LEGAL ACTION CENTER

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March 8, 1996

Jennifer Klein
Domestic Policy Council
2nd Floor, West Wing
The White House
Washington, D.C. 20500

Dear Jennifer:

It was nice to see you again at the Medicaid advocates' meeting with Carol Rasco last Wednesday. As I mentioned, we are deeply concerned about how Medicaid reform legislation will define disability for purposes of mandated eligibility and how that definition will affect beneficiaries with drug and alcohol problems. In FY 1994, Medicaid contributed $1.3 billion to the treatment of drug dependence and alcoholism. Loss of this funding would put even more pressure on a treatment system that cannot meet current demand and that faces substantial cuts in FY 96 appropriations.

We believe that the Medicaid definition of disability must go beyond Federal SSI eligibility criteria. An estimated 25,000 individuals whose only disabling condition is drug dependence or alcoholism are on the verge of losing their SSI and DI as a result of the "Senior Citizens Freedom to Work Act," which has passed the House and is awaiting approval in the Senate. The bill explicitly ends the disability status of drug dependence and alcoholism for purposes of determining eligibility for SSI and DI.

The new Medicaid definition of disability also should not exclude, nor allow States to exclude, coverage or services for individuals with drug and alcohol problems. Medicaid is among the only means that low-income individuals with drug and alcohol problems have for paying for health care, including some treatment. Not treating them will ultimately cost society more.

We recommend the following definition of a drug- or alcohol-related disability:

- Any individual who would have been eligible for Medicaid benefits under Section 201 of P.L. 103-296[1] before enactment of this Act.

[1] "The Social Security Independence and Program Improvements Act of 1994." This bill made significant changes to the SSI and DI programs for individuals disabled by alcoholism and drug dependence by requiring them to have representative payees, be in treatment, be monitored for compliance, and receive benefits for a maximum of 36 months.

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In addition, we would urge the President to advocate for expanding the access of Medicaid beneficiaries to appropriate, cost-effective drug and alcohol treatment services as a way to control costs in the program. Untreated alcoholism and drug dependence contribute significantly to other major health problems and, consequently, to Medicaid expenditures. One study estimated that in 1991 at least one of every five Medicaid dollars spent on hospital care and one in every five Medicaid hospital days were attributable to substance abuse. The study also estimated that Medicaid expenditures related to substance abuse would exceed $7.4 billion in Fiscal Year (FY) 1994.[2]

Yet the cost offsets of treatment are well documented. For example, untreated alcoholics incur general health care costs that are, on average, at least 100 percent higher than those of non-alcoholics.[3] After treatment, health care costs for alcoholics in recovery decrease to the level of those of non-alcoholic individuals.

For your information, I have also enclosed a fact sheet that explains our objections to the Governors' Agreement on Medicaid. Thank you for your interest in this. If you have any questions or need more information, please don't hesitate to call me at (202) 544-5478.

Sincerely,

Gwen Rubinstein

Gwen Rubinstein
Health Policy Associate

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[2] "The Cost of Substance Abuse to America's Health Care System. Report #1: Medicaid Hospital Costs," 1993.

[3] "Socioeconomic Evaluations of Addictions Treatment," Report of the President's Commission on Model State Drug Laws, 1993.

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Governors' Agreement on Medicaid

Issues for Clients with Drug and Alcohol Problems

The Governors' agreement on Medicaid is very similar to what was contained in the vetoed Budget Reconciliation bill. The Governors' proposal is a block grant that guarantees eligibility for certain beneficiaries and coverage of certain benefits, although States would have total discretion on amount, duration, and scope of benefits.

Among the issues that could affect beneficiaries with drug and alcohol problems, as well as their treatment and prevention providers:

- Medicaid reform should contain the provision, included in budget reconciliation, that would permit coverage of non-hospital residential drug and alcohol treatment services, which are not currently Federally reimbursable. These services are often the most effective for pregnant women and women with children, and they help promote family stability.

- The definition of "disability" adopted for mandated eligibility should not exclude, nor allow States to exclude, coverage for individuals with drug and alcohol problems. The elimination of Medicaid-financed services -- $1.3 billion in treatment in Fiscal Year 94 -- would put even more pressure on a treatment system that cannot meet current demand.

- The agreement stipulates that "States must be able to use all available health care delivery systems" for the Medicaid population, without approval from the Federal government. This could give States license to take discretionary Substance Abuse Block Grant Funds and use them in their Medicaid program instead of for their intended purposes. It could also eliminate Federal oversight of State Medicaid managed care programs.

- Current statutory consumer protections against managed care would be repealed, which would expose Medicaid recipients, including those with drug and alcohol problems, to abuses by unregulated managed care organizations.

- The provider right of action would be eliminated, and client cost-sharing protections would not be maintained.

For more information, contact Gwen Rubinstein at (202) 544-5478.

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