

**AMERICAN BAR ASSOCIATION
ADOPTED BY THE HOUSE OF DELEGATES**

August 13-14, 2007

RECOMMENDATION

RESOLVED, That the American Bar Association affirms the principle that dependence on alcohol or other drugs is a disease, supports the principle that insurance coverage for the treatment of alcohol and drug disorders should be at parity with that for other diseases, and urges that:

1. All federal, state, territorial, tribal and local legislative bodies and governmental agencies repeal laws and discontinue policies and practices that allow health and disability insurers to provide coverage for the treatment of such disorders that is not at parity with coverage for other diseases.
2. States with mandated benefit laws that do provide coverage for the treatment of such disorders that is at parity with coverage for other diseases should establish policies and practices that ensure that such laws are enforced.
3. The federal government should require health and disability insurers regulated under the Employee Retirement Income Security Act of 1974 to provide coverage for the treatment of such disorders in a manner that is at parity with coverage for other diseases and which preserves state laws without limiting the scope of their coverage.

REPORT

I. STATEMENT OF THE PROBLEM

Drug and alcohol abuse and dependence are significant health problems with severe consequences. Today, there is greater recognition and acceptance than ever that addiction is a treatable, chronic illness.¹ Nevertheless, current insurance laws and regulations covering both private and public (Medicaid and Medicare) insurers typically do not adequately require comprehensive substance abuse treatment.² Parity in health and disability benefits coverage for dependence on alcohol and other drugs, similar to other treatable chronic diseases, offers individuals in recovery the greatest opportunity to address their addiction successfully.

The National Survey on Drug Use and Health (“NSDUH”) is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years or older.³ According to the 2005 NSDUH, the estimated number of persons aged 12 or older needing treatment for an illicit drug or alcohol use problem was 23.2 million (9.5 percent of the population aged 12 or older).⁴ Of these, 2.3 million (0.9 percent of persons aged 12 or older and 10.0 percent of those who needed treatment) received treatment at a specialty facility.⁵ Thus, there were 20.9 million persons (8.6 percent of the population aged 12 or older) who needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance use facility in the past year.⁶

¹ As early as 1972, the American Bar Association’s House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, which recognized that treatment, rather than criminal penalties, were the appropriate response to alcoholism.

² Department of Health and Human Services, *Changing the Conversation: Panel Reports, Public Hearings, and Participant Acknowledgements*, (Rockville, Maryland: DHHS, 2000), page 19. The Substance Abuse and Mental Health Services Administration (“SAMHSA”) Center for Substance Abuse Treatment (“CSAT”) began the National Treatment Plan Initiative (“NTP”) in the fall of 1998, to provide an opportunity for the field to reach a working consensus on how best to improve substance abuse treatment, and then to pursue action to effect needed change. *Changing the Conversation* is the first product of the NTP Initiative.

³ Substance Abuse and Mental Health Services Administration. (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD, page 9. Prior to 2002, the survey name was the National Household Survey on Drug Abuse (“NHSDA”). The NSDUH presents national estimates on rates of use, numbers of use, and other measures related to illicit drugs, alcohol, and tobacco products. Measures related to mental health problems are also presented, including data on depression and the co-occurrence of substance use and mental health problems. NSDUH is the primary source of statistical information on the use of illegal drugs by the U. S. population. Conducted by the Federal Government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at the respondent’s place of residence. The survey is sponsored by the Substance Abuse and Mental Health Services Administration (“SAMHSA”), U. S. Department of Health and Human Services, and is planned and managed by SAMHSA’s Office of Applied Studies (“OAS”).

⁴ *Ibid*, page 75.

⁵ *Ibid*. A specialty facility is defined by the NSDUH as a hospital (inpatient only), drug or alcohol rehabilitation facility (inpatient or outpatient), or mental health center. It does not include treatment at an emergency room, private doctor’s office, self-help group, prison or jail, or hospital as an outpatient.

⁶ *Ibid*

Based on 2004–2005 NSDUH combined data, among persons who needed but did not receive illicit drug or alcohol use treatment, felt they needed treatment, and made an effort to receive treatment, the four most often reported reasons for not receiving treatment were (a) cost or insurance barriers (44.4 percent), (b) other access barriers (21.2 percent), (c) not ready to stop using (21.1 percent), and (d) stigma (18.5 percent).⁷

Current insurance benefit programs, both public and private, typically do not adequately cover substance use treatment.⁸ Many insurers do not cover specific services, are for a limited number of units of service with annual or lifetime annual caps, or provide coverage for no -- or severely limited -- continuing care.⁹ In addition, since alcohol and substance use and dependence are chronic, relapsing illnesses, an individual may exhaust his insurance coverage and be forced to rely on the use of publicly funded substance abuse treatment systems.¹⁰ These publicly funded resources (for example, Medicaid) were originally intended to serve as a safety net and instead have become the primary insurance option for many individuals in need of treatment.¹¹ Government insurance packages (including Medicaid) generally do not provide comprehensive treatment.¹²

II. CONSEQUENCES OF INADEQUATE TREATMENT FOR SUBSTANCE USE

The consequences of inadequate treatment for substance use are evident throughout the workplace, in the education, welfare, and justice systems and the nation's economy.¹³ Together, unipolar major depression and drug/alcohol use and dependence are among the leading causes of death and disability among American women and the second highest cause among men (behind heart disease).¹⁴ Increasing evidence demonstrates that substance use problems result in a considerable burden on the workplace and cost to employers due to absenteeism, "presenteeism" (attending work with symptoms that impair performance), disability leave, and "critical incidents," such as on-the-job accidents.¹⁵ It is axiomatic that adequate treatment could substantially alleviate many of these problems.

Substance use problems and illnesses of parents and others lead to poor educational achievement by children, resulting in emotional and behavioral problems.¹⁶ Children with poor

⁷ Ibid, page 77.

⁸ *Changing the Conversation: Panel Reports, Public Hearings, and Participant Acknowledgements*, page 19.

⁹ Ibid

¹⁰ Ibid and page 5.

¹¹ Ibid, page 19.

¹² Ibid

¹³ *Improving the Quality of Health Care for Mental and Substance-Use Conditions, Executive Summary*.

Washington, D. C. : Institute of Medicine of the National Academies, 2006, page 6. The Institute of Medicine was established in 1970 by the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. The Institute acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an adviser to the federal government and, upon its own initiative, to identify issues of medical care, research, and education. Dr. Harvey V. Fineberg is the president of the Institute of Medicine.

¹⁴ Ibid

¹⁵ Ibid, page 7.

¹⁶ Ibid

school achievement are at risk for delinquent and antisocial behavior, withdrawal from school and repeated adolescent pregnancies.¹⁷

Substance use problems and illnesses also affect the nation's child welfare system.¹⁸ According to the Casey Family Programs, birth parents' substance abuse is among the most common reasons for their childrens' placement into foster care.¹⁹

III. PARITY FOR SUBSTANCE USE TREATMENT

The Americans with Disabilities Act ("ADA"), passed in 1990, is landmark civil rights legislation restricting disability-based discrimination in employment, government services, and public accommodations.²⁰ Drug and alcohol addictions are recognized disabilities according to the ADA.²¹ This interpretation of the ADA is based on precedent established under Section 504 of the Rehabilitation Act, which is legislation preceding the ADA that addressed discrimination by recipients of federal funds.²² The legislative history of the ADA confirms that addiction is protected by the Act and courts applying the ADA have recognized its application to the disability of addiction.²³ Drug addiction and alcoholism are specifically listed as "physical or mental impairments" in the ADA's implementing regulations passed by the Equal Employment Opportunity Commission ("EEOC").²⁴ The ADA, however, provides no protection for current users of illegal drugs; it only applies to alcoholics and drug addicts who are in recovery.²⁵

According to the EEOC, disability-based discrimination in employer-provided health insurance plans is prohibited by the ADA.²⁶ In the 1993 implementation guidance on the application of the ADA to health insurance, the EEOC stated that its ADA implementation regulations explicitly covered discrimination in "fringe benefits," and that application to insurance benefits was specifically contemplated in Section 501(c) of the Act.²⁷

¹⁷ Ibid

¹⁸ Ibid

¹⁹ *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study*. Revised March 14, 2005. Compiled by Peter J. Pecora, Ronald C. Kessler, Jason Williams, Kirk O'Brien, A. Chris Downs, Diana English, James White, Eva Hiripi, Catherine Roller White, Tamera Wiggins, and Kate Holmes. Casey Family Programs' mission is to provide and improve and ultimately to prevent the need for foster care.

²⁰ Starr, Sonja B., *Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction Treatment*. 111 Yale Law Journal 2321, 2345.

²¹ Ibid

²² Ibid

²³ Ibid. See for example, Hoffman v. MCI Worldcom Communications, Inc., 178 F. Supp. 2d 152, 155 (D. Conn., 2001) (stating that "drug and alcohol addiction satisfies the disability prong" of the ADA); Thompson v. Borg-Warner Protective Servs. Corp., No. C-94-4015, 1996 U. S. Dist. LEXIS 4781, at *22 (N. D. Cal. Mar. 12, 1996) ("Drug addiction and alcoholism are protected disabilities under the ADA.").

²⁴ Ibid

²⁵ Ibid. See for example: Hoffman, 178 F. Supp. 2d at 155 (rejecting an ADA claim related to plaintiff being fired from his job because the plaintiff was a drug user at the time of dismissal).

²⁶ Ibid, page 2346.

²⁷ Ibid

The term “parity” refers to a policy that substance abuse benefits should be equal to the benefits for general medical services.²⁸ Parity legislation typically encompasses the expansion of coverage for substance abuse by removing limits on care (such as annual and lifetime ceilings on expenditures for substance abuse care or limits on the number of outpatient visits or inpatient days) or the reduction of co-payments or deductibles for substance abuse care.²⁹ Historically, these types of limits and higher cost-sharing provisions have led to substance abuse insurance benefits that differed from those for general medical care, including other chronic illnesses, and have been considered a barrier to accessing adequate substance abuse care and treatment.³⁰

State Parity Legislation

Nine states include coverage for substance abuse treatment under their parity statutes.³¹ Vermont implemented the nation’s most comprehensive parity law in 1998.³² As a result, the implementation and effects of Vermont’s parity law have been the most systematically studied.³³ Only 0.3 percent of Vermont employers discontinued health coverage for their employees due to the health parity law, and out-of-pocket expenses for mental health/substance use services declined after implementation of the parity law.³⁴ The implementation of parity resulted in an increase in managed care for mental health/substance use services, which was a major factor in controlling costs and may have reduced utilization for some services and beneficiaries.³⁵

However, a study found that less than half of Americans in 1999 were affected by either state or federal parity laws.³⁶ The Employee Retirement Income Security Act (“ERISA”) provides the greatest exemption of health plans from state parity laws.³⁷ ERISA exempts self-insured employer-sponsored health plans from its coverage, so that these health plans are subject solely to federal parity regulations and are exempt from any state parity law or policy beyond what is required by the 1996 Mental Health Policy Act.³⁸ The impact of this exemption is significant nationally since 39 percent of those enrolled in employer-sponsored health insurance plans are in self-insured plans (those covered by ERISA).³⁹ Federal law and the laws of many states exempt small employers (states most often define “small employers” as those with 50 or

²⁸ Department of Health and Human Services, *Evaluation of Parity in the Federal Employees Health Benefits Program (FEHBP): Final Report*. December 2004. page 9.

²⁹ Ibid

³⁰ Ibid

³¹ Ibid. These nine states with parity statutes that apply to substance use conditions are Connecticut, Delaware, Kentucky, Maryland, Minnesota, Rhode Island, Utah, Vermont, and Virginia.

³² Ibid, page 15.

³³ Ibid, page 16.

³⁴ Ibid

³⁵ Ibid

³⁶ Ibid, page 17. See Maxfield, M., Achman, L., and Cook, A. (2004). *National Estimates of Mental Health Insurance Benefits*. DHHS Pub. No. (SMA) 04-3872. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

³⁷ Ibid

³⁸ Ibid

³⁹ Ibid. See Maxfield, M., Achman, L., and Cook, A. (2004). *National Estimates of Mental Health Insurance Benefits*. DHHS Pub. No. (SMA) 04-3872. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

fewer employees) from compliance with state parity laws.⁴⁰ Therefore, health and disability insurance plans regulated by ERISA should be required to provide treatment for alcohol and substance use at parity with other chronic medical conditions.

Furthermore, states with mandated parity benefits should establish policies to ensure that laws are enforced as written.⁴¹ Non-compliance with mandated parity benefits results in substantial discrimination and ineffective treatment for individuals in recovery from dependence on drugs and alcohol.

Federal Employees Health Benefit Program Parity Policy

The Federal Employee Health Benefits (“FEHB”) Program is the largest employer-sponsored health insurance program in the nation, serving more than 8 million federal employees, annuitants and their dependents.⁴² The U. S. Office of Personnel Management (“OPM”) administers the FEHB Program, which currently offers approximately 250 health plan choices, providing in excess of \$29 billion in health care benefits annually.⁴³

In June 1999, President Bill Clinton directed OPM to institute a parity policy, expanding mental health and substance abuse coverage within the FEHB Program.⁴⁴ In an annual “call letter”⁴⁵ issued by the OPM in 2000, the agency indicated that effective January 2001, the aim of the policy would be to provide the same coverage for mental health and substance use as that for general medical care with respect to benefit design features, such as deductibles, co-payments, and limits on visits and inpatient days.

As of January 1, 2002, all FEHB plans had complied with the parity policy; two-thirds incurred no additional administrative costs as a result of parity, and none reported major problems with implementation.⁴⁶ In addition, no plans resigned from the FEHB Program to avoid implementation of the parity policy.⁴⁷ The parity policy change enhanced mental health and substance use benefits for FEHB Program enrollees.⁴⁸ When the parity policy was implemented, two-thirds of the plans had entered into managed care arrangements with a specialty mental health/substance use vendor.⁴⁹

⁴⁰ Ibid

⁴¹ Join Together. *Ending Discrimination Against People with Alcohol and Drug Problems: Recommendations from a National Policy Panel*. Boston, MA: Join Together, Boston University School of Public Health. 2003. page 6. Join Together, founded in 1991 by a grant from The Robert Wood Johnson Foundation to the Boston University School of Public Health, supports community-based efforts to reduce substance abuse.

⁴² *Evaluation of Parity in the Federal Employees Health Benefits Program (FEHBP): Final Report*, page 9.

⁴³ Ibid

⁴⁴ Ibid

⁴⁵ Ibid, page 11. The “call letter” OPM issues each spring to carriers includes benefits policy guidance on negotiations for the next contract year.

⁴⁶ Ibid, page 8.

⁴⁷ Ibid

⁴⁸ Ibid

⁴⁹ Ibid

The impact of the parity policy was assessed in detail in nine FEHB plans that include fee-for-service and health maintenance organizations from regions across the country where Federal employees, their dependents, and retirees reside.⁵⁰ Overall, the evaluation showed that parity could be implemented with some increase in access to mental health and substance abuse care but little or no increase in mental health and substance use spending.⁵¹ Users of services in most, but not all, plans experienced a decrease in out-of-pocket spending for mental health and substance use care, indicating that parity provided the intended additional financial protection for mental health and substance use expenditures for many enrollees.⁵² Parity also resulted in little or no impact on quality of treatment of major depressive disorder or substance use disorder.⁵³

In summary, the parity policy was implemented as intended with little or no significant adverse impact on access, spending or quality, while providing most users of mental health and substance use care with enhanced financial protection from unreimbursed out-of-pocket expenses.⁵⁴

Other studies, in addition to the FEHBP evaluation of the parity policy, have demonstrated the cost effectiveness of treatment coverage for substance abuse.⁵⁵

IV. “THE PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT”

In March 2007, Congressmen Patrick J. Kennedy (D-Rhode Island) and Jim Ramstad (R-Minnesota) introduced “The Paul Wellstone Mental Health and Addiction Equity Act” (H. R. 1424).⁵⁶ The legislation expands the Mental Health Parity Act of 1996 by requiring group health plans that offer benefits for mental health and addiction to do so on the same terms as benefits for other diseases.⁵⁷ The legislation closes the loopholes that currently allow plans to charge higher copayments, coinsurance, deductibles, and maximum out-of-pocket limits and impose lower day and visit limits on mental health and addiction care.⁵⁸

The Kennedy-Ramstad legislation is modeled after the Federal Employee Health Benefits Program, which implemented equality in mental health and addiction coverage in 2001.⁵⁹ The bill also applies to group health plans of 50 or greater participants.⁶⁰

⁵⁰ Ibid

⁵¹ Ibid

⁵² Ibid

⁵³ Ibid

⁵⁴ Ibid

⁵⁵ *Ending Discrimination Against People with Alcohol and Drug Problems: Recommendations from a National Policy Panel*, page 5. See, for example, Milliman & Robertson, Inc. *Premium Estimates for Substance Abuse Parity Provisions for Commercial Health Insurance*, 1997. See also Substance Abuse and Mental Health Services Administration. *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, 1998.

⁵⁶ “Kennedy-Ramstad Introduce Historic Mental Health Parity Bill.” News from Congressman Jim Ramstad. March 7, 2007. page 1.

⁵⁷ Ibid

⁵⁸ Ibid

⁵⁹ Ibid, page 2.

⁶⁰ Ibid

In February 2007, the Senate Health, Education, Labor and Pensions Committee approved similar legislation, “The Mental Health Parity Act of 2007,” (S. 558) sponsored by Senators Edward Kennedy (D-Massachusetts), Peter Domenici (R-New Mexico), and Michael Enzi (R-Wyoming).⁶¹ Among the differences between the House and Senate legislation, the Senate bill does not require health plans offering mental health benefits to cover the same mental health and addiction disorders that are included in the health plans available to members of Congress.⁶²

V. RELATED ABA POLICY POSITIONS

The American Bar Association has several policies that address long-term solutions to dependence on alcohol and other drugs.

At the 1972 Midyear Meeting, the House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, which provides for treatment of alcoholics and intoxicated persons instead of subjecting such persons to criminal penalties, establishes facilities and machinery for treatment of such persons, and provides for voluntary commitment to a treatment facility or involuntary commitment by court order.

At the 1975 Midyear Meeting, the American Bar Association reaffirmed its support for the Uniform Alcoholism and Intoxication Treatment Act drafted by the National Conference of Commissioners on Uniform State Laws and urged states that have not already done so to utilize the newly available federal funding (P. L. No. 93-282) to implement its provisions. The American Bar Association also generally reaffirmed its support for the principle of decriminalization of alcoholism.

At the 1994 Midyear Meeting, the House of Delegates approved a policy supporting development of a comprehensive, systemic approach to addressing the needs of defendants with drug and alcohol problems through multidisciplinary strategies that include coordination among the criminal justice, health, social service and education systems, and the community. The policy urges the courts to adopt certain treatment-oriented, diversionary drug court programs as one component of a comprehensive approach. The policy also urges bar associations to facilitate the development of such programs that result in dismissal of drug-related charges upon the completion of drug rehabilitation.

At the 1995 Annual Meeting, the House of Delegates endorsed the U. S. Sentencing Commission’s proposal to amend federal sentencing guidelines to eliminate differences in sentences based on drug quantity for offenses involving crack versus powder cocaine, and assign greater weight in drug offense sentencing to other factors that may be involved in the offense, such as weapons used, violence, or injury to another person.

⁶¹ Ibid, page 2.

⁶² Ibid

At the 1995 Annual Meeting, the House of Delegates approved a policy urging bar associations to join the American Bar Association in developing and encouraging initiatives aimed at preventing inhalant abuse.

At the 1997 Annual Meeting, the House of Delegates approved a policy supporting the removal of legal barriers to the establishment and operation of approved needle exchange programs that include drug counseling and drug treatment referrals in order to further scientifically-based public health objectives to reduce HIV infection and other blood-borne diseases and in support of the American Bar Association's long-standing policy on substance abuse.

At the 2004 Annual Meeting, the House of Delegates approved a policy urging federal, state, territorial and local governments to eliminate policies that sanction discrimination against people seeking treatment or recovery from alcohol or other disease, including specific recommendations in the area of public benefits.

At the 2005 Annual Meeting, the House of Delegates approved a policy urging all state, territorial and local legislative bodies and governmental officials to repeal laws and discontinue practices that permit insurers to deny coverage for alcohol or drug related injuries or losses covered by accident and sickness insurance policies that provide hospital, medical and surgical expense coverage; the policy also supports the 2001 amendment by the National Association of Insurance Commissioners to its model law, the Uniform Accident and Sickness Policy Provision law, for injuries involving alcohol or drugs, permitting coverage in accident and sickness insurance policies that provide hospital, medical and surgical expense coverage.

At the 2006 Annual Meeting, the House of Delegates approved a policy urging all federal, state, territorial and local legislative bodies and governmental agencies to adopt laws and policies that require health and disability insurers who provide coverage for the treatment of both abuse of and dependence on drugs and alcohol to do so in a manner that is based on the most current scientific protocols and standards of care, so as significantly to enhance the likelihood of successful recovery for each patient.

VI. CONCLUSION

The Standing Committee on Substance Abuse ("Standing Committee") has previously recommended to this House, and the House has adopted, a number of resolutions aimed at ending discrimination against persons suffering from dependence on alcohol or other drugs. The Standing Committee believes that adoption and enforcement of a policy of insurance coverage parity at the federal, state, territorial and local levels is a vital further step in ending such discrimination.

The Standing Committee further believes that the available evidence demonstrates that parity can be instituted at low cost and with great societal benefits. Extension of insurance coverage to those suffering from the disease of substance abuse should help reduce crime, child neglect, job absenteeism and accident rates. The American Bar Association should be a leader in supporting parity.

The recommendation is consistent with several of the American Bar Association's missions and goals, including Goal I (To promote improvements in the American system of justice) and Goal III (To provide ongoing leadership in improving the law to serve the changing needs of society).

Respectfully submitted,

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Chair
Standing Committee on Substance Abuse
August 2007