many states and the Federal government have taken steps to require businesses that offer health insurance for their employees to cover alcohol and drug treatment on equal basis with coverage for treatment of other illnesses. Forty-two states require equitable coverage for some or all mental illnesses. Seven states also require equal coverage for treatment of alcohol-related problems (Connecticut, Delaware, Maine, Minnesota, Vermont, Virginia, and West Virginia). To aid their consideration of substance abuse parity legislation, 11 states conducted studies of the costs and impact of equitable coverage of treatment for alcohol and other drug problems.

The parity reports recognize that states have a significant financial, social and political interest in preventing and treating the disease of alcoholism and other alcohol-related problems. (NCASA, 2001) Overall, the parity studies recommended including substance abuse in parity. “A state requirement is the only real option that will accomplish the objective of improved mental or nervous coverage at a reasonable premium cost,” concluded Ronald E. Bachman, Principal, PricewaterhouseCoopers. (Bachman, 2001) The experts found it is more cost-efficient and is easy to include with mental health coverage, resulting in increased productivity, saving tax dollars, fewer hospitalizations, shorter inpatient stays and the use of less expensive outpatient services.

“Parity creates a level playing field for all insurers and provides adequate risk-sharing over a large population to minimize any premium increase due to the claims experience of any one group,” concluded the New Jersey task force. (Bachman, 2001)

Ripple Effect

Minnesota found that almost 80 percent of the costs of substance abuse treatment were offset in the first year following treatment due to decreased use of hospital, emergency room and detoxification services and reduced arrests. (North Carolina, 2000) California found that criminal activity declined by 66 percent, drug and alcohol use declined by 40 percent, and hospitalizations declined by 33 percent following treatments. (Gerstein, 1994)

The Ohio Department of Alcohol and Drug Addiction Services found that one year after participants completed treatment, “absenteeism was reduced by 61 percent, incomplete work by 37 percent, and mistakes in work by 36 percent,” according to Director Lucille Fleming. (Fleming, 1996)

A Healthier Approach

The report by the Alaska task force explicitly recognizes the connections between mental illnesses and addictions: “There is a high incidence of substance abuse among the mentally ill, and unless both disorders are treated, positive outcomes for either are unlikely. As the director of the Ohio Department of Alcohol and Drug Addiction Services observed, improving access to treatment effects change measured by “real numbers, real people, [and] real benefits to the employer, to the employee, and to ... taxpayers. (Alaska, 1999)

Conclusion:

Before I conclude, I would like to thank the committee for the opportunity to address this important issue. In considering Medicare parity, these points are key:

- Parity is the right thing to do.
- Now is time to eliminate disparities in Medicare coverage.

- Parity will fix problems in service use and provider payment.
- Parity will lead to better healthier seniors.
- The benefits of parity outweigh the slight increase in initial cost.

I wish to thank the committee for this opportunity and look forward to answering any questions that you may have.

* A detailed list of references is available upon request.