

My name is Michael Botticelli. For the past six years, I have been the Director of the Bureau of Substance Abuse Services at the Massachusetts Department of Public Health.

For over 20 years, I have also been a person in recovery from the disease of addiction.

Thank you for the opportunity to talk to you today.

I am also here today to represent the National Association of State Alcohol and Drug Abuse Directors, an organization composed of all 50 state substance abuse directors and those of our territories. I am joined today by NASADAD Policy Staff who stand ready to assist you in any way.

I would like to make three points regarding my talk today:

First, health reform legislation should include substance use disorder prevention, intervention treatment and recovery support services in order to promote the health of our residents and save taxpayer money,

Second, the Substance Abuse Prevention and Treatment Block Grant – a formula grant to all States managed by the Substance Abuse and Mental Health Services Administration - should be maintained and bolstered – even with passage of comprehensive health reform legislation—because it fills the many gaps in coverage that still exist, even in the face of health reform.

And third, our experience in Massachusetts can help illustrate additional lessons learned beyond the two I noted above.

While we have made significant progress, substance use problems continue to take an enormous toll on our youth, adults, families and communities in the Commonwealth.

In 2008, we had over 121,000 admissions to publicly funded services in Massachusetts -- an increase of almost 19,000 since 2006 -- with alcohol and heroin use constituting the most often reported substance of choice.

31% report injection drug use; 20% of the clients we serve are homeless at the time of admission; 70% are unemployed, and 40% are referrals from our criminal justice system.

In Massachusetts and throughout the country, the performance and accountability of our system is paramount to work that we do. We have partnered with the Substance Abuse and Mental Health Services Administration to implement National Outcomes Measures – which are data that we report to help us gauge the impact our services have on people's lives.

The data consistently prove what the research tells us: effective services for substance use disorders helps people recover and lead full and healthy lives.

For Massachusetts clients we reported the following outcomes in January 2009:

- A 55.2% increase in Abstinence from alcohol when comparing admission to discharge. The rate is 37.9% nationally.
- A 75.5% increase in abstinence from illicit drug use when comparing admission to discharge. The rate is 47.35 nationally.
- A 41.1% increase in Employment Status when comparing admission to discharge. The rate is 15.3% nationally.
- A 36.6% increase in Housing Status when comparing admission to discharge. The rate is 2.8% nationally.

Massachusetts is also one of several states who have, or are in the process of implementing, pay-for-performance contracting standards for our programs, where we build into our contracts certain requirements that, for example, examine outcomes such as client engagement and retention in care.

One area of extreme concern is the rise in prescription drug abuse -- primarily prescription pain medication. This increase is layered on top of historically high rates of heroin use in the Northeast. Of particular concern is the number of young adults affected by prescription drug abuse. For the past several years we have seen a dramatic increase in the number of 18-25 year olds entering our treatment system.

Our State has also seen steep and steady increases in the number of fatal opioid related overdoses. Two people a day are dying of an opioid related overdose. In 2007, the last year for which we have complete data, 637 people died as a result of prescription pain medication and heroin use in Massachusetts. Sadly, it is also the group in Massachusetts and nationally that are most likely to be uninsured: 19 to 24 year olds. Prior to health care reform 25.4% of 19-24 year olds were uninsured.

In April 2006, Massachusetts passed landmark health care reform legislation with the goal of providing coverage to every person in the Commonwealth.

This reform was organized around three key elements:

First, it required every adult to have health insurance

Second, it required employers with 11 or more employees to offer coverage,

and

Third, it noted that government had an obligation to subsidize coverage for our neediest citizens who do not qualify for other entitlement programs.

It also appointed an Authority to oversee plans, costs and benefits.

Health Care reform programs in Massachusetts fall into two general categories: Commonwealth Care and Commonwealth Choice.

Commonwealth Care plans provide subsidized coverage for those below 300% of the federal poverty level. Those with incomes below 150% of FPL are entitled to coverage with no premiums payments or deductibles. There are no co-payments for most services. For those with incomes between 150 and 300% of FPL, there are a range of plans with premiums ranging between \$39 and \$219 and co-pays ranging from 0 - \$250.

The second category, Commonwealth Choice, provides individual and families above 300% of FPL and employers with a wide variety of plans offering a range of coverage, premium, co-pay and deductible options. All of these plans are subject to our state parity legislation which goes into effect July 1 and are also subject to our existing managed care laws.

These laws require plans to have an appeal process when benefits are denied and also allow for an independent review of denials with our state Office of Patient Protection. Plans are also required to inform consumers of these rights at the time of denial.

Since the implementation of health care reform, over 450,000 adults have enrolled in subsidized or private health insurance plans – thereby reducing the percentage of uninsured adults to 2.6%, which is the lowest in the country. Over 175,000 low income adults have enrolled exceeding estimates by over 30,000 people.

All of the Commonwealth Care plans for those below 300% of the federal poverty level provide coverage for inpatient and outpatient substance use disorder treatment.

Commonwealth Care plans also pay for medication assisted treatment -- chiefly medications for those addicted to prescription pain medications and other opioids such as heroin. While there are no co-payments for inpatient, outpatient and opioid treatment for those below 150% of FPL, there are co-payments of \$50-\$250 per episode of inpatient care and \$15 per visit for outpatient care.

This coverage has significantly decreased the number of uninsured clients presenting for treatment to our publicly funded program, and the percent of uninsured clients entering our acute detoxification programs has decreased from almost 55% in 2007 to 21% in 2009. Our providers also report a decrease of almost 80% of the number of uninsured clients seeking access to detoxification who are uninsured. Calls to our Helpline from those who are uninsured have decreased by almost 50% since 2007.

And most importantly, admissions to our publicly-funded treatment programs have increased by almost 15,000 from 2007 to 2008.

While this is certainly an improvement, it has not been without challenges. We still see a significant number of uninsured clients presenting for substance use treatment. Because of this, we still desperately need other state and federal appropriations to support services for these clients.

I can personally attest to the fact that those with active addiction are not known for self-care behavior and enrolling in a health insurance program is not a top priority. Seeking care and treatment for addiction is often the first encounter clients have with any health care provider and providers us with a unique opportunity to help clients enroll in coverage. We are also hearing from our providers that even modest premiums and co-payments are proving problematic for some clients. For many of our low-income clients, a co-payment of \$50 or \$250 is insurmountable to enter treatment. As in my case and with many others who suffer from addiction, financial destitution is typical and is often motivation to seek care. Premium payments are also proving difficult for some of our clients.

We are seeing an emerging pattern of enrollment and dis-enrollment for certain people as they are unable to afford to keep up with premium payments.

Now let's return to my original three points:

First, health reform legislation should include substance use disorder prevention, intervention treatment and recovery support services in order to promote the health of our residents and save taxpayer money.

As you can see, health reform in Massachusetts led to significant improvements for people with substance use disorders. More people are insured; and more people are seeking and receiving services.

The second point was that the Substance Abuse Prevention and Treatment Block Grant should be maintained and bolstered – even with passage of comprehensive health reform legislation— because it's needed to fill the many gaps in coverage that still exist --- even with health reform.

In Massachusetts for example, we use our federal Block Grant and other federal funds and our state appropriation to provide a continuum of prevention, intervention treatment and recovery support services that are not reimbursed by other payers.

In particular, almost 70% of our expenditures support services not reimbursed by other payers. These services include a variety of prevention programs, outreach, screening and early interventions services, residential treatment, housing and homeless services, criminal justice programs and recovery support services such as care management, employment and housing assistance.

And my last point, number three, our experience in Massachusetts can help illustrate important lessons learned.

Acknowledging that those with addictive disorders have unique financial challenges, great care and attention should be focused on reducing barriers to accessing care creating by premiums, co-pays and deductibles.

All plans should be subject to existing federal and state parity and other laws and should be transparent in how they determine medical necessity. They should also include a fair and independent review process for denials of coverage and inform consumers of their rights.

Finally, building on the work of federal and state efforts, performance monitoring, performance contracting and outcomes reporting should be a required part of any legislation.

Thank you for your time and attention today and I would happy to answer any questions.