Public Policy Statement on Parity in Benefit Coverage: A Joint Statement by ASAM and AMBHA

The American Managed Behavioral Healthcare Association (AMBHA) and the American Society of Addiction Medicine (ASAM) join together in advocating that

Health Plan Coverage for the Treatment of Alcohol, Nicotine, and other Drug Dependencies should be Non-Discriminatory

Two key phrases in this statement are "drug dependencies" and "non-discriminatory." By non-discriminatory we mean "coverage on the same basis as any other medical care."

In a May 30, 1997 joint statement, AMBHA and ASAM observed: "Addictive disorders are...

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1 The American Psychiatric Association's DSM-IV, "Substance Dependence" observes that "the essential feature of substance dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior." [DSM-IV, p.176]

Further, the Institute of Medicine states: "As a consequence of its compulsive nature, involving the loss of control over drug use, dependence (or addiction) is typically a chronically relapsing disorder.... [IOM, p.19]...addiction...[is] a brain disease similar to other chronic and relapsing conditions such as hypertension, diabetes, and asthma...." [IOM, p.20] [Institute of Medicine (IOM), National Academy of Sciences 1996 publication, Pathways of Addiction: Opportunities in Drug Research.]

To further clarify the IOM and DSM-IV definitions we cite E.M. Steindler, "Addiction Terminology," from N.S. Miller, editor, Principles of Addiction Medicine (Chevy Chase, MD: ASAM, 1994):

**Addiction**: A disease process characterized by the continued use of a specific psychoactive substance, despite physical, psychological or social harm.

**Dependence**: Used in three different ways: a) physical dependence, a physiological state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by readministration of the substance; b) psychological dependence, a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence; c) one category of psychoactive substance use disorder.

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primary disorders which require their own unique and specialized treatment. By addictive disorders we mean alcohol, nicotine and other drug dependencies. Individuals with addictive disorders may also experience mental illness and may also experience primary health problems."

■ The Nature of the Problem

As America continues to confront unprecedented problems from the widespread prevalence of alcoholism and other drug dependencies and the annual direct and indirect costs these problems create, access to treatment for addictive diseases is becoming increasingly important. Many persons in need of such treatment are covered for their overall health care by a variety of public and private third-party payment plans that severely restrict or exclude addiction treatment services, thereby denying patients access to quality care. These patients face limits on duration of treatment and on total dollar benefits that are far narrower than the limits placed on other medical care they receive.

AMBHA and ASAM have joined together in acknowledging that a disparity between health benefit coverage for drug dependencies and other medical care exists, to declare our opposition to such discriminatory benefit design, and to emphasize that treatment of drug dependencies is cost effective.

■ Recent Legislative Responses

On September 26, 1996 President Clinton signed into law the "Mental Health Parity Act of 1996" (Title VII of P.L. 104-204). For the first time, the federal government prohibited some health plan discrimination against mental illness. Specifically, the federal government prohibits the use by health plans of annual and lifetime financial caps which are different from mental illness and other physical illnesses. Addictive disorders are expressly not covered by federal legislation.

Recently state legislatures have enacted health benefit parity requirements - Arkansas, Colorado, Connecticut, Indiana, Maryland, Maine, Minnesota, New Hampshire, North Carolina, Rhode Island, Texas, and Vermont have enacted such laws. Indiana, North Carolina, and Texas laws apply only to health insurance for state employees. Of these 12 state parity laws, only Maryland, Minnesota, North Carolina, and Vermont cover both mental illness and drug dependency.

■ The Logic of Current Practice

Purchasers and public policy makers should consider the following logic and current state of practice:

1. health insurance provides financial coverage for diagnosis, treatment, and prevention of acute and chronic diseases.

2. addiction medicine is involved in the diagnosis, treatment, and prevention of substance
related disorders, which are acute or chronic diseases.

3. addiction is a complex neurobehavioral disorder, involving biochemical abnormalities of the brain that involve reinforcement and reward systems of the central nervous system; addiction is manifested by aberrant behaviors that can compulsively persist despite adverse consequences from those behaviors; addiction is not a character weakness.

4. addiction diagnosis is objective, standardized, and scientific, no less so than for other chronic diseases.

5. addiction treatment is effective.\textsuperscript{3 4 5 6 7}

6. barriers to effectiveness of addiction treatment are the same as barriers to effectiveness of treatment interventions for other chronic diseases: patient compliance and readiness to change, socioeconomic complications to care-delivery and management, and co-morbid emotional-behavioral conditions all adversely impact treatment success for substance addiction and for other chronic illnesses. There is nothing intrinsic to addiction treatment that should generate pessimism about treatment efficacy rates, and such pessimism is not supported by clinical research or experience.

7. relapse is inherent in addictive disease, but also inherent in virtually all chronic disease; relapse is usually a sign of chronicity, not a sign of treatment failure. By relapse, we mean a return to the signs and symptoms meeting criteria for a substance use disorder, not a return to use per se.

8. insurance benefits for addiction treatment should be equivalent to benefits for the treatment of other chronic diseases.

9. treatment for the disease of addiction is cost-effective, and can be cost-saving for

\begin{itemize}
  \item National Treatment Improvement Evaluation Study (NTIES), 1996: The use of heroin by methadone maintenance treatment patients declined by 51%.  
  \item California Drug and Alcohol Treatment Assessment (CALDATA), 1992: Compared with pretreatment rates, patients participating in methadone maintenance treatment experienced a 67% decrease in the use of substances.  
  \item Comprehensive Assessment and Treatment Outcome Research (CATOR), 1992: Estimated one-year abstinence rates were 60% for inpatients and 68% for outpatients who were available to follow-up.  
  \item NTIES: Between the pretreatment and follow-up period, of nonmethadone outpatients, marijuana declined 42%, crack cocaine by 52%, heroin use by 41%, and the use of any drug by 41%. Alcohol related problems declined 62%.  
  \item CATOR: Following treatment, 70% of patients who attended AA regularly, 70% of patients who participated in continuing care, and 90% of patients who both attended AA regularly and participated in continuing care for the entire year maintained their abstinence.
\end{itemize}
the health care system overall.\textsuperscript{8}

10. because of medical cost offsets, to NOT treat the disease of addiction is costly - economically as well as socially;\textsuperscript{9,10} benefit structures should not create barriers to effective intervention to diagnose and treat addiction.

**Advocacy Position**

AMBHA and ASAM support and advocate:

**Benefit plans for the treatment of addictive disorders, in both the public and private sectors, shall be comprehensive; i.e., they shall cover the entire continuum of clinically effective and appropriate services provided by competent licensed professionals, and should provide identical coverage and funding to those benefits covering physical illness, with the same provisions, lifetime benefits, and catastrophic coverage.**

**Next Steps:**

A national dialogue must take place among consumers, family members, professions, managed care organizations, employers, and state and federal government addressing the following critical issues:

1. In an environment of global competition, increasing health care needs, an aging population, and constraints on tax revenues, we need to identify best practices that demonstrate comprehensive coverage and its affordability, and we need to encourage the adoption of these best practices in public and private benefit plans.

2. We need to reduce the amount of variability between states regarding the interpretation of parity legislation, increase the consistency between various state laws on this issue, and prevent legislation on federal and state levels that inhibit the adoption of the best practices we have identified.

3. It is necessary to achieve consensus on what it means for a service to be "medically or clinically necessary", "appropriate" and a legitimate use of a benefit plan for behavioral health problems and services.

\textsuperscript{8} California Drug and Alcohol Treatment Assessment (CALDATA), 1992: Compared with pretreatment rates, patients participating in methadone maintenance treatment experienced a 39\% decrease in hospitalizations.

\textsuperscript{9} California Drug and Alcohol Treatment Assessment (CALDATA), 1992: Compared to pretreatment rates, patients participating in methadone maintenance treatment experienced an 84\% decrease in criminal behavior.
