ERA OF ACCOUNTABILITY

by Deb Beck, consultant to the National
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Reflecting a growing national consensus on this issue, in the 1970's and 1980's, many states enacted laws requiring commercial group health insurance plans to provide some level of treatment for alcohol and/or drug addiction. Since that time, a few additional laws were enacted and currently 43 states and the District of Columbia have such a law on the books.

In support of enactment of these laws, states marshalled the well-articulated body of research delineating the cost of untreated addiction to the health care system, to the workforce, to the larger society and the cost benefits of provision of addiction treatment.[1]

Over 70% of people with drug and alcohol problems are in the workforce, many with employment-based health plans that fall under the requirements of state laws.[2] For this reason, enactment of these laws represented a major step forward in providing intervention early in the progression of the disease before the advent of job loss, danger to health and other consequences.

However, despite enactment of all of these laws, payment for addiction treatment by commercial insurers has eroded dramatically over the years leaving public payers and charity on the hook for services already paid for by the subscriber through insurance premiums.[3]

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[1] For example, *"Socioeconomic Evaluations of Addictions Treatment",* James W. Langenbucher et al., Center of Alcohol Studies Rutgers University, prepared for the President's Commission on Model State Drug Laws, 1993 and *"Volume IV, Treatment",* The White House, President's Commission on Model State Drug Laws, December 1993.

[2] *"Overview of Findings from the 2002 National Survey on Drug Use and Health",* DHHS Publication No. (SMA) 03-3774, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2003. (page 5)

[3] In an article entitled, "*U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001"*, Tami L. Mark et al., Health Affairs, March 29, 2005, the authors describe this trend:

--- Over the 1991-2001 period of analysis, "Private insurance payment for SA actually dropped in real dollars, increasing the public share of SA spending." (page W5-133)

The Pennsylvania Story

In 1986, Pennsylvania joined the national movement toward requiring coverage for addiction and enacted a law providing comprehensive treatment for alcoholism in all commercial group health plans. In 1989, the law was re-authorized and amended to include drug addiction. Under the law (PA, Act 106 of 1989), treatment benefits are accessed through certification and referral by a licensed physician or a licensed psychologist.

In the mid-1990's, insurers began to subcontract administration of this law out to profit-making behavioral health managed care firms and soon, few could access treatment already paid for and covered in the health plan. In short order, Pennsylvania's nightmare began. Desperate families were blocked from getting help for loved ones. Employee Assistance Programs working for business and industry and Student Assistance Programs working in the schools were no longer able to intervene quickly to refer troubled employees and students for help. Treatment programs became battlegrounds and some were threatened with loss of network status when they dared to fight for treatment for patients. Treatment was delayed, denied or minimized and suffering families already devastated by the addiction of loved ones were forced to beg for treatment from anonymous strangers on toll-free lines. Despite the clear requirements of the law, certifications and referrals by physicians and psychologists were routinely set aside or denied.

In summary, in the mid 1990's, families and treatment programs alike encountered an ever-changing, labyrinthian process shrouded in procedural and

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--- "During the first five years, private insurance spending for SA fell 2.4% annually; during the second five years, it increased only 0.1% annually." (page W5-138)

administrative maneuvers all driving to the same result – delay, denial and minimization of needed care.

Soon, we began to learn of deaths of people who were unable to access their own insurance coverage. The first we heard about occurred in our state's capital in Harrisburg, Pennsylvania. A working man and honorably discharged veteran sought treatment for alcoholism under his employer's group health insurance policy. He pleaded with his managed care firm repeatedly for help, was turned away and finally took his own life. Next, we learned about a similar death – this time of a mother of two small children in Lancaster.

These two deaths would foreshadow additional loss of life to come.

Around the same time, workplace Employee Assistance Programs in southeastern Pennsylvania sounded a clarion call. Suddenly, EAPs were no longer allowed to use their skills to assess and place employees directly into treatment. Now they were required to refer the employee outside the workplace to a managed care entity unacquainted with the worksite and its dangers and often with little or no training or actual experience in addictions. In addition, the managed care firms operated with financial incentives to delay, deny or minimize the need for treatment.

It was time to put a stop to violations of law in our state.

The Process Begins

With the help of Employee Assistance Professionals, a simple, one page form was developed to assess the problem and begin the collection of data. The form was broadly distributed to groups such as: employee assistance programs, student assistance programs, certified addictions counselors, recovery organizations, licensed drug and alcohol addiction treatment programs, statewide drug and alcohol specific organizations, parent and family groups and others.

Thus began the painstaking and painful process of accumulating and documenting complaints.

In a matter of days, complaint forms and calls poured into our offices often describing extraordinary obstacles blocking access to treatment already paid for and provided in the insurance policy.

Driven by the outpouring of human pain, we developed and began to implement a comprehensive strategy to ensure enforcement of our law.

Shopping bags full of complaints and stories were sorted and prepared by political subdivisions for meetings with members of the General Assembly.[4] In short order, Pennsylvania's General Assembly stood tall, raised questions about enforcement and over a five year period kept the Klieg lights glaring brightly on the issue through multiple, bi-partisan hearings. The Office of the Attorney General moved to the fore, studied the problem and convened numerous meetings with advocates, aggrieved families, treatment programs, Employee Assistance Professionals, Student Assistance Professionals, people in recovery and others.

In support of this effort, we continued to categorize consumer complaints, conducted facility surveys and provided other material. Working with the Attorney General's Office, we developed and refined a consumer complaint process that we thought might work with our population and within the laws of our state.

At the same time, we provided intensive training for treatment programs, EAPs, SAPs, family and parent groups, recovery organizations and others across the state about our insurance law (Act 106 of 1989), how to file complaints and how to utilize the newly developed enforcement tools.

[4] All confidentiality protections were carefully maintained.

The Attorney General's office investigated consumer complaints and in 2000, opened the Health Care Unit establishing a toll-free number to handle consumer complaints about health insurance.[5]

In 2002, we approached the gubernatorial candidates on this issue. Candidate Ed Rendell, who became Governor in 2003, committed to enforcement of the law. In 2003, the Pennsylvania Insurance Department issued a Policy Statement upholding the law:

> *"Under the Act, the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. It is the Department's determination that the same prerequisite applies for inpatient detoxification coverage. The certification and referral in all instances controls both the nature and duration of treatment."*
> *(PA Insurance Department, Drug and Alcohol Use and Dependency Coverage, Notice 2003-06)*

Court Action

In January 2004, Pennsylvania's insurance industry challenged the Policy Statement of the Pennsylvania Insurance Department and filed a complaint with the Commonwealth Court of Pennsylvania.

This action began our journey through the courts and while the road was long, at the end of the day the Pennsylvania Supreme Court upheld the rights of the treating clinician to control access to treatment.

In February of 2004, the Insurance Department and the Office of the Attorney General responded by filing a joint brief in the Commonwealth Court in

[5] This effort has been maintained by three consecutive Attorneys General – Mike Fisher, Gerald Pappert and Thomas Corbett

support of the Policy Statement. In July, an Amicus Brief was filed in support of the Policy Statement by the County Commissioners Association of Pennsylvania, the Pennsylvania Association of Drug and Alcohol Administrators, the Pennsylvania Children and Youth Administrators, the Pennsylvania Council of Chief Juvenile Probation Officers and the Pennsylvania Association of Student Assistance Professionals. A separate Amicus Brief was filed by the Pennsylvania District Attorneys Association.

In September 2004, the case was argued before the Commonwealth Court of Pennsylvania by the Insurance Department. The Insurance Department's lawyers were joined in the courtroom by the Insurance Commissioner of Pennsylvania, the Attorney General of Pennsylvania and the Chief Deputy Attorney General of the Health Care Unit. In April 2005, the Court ruled that the insurers' case was not yet ripe for judicial resolution and dismissed the complaint without prejudice. In May of 2005, the insurers appealed the Commonwealth Court ruling to the Supreme Court of Pennsylvania.

In February of 2006, the Supreme Court ruled that the case was indeed ripe for resolution and returned the case to the Commonwealth Court. In July of 2007, the Commonwealth Court ruled in favor of the Insurance Department and upheld the Policy Statement and the right of treating clinicians to control access to treatment.

At several points along the way, the insurers filed motions seeking to derail the input from the public interests groups named above: each of these efforts failed.

In 2009, the Supreme Court of Pennsylvania ruled upholding the Policy Statement of the Insurance Department and the right of the treating clinicians to control access to treatment.

The Enforcement Effort Goes On

As part of the continuing enforcement effort, a study of cost shifting by insurers to public funding was conducted. Building upon this work, attorney Greg Heller provided a companion legal analysis of the study identifying potential causes of action to assist states in recovering public funding. These two works are briefly described below.

Evidence of Shifting of Cost to Public Funding

In 2006 the Drug and Alcohol Service Providers Organization of Pennsylvania and the National Alliance for Model State Drug Laws jointly funded an analysis of cost shifting by insurers to public funds and charity. Conducted by attorney Greg Heller and the accounting and consulting firm Parente Randolph LLC, this analysis examined financial and other data from 100% of all admissions to a residential facility for adolescents over a two year period.

Despite the plain requirements of PA's commercial insurance law (Act 106 of 1989), the study found:

--- Over 30% of the young people admitted to the treatment facility had documented evidence of commercial insurance coverage – 30.9% in the first year of the analysis, 37% in the second year.

--- Over 12,700 residential treatment days were provided in the course of the two year study.

--- Less than 1% of these days were paid for by a commercial insurer.

--- Public funding paid for over 95% of the treatment days in FY02-03 and over 82% of the days in FY03-04.

--- In addition, costs of treatment were absorbed by the program for almost 4% of the days in FY02-03 and over 14% of the days in FY03-04.

Put another way, despite good commercial insurance coverage for addiction, 99% of the cost of all treatment was provided through public funding and charity.

Restoring Public Funding as a Component of Enforcement

In 2008 the National Alliance for Model State Drug Laws contracted with attorney Greg Heller to further explore the cost shifting by insurers and to provide a companion legal analysis. In his article, *"The Cost-Shifting Consequences of Failed Managed Care Regulation: Some Lessons from Pennsylvania's Experience with Addiction Treatment"* (6/1/09), Greg Heller explores the importance of enforcement of state insurance laws providing treatment for addiction, the shift to public funding and potential causes of action that could be brought on behalf of the states to assist with enforcement of state laws and possibly recover lost public funding.

The enforcement effort is by no means over in Pennsylvania and will require constant vigilance. We expect to watchdog compliance, survey programs, train and re-train groups and policy holders on the law for many years to come – until every insurer operating in the state is brought into compliance with state law.

Related Articles and Research

In a Health Affairs article entitled, "*U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001"* (March 2005), the authors describe the erosion of insurance payments for addiction treatment and suggest that increased application of managed care techniques may explain this trend.[6] This theory is consistent with the Pennsylvania experience. With the arrival of managed care in our state, use of residential treatment and lengths of stay in both residential and outpatient often dropped below clinical efficacy and best practices. In fact, for a

[6] "*U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001"*, Tami L. Mark et al., Health Affairs, March 29, 2005.

period of time, managed care rendered meaningless the national effort to encourage the use of evidence-based practices regarding the appropriate levels of care and provision of appropriate lengths of stay.

In 2000, in its report to Congress studying the impact of the Mental Health Parity Act of 1996, the General Accounting Office found that despite this new parity law, access to mental health benefits remained limited. In this regard, the GAO noted an increase by employers in the use of managed care, as well as other design features limiting use of the benefits. [7] Similar dynamics may also be at work in states that have enacted state parity laws regarding addiction treatment and/or mental health.

If this pattern holds true, implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010 are also likely to encounter an increase in use of managed care techniques that will threaten and could limit its promise of increased access to and provision of addiction treatment.

In summary, these articles and our experience in Pennsylvania identify significant problems and obstacles when managed care techniques are applied to the provision of addiction treatment or applied without adequate oversight and enforcement.

Discussion

43 states and the District of Columbia have laws on the books requiring that commercial group health insurance plans provide some level of treatment for alcohol and/or drug addiction.

[7] *"Mental Health Parity Act - Despite New Federal Standards, Mental Health Benefits Remain Limited",* United States General Accounting Office, May 2000.

Over the years, during conferences and meetings held by the National Alliance for Model State Drug Laws around the country, we were startled to learn that many of these state laws are not being utilized or enforced. As a result, people with commercial insurance plans are forced to seek help through public funding and charity.

In this time of revenue shortfalls, freezes and recession, it is unconscionable that desperate families in any state would be unable to access help already paid for and provided by law and contract. In addition, the federal insurance landscape is shifting rapidly and in ways that are difficult or impossible to fully predict.

For all of these reasons, we must move forward and usher in a new era of accountability and ensure that current state laws requiring coverage for addiction treatment in commercial insurance are enforced and that public dollars are reserved for the destitute and the working poor. This effort takes on renewed importance as states move forward with implementation of the addiction treatment provisions of two new federal laws: the Mental Health & Addiction Equity Act of 2008 and the Affordable Care Act of 2010.

Finally, the Heller documents on cost shifting by insurers and the companion legal analysis lay significant groundwork for additional enforcement actions and for restoration of any ill-gotten gains.

Closing

The enforcement journey has been by turns difficult and exhilarating. We are beholden to many: to courageous families stepping forward to share their pain, to the Office of the Attorney General and the Pennsylvania General Assembly, to directors and staff in treatment programs speaking out despite the threats, to judges, district attorneys and probation officers who identified the connection between delays in treatment and crime and of course, to

Pennsylvania's strong and loving recovering community that watches over us all while lending to the effort a great treasure of skills and wisdom.

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