

HEALTHCARE REFORM COMMITTEE

Chairman Kaiser and members of the committee,

My name is Kurt Snyder and I am the Executive Director of the Heartview Foundation. I am the President of the North Dakota Addiction Counselors Association, an Advisory board member to the Central Rockies Addiction Technology Transfer Center, and a member of the North Dakota Recovery Council. I am also a person in long-term recovery and for me that means that I have not used drugs or alcohol since June 10, 1993. My recovery started as a result of a 128 days in a residential facility in San Antonio Texas. I am very happy to report that over the past 20 years, my utilization of healthcare services has been extremely low and my contributions to society and my family has been very good.

An estimated 22.5 million Americans are in need of addiction services. However, only approximately 2.5 million receive addiction services each year. Prescription drug abuse has been declared an epidemic by the Center for Disease control and a new study finds that more than 40 people die every day from overdoses involving narcotic pain relievers like hydrocodone (Vicodin), methadone, oxycodone (OxyContin), and oxymorphone (Opana).¹ Substance abuse is the number one public health issue in the United States.² As a result of the "war on drugs" our prison systems have swelled and a literal boom has occurred in the expanding of penal facilities in our state and nation. 85% or approximately 2 million of the 2.3 million inmates that crowd our prisons either have substance use disorders or substances were involved in their crime. This has been the state of affairs for those who suffer with addiction disorders even in light of the fact that the American Medical Association declared alcoholism was a disease in 1956. And in 1991, the AMA went further to declare that the classification of the disease was recognized under both psychiatric and medical sections of the International Classification of Diseases. Addiction is a chronic disease that shares similar adherences and relapse rates to other chronic diseases such as type 2 diabetes, hypertension and asthma.³ Conversely, the returns on investments of treatment of substance use disorders can be large.⁴ Studies in Washington state

¹ http://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html

² Royce, J.E., & Stratchley, D. (1996). Alcoholism and other drug problems. New York: Free Press.

³ McLellan, AT; Lewis, DC; O'Brien, CP; Kleber, HD (2000). "Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation". *JAMA: the Journal of the American Medical Association* 284 (13): 1689-95. doi:10.1001/jama.284.13.1689. PMID 11015800

⁴ The Office of National Drug Control Policy has information on effective treatment and cost savings at <http://www.whitehousedrugpolicy.gov>.

clinics demonstrated that each dollar invested in inpatient and outpatient substance abuse treatment yielded returns of about 10 and 23 times their initial investments, respectively.⁵

These and many other statistics are why mental health and substance abuse services were listed as one of the ten essential benefits requirements of the ACA and led to the passing of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. With these mandates and the process HHS laid out for the picking of the benchmark plan, North Dakota chose the Sanford Health Plan HMO. North Dakota also chose to participate in the Medicaid Expansion. It is estimated that 20 to 30K North Dakota citizens will enroll in the new Medicaid expansion and an additional 20K newly insured in the private "marketplace". This is great news as it provides a funding mechanism to address this critical issue for so many more ND citizens.

However, the impact of these actions will result in adverse results.

1. The Medicaid expansion remains unclear as the RFP has not been awarded. Questions remain about scope and breadth of benefits for substance abuse services. Medicaid cannot respond as of yet on the "network of providers" that will be established to serve these newly insured. Will it only be the human service centers? Will it include the only a small segment of the ND licensed treatment programs (those with a medical director) or the entire network of ND licensed programs? If this is narrowly defined it will put the brunt of the burden on the human service centers versus utilizing the underutilized and very capable private sector of licensed programs, many of which are located in rural areas of the state. It is very important that the "network of providers" is inclusive and can offer coverage throughout our provider network.

2. The Sanford Health Plan that was chosen, as our benchmark plan, undercuts and will lead to the elimination of very critical levels of care needed to address the addiction issues of our citizens. Effective 1/1/14, BCBSND is removing its coverage of Low Intensity Residential from all of its healthcare plans including grandfathered, metallic and non-metallic plans. This action will remove a very cost-effective residential service that is essential to adequately serving the needs of our state. Basically, Low Intensity Residential is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the world of work, education and family life. It is a safe supportive environment that is critical in terms of serving the demographics of our state. Imagine someone in small town North Dakota that has to travel over 100 miles multiple times per week over a number of months with incremental whether and trying to remain abstinent in

⁵ French, M.T., H.J. Salome, A. Krupski, J.r. McKay, D.M. Donovan, A.T. McLellan, and J. Durell. (2000) "Benefit cost analysis of residential and outpatient addiction treatment in the State of Washington." *Evaluation Review*, 24(6), 609-634.

a community and within a family that is not supportive of recovery. It also critically limits the ability of anyone who lacks a safe and supportive environment or those that need the structure to assist in abstinence and those that lack skills listed above.

3. In addition, the Sanford Health Plan has an exclusion for residential services for those 21 years of age and older. As a result, all the metallic plans of BCBSND will option out of any residential coverage for this group even though North Dakota Century Code mandates the coverage of residential for substance abuse services.⁶ This action will lead to all those in and out of the marketplace with a metallic plan to have NO residential coverage at all! The impact of this action will be devastating to the providers ability to meet the needs of those whose meet the criteria for Low and High Intensity Residential. This will have a great effect on hospitals as well. With treatment providers unable to offer residential services to this group of people, the hospitals will see a significant increase of the revolving door utilization of acute services including ER visits and hospitalizations. This is further complicated by the ACA as payment will not be made to a hospital when a patient is readmitted within 30 days. Currently, approximately 1/3 of all hospital readmissions are substance users. Substance abuse affects every segment of our health care system, contributing to or causing more than 70 conditions that require hospitalization, complicating the treatment of most illnesses, prolonging hospital stays, increasing morbidity and sharply raising costs.⁷ The population who qualify for residential services in terms of impairment of their illness will require more costly interventions and delay the needed addiction treatment services. In essence, **the benchmark plan has led to insurers significantly cutting the benefits available to all plans**, not just the plans of the ACA. This unfortunate result is in direct conflict with the legislative intent of both the ACA and mental health parity.

5. Medicaid expansion and the ACA does ensure that all the citizens of North Dakota will be insurable and thus increase their opportunity for accessing mental health and addiction services. This will stretch our states treatment provider network as citizens will now be able to utilize private, as well as, public services. Historically, many of these individuals were limited only to the services within the human service centers. This is extremely important in light of workforce issue regarding addiction professionals. (I have attached a workforce study for your review) But the top tier of services (Low and High Intensity Residential) will not be available or significantly diminished leading to a great number of individuals remaining at severe risk of suicide, overdose and a variety of other destructive consequences. Most of the human service

⁶ North Dakota Century Code 26.1-36-08.1

⁷ Califano, J. (1994). Radical Surgery. New York, NY: Times Books.

centers offer some residential services. And those in need of residential without the benefit coverage will be forced into the public sector. This leads to the sickest individuals with metallic plans, needing to be served in the human service centers at the expense of the taxpayer versus the funding mechanism that the ACA provides.

6. The rural populations and Bakken affected areas of the state lack access to mental health and substance abuse services. The ACA will do little to change this fact. However, with the limitation and reduction of residential services, these individuals will have less access and little hope of an effective intervention. Previously with residential options, these folks would have been able to access services in a more populated area or outside of the Bakken region. The intervention will come only as their illness has progressed to the point that they have life threatening medical issues or have become an imminent threat to themselves and others.

Promising Practices:

- Tele-health can be a viable opportunity to expand and connect with rural populations. Currently tele-health is not a covered service but make sense for serving the demographics of our state.
- Recovery Coaches are a peer based recovery support that has great potential for North Dakota. Recovery Coaches are trained to be resource rich and can help recoverees be successful in job searches, finding affordable housing, education, community events. There is currently 20 Recovery Coaches working here in the Bismarck area but can and should be expanded throughout the state.
- Substance users have high rates of coexisting medical issues and the new epidemic of prescription drug abuse makes integration of behavioral health and primary care a priority. Recovery based health care would connect them to health screenings, medication management, pain management, future surgeries and re-intervention techniques .
- SBIRT - Screening Brief Intervention and Referral for Treatment is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders for use in community settings. Combined with effective integration of behavioral health and primary care, SBIRT can identify and connect substances users to appropriate care settings.



Employer Demand for Addiction Counseling Skills in Montana, North Dakota, and South Dakota

Methodology: This report includes data from online job postings in the United States in 2010, 2011, 2012, and 2013. H1 represents data from January through June of each calendar year, and H2 represents data from July through December.

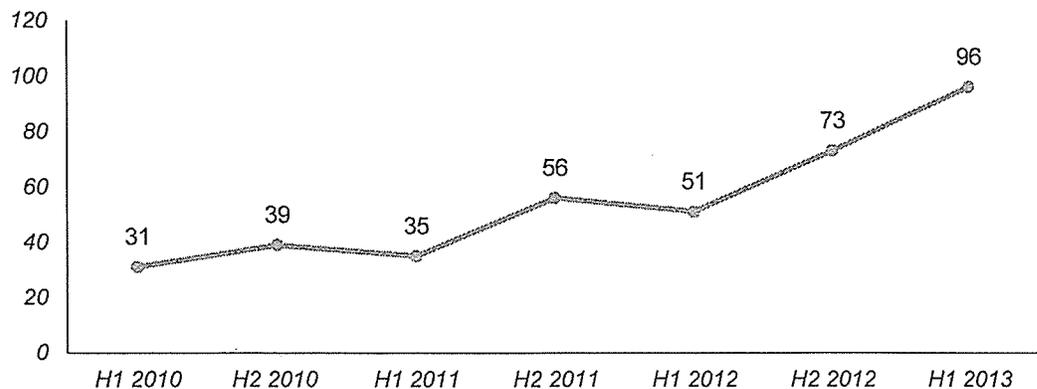
The Forum searched online regional job postings across Montana, North Dakota, and South Dakota to estimate employer demand for job applicants with skills in counseling services and/or addiction counseling. Throughout this report, the Forum refers to data specific to these states as "regional." Because few jobs specifically require or prefer a graduate degree (i.e., were not open to those with a bachelor's degree and years of experience), the Forum included all job postings that require a bachelor's degree and/or a graduate degree.

Demand over Time

The number of regional job postings that require counseling services or addiction treatment skills increased by 89 percent from H1 2012 to H1 2013. Regional job postings increased by 194 percent from H1 2010 to H1 2013, indicating a strong growth in the region for positions that require counseling services or addiction treatment skills. Although EAB analysis cannot project continued employer demand, the trend line below indicates continued strong demand for graduates of programs that confer addiction treatment and counseling services skills.

Number of Regional Job Postings That Require Counseling Services or Addiction Treatment Skills

January 1st, 2010 to June 30th, 2013



Source: Burning Glass Labor/Insight™

Top Occupations

The most common occupations in regional job postings that require counseling services and addiction counseling skills are substance abuse counselors, mental health counselors, and substance abuse social workers. Popular occupations also include other related social worker occupations (e.g., child, family, school, and healthcare) and counselors (e.g., school or genetic). While many graduates of academic programs in addiction counseling might seek positions as substance abuse counselors or other related positions, many may also seek employment in school settings. Academic programs could include school-related courses (e.g., child development, adolescent behavior) in program curricula.

Top Occupations for Regional Job Postings That Require Counseling Services or Addiction Treatment Skills

October 1st, 2012 to September 30th, 2013



n = 209 job postings with 5 unspecified
Source: Burning Glass Labor/Insight™

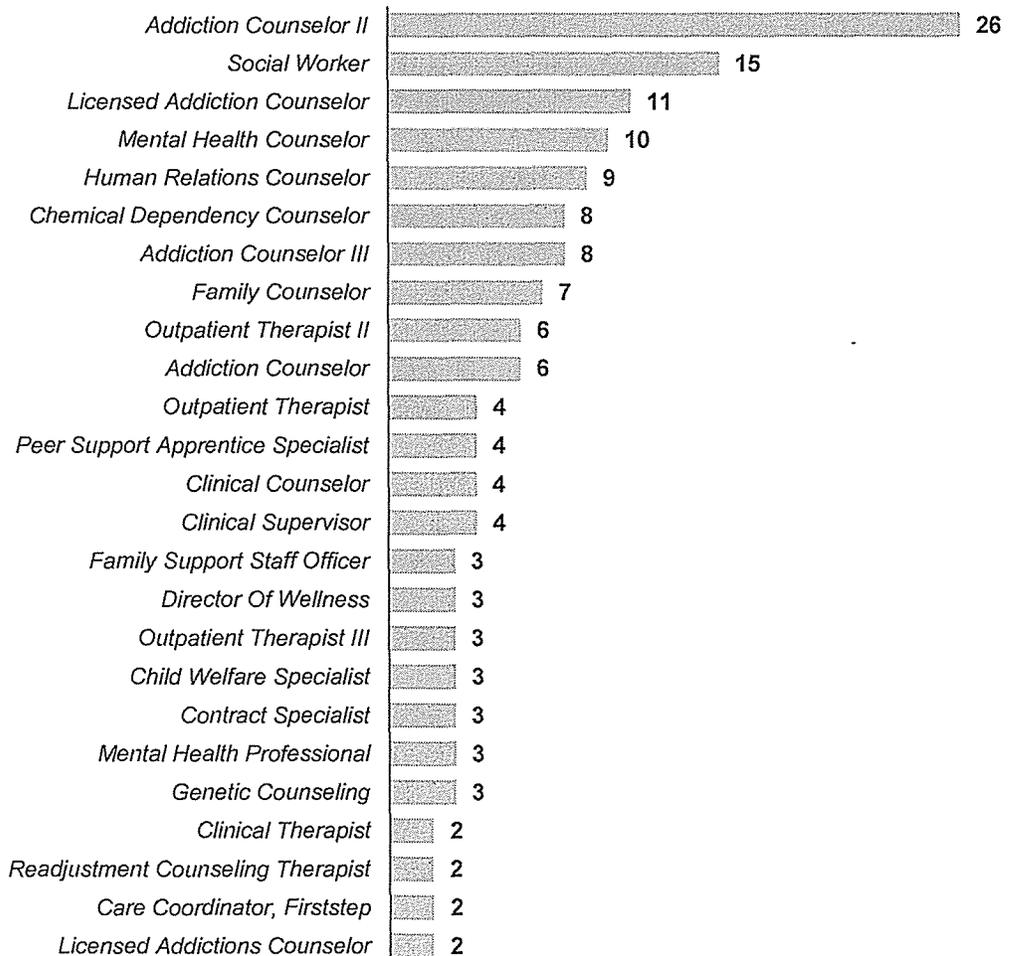


Top Titles

Addiction counselors, social workers, and addiction counselors are the most popular job titles among regional postings that require counseling services and/or addiction treatment skills. However, these three top titles represent only one quarter of profiled postings. Eight of the top 10 titles of profiled job postings include the word "counselor" in the job title. While some of these (i.e., addiction counselor, licensed addiction counselors, and chemical dependency counselors) are addiction-related titles many others (e.g., family counselors, or human relations counselors) are not.

Top Titles for Regional Job Postings That Require Counseling Services or Addiction Treatment Skills

October 1st, 2012 to September 30th, 2013



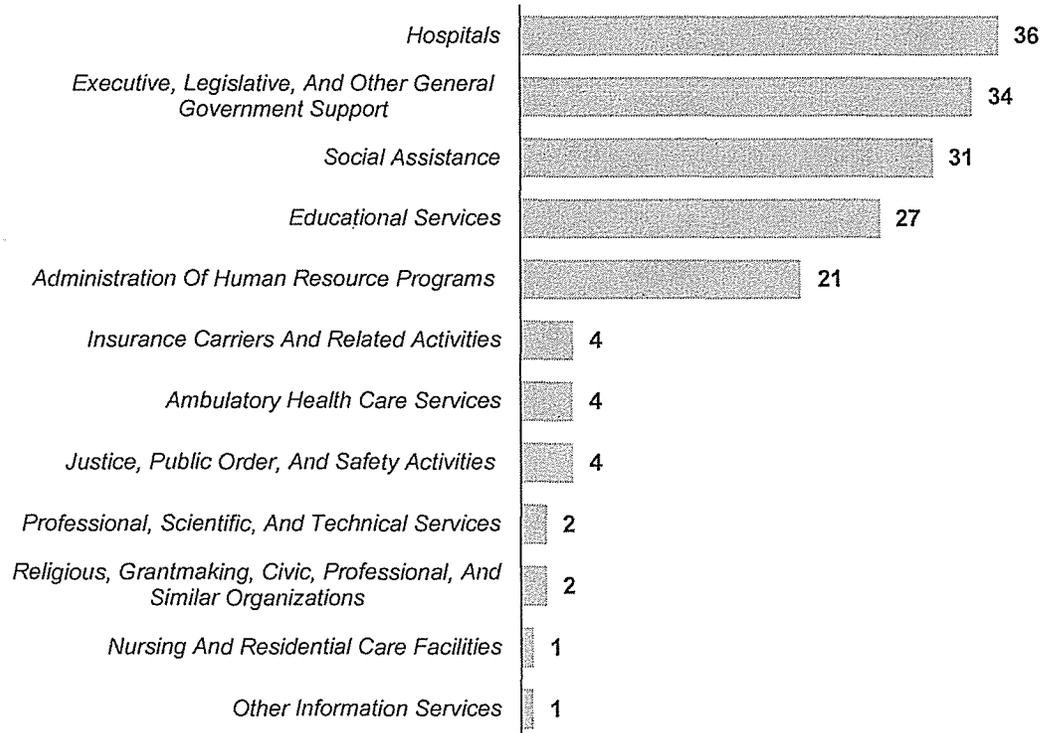
n = 209 job postings with 0 unspecified
Source: Burning Glass Labor/Insight™

Top Industries

The distribution of postings across the top three industries that demand individuals with counseling services and/or addiction treatment skills (i.e., hospital, government support, and social assistance) is approximately equal; each industry maintains 15 percent of profiled job postings. Individuals that hold a degree and counseling services and/or addiction treatment skills might also consider jobs in the educational services industry, such as teachers or school counselors.

Top Industries for Regional Job Postings That Require Counseling Services or Addiction Treatment Skills

October 1st, 2012 to September 30th, 2013



n = 209 job postings with 42 unspecified
Source: Burning Glass Labor/Insight™

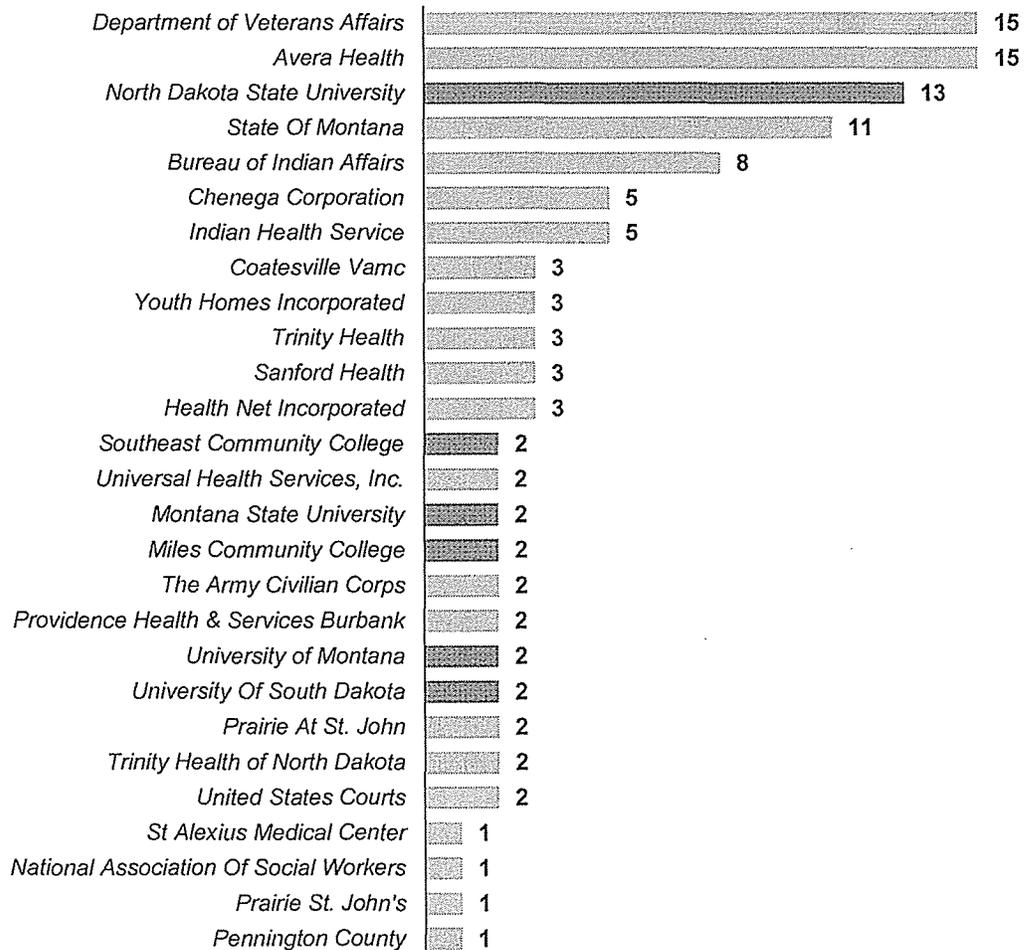


Top Employers

The top regional employers for professionals with counseling services and/or addiction treatment skills in the last twelve months were the Department of Veterans Affairs, Avera Health, and North Dakota State University. Outside these top three employers, no single employer posted more than five percent of the overall postings for jobs that require counseling services and/or addiction treatment skills, indicating that a high volume of employers post only a few positions each that require such skills. A large number (i.e., 23 of 209) of employers are educational institutions. They are highlighted below in orange.

Top Employers for Regional Job Postings That Require Counseling Services or Addiction Treatment Skills

October 1st, 2012 to September 30th, 2013



n = 209 job postings with 87 unspecified
Source: Burning Glass Labor/Insight™

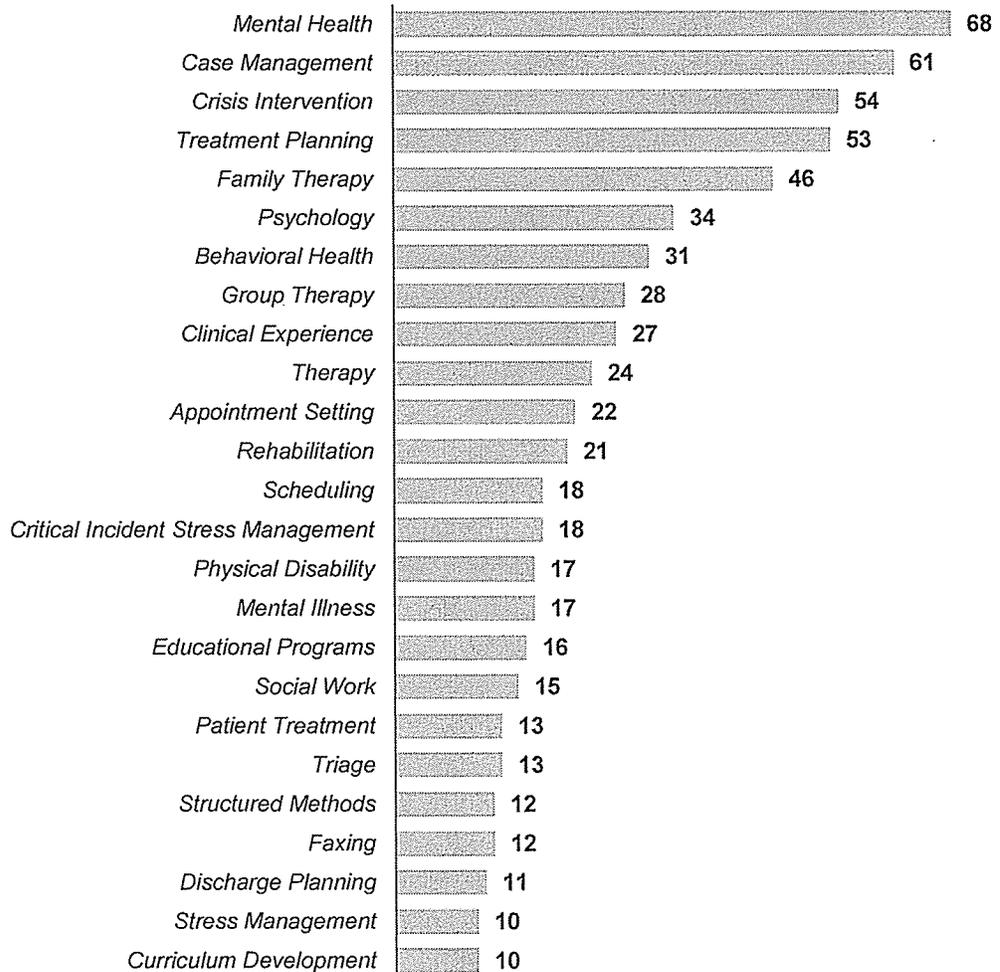


Top Skills

Mental health and case management are the top skills that regional employers seek in concurrence with counseling services and addiction treatment skills. To meet employer demand, academic programs should focus their efforts on both traditional counseling-related curricula as well as administrative management. Other areas of concentration could include family therapy, group therapy, and education programs. Many employers (i.e., 27) seek candidates that have clinical experience. Academic programs might consider integrating demand for this skillset into course curricula through formal internship opportunities.

Top-Demanded Skills for Regional Job Postings That Recur with Counseling Services or Addiction Treatment Skills

October 1st, 2012 to September 30th, 2013



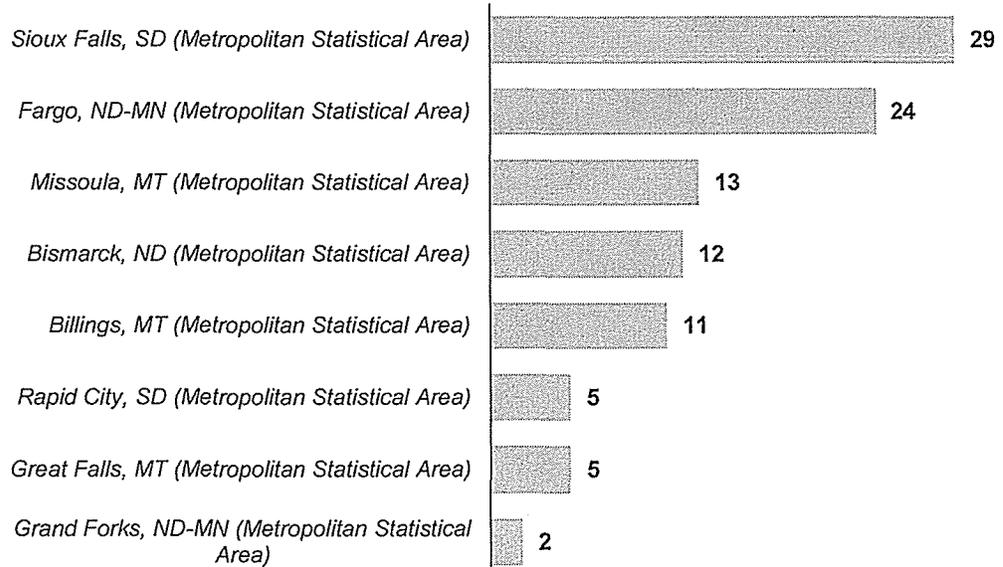
n = 209 job postings with 85 unspecified
Source: Burning Glass Labor/Insight™

Top Locations

Sioux Falls, SD maintains the largest concentration of profiled regional job postings (i.e., 29 of 209, or 14 percent). Other regional Metropolitan Statistical Areas (MSAs) that exhibit a high concentration of job postings that require counseling services and/or addiction treatment skills include Fargo, ND and Missoula, MT. The top five MSAs combined though only account for 43 percent of total job postings; this indicates that many job postings are in rural areas of Montana, North Dakota, and South Dakota. The distribution on the remaining jobs is sporadic across many MSAs each of which feature only one or two job postings.

Top Locations for Regional Job Postings That Require Counseling Services or Addiction Treatment Skills

October 1st, 2012 to September 30th, 2013



n = 209 job postings with 0 unspecified
Source: Burning Glass Labor/Insight™

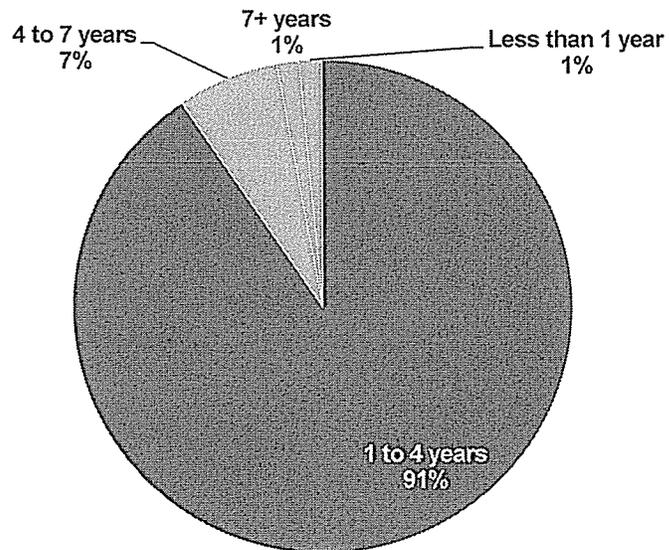


Experience Requirements

Ninety-one percent of regional job postings in the last twelve months that require counseling services and/or addiction counseling skills demanded applicants with one to four years of work experience, which indicates a large market for entry-level positions. Very few job postings (i.e., eight percent) require applicants to have more than four years of experience.

Requested Experience Distribution for Regional Job Postings That Require Counseling Services or Addiction Treatment Skills

October 1st, 2012 to September 30th, 2013



n = 209 job postings with 72 unspecified
Source: Burning Glass Labor/Insight™



Burning Glass Labor/Insight™

Burning Glass – The Education Advisory Board’s Partner for Real-Time Labor Market Data

Part of the data included in this report made possible through our partnership with Burning Glass, a Boston-based firm specializing in use of web spidering technology and Artificial Intelligence engines to mine more than 80 million online job postings for real-time employer demand data. Under the partnership, the Education Advisory Board may use certain features of Burning Glass’s proprietary tool called Labor/Insight™ to answer common member questions about employer demand for specific educational requirements, job titles, and competencies over time and by geography. A fuller description of the tool is available at <http://www.burning-glass.com/products/labor.html>.

Learn about Burning Glass and Labor/Insight™

Many Education Advisory Board member institutions subscribe to the Labor/Insight™ tool, to provide program directors and marketers desktop access to the tool’s full suite of features. Burning Glass is pleased to provide Labor/Insight™ to our members at a substantial discount. For more information about the service, please contact Kelly Bailey, Business Development Manager, kbailey@burning-glass.com or 732-800-2484.

Definition of Terms

The total number of “unspecified” job postings included in a data sample is indicated below all charts and graphs in this report. Job postings are considered “unspecified” for a skill, industry, employer, geography, certification, education requirement, or major when the job posting did not advertise for one of these particular job characteristics and therefore should be subtracted from the total number (n value) of job postings analyzed in the query. Capital cities may be overrepresented in instances where job postings do not specify a location within a state.



Cost Offset of Treatment Services

There is a great paucity on nationwide data related to the cost benefit of substance use treatment. However, the limited research in some States suggests that there is a major benefit to substance use treatment. According to recent estimates¹, the total financial cost of drug use disorders to the United States is estimated to be \$180 billion annually. The economic costs of alcohol abuse were 184.6 billion in 1998². Accessible and effective community-based alcohol and drug treatment is imperative to reduce society's financial burden from problems associated with drug use. As the U.S. economy faces unsustainable escalations in health care costs, we need to ensure needed substance use disorder treatment and recovery programs help reduce health and societal costs.

The benefits of treatment far outweigh the costs. Even beyond the enormous physical and psychological costs, treatment can save money by diminishing the huge financial consequences imposed on employers and taxpayers.

Cost Savings of Treatment: California, New York, and Washington

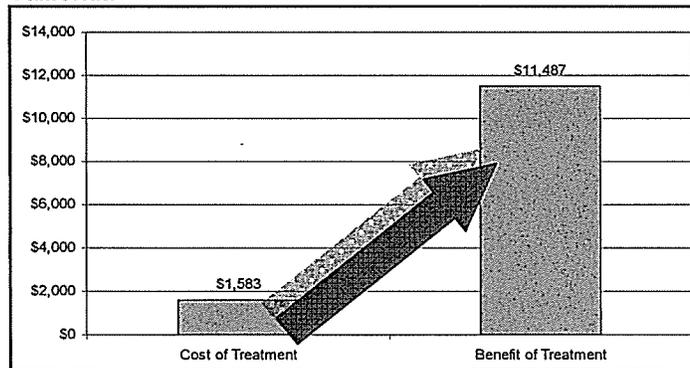
Treatment has been shown to have a benefit-cost ratio of 7:1³. The largest savings were due to reduced cost of crime and increased employer earnings (see Figure 1).

For every \$100,000 spent on treatment,



\$487,000 of health care costs⁴ and
 \$700,000 of crime costs were
 shown to be avoided⁵.

Figure 1. Cost Offset of Substance Abuse Treatment in California

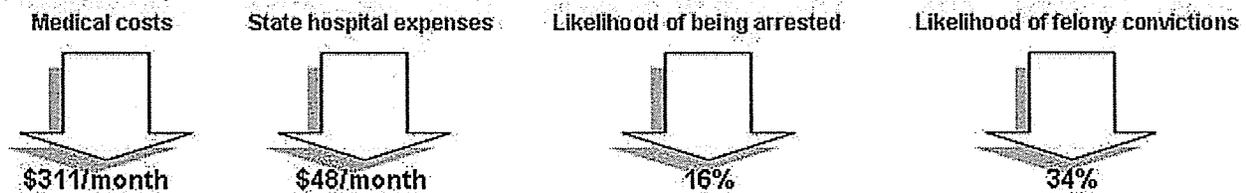


Public Assistance in Washington

A comparison of medical expenses of Medicaid clients⁶ who received treatment noted these savings:

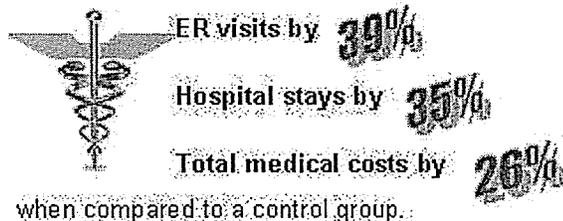
Modality	Savings per Medicaid member per month
Inpatient	\$170
Outpatient	\$215
Methadone	\$230

Spending money on treatment has led to important health and public safety cost reductions in Washington⁷:



Health Care Utilization Savings: California

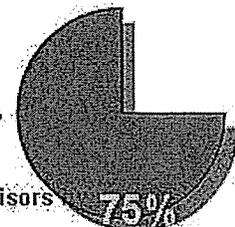
Treated patients have been shown to reduce⁸:



Employers

Employees treated for substance use⁹ have:

- reduced absenteeism,
- reduced tardiness,
- lowered on-the-job injuries,
- fewer mistakes, and
- disagreements with supervisors



Benefit-Cost Comparisons

- A study¹⁰ comparing the direct cost of treatment to monetary benefits to society determined that on average, costs were \$1,583 compared to a benefit of \$11,487 (a benefit-cost ratio of 7:1).
- In an analysis¹¹ of methadone detoxification patients (n=102), authors observed that for every dollar spent on treatment, \$4.87 of health care costs were offset.
- In comparing cost offsets in Washington State of people in treatment to non-treated, authors noted:¹² lower medical costs (\$311/month); lower state hospital expenses (\$48/month); lower community psychiatric hospital costs (\$16/month); reduced likelihood of arrest by 16%; and reduced likelihood of felony convictions by 34%.

Health Care Utilization

- In a study¹³ examining nearly 150,000 Medicaid claims for beneficiaries in six states, authors determined that people with substance abuse disorders had significantly higher expenditures for health problems compared to others.
- In comparison of medical expenses for welfare clients in Washington State¹⁴ (n=3,235 treatment group and n=4,863 control) it was determined that substance abuse treatment was associated with a reduction in expenses of \$2,500 per year.
- In reviewing selected beneficiaries in Oregon's Medicaid program,¹⁵ researchers concluded that eliminating the substance abuse benefit led to increased medical expenditures.
- A review¹⁶ of over 1,000 patients in a Sacramento chemical dependency program noted a substantial decline in hospital (35%), emergency room (39%), and total medical costs (26%) when compared to a control group.
- A recent article¹⁷ on medical costs concluded that health care costs are higher for families with a person who has a dependency problem than for other similar families.

Employer Savings

An intake-to-follow-up assessment¹⁸ study of nearly 500 people treated at Kaiser Permanente's Addiction Medicine program demonstrated significant reduction in missed work, conflict with coworkers, and tardiness. It also noted that employers break even on investing in chemical dependency treatment.

Every \$1 spent on addiction treatment saves \$7 in crime and criminal justice costs. When researchers added savings related to health care, the savings-to-cost ratio was 12:1.¹⁹

¹ Office of National Drug Control Policy (2004). "The economic costs of drug abuse in the United States, 1992-2002." Washington, DC: Executive Office of the President (Publication No. 207303).

² Harwood, Henrick. (2000). "Updating estimates of the economic costs of alcohol abuse in the United States." Report prepared by the Lewin Group for the National Institute on Alcohol Abuse and Alcoholism.

³ Ettner, S.L., D. Huang, et al. (2006). "Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'?" *Health Services Research*, 41(1): 192-213.

⁴ Hartz, D.T., P. Meel, et al. (1999). "A cost-effectiveness and cost-benefit analysis of contingency contracting-enhanced methadone detoxification." *American Journal of Drug and Alcohol Abuse*, 25(2):207-18.

⁵ NIDA, Principles of Addiction Treatment, 1999.

⁶ Wickizer, T.M., A. Krupski, et al. (2006). "The effect of substance abuse treatment on Medicaid expenditures among GA clients in WA State." *Milbank Quarterly*, 84(3): 555-76.

⁷ Estee, S. and D. Norlund (2003). Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report. R.a.D.A. Division and W.S.Do.S.a.H., Services, Washington State.

⁸ Parthasarathy, S., C. Weisner, et al. (2001). "Association of outpatient alcohol and drug treatment utilization and cost: revisiting the offset hypothesis." *Journal of Studies on Alcohol and Drugs*, 62(1): 89-97.

⁹ CATOR Connection, Comprehensive Assessment and Treatment Outcome Research, St. Paul, MN, 1990.

¹⁰ Ettner, op cit.

¹¹ Hartz, D.T., P. Meek, et al. (1999). "A cost-effectiveness and cost-benefit analysis of contingency contracting-enhanced methadone detoxification." *American Journal of Drug and Alcohol Abuse*, 25(2):207-18.

¹² Estee and Norlund, op cit.

¹³ Clark, R. E., M. Samnaliev, et al. (2009). "Impact of substance abuse disorders on Medicaid beneficiaries with behavioral health disorders." *Psychiatric Services*, 60(1): 35-42.

¹⁴ Wickizer and Krupski, op cit.

¹⁵ McConnell, K.J., N.T. Wallace, et al. (2008). "Effect of eliminating behavioral health benefits for selected Medicaid enrollees." *Health Services Research*, 43(4): 1348-65.¹⁶

¹⁶ Parthasarathy and Weisner, op cit.

¹⁷ Ray, G.T., J.R. Mertens, et al. (2007). "The excess medical cost and health problems of family members of persons diagnosed with alcohol or drug problems." *Med Care*, 45(2): 116-22.

¹⁸ Jordan, N., G. Grissom, et al. (2008). "Economic benefit of chemical dependency treatment to employers." *Journal of Substance Abuse Treatment*, 34(30): 311-19.

¹⁹ NIDA, Principles of Addiction Treatment, 1999.