



national association of addiction treatment providers

Testimony By

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Background

The Institute of Medicine serves as adviser to the nation to improve health. As an independent, scientific adviser, the Institute of Medicine strives to provide advice that is unbiased, based on evidence, and grounded in science. The mission of the Institute of Medicine embraces the health of people everywhere.

In 2001, the Institute of Medicine released the landmark report, Crossing the Quality Chasm: A New Health System for the 21st Century. This report concluded that the U.S. health care system is in need of fundamental change and recommended a framework and strategies for achieving substantial improvements in the quality of health care.

The Quality Chasm's framework consisted of:

- *six aims for improving health care: i.e., making healthcare more safe, effective, patient-centered, timely, efficient, and equitable;*
- *ten rules to guide the redesign of healthcare; including:*
 1. *Care based on continuous healing relationships.*
 2. *Customization based on patient needs and values.*
 3. *The patient as the source of control.*
 4. *Shared knowledge and the free-flow of information.*
 5. *Evidence-based decision-making.*
 6. *Safety as a system property.*
 7. *The need for transparency.*
 8. *Anticipation of needs.*
 9. *Continuous decrease in waste.*
 10. *Cooperation among clinicians.*
- *specific internal organizational supports needed to achieve the aims and the rules; e.g., information technology, knowledge management strategies to support evidence-based practice, and*
- *organizational supports from the external environment; e.g., public and private payment and purchasing strategies or regulatory actions to support and encourage healthcare organizations in undertaking change.*

This initial report did not include an analysis of the Behavioral Health Care System, and the IOM was encouraged to include Behavioral Health in their comprehensive review. A special IOM Committee was formed that would address this significant aspect of the total health care system in this country. The formal charge to the Committee on Crossing the Quality Chasm - Adaptation to Mental Health and Addictive Disorders is to explore the implications of the Chasm report for the field of mental health and addictive disorders and to develop an agenda for change. The committee will examine both "environmental factors" such as payment, benefits coverage and regulatory issues, as well as, health care organization and delivery issues.

Introducing the National Association of Addiction Treatment Providers

The National Association of Addiction Treatment Providers is very pleased and honored to participate in this Institute of Medicine process and provide testimony concerning the delivery of high quality addiction treatment services within the overall delivery of health care within this country. NAATP has represented addiction treatment provider organizations since 1978 and currently has a membership of over 270 organizations that provide treatment to over 100,000 patients in inpatient and outpatient settings per year. NAATP is proud to represent those addiction treatment programs across this country with the strongest name recognition.

We applaud the efforts of the IOM both currently and in the past to provide advice to all segments of our society concerning the improvement of all aspects of our health care delivery system. We sincerely hope that the Institute of Medicine will seize this opportunity to engage all sectors of the health care system in a discussion about the importance, value and impact of addiction treatment and the overall price we pay as a society for ignoring, at best, and discriminating against the disease, at worst.

As an association which was first incorporated in 1978, the National Association of Addiction Treatment Providers has a longitudinal perspective in looking at the way in which addiction treatment is delivered, received and funded in this country. The particular area of expertise held by the National Association of Addiction Treatment Providers is with those persons seeking addiction treatment with some level of private insurance. Therefore, our testimony will focus heavily on patients treated in the “private sector” as opposed to those in the public sector whose funding comes from federal and state sources.

Introduction

As we will point out below, the delivery of behavioral healthcare is extremely fragmented and highly discriminatory. The complicated approval and utilization review barriers prevent many from ever receiving the help they need. The higher co pays, deductibles and day and visit limits imposed on persons seeking addiction treatment as opposed to those on other diseases makes this a discriminated disease. These barriers contribute to the very significant “blocks” which exist for persons seeking treatment. For many, these barriers are the deciding factors which determine whether they actually receive treatment, or simply get lost in the system or just give up hope.

Because of this, there has been a tremendous shift in the treatment of addictive diseases from the private sector to the public sector. This cost shifting has placed an almost unbearable burden on the already fragile tax structure in this country. The federal government has assumed responsibility for the vast majority of addiction treatment costs in this country despite the fact that approximately 77% of those with an addictive disease

are working Americans.¹ This shift from the private to the public sector alone should be a clarion call that there is something wrong with the way in which addiction treatment can be accessed and the way in which it is incorporated into the overall delivery of health care.

A soon to be released report, by SAMHSA, on private expenditures on mental health and substance abuse is expected to show a further decline in private expenditures on addiction treatment even though as much as 80% of addiction treatment occurs in the private sector. Between 1982 and 1992, private substance abuse and mental health spending for adolescents declined by 71%.² It is clear from this information that the private sector has simply been shifting the cost of treating addicted Americans to the federal and state governments and this trend may be accelerating. As we mention in this testimony, a variety of mechanisms- behavioral managed care carve outs, unnecessarily rigid medical necessity definitions and arbitrary utilization review criteria have all caused private sector expenditures for addictive diseases to drop dramatically. This drop in expenditure is not correlated to the decline in the prevalence of the disease, but rather a direct result of cost shifting from the private sector to the public sector! **We urge the Institute Of Medicine to lend its voice and credibility in seeking to establish reasonable and uniform definitions of medical necessity and of seeking standardization in the area of utilization review criteria which are consistent with other chronic diseases.**

We believe that there is a misguided approach to the treatment of addictive diseases which has been driven by a combination of not understanding this disease as a chronic disease and the extreme discrimination faced by persons seeking treatment for addictive diseases. As a result, the fragmented delivery system in this country has focused on symptom reduction at the expense of sustained long term recovery. Therefore, access to inpatient or “non-ambulatory” addiction treatment is rarely available to persons seeking treatment even though 70% of Fortune 500 companies’ health plan summaries claim to cover up to thirty days of inpatient addiction treatment. Instead of treatment that supports sustainable long term recovery, the treatment available to most persons focuses on immediate symptom reduction. We feel that it is necessary to address the chasm that exists between language in health plans and the reality discovered when individuals seek to access those benefits. **The wisdom of the Institute of Medicine could certainly assist in addressing the issues of health care plan language and the reality of access to coverage.**

If we continue to ignore the provision of adequate addiction treatment which is based on the best science and which supports sustainable long term recovery, then the American Society will be asked to shoulder an even larger economic burden. Untreated addiction costs America \$400 billion dollars per year.³ Furthermore, untreated addiction is more expensive than 3 of the nation’s top 10 killers: 6 times more expensive than America’s number one killer; heart disease (\$133.2billion/year), 6 times more than diabetes (\$130 billion/year), 4 times more than cancer (\$96.1 billion/year).⁴ As if those numbers are not compelling enough, when disability claims are analyzed, addictive diseases emerge as the leading single cause for claims! The economic indicators alone should be catapulting us to address this disease in a comprehensive and decisive manner; instead we are stuck with a fragmented, cost shifting system that further suffers under the weight of discrimination.

The scientific research available which contributes to the understanding of addictive diseases as a brain disease is overwhelming⁵, yet we continue to function as if this evidence does not exist!

The comments we have chosen to provide to this panel will be organized around **five** very important and critical themes. Following the presentation and exploration of those themes, we will briefly address the three questions that this panel has identified as critical to their work in producing a final report for release in the late summer of 2005.

Five themes affecting the delivery of quality addiction treatment

While there are many factors that contribute to the creation of a quality health care delivery system, the National Association of Addiction Treatment Providers believes that there are five organizing principles or themes that must be addressed and understood in order for this country to have a quality addiction treatment delivery system which is fully integrated into the delivery of general health care. To create a parallel delivery system is to beg for redundancy and to invite segmentation in the delivery of addiction treatment.

I. Addictive Disease is a Primary disease and not a symptom of another diagnosis

Perhaps one of the tragic phenomena of the 21st century is that Addictive Disease Disorders are still viewed both implicitly and explicitly as a symptom of another diagnosis. The 1930's, 40's, 50's and 60's were years when untold thousands of individuals in this country with Addictive Diseases were treated by health care professionals, yet their addictive disease was routinely viewed as a "*symptom of or a result of*" another diagnosis. This is especially true in the area of mental health and psychiatric treatment where addictive diseases were viewed and treated as a *symptom* of a mental illness and not fully appreciated as a primary disease. Consequently, their addictive disease was ignored or marginalized and many of those persons died a premature death because their primary diagnosis was not valued and treated.

If the early years of the 21st Century have taught us anything, then there is reason to be concerned that we are regressing to the 30's, 40's, 50's and 60's where Addictive Diseases are again marginalized as a primary diagnosis and instead are being seen as a subset of other diseases, such as mental illness, or are being seen as a "pseudo-disease" and persons with the diagnosis are viewed as persons lacking appropriate will power. The latest trend to overload the "co-occurring" or "co-morbid" band wagon may very well be a thinly veiled attempt to again treat addictive diseases as symptoms. We have known for over fifty (50) years that individuals with addictive diseases present with other primary diseases as well. Why put all of our efforts to identify those individuals with both mental health and addictive diseases and ignore those persons with addictive diseases and liver diseases, stomach diseases and a host of other primary diseases? Any discussion in the area of "co-occurring" diseases must begin with the understanding that addictive diseases is a primary diseases, which just happen to manifest themselves in a single individual who has other primary illnesses at the same time. The key is to understand that addictive

diseases have a proscribed course of treatment and that specially trained professionals are best suited to treat such individuals..

The impact of the erosion of the understanding of Addictive Disease as a primary disease has significant implications in two specific areas. In the **first area**, the development of *quality indicators* is of paramount importance for the implementation of a comprehensive quality health care system. If addictive disease disorder is not viewed as a primary disease, then the quality indicators will be generic in nature to a nebulous behavioral health issue and not helpful in supporting long term quality treatment of persons with addictive diseases. The National Association of Addiction Treatment Providers believes that most quality indicators proposed to date focus on symptom reduction as opposed to life long management and recovery of this disease. The ground breaking work by Dr. Thomas McLellan, et al, *Reconsidering the Evaluation of Addiction Treatment: From Retrospective Follow-Up to Concurrent Recovery Monitoring* (See **Attachment 1**) provides an excellent working model for developing performance measures to examine the quality of addiction treatment. **The National Association of Addiction Treatment Providers believes that quality indicators need to focus on compliance issues and cost offset as a result of providing treatment aimed at supporting long term sustainable recovery.**

The **second area** of impact with this erroneous understanding of Addictive Diseases is intrinsically linked to the way in which treatment for this disease is funded. This is especially true on the so called “private side” where treatment is funded through employer sponsored health care plans, commonly known as “health insurance”. Payment for addictive disease disorders has been carved out of the general health care payment system and managed by companies specializing in “behavioral health care”. There are two inherent problems with this system.

1. Most of the Managed Behavioral Health Care companies have considerable more experience on the Mental Health side and have tended to fold addictive diseases into a mental health model. This has resulted in an adversarial relationship between Managed Care Organizations and providers of addiction treatment. Unless addiction treatment is seen as an asset and not a liability to the MCO’s, quality will always suffer.
2. Because money designated for “behavioral health services” has been carved out, there is a disincentive for MCO’s to pay attention to the “cost offset studies” which show that appropriate treatment for addictive disease disorders reduces overall all health care costs both in the short term and the long term. The fragmented payment and health management system works against the delivery of quality addiction treatment.

II. Addictive Disease is a Chronic Disease for which Life Long Management is Necessary

Scientific research conducted over the past ten years by Federal agencies such as NIDA, NIAAA and SAMHSA as well as other private research organizations have led to a consensus that addictive disease is a chronic disease with similarities to diseases such as asthma, hypertension and diabetes. Nevertheless, this research consensus has not yet been incorporated into the every day life of policy makers, payment agencies and the public understanding of this disease.

Instead, Addictive Disease remains a disease which is often viewed as if it were an acute disorder and our language speaks of “cures”, “success rates” and “relapse rates”. Language which is almost non-existent when speaking of asthma, hypertension and diabetes, has become second nature in describing aspects of treatment for addictive disease disorders. Measurements and quality indicators have not yet caught up to the research and instead focus on the “stabilization” and “symptom reduction” cycle of this disease.

There is a growing body of literature and research which examines addictive diseases from a chronic disease understanding. Dr. David Lewis from Brown University and Dr. Thomas McLellan from the University of Pennsylvania are two of the leading figures in providing the research and disseminating the findings. Their work demonstrates that persons treated for addictive diseases have a higher compliance rate than do those treated for other chronic diseases such as asthma, hypertension and diabetes. Despite this research the delivery and payment system for addictive diseases continues to be fixated on symptom reduction and measuring “cure rates” as opposed to compliance rates. Using the work of Dr. David Lewis, the George Washington University Medical Center has published information regarding treatment for alcoholism. Their **Primer 1** which is **Attachment 2** to this testimony examines *Treating Alcoholism as a Chronic Disease*. A paradigm shift in understanding the disease as a chronic disease would result in a very different delivery system, payment system and quality measurement system.

In addition to the citation from the George Washington University Medical Center work, we are also including another presentation which is a compilation of articles and sources demonstrating how addiction treatment compares to treatment provided to other chronic diseases. In all instances, the “outcome” of addiction treatment or the results of addiction treatment compares extremely favorably compared to the outcomes for treatment of other diseases. (See **Attachment 3**) This favorable comparison is especially evident when the “compliance” issue is examined which we are strongly suggesting as a quality indicator of effective treatment.

A preoccupation with stabilization and symptom reduction has often meant that individuals diagnosed with an addictive disease are not afforded the full attention that this chronic disease demands and instead both the payment system and the treatment system ignore the life long management component of treatment for this disease. The current

payment system for addiction treatment rewards programs for rapid stabilization and symptom reduction and penalizes those programs that attempt to develop quality approaches to long term recovery and life long management of this disease.

For quality treatment to prevail and for the over all health indicators of our society to improve, addictive disease disorders must be viewed as a chronic disease, quality indicators need to reflect this paradigm shift and payment mechanisms need to be in place that sustains life long management opportunities.

III. Rigorous standardization of treatment protocols and quality indicators of effective treatment incorporating the themes of Addictive Disease as a Primary Disease and of it being a Chronic Disease have not been followed

Perhaps, the single greatest impediment to delivering quality addiction treatment has been the capricious way in which guidelines, standards and admission criteria have been applied. Without a standardized understanding of this disease, without a standardized commitment to treatment expectations, without a standardized understanding of the chronic nature of this disease, we will continue to rely on decisions made in a crisis about persons in a crisis and not rely on a larger understanding of this primary chronic disease to guide us. Providers of addiction treatment encounter on a daily basis a variety of definitions and approaches to addiction treatment unknown to the treatment of other diseases. Under the guise of “medical necessity”, decisions are made about symptom reduction as opposed to crafting and paying for treatment that has long term recovery and life long management of the disease as its core tenant. Without some commitment to a standardized understanding of the nature and purpose of addiction treatment, we will be left with decisions being made based on criteria other than treatment or recovery or quality standards. The National Association of Addiction Treatment Providers suggests that the seminal work of Dr. Thomas McLellan, et al (See **Attachment 1**) is an excellent beginning point from which to craft those standard definitions and understandings.

It is certainly arguable that the disease of addictive disease disorder carries with it significant social and behavioral issues. Nevertheless, we must ensure that a quality health care delivery system does not disproportionately focus on the behavioral issues as opposed to losing sight of the larger issue of the primary chronic disease needing life long management. The research regarding brain degeneration as a result of this disease has become lost in the rhetoric focused on the behavioral consequences of the disease. Harm reduction should never guide our health care policy regarding the treatment of addictions!

IV. Managed Care Organizations threaten addiction treatment and long-term recovery by wrongfully denying coverage

The National Association of Addiction Treatment Providers is outraged about the damaging effects the inequitable treatment of addiction services has on individuals in need of addiction treatment, public funding systems that are required to pick up the cost of providing addiction treatment, the taxpayers who ultimately absorb the cost, and the many families that are destroyed by the inaccessibility of treatment. Immediate action is required to halt the wrongful denial of coverage for addiction treatment services by Managed Care Organizations (“MCOs”). These MCOs reduce costs by, among other things, implementing procedural and other non-clinical barriers to treatment that equate “management” with “denial”. For example:

- i. Payment is subject to arduous, time consuming, and inefficient approval and benefit verification procedures.
- ii. MCOs employ in addition to stated “clinical criteria,” subjective, economic or other non-clinical criteria to determine whether recommended addiction treatment is “medically necessary” and some of these criteria impose conflict with state licensure requirements.
- iii. MCOs do not inform individuals about the difference between coverage for treatment and authorized treatment thereby creating an aura of distrust between them and the treatment provider.
- iv. MCOs have instituted procedural barriers such as doctor-to-doctor reviews and have forced providers and the insured to routinely pursue multiple appeals for denials.
- v. MCOs are denying authorization of treatment for court-ordered treatment without regard to “medical necessity”.
- vi. MCOs utilize other restrictive techniques such as enforcing arbitrary geographic limitations.
- vii. When MCOs approve length of stays, they are typically shorter than those recommended and supported by the clinical and medical treatment team.
- viii. MCOs, despite clear clinical recommendations from clinical providers, authorize levels of treatment that are below those recommended.

While MCOs attempt to reduce cost, the process has become more costly to providers since practitioners are forced to devote excessive time for authorization reviews and appeals and staff positions exist that do not provide clinical service but exist solely to deal with managed care communications. MCOs further drive up social costs by denying coverage for addiction treatment to individuals who pay for such coverage. These individuals forgo treatment, pay out of pocket, or tap into public health care resources. This cost-shifting places a tremendous burden on already overburdened families and public payers, and leaves fewer resources for the uninsured and others for whom the public payer system is intended.

Addiction treatment has continued to be battered by MCOs that are specifically designed to manage the behavioral health benefit. In most instances, they are carved out and not viewed in the same way as other health care. The cost of addiction treatment is a very small portion of the overall cost of total health care, but for the four to eight national MCOs, it is their entire existence.

MCOs are choosing to violate these laws, relying on inconsistent and lax enforcement. Others circumvent the spirit of these laws by exploiting semantic loopholes, or by implementing procedural hurdles that impede access. Coverage for addiction treatment is especially vulnerable to denial or restriction, in light of the general absence of support for parity of such treatment under state laws.

Lax, or in some cases, non-existent, enforcement of anti-discrimination laws further exacerbates the problem. Without stringent enforcement, insurance companies have no incentive to discontinue a practice that results in significant savings. Providers and consumers of these services need to unite and encourage federal and state law makers, Attorneys General, insurance regulatory oversight agencies and other key policymakers to no longer tolerate this blatant disregard of these laws and contractual rights of the insured.

It is unconscionable that families suffering from addiction are unable to access the treatment to which they are entitled under insurance contracts by law. Equally unconscionable is the wrongful shifting of the burden onto a public system that has no capacity to absorb it.

The National Association of Addiction Treatment Providers has developed a “draft” position paper on Managed Care and its impact on the delivery of quality addiction treatment. (See **Attachment 4**)

V. Addictive Disease remains a highly discriminated disease which impacts every aspect of delivering quality treatment and the funding for that treatment

Throughout all facets of the above five organizing principles, the key reality is that addictive diseases, the patients with this diagnosis and the persons offering treatment for this disease experience profound discrimination.

- The discrimination takes the form of wanting to move our understanding of this disease from a medical model to a behavioral model or a model that understands this as a “lack of willpower” issue.
- The discrimination takes the form of the inability at the federal level to pass a parity bill which would require those insurance policies that provide coverage for addiction treatment to not limit coverage or payment for this disease in ways that they do not apply to other diseases.
- The discrimination takes the form of employers being able to develop employment policies that block the possibility of an individual being re-employed after they have demonstrated sustained management of their disease if they were first terminated for behavior associated with the disease of addictive disorder.

- The discrimination takes the form of insurance companies being able to provide payment for the stabilization of this disease and characterizing that as quality treatment.
- The discrimination takes the form of physicians and other health care professionals not routinely talking to their patients about addictive diseases in the same way that they would talk to patients about other diseases and other at risk populations.
- The discrimination takes the form of students with a history of drug violations not being able to receive student loans even if they have received treatment for their disease and are demonstrating sustained recovery.

Conclusion

The Institute of Medicine has identified six aims for the delivery of high quality health care. Those aims were first introduced in the *Crossing the Quality Chasm* and include: safe, effective, patient-centered, timely, efficient and equitable. The National Association of Addiction Treatment Providers supports those overall aims for a quality health care delivery system and urges the IOM to work to include Addictive Disease into the total understanding of a health care delivery system. We further urge the IOM to address the inherent differences in addressing chronic diseases vs. acute disease symptoms as it builds a plan for the future.

We believe that any strategy should address the issues of:

- **Addictive Disease is a Primary Disease**
- **Addictive Disease is a Chronic Disease for which Life Long Management of the Disease is needed**
- **Addictive Disease needs standardized quality indicators based on the first two principles and standardized commitment to sustained long term recovery and life long management of the disease as the driving forces for treatment interventions**
- **Addictive Disease needs to be managed as a chronic disease and not denied coverage by organizations representing health insurance companies**
- **Addictive Disease will remain marginalized as long as discrimination is allowed, supported and institutionalized**

The work of ensuring that quality health care is available to Americans and that it is safe, effective, patient-centered, timely, efficient and equitable is extremely important. Thus, the National Association of Addiction Treatment Providers would like to commend the Institute of Medicine for the work that it has done and continues to do. We believe that for behavioral health care to access the principles of **safe, effective, patient-centered, timely, efficient and equitable**, then the five core areas of concern need to be addressed so that the persons with addictive diseases can fully participate in the health care system in this country and that by so doing this, the overall health of our country will increase.

On behalf to the National Association of Addiction Treatment Providers, I would like to thank you for this opportunity to testify on behalf of NAATP and its members regarding

this very important issue of quality and the incorporation of addictive disease treatment into the total quality equation.

¹ Substance Abuse and Mental Health Services Administration: Results from the 2002 National Survey on Drug Use and Health: National Findings, 2003.

² Mark, T. and Coffey, R.: What Drove Private Health Insurance Spending on Mental Health and Substance Abuse Care: 1992 to 1999? Health Affairs; 2003; 22: 165-172.

³ Substance Abuse: The Nation's Number One Health Problem, Brandeis University, Schneider Institute for Health Policy, 2001.

⁴ Substance Abuse: The Nation's Number One Health Problem, Brandeis University, Schneider Institute for Health Policy, 2001.

⁵ Leshner, A.: Addiction is a Brain disease and it Matters, Science, 1997; 278: 45-57.