Model Managed Care Consumer Protection Act

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Policy Statement

During the last 30 years, a number of companies and some insurers, recognizing cost benefits to employers and workers alike, moved forward and instituted alcohol and other drug treatment coverage in company and insurance health plans.

As awareness of the cost of untreated alcohol and other drug problems to health care and to the workplace grew, some state legislatures responded by enacting laws requiring coverage for addiction treatment in health insurance policies.

In response to these new laws and workplace policies, workers were encouraged by co-workers and employee assistance programs (EAPs) to come forward and seek help. Skilled employees were salvaged and able to keep their jobs. Research on pre- and post-effects of treatment on workplace alcohol and other drug problems and on health care utilization accelerated.

The research on the cost benefits of addiction treatment became increasingly available to business and policy makers which in turn led to the passage of still more laws requiring coverage for this illness through health insurance policies.

Cost offset and cost benefit studies demonstrate that untreated addicted people and their families use health care at rates much higher than for general populations. The results of some of these studies are summarized below.

COST BENEFITS OF ADDICTION TREATMENT

Supporting the evolution of these state laws is a growing body of research on the costs of untreated alcohol and other drug addictions to the workplace, to the insurers and to the criminal justice system.

Study after study from business and industry, from health insurers and universities demonstrates, on the one hand:

(a) High health care utilization by the untreated alcoholic and addict prior to addiction treatment for a wide array of addiction related illnesses, accidents and injuries.

- "On the average, untreated alcoholics usually incur general health care costs that are at least 100% higher than those of nonalcoholics over pretreatment levels... In the last 12

Without such treatment through insurance, the individual with an addiction will continue to deteriorate in a downward spiral eventually losing employment, insurance, health and becoming dependent on public funding. When this occurs, the high health care utilization caused by untreated addiction shifts to welfare, to Medicaid, to Medicare and to the taxpayer.

Even with the more deteriorated addicted individual on Medicaid, the studies find the same patterns at work as with the still insured. High health care use prior to treatment is followed by marked reductions in health care use after treatment of the addiction has occurred. In addition, other benefits accrue in savings to the state from reductions in welfare cash grants, food stamps, etc. as many individuals in recovery find jobs and move back into self-sufficiency.

The end result of this process of legislation and research is that 43 states have now put laws into effect requiring the coverage of addiction treatment.

THE NEED FOR CONSUMER PROTECTIONS

Despite the widespread passage of laws requiring coverage of addiction in insurance plans, denial and stigma - in fact intense shame - continues to surround addictive diseases and works to keep utilization of the treatment benefit extremely low. Utilization of the benefit by subscribers has been stalled at the rate of less than 1% of subscribers for many years. A survey by MEDSTAT Systems, Inc., a health care information company, showed only one-third of one percent (9,000 people) of three million insured people received inpatient substance abuse treatment in 1989.

This under-utilization perpetuates the health care spending on addiction related accidents and illness and limits capturing of health care savings through treatment of the primary illness.

Denial and stigma keep the employee out of treatment but also prevent employers from realizing the full benefit in reductions in health care spending, in reduction in workplace accidents and disciplinary problems.

Presently, a new development in health care is further complicating this picture. Responding to the high costs of health care and the need to control spending, many health maintenance organizations and insurers have begun to subcontract the administration of some health benefits, including alcohol and other drug treatment to managed care firms.

Because of the recent emergence of this industry, managed care is presently almost entirely unregulated in the 50 states and by the federal government. Although the state and federal government regulate health maintenance organizations, health insurers and alcohol and other drug treatment providers, there are few such regulations governing the activities of managed care firms.

In the absence of regulation, managed care firms often lack staff with specific skills and training in alcohol and other drug diagnosis and referral and often fail to use acknowledged alcohol and other drug criteria to assist in diagnosis and placement decisions. In addition, many have financial arrangements that can create incentives to undertreat, combined with grievance procedures that are run in-house to the company in question.

One result of the absence of regulation is that individuals seeking alcohol and other drug treatment are having increasing difficulty accessing the alcohol and other drug treatment benefit already provided and paid for in the health insurance policy.

Other difficulties in accessing help revolve around managed care policies regarding admissions to detoxification. Alcohol and other drug addicts in need of admission to a detoxification center often can neither understand nor wait out the managed care approval process to obtain care. Delays in approval for admission to detoxification lead to relapse, further damage to health and sometimes to job loss. Yet admission to detoxification, when properly handled, is a medical crisis that presents a window of opportunity to recovery for the individual and an opportunity for health care savings as well.

Many managed care firms are not available after 5:00 p.m. or on weekends, making pre-approval requirements all the more difficult.

The practical effect is obvious. These services, already paid for by the insured or the insured's employer, may not be available at the point in time when they are most needed.

Cost shifting is also occurring here. In some cases, treatment already covered by insurance and paid for by the patient or the patient's employer is being shifted to public funding sources such as Medicaid, block grant monies and other state funding. Others go untreated altogether with the predictable societal costs of increased medical expenses, lost jobs with resulting unemployment and welfare costs, broken families and ultimately, crime.

Without consumer protections in place, this combination of factors is potentially dangerous and likely to lead to still further reductions in utilization of alcohol and other drug treatment benefits. As has been discussed at length elsewhere, this failure to treat causes still higher health care spending on addiction related illness and accidents and eventually lead to job loss.

The managed care consumer protections included in this Act, are designed to protect consumers from the problems previously discussed.

The Act establishes the use of acknowledged alcohol and other drug diagnostic criteria, establishes standards for the alcohol and other drug credentialling of managed care assessment personnel, addresses potential conflicts of interest by removing fiscal incentives that may affect clinical decision-making, establishes a clear and accessible grievance procedure, and requires that subscriber materials be written in clear and simple language. In addition, the [Act] sets up a system of accountability including reporting procedures and performance standards.

The Act provides for immediate care of individuals under the influence of or in withdrawal from alcohol or other drugs by classifying detoxification as an emergency service. The emergency service provision would allow the treatment of the patient to go forward immediately, subject to concurrent, retrospective review and the grievance procedure. This allows the dispute over who pays for treatment to go on after the patient is safe and medically stabilized.

This Act additionally recognizes the role of employee assistance programs (EAPs) and student assistance programs (SAPs) that do alcohol and other drug abuse and additional assessments, referrals and follow-up for businesses and schools. These programs are, in effect, managed care for the businesses and schools. Employee assistance and student assistance professionals, unlike either traditional managed care providers or treatment providers, have no potential financial conflict of interest in their professional assessments and referrals, have direct contact with the alcohol or other drug troubled person, and can provide follow-up, support and accountability to the employer, or school. Where these programs are in place, the [Act] allows them to override the decisions of a

managed care firm, subject to the managed care firm's right to appeal using the grievance procedure ordinarily available to the aggrieved insurance policyholder.

The same authority to override the denial of benefits by managed care providers is provided to criminal justice officials responsible for treatment and referral for criminal defendants.

Responsible managed care firms are already moving in the direction of many of the provisions of the Act. They are looking at diagnostic criteria and staff credentials and at the potential harm of fiscal incentives that may lead to denial of needed care. As a result, these managed care firms are providing the full continuum of needed alcohol and other drug treatment services and find themselves at a competitive disadvantage with managed care firms that continue less responsible practices.

In summary, the Act provides reasonable protections that are intended to permit insurance policyholders to receive the benefits they paid for and are entitled to. It also will ensure that responsible managed care firms can carry out their worthy functions without finding themselves at a competitive disadvantage with firms whose lack of training and skills and fiscal incentives lead to the appearance of cost savings when in fact, cost shifting to the public health system has occurred.

ENDNOTES

1. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4*, in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT 11 (Center of Alcohol Studies, Rutgers University, 1993).
2. *Id.* at 19.
3. *Id.* at 26.
4. *Id.* at 13.
5. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Addictions Treatment in Workforce Populations, Chapter 5*, at 13.
6. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 13.
7. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 25.
8. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 26.
9. *Id.*
10. *Id.*
11. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 13.
12. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at 14.
13. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 5.
14. National Association of Addiction Treatment Providers (NAATP), TREATMENT IS THE ANSWER - THE COST EFFECTIVENESS OF ALCOHOLISM AND DRUG DEPENDENCY TREATMENT, White Paper (March 1991).

Highlights of the Model Managed Care Consumer Protection Act

- Requires the use of alcohol and other drug abuse and addiction criteria when doing assessments.
- Establishes a method to approve alternative alcohol and other drug assessment criteria.
- Establishes credentials of personnel doing alcohol and other drug assessments.
- Bars conflict of interest by clinical decision-makers.
- Establishes procedures for handling emergency and non-emergency admissions.
- Allows employee assistance programs, student assistance programs and officers of the court the ability to override managed care decisions subject to the grievance procedure.
- Establishes a grievance procedure.
- Sets standards for recruitment practices.
- Sets rules for disenrollment and establishes performance standards.
- Bars discrimination against individuals referred to treatment as a result of a contact with the legal or criminal justice system.
- Establishes reporting requirements.
- Requires consumer materials to be reviewed for simplicity and clarity of language.

Model Managed Care Consumer Protection Act

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Managed Care Consumer Protection Act."

Section 2. Legislative Findings.

(a) The Alcohol, Drug Abuse and Mental Health Administration has estimated the annual cost of alcohol and other drug problems to business in America to be almost $100 billion.[1] Such estimates typically include calculations of factors such as increased medical claims, medical disability costs, decreased productivity, injuries, theft and absenteeism.

(b) Alcohol and other drug addicted individuals covered by health insurance use medical benefits at rates as high as ten times greater than the remaining population.[2] The babies whose future lives are compromised by being born exposed to alcohol and other drugs will also use more medical benefits in their lifetimes than their unimpaired counterparts.[3] Delays or denials in providing treatment leads to higher health insurance costs for all health insurance consumers.

(c) The cost of prompt addiction treatment in reduced benefit utilization alone can be recovered within one to three years, based on studies of health care utilization pre- and post-addiction treatment.[4] Those cost benefits are further enhanced by increased productivity, reduced accidents, reduced crime, reduced absenteeism, and healthier parenting.

(d) One in ten Americans who use alcohol and other drugs will become an alcohol or drug abuser or will become addicted.[5] One out of four families in American are impacted by alcohol or other drug abuse.[6]

(e) Alcohol and other drug treatment is a cost effective means of achieving significant social and fiscal goals including: health care cost containment, restoration of health, restoration and healing of families, prevention of child abuse and fetal alcohol/drug syndrome, reduction in deaths on the highways, workplace savings, reduction in illegal drug trafficking, theft, and other crimes, with their attendant criminal justice system and prison costs, and removal of a major obstacle to successful re-employment and tax-paying self-sufficiency.

(f) In spite of the widespread prevalence of this disease, addiction treatment policies are utilized by one percent of policyholders, as a result of the denial and family embarrassment that is part of the disease of alcohol and other drug dependency.

(g) Any delays or obstacles to obtaining alcohol and other drug treatment can cause people in need of care or seeking care for a loved one to suffer serious, adverse consequences or to draw on public health funding sources.

[1] Small Business Administration, U.S. Department of Labor, and Office of National Drug Control Policy, WORKING PARTNERS: CONFRONTING SUBSTANCE ABUSE IN SMALL BUSINESS, National Conference Proceedings Report 6 (July 13-14, 1992).

[2] Blue Cross of Greater Philadelphia, 1986 COMMUNITY DATA REPORT (July 1986); Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4*, in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993). For additional information on the use of health care benefits by people with untreated alcohol and other drug problems, see also the Policy Statement for the Health Care Professionals Training Act.

[3] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at *Addictions Treatment with Pregnant Women, Chapter 7.*

[4] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2.

[5] U.S. Department of Health and Human Services, ALCOHOL AND HEALTH, Seventh Special Report to the U.S. Congress 7 (January 1990).

[6] Fitzgerald, K.W., ALCOHOLISM, THE GENETIC INHERITANCE 104, 213 (1988); NCADD, FACT SHEET: ALCOHOLISM AND ALCOHOL-RELATED PROBLEMS (12 West 21 Street, New York, NY)..

(h) Sound and reasonable consumer protection legislation will ensure that such delays and obstacles will not occur.

(i) The streamlining of managed care will assure timely access to skilled assessment and treatment. Such access assures managed care practices that are medically, socially and fiscally sound. This streamlining advances the goals of cutting health care costs, reducing fetal alcohol and other drug syndrome, reducing accidents on the highways and in the workplace and reducing demand for drugs, all of which should promote the general welfare of the people of this state.

COMMENT

This section identifies the high cost of untreated alcohol and other drug abuse and addiction to the health care and criminal justice systems and to the business community. Although the prevalence of the problem is approximately 1 in 10 in the population who use drugs or alcohol, denial is widespread and alcohol and other drug abuse treatment benefits are chronically underutilized.[7] To avoid relapse and continued health care expenditures, managed care firms dealing with people with alcohol and other drug problems must be prepared to respond with skill, clarity and timeliness. Any delays in assessment and treatment will contribute to the economic losses cited here.[8]

Skilled identification, intervention and referral while the individual is employed and has insurance coverage will save money in health care and will reduce the likelihood of deterioration to the point of dependency on the welfare system. Once this deterioration has occurred however, the need for longer term, more intensive treatment is increased and the cost of any such treatment will be shifted to Medicaid. (See the [Model Medicaid Addiction Costs Reduction Act]). Because of this downward spiral of addiction, delays and missteps must be avoided if cost reductions in health care are to be realized. Addressing addiction early and thoroughly is key to conserving both insurance and Medicaid monies.

Section 3. Purpose.

Health maintenance organizations and managed care firms doing business in this state shall fully satisfy the requirements of the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment]. It is therefore the purpose of this [Act] that health maintenance organizations and managed care firms doing business in this state shall make benefit coverage decisions in an open, professionally sound, and ethical manner and shall satisfy all requirements of this [Act].

COMMENT

The purpose of the [Act] is to establish standards and rules for the professional operation of health maintenance organizations and managed care firms in regard to the provision of alcohol and other drug treatment services. Although insurers, health maintenance organizations and alcohol and other drug treatment programs are subject to state and federal regulations and other mechanisms providing for accountability, very few states regulate managed care firms handling alcohol and other drug assessments.

Managed care firms that have already established rules on credentialing of staff, diagnostic criteria and fair and timely grievance procedures will encounter no difficulty complying with the provisions of the [Managed Care Consumer Protection Act.]

Section 4. Establishment and Disclosure of Criteria for Treatment.

(a) Every health maintenance organization and managed care firm doing business in the state shall disclose the specific criteria used by that health maintenance organization, any primary care physician and the utilization, review, and appeal personnel to determine the type, level, and course of treatment that will be available for any member suffering from alcohol and other drug abuse or chemical dependency. Criteria shall be filed with and maintained by the [state agency that regulates health maintenance organizations]. Health maintenance organizations that subcontract any alco-

[7] National Association of Addiction Treatment Providers (NAATP), TREATMENT IS THE ANSWER - THE COST EFFECTIVENESS OF ALCOHOLISM AND DRUG DEPENDENCY TREATMENT, White Paper (March 1991).

[8] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993).

hol and other drug abuse or chemical dependency services shall file criteria with the state [agency that regulates health maintenance organizations] for each of their subcontractors. Filing of the criteria with the [agency that regulates health maintenance organizations] shall occur within 60 days of the effective date of this [Act] and within 60 days of issuance or renewal of any contract thereafter. The existence and name of the criteria shall be disclosed to members in each health maintenance organization's member contract, and the criteria shall be provided immediately and at no cost to the member by the health maintenance organization upon request.

(b) Health maintenance organizations, their subcontractors or personnel involved in patient interviewing or assessment and utilization and review shall utilize criteria established by the American Society of Addiction Medicine (ASAM) or criteria established by the Cleveland Clinic (Cleveland Criteria). In addition, with the approval of the [single state authority on alcohol and other drugs], nationally recognized alcohol and other drug diagnostic criteria or alternative alcohol and other drug diagnostic criteria may be used. Health maintenance organizations may utilize the criteria beginning 60 days after submission, pending approval or disapproval by the [single state authority on alcohol and other drugs]. Disapproval shall be provided in writing by the [single state authority on alcohol and other drugs] based on the adequacy of the criteria to protect the health of subscribers of the health maintenance organization.

(c) Any changes to ASAM or Cleveland Criteria, by their respective organizations, will not require review by the [single state authority on alcohol and other drugs]. Any changes to all other criteria shall be submitted to the [single state authority on alcohol and other drugs] for approval or disapproval.

(d) In addition to the assessment criteria established in subsection (b), certain complicating factors affecting the determination of type, level of care and course of treatment shall also be considered and addressed within the limitations of the health maintenance organization in developing alternative criteria. These factors shall include, but not be limited to:

(1) Job safety and job security;

(2) Public safety;

(3) Alcohol and other drug use by the immediate family;

(4) Alcohol and other drug use by the extended family;

(5) Alcohol and other drug use within the environment of the member;

(6) Length and severity of addiction;

(7) Age of onset;

(8) Drug or combination of drugs and alcohol;

(9) Employer standards for alcohol and other drug use relative to employees;

(10) Pressures for the creation of drug-free workplaces;

(11) Geographic availability of treatment programs; and

(12) Supportiveness of living and work environment and other complicating factors.

COMMENT

This section assures that health maintenance organizations and managed care firms doing business in the state use assessment criteria appropriate to alcohol and other drug abuse and addiction. Two commonly known assessment criteria are specified for use. In addition, the section provides procedures for the approval of alternative criteria. Minimum factors to be included in any such alternative assessment criteria are also delineated to guide in criteria development. Alcohol and other drug assessment criteria selected or developed by health maintenance organizations or managed care firms must be filed with the state and disclosed to subscribers.

Use of proper alcohol and other drug diagnostic criteria will enhance early identification and aid in treatment placement appropriate to the needs of the individual. Failure to diagnose or failure to appropriately treat people with alcohol and other drug problems often costs more than providing appropriate treatment in the first place. Use of proper diagnostic and placement criteria are thus critical in reducing the health care spending of untreated alcoholic and other addicts for a wide array of addiction related accidents and illnesses.

Section 5. Minimum Standards for Decisions and Assessments; Minimum Qualifications of Decision-Making Personnel.

(a) All decisions and assessments using the approved

criteria for alcohol and other drug treatment and reviews of individuals, including counseling and intervention, provided to families with alcohol and other drug problems shall be completed in accordance with the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment] by trained personnel with acknowledged certification in the area of alcohol and other drug abuse or chemical dependency.

(b) Acknowledged certification as described in subsection (a) shall mean:

(1) Certification by ASAM in the area of alcohol and other drug treatment;

(2) Certification as a certified addiction counselor (CAC);

(3) Certification under any alcohol and other drug program recognized by ASAM; or

(4) Certification by any three-year training program in a facility licensed by the [single state authority on alcohol and other drugs] or equivalent out-of-state facility.

COMMENT

This section ensures that personnel doing alcohol and other drug abuse and addiction assessments for health maintenance organizations and managed care firms have skills appropriate to the task.

Alcohol and other drug addicted individuals can be difficult to diagnose and refer. Denial is intense and family members and friends often assist in minimizing the problem. Special training and skills are needed both to diagnose and to gain the individual's acceptance and ensure follow-through on treatment recommendations.

Although untreated addicted individuals frequent the health care system for treatment of addiction related illnesses, the primary illness at work usually escapes identification. Presently less than 5% of untreated addicted people already in the health care system have that addiction identified. For this reason, the [Model Health Professionals Training Act] is a critical companion to the [Model Managed Care Consumer Protection Act]. With skilled professionals doing the diagnosis and placement, the primary illness will be identified and treated. At this point, significant health care savings in alcohol and other drug related illnesses and accidents will become available to the health maintenance organizations, managed care firms and insurers. Such health care cost reductions cannot be realized without these highly skilled assessors.

Section 6. Conflict of Interest by Decision-Makers.

No health maintenance organization, managed care firm, employee assistance program or treatment program shall provide or establish contracts or arrangements to complete initial patient interviews, assessments, pre-certification, concurrent review or any subsequent review where direct compensation, or any specific part of compensation to individual or clinical decision makers or managed care firms depends on the determination of type or course of treatment, length of stay or level of care for an individual patient or groups of patients, whether the individual is an individual subscriber or a subscriber in a group plan.

COMMENT

This section bars health maintenance organizations, managed care firms and others from establishing arrangements that tend to create financial incentives to deny or reduce care.

Where these arrangements exist, the managed care firm's duty to ensure proper treatment may be in direct conflict with its financial interests. National and state law is replete with provisions established to avoid such conflicts of interest. These laws appear to reflect a national consensus and policy direction that conflicts of interest in legal, medical and other fields are against the public interest.

Section 7. Denial of State Requirements for Alcohol and Other Drug Treatment.

Health maintenance organizations and managed care subcontractors shall be required to fulfill the conditions of the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment]. Nothing in this [Act] shall prohibit health maintenance organizations or managed-care subcontractors from subcontracting with alcohol and other drug treatment programs licensed by the [single state authority on alcohol and other drugs].

COMMENT

This section assures that both the health maintenance organization and managed care subcontractors fall under the requirements of the existing state insurance

laws establishing coverage for the treatment of alcohol and other drug problems. The section also clarifies that the health maintenance organization and managed care firm may subcontract the assesment process to alcohol and other drug treatment programs licensed by the [single state authority on alcohol and other drugs].

Section 8. Standards and Review Procedures for Treatment Coverage Decisions.

(a) When a patient has begun treatment with a program licensed by the [single state authority on alcohol and other drugs], the health maintenance organization or subcontractor shall not intercede in treatment until the mandated minimum lengths of stay established by the program and the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment] have been satisfied unless otherwise indicated based on the criteria approved under subsections (a) through (d) of Section 4 of this [Act].

(b) Alcohol and other drug, or alcohol and other drug detoxification shall be considered an emergency condition pursuant to the emergency provisions of the [insert state statute regulating health maintenance organizations].

(c) All non-emergency assessments for care must be completed within 48 hours or the patient shall be permitted to access service for care, pending an assessment and subject to retrospective or concurrent review and grievance procedures.

(d) Where there is a dispute between an employee assistance program, a student assistance program or [insert title of official designated by the court to oversee addiction treatment for criminal defendants] and a health maintenance organization or managed care firm regarding the treatment of an alcohol and other drug abusing or addicted person, services shall be provided in accordance with the recommendation of the employee assistance program, student assistance program, or [designated court official]. Under such circumstances, the health maintenance organization or managed care firm shall have the right of appeal in the same manner as provided to a subscriber for whom benefits have been denied.

(e) Nothing in this [Act] interferes with the right of the health maintenance organization to concurrent and retrospective review and to request documentation on the progress of the individual at reasonable intervals, as provided in the licensure standards of the [single state authority on alcohol and other drugs]. Concurrent and retrospective review of care shall be based on the approved criteria for care and shall be subject to the applicable grievance procedure.

COMMENT

Under this section, health maintenance organizations and managed care firms are barred from interceding in treatment unless otherwise indicated by the assessment criteria selected by the health maintenance organization or managed care firm. Health maintenance organizations and managed care firms are not responsible for payment for treatment that is not indicated by the health maintenance organization's own assessment criteria and concurrent and retrospective review.

This section also recognizes the emergency nature of detoxification and calls for it to be treated like other medical emergencies. Since detoxification can be life threatening and requires medical monitoring, admission to treatment is permitted. (See the [Model Addiction Costs Reduction Act], Section 6, Inpatient Detoxification, for a discussion of the process of detoxification). Here again, the health maintenance organization or managed care firm is not responsible for payment unless indicated by the diagnostic and placement criteria of the health maintenance organization or managed care firm. In addition, all admissions are subject to concurrent and retrospective review and appeal through the grievance procedure.

Subsection (c) establishes a 48 hour response time for non-emergency assessments. When pressure from family, friends, employers or police create a crisis, the opportunity must be seized. Fast response here is critical and also consonant with the nature of addiction and denial. In addition, rapid response focuses on the larger goals of society: health care cost reduction, crime reduction, and preservation of families.

Subsection (d) allows disinterested parties serving managed care functions for business, for schools and for the criminal justice system to recommend and place the alcohol and other drug abuser in treatment. This subsection streamlines present practice where the employee assistance program for a business does an intervention and assessment and then may have to refer the individual to a managed care firm to do an additional assessment before treatment can begin. The streamlining eliminates the double handle and potential for delays, relapse and job loss while awaiting re-evaluation.

When the health maintenance organization or managed care firm disagrees with the assessment of the employee assistance program, student assistance program, or official designated by the court, the managed care firm may appeal through the grievance procedure.

Section 9. Notice of and Statement of Reasons for Denial of Treatment Coverage.

Any time a health maintenance organization or managed care subcontractor denies access for specific covered treatment or treatment modality or denies continuation of existing treatment, the denial shall be provided in writing to the patient, the referral source and the alcohol and other drug facility providing treatment and shall set forth the specific reasons for denial and the name of the individual making that decision.

COMMENT

This section requires the health maintenance organization or managed care firm to notify the patient, the referral source and the treatment program if payment for treatment is to be denied. In addition, denials are to be provided in writing and will include the reason for denial and the name of the decision-maker.

Denials in writing will clarify miscommunications about treatment between managed care subscribers, treatment programs and referral sources such as the employer and will ensure that all parties involved are aware of the denial and the need to begin discharge planning, initiate the appeal process or seek alternative funding.

On occasion, the denial of treatment by the managed care firm reinforces the denial of the alcohol and other drug problem by the subscriber and leads the subscriber to leave or delay treatment. These actions have both health care and potential public safety ramifications. With both the referral source and treatment program alerted to the denial of treatment, steps can be taken to counteract this problem.

Section 10. Grievance Procedures for Complaints.

(a) The state [agency that regulates health maintenance organizations] shall establish a grievance procedure to handle complaints and grievances regarding the provision of alcohol and other drug treatment services. These procedures shall be reviewed and jointly approved by the [single state authority on alcohol and other drugs] and the [state agency that regulates health maintenance organizations] to assure appropriateness for use with individuals and families afflicted with alcohol and other drug abuse and chemical dependency.

(b) Because of the physical and psychological nature of alcohol and other drug abuse with the potential for accidents, impairment, withdrawal and danger to the public safety, complaints and grievances regarding alcohol and other drug treatment shall follow a one-level grievance procedure and shall be resolved in 30 days from submission of the complaint.

(c) At the point of an inquiry requiring corrective action or a complaint regarding alcohol and other drug treatment services, subscribers shall be advised of the one-step grievance procedure.

(d) Health maintenance organizations and managed care firm shall routinely advise subscribers of the grievance procedure and how to initiate the process.

(e) At the point of denial of requested alcohol and other drug treatment, the health maintenance organization or managed care firm shall re-advise the subscriber of the grievance procedure and of how to initiate the process.

(f) There shall be established an Alcohol and Other Drug Grievance Review Committee which shall consist of three persons appointed by the governor. The Committee shall consist of: a member of the American Society of Addiction Medicine, or a certified addiction counselor selected from a list provided by the [state's professional association of health maintenance organizations], a representative of an alcohol and other drug treatment program selected from a list provided by the [insert name of state's association of licensed alcohol and other drug programs], and a past consumer of addiction treatment service selected from a list provided by the [single state authority on alcohol and other drugs]). The governor may return any list to the submitting organization for inclusion of additional names.

(g) The subscriber may not be excluded from the grievance review. The subscriber may be represented or assisted by counsel, a representative from an employee assistance program, student assistance program, alcohol and other drug treatment program, physician, family member or other persons designated by the subscriber. The subscriber or person designated by the subscriber shall be afforded the opportunity to present the case at any grievance review.

(h) The state [agency that regulates health maintenance organizations] shall compile and maintain records on inquiries requiring corrective action, complaints and grievances regarding alcohol and other drug treatment services.

COMMENT

This section calls on the state to establish a grievance procedure that is timely, involves personnel skilled in dealing with alcohol and other drug abuse problems and is independent of the health maintenance organization, the managed care firm and the alcohol and other drug treatment provider. In addition, the state will compile records on grievances regarding provision of alcohol and other drug treatment services.

This process offers complaint and grievance procedures common in other processes for products, health care and employee grievances. These procedures typically include: representation by all parties to the dispute including the consumer, experts on the problem, a disinterested third party and the public.

These components offer protection for the health maintenance organization and managed care firm as well as for the consumer. The process will ensure that timely and appropriate treatment decisions are made and may eliminate unnecessary litigation.

Section 11. Disenrollment.

(a) Termination of coverage may occur only after full transfer to the next health insuring organization has occurred or after alcohol and other drug treatment has been completed.

(b) During the course of alcohol and other drug treatment, if a subscriber enters an alcohol and other drug inpatient facility, for the purposes of health insurance coverage, the subscriber's residence shall be construed to be his or her residence prior to beginning the course of treatment.

COMMENT

In subsection (a), subscriber coverage for alcohol and other drug treatment may not be terminated once authorized treatment has begun. Patients being transferred from one health maintenance organization or managed care firm to another can encounter lengthy disenrollment procedures with neither organization accepting responsibility for care.

Subsection (b) clarifies that when referral for treatment places the patient in residence outside the geographic area of the health maintenance organization or managed care firm, the individual remains, the responsibility of the referring managed care firm.

Section 12. Non-Discrimination in Treatment Coverage and Provision of Treatment.

No subscriber of a health maintenance organization shall be deprived of alcohol and other drug treament or coverage due to identification of an alcohol and other drug problem that occurs as a result of contact with the legal or criminal justice system.

COMMENT

Few people with alcohol and other drug problems reach a decision to seek help on their won without some kind of intervention. Typically, an accumulation of outside pressures drive that decision. For many, the process of recovery begins with an intervention by an employee assistance program, a student assistance program, a family member or the criminal justice system. The type of intervention employed should not be used as grounds to deny treatment but should instead be used as an opportunity to assist the individual, to reduce health care costs, cut crime and meet other goals consistent with the needs of society.

Section 13. Recruitment Standards.

The [agency that regulates health maintenance organizations] shall establish standards governing the subscriber recruitment practices of health maintenance organizations and methods for evaluating those practices including but not limited to consumer surveys and complaints. Health maintenance organizations shall submit recruitment plans to the [agency that regulates health maintenance organizations] for review and approval.

COMMENT

This section calls on the state agency with responsibility for regulating health maintenance organizations and managed care firms to establish standards to govern recruitment practices and a method to evaluate those practices.

This section will have no impact on managed care firms that have developed sound policies defining responsible recruitment practices.

Section 14. Performance Standards.

(a) As part of registration with the [agency that regulates health maintenance organizations], the health maintenance organization shall submit a plan, which shall include but not be limited to:

(1) An estimate of prevalence of chemical dependency in the subscriber pool;

(2) An estimate of the need for each type of alcohol and other drug treatment service and lengths of stay in each year;

(3) A follow-up plan to ensure continuing care;

(4) An outreach plan setting goals to increase identification and treatment of subscribers with alcohol and other drug problems, methods of access to assessment and treatment displaying timeliness and appropriateness for handling alcohol and other drug affected individuals;

(5) A proposed program network demonstrating the full continuum of care, geographic availability, cultural sensitivity and planning for special needs populations; and

(6) A method to provide measures of performance within each of these categories.

(b) Plans will be reviewed and approved by the [state agency that regulates health maintenance organizations].

(c) Each health maintenance organization and managed care firm doing business in this state shall include in its annual report an assessment of its success in meeting the goals established in its plan.

COMMENT

Here health maintenance organizations are required to register with the state and submit an annual plan and a method to measure performance against that plan. The performance standards delineated here assure that health maintenance organizations and managed care firms consider measures of success in addition to reductions in spending and units of service provided.

The performance standards described are similar to those employed by other managed care entities like employee assistance programs, student assistance programs and others. Responsible managed care firms have already taken steps to measure performance in ways similar to those being proposed.

Section 15. Reporting Requirements.

(a) As part of its annual reporting requirements to the [state agency that regulates health maintenance organizations] each health maintenance organization shall report its ownership status, whether a parent organization or a subsidiary organization, and if a subsidiary organization, then its parent organization; each health maintenance organization shall fully disclose its financial arrangements and considerations between it and any managed care organization performing work for that health maintenance organization; and each health maintenance organization shall include, for itself and its subcontractors, the following information: the total number of members, the numbers receiving alcohol and other drug treatment benefits, the alcohol and other drug treatment benefits provided by type of service, the level of care, the length of stay within each type of service, the names and addresses of all subcontracting organizations handling this benefit and the names of all alcohol and other drug treatment facilities utilized within the reporting year. In addition, the [state agency that regulates health maintenance organizations] shall submit copies of all plans and reports relating to alcohol and other drug abusers to the [single state authority on alcohol and other drugs] for review and comment. The [state agency that regulates health maintenance organizations] shall review these annual reports for general compliance and to determine that the health maintenance organization and managed care firms are providing treatment to its members and are providing the full continuum of services as required under the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment].

(b) The [state agency that regulates health maintenance organizations]shall submit these reports with a summary to the legislature at the end of two years on the extent to which health maintenance organizations are providing treatment for alcohol and other drug abuse to their members as required in the [Model Addiction Costs Reduction Act] [or existing state insurance law mandating minimum levels of coverage for alcohol and other drug treatment].

COMMENT

This section sets up annual reporting requirements by health maintenance organizations to the state that include: disclosure of ownership status, disclosure of financial arrangements with managed care firms, num-

bers of subscribers using each of the alcohol and other drug abuse treatment benefits and modalities and length of stay required by the state and the names of all facilities and programs providing treatment services in the network. This reporting will simplify the task of monitoring for compliance with state laws requiring health maintenance organizations to provide coverage for alcohol and other drug treatment. Because of the importance of alcohol and other drug treatment in reducing health care costs, workplace problems, family stress and crime, the section calls for an additional report to the legislature.

This section provides reporting requirements and systems of accountability by managed care firms similar to those required of insurers, health maintenance organizations and alcohol and other drug treatment programs.

Section 16. Plain Language Requirement; Promulgation of Rules and Regulations Generally.

The [state agency that regulates health maintenance organizations] shall promulgate rules and regulations to implement this [Act]. The [state agency that regulates health maintenance organizations] shall specifically require health maintenance organizations subject to this [Act] to submit for departmental review and approval as to simplicity and clarity of language all subscriber forms, benefit handbooks or other material setting forth rights and duties. The [state agency that regulates health maintenance organizations] shall establish filing fees for health maintenance organizations and subcontractors required under this [Act] at a level adequate to support all costs of implementing this [Act].

COMMENT

This section sets up review of subscriber materials to assure ease of comprehension of benefits, rights and grievance procedures. Presently, some of the material provided to subscribers is difficult to read and comprehend - particularly at a moment of crisis or illness.

Section 17. Liberal Construction.

The provisions of this [Act] shall be liberally construed to effectuate the purposes, objectives and policies set forth in Section 2 and 3 of this [Act].

Section 18. Severability.

If any provision of this [Act] or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or application of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 19. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date].

Appendix D

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