



national association of addiction treatment providers

**THE MANAGED CARE CRISIS: A THREAT TO ADDICTION TREATMENT AND
LONG-TERM RECOVERY**

**NAATP's Position Paper on the Managed Care Industry's Increasing Denial of
Coverage for Addiction Treatment**

May 15, 2004

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THE CURRENT CRISIS

The National Association of Addiction Treatment Providers represents organizations across the country that interact and intersect with managed care as a routine way of receiving payment for the services they provide. The majority of the NAATP members receive their revenue from employer sponsored health care plans (insurance). In addition to many other realities, there are principles that apply to the working and nonworking insurance mechanism.

The cost of health insurance continues to rise. In employer-provided health plans, employers pass along a greater portion of the increased costs to employees, offer plans where employees may opt out of certain benefits, or explore dropping health care as a benefit. Individuals without employer-provided health plans are lucky to obtain coverage at all. The escalating cost of health care has led many insurers to seek help in managing the process. Many increasingly turn to managed care organizations (“MCOs”) that are specifically focused on managing behavioral health care benefits. In fact, the number of Americans covered by “carved out” behavioral health managed care arrangements more than doubled in the five year period from 1992-1997.¹

MCOs reduce costs by, among other things, implementing procedural and other non-clinical barriers to treatment that equate “management” with “denial”. For example:

- Payment is subject to arduous, time consuming, and inefficient approval and benefit verification procedures.
- MCOs employ in addition to stated “clinical criteria,” subjective, economic or other non-clinical criteria to determine whether recommended addiction treatment is “medically necessary” and some of these criteria imposed conflict with state licensure requirements.
- MCOs do not inform individuals about the difference between coverage for treatment and authorized treatment thereby creating an aura of distrust between them and the treatment provider.
- MCOs have instituted procedural barriers such as doctor-to-doctor reviews and have forced providers and insureds to routinely pursue multiple appeals for denials.
- MCOs are denying authorization of treatment for court-ordered treatment without regard to “medical necessity”.

¹ The Impact of Managed Care on Addiction Treatment: A Problem in Need of a Solution. The American Society of Addiction Medicine, April 1999.

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- The involvement of MCOs has been shown to increase the administrative burden of utilization review, which lessens resources available for patient care.²
- Lax enforcement encourages MCOs to continue to deny coverage for medical detoxification and residential addiction treatment or curtail lengths of stays, even when prohibited by state law.
- MCOs utilize other restrictive techniques such as enforcing arbitrary geographic limitations.
- When MCOs approve length of stays, they are typically shorter than those recommended and supported by the clinical and medical treatment team.
- MCOs, despite clear clinical recommendations from clinical providers authorize levels of treatment that are below those recommended.
- While MCOs attempt to reduce cost, the process has become more costly to providers since practitioners are forced to devote excessive time for authorization reviews and appeals and staff positions exist that do not provide clinical service but exist solely to deal with managed care communications.

Without a doubt, MCOs can bring about a reduction in health care costs. However, the use of MCOs drives up the societal costs of addiction.

- A study of cocaine-abusing pregnant women found that, among those who received treatment, the average NICU stay was seven days, at an average cost of \$14,500. For untreated women, the average length of stay more than quadrupled, and costs tripled. (McClellan, citing Svikis, et al.)
- Between 1992 and 1998 the overall **cost of drug abuse to society increased** at a rate of **5.9 percent annually** and reached **\$143.4 billion annually**. (Office of National Drug Control Policy).
- **Drug abuse is the nations' number one health problem**. It strains the health care system and contributes to the death and ill health of millions of Americans every year. (Robert Wood Johnson Foundation)
- Approximately **1 in 4** of the more than two million **deaths** each year in the U.S. is attributable to alcohol, tobacco and illicit drug use. (Robert Wood Johnson Foundation)
- Problems related to addiction were estimated to cost this country close to **\$ 3 million** in 1995. That figure is surely higher today, after nearly a decade of additional growth in the use of MCOs.

² Olmsted, T., White W. and Sindelar, J., The Impact of Managed Care on Addiction Treatment Services (Health Service Research, April 2004).

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- Addicts incarcerated for drug-related felonies who do not receive treatment are substantially more likely to end up back in prison than those who receive treatment. (McClellan).
- Drug injectors who do not enter drug treatment are up to **6 times more likely** to become infected by **HIV** than those who enter and remain in treatment. (National Institute on Drug Abuse)
- **11% of U.S. children** live with at least one parent who is in need of treatment for drug abuse. (US Department of Health & Human Services)
- In a recent survey by the National Center on Child Abuse Prevention Research, 85 percent of States reported addiction was one of the two major problems exhibited by families in which maltreatment was suspected (National Center on Child Abuse Prevention Research, 2001)
- **Prenatal exposure** of children to licit and illicit drugs is a substantial problem in the United States. More than **one million children** are exposed each year to licit and illicit substances during gestation. (RAND Corporation)

MCOs further drive up social costs by denying coverage for addiction treatment to individuals who pay for such coverage. These individuals forgo treatment, pay out of pocket, or tap into public health care resources. This cost-shifting places a tremendous burden on already overburdened families and public payers, and leaves fewer resources for the uninsured and others for whom the public payer system is intended.

Some lawmakers and other state officials have responded to this trend of denial of access and dumping into the publicly funded system. For example, the Minnesota attorney general filed a lawsuit against Blue Cross over the company's processing of mental health, eating disorder and chemical dependency claims. In 2001, Minnesota and Blue Cross reached a settlement. Among a number of mandated reforms, Blue Cross agreed to:

- Institute certain review procedures for denials of chemical dependency treatment;
- Allow the appointment of a health care auditor to periodically review processing of claims;
- Pay the State of Minnesota in the amount of \$8.2 million for cost shifting to the publicly funded system;
- Pay for court-ordered treatment based on an evaluation and recommendation of a health professional;
- Provide "parity" for mental health and chemical dependency treatment so that, when Blue Cross includes such coverage in a contract, the contract will include both inpatient (including residential treatment centers) and outpatient treatment at the same level as for medical services;

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- Improve access to necessary treatment;
- Ensure that a sufficient number of appropriate health care providers are available to provide treatment within a medically appropriate period of time, not to exceed 10 days;
- Inform patients what treatment it will pay for if a denial is made because of lack of medical necessity;
- Ensure that its networks offer reasonable access and coverage for treatment for eating disorders and chemical dependency, and the company recognizes the medical necessity of treatment for these conditions, including 28 day inpatient treatment (which includes residential treatment centers) for chemical dependency; and
- Not sanction any health care provider for providing medically necessary benefits nor provide any financial or other incentive to its claim reviewers to deny coverage.

Of course, the social costs of untreated addiction cannot be measured solely in dollars: untreated addiction also results in job loss and broken families. Those who are unable to obtain help deteriorate into our jails and prisons.

Conversely, the societal and economic benefits to addiction treatment far outweigh the costs of providing coverage for such services. National studies show that for **every \$1 spent on addiction treatment, \$7 is saved** in the criminal justice, state prison, medical (including Medicaid), foster care, and DCFS systems. (1994 California Drug & Alcohol Treatment Assessment). Studies show that **drug treatment decreases criminal activity** during and after treatment. (National Institute on Drug Abuse)

Addiction treatment has continued to be battered by managed care organizations that are specifically designed to manage the behavioral health benefit. In most instances they are carved out and not viewed in the same way as other health care. The cost of addiction treatment is a very small portion of the overall cost of total health care, but for the four to eight national managed care organizations, it is their entire existence.

The **National Association of Addiction Treatment Providers** finds it unconscionable that families suffering from addiction are unable to access the treatment to which they are entitled under insurance contracts and the law. Equally unconscionable is the wrongful shifting of the burden onto a public system that has no capacity to absorb it. NAATP is committed to working toward a solution to this crisis.

WHAT IS THE CAUSE OF THE CRISIS?

The **National Association of Addiction Treatment Providers** has conducted a multi-state survey to examine the cause(s) of the current crisis in order to develop a strategy

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to remedy the crisis. The respondents represented 38 states and 1 other country. See www.naatp.org for the results of the May 2004 survey.

Unfortunately, it is a conscious business strategy to discriminate against persons in need of addiction treatment because it presents an attractive means to achieve short-term savings in a population that is generally stigmatized and disenfranchised. Indeed, we have found that the discriminatory denial of coverage for addiction treatment occurs even in those states that have enacted laws prohibiting insurance companies from engaging in such discrimination.³

In fact, a separate study by Ensuring Solutions, of 70 health plans studied in 36 states, at least 10 major health plans in five states, Florida, Georgia, Nevada, New York and West Virginia, failed to comply with state laws governing insurance coverage for addiction (for study purposes, the insurers remained unnamed). The most common violation found was that health plans are not allowing patients to remain in treatment as long as required by state law.

MCOs are choosing to violate these laws, relying on inconsistent and lax enforcement. Others circumvent the spirit of these laws by exploiting semantic loopholes, or by implementing procedural hurdles that impede access. Coverage for addiction treatment is especially vulnerable to denial or restriction, in light of the general absence of support for parity of such treatment under state laws.

Lax, or in some cases non-existent, enforcement of anti-discrimination laws further exacerbates the problem. Without stringent enforcement, insurance companies have no incentive to discontinue a practice that results in significant savings. Providers and consumers of these services need to unite and encourage state law makers, Attorneys General, insurance regulatory oversight agencies and other key policymakers to no longer tolerate this blatant disregard of these laws and contractual rights of insureds.

RESOLVING THE CRISIS

The **National Association of Addiction Treatment Providers** is outraged about the damaging effects the inequitable treatment of addiction services has on individuals in need of addiction treatment, public funding systems that are required to pick up the cost of providing addiction treatment, the taxpayers who ultimately absorb the cost, and the many families that are destroyed by the inaccessibility of treatment. It is the position of the **National Association of Addiction Treatment Providers** that immediate action is required to halt the wrongful denial of coverage for addiction treatment services by managed care organizations.

³ For example, an Illinois statute generally requires an insurer to cover services provided by entities licensed by the Illinois Department of Human Services to provide alcoholism or drug abuse treatment provided that: (a) the insurer's policy provides coverage for alcoholism or drug abuse on an inpatient and an outpatient basis; (b) the charges are otherwise eligible for reimbursement; (c) the services are medically necessary; and (d) the services are within the scope of the services the entity is licensed to provide. (215 ILCS § 5/367d.1).

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The **National Association of Addiction Treatment Providers** and its member organizations are actively involved in all parts of the country in efforts to remedy this crisis. Specifically, the **National Association of Addiction Treatment Providers is proud to support and encourage the following activities:**

- Working with legislators and policy makers in several states to encourage the enactment and effective enforcement of state laws prohibiting the wrongful denial of coverage for addiction treatment.
- Meeting with executives of MCOs in order to educate and encourage them to revise policies and practices.
- Drafting a model benefit plan.
- Developing a candidate report card to help voters determine which elected officials are doing their part to increase the availability and accessibility of addiction treatment.
- Supporting the development of a cohesive, equitable national health care policy.
- Sponsoring trainings and regional forums for discussion.
- Developing a toolkit with strategy resources for members.
- Keeping members informed of legislative developments, lawsuits, and other relevant managed care developments through e-mails, newsletters and website articles.
- Organizing a consumer advocacy and education effort.
- Gathering data and evaluating strategies for interventions with Managed Care Organizations.
- Exploring legal remedies available on behalf of NAATP membership.
- Developing model state laws and supporting enforcement of current laws.
- Pursuing federal legislation.

CONCLUSION

The **National Association of Addiction Treatment Providers** will continue to raise its voice in support of access and long-term recovery viability. Addiction treatment must be returned to the mainstream of healthcare. **NAATP** enthusiastically endorses any attempt to increase the accessibility and availability of addiction treatment, and the payment for these services by private insurers who have a legal and ethical obligation to provide such coverage. NAATP stands ready to work with any and all organizations that wish to participate in remedying the crisis we are now facing.