

THIS TREATMENT CENTER IS CLOSED DUE TO POPULAR DEMAND

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by

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Roger M. is feeling pretty tipsy this morning, so he's letting his fingers do the walking. In a moment of clarity he's seen his life for the unmanageable mess it is and is searching the yellow pages for help. But after calling around, Roger's desperate. There's not a place in town that will give him a bed. Sure, there are a couple of reputable hospitals within a few miles of his home with chemical dependency (CD) programs and empty beds, but Roger's not rich enough to pay cash for treatment, not poor enough for Medicare, and he just found out his insurance policy doesn't cover drug

abuse. Roger feels he'll just have to tough it out on his own. Or go on drinking. Or die.

When you talk to alcoholic/addicts like Roger you realize that even for comparatively solid citizens who need help with substance abuse, tough times are here. When you talk to health professionals, you realize it's more than tough times. It's a crisis.

Private alcohol and drug abuse centers--the ones that haven't already closed up shop--are running scared. They've taken a heady fall from the good old days when insurance payments kept their centers 90 percent full and their bottom lines booming. Ambitions are a lot less grand, now, and no one's talking about raking in money by the bucket. The key word of the nineties is SURVIVAL.

If you're a student of irony, here's your doctoral thesis: at a time when everyone agrees that drug abuse is one of America's most critical problems, why should treatment centers be worried about surviving? And at a time when 80 percent of doctors and lay public agree that alcoholism is a disease, why are insurance companies getting tight-fisted about treating it?¹

To get to the answers you have to wade through a lot of claims and counter claims, because the insurance and treatment industries may be standing cheek to jowl, but they're hardly seeing eye to eye.

Treatment providers say that what we're witnessing in this funding crunch is a "regression to an 'addiction-as-crime' mind-set," as former First Lady Betty Ford put it. As the middle class cleans up its act, addiction becomes a criminal act, not a medical problem, so there's a growing legitimacy to de-emphasize--and refuse--treatment. In

other words, it's okay for insurance companies to Just Say No.

Insurance companies say that the real issue is just economic reality: inpatient CD treatment is too expensive and eats up too much of their subscribers's funds. They claim that it's the over-utilization of inpatient care by for-profit institutions that has triggered their drive to keep costs down. Insurance spokespeople insist that they're not out to deny anyone necessary inpatient care; they just think care can be given more cheaply some other way.

If you're looking for a clear villain in all of this, forget it. No matter which camp you're in, not only do you have to admit that the other side has its points, you may even find yourself rooting for them. Treatment provider Dr. Michael Stone, Medical Director of Cornerstone Recovery Center in Tustin, California, feels that insurance companies "have woken up and found that not all addicts need to be in an inpatient facility. They don't want needless costs."

Needless costs? Is that what's been going on? No doubt some hospitals, hungry for business, have overutilized insurance claims by stretching out treatment for people who didn't need it or could have used less of it. (One managed care director professed astonishment at how so many addicts achieve recovery on the very day their insurance coverage runs out.)

But it's important to recognize certain social dynamics that may give the appearance of widespread overutilization. First, drugs like crack and ice are far more potent and addictive than yesterday's favorites. They wreck more havoc to a person's brain, emotions and social systems. So addicts are getting into treatment with more

complicated needs than ever before. Then there's the whole issue of what kind of person becomes an addict. Sure, it may be a disease, but who catches it? In other words, are there psychological problems that go along with addiction? The latest evidence is that a majority of alcoholic/addicts suffer from an underlying depression and a big minority have personality disorders that require some psychiatric intervention.² So while there's little doubt that some addicts don't need inpatient care, for those who do-- for people like Roger M.--and for those of us who are committed to a War on Drugs, the revolution in CD reimbursement looks a lot like a War on Drug Addicts.

EXPENSIVE, BUT WORTH IT. With a \$4 billion CD bill in 1988, sobriety sure doesn't come cheap. But if drug and alcohol abuse is America's number one problem, it is grossly under-represented as a percentage of insurance costs. The National Association of Addiction Treatment Providers (NAATP) estimates that, although between 6 percent to 23 percent of the employed population has a treatable substance abuse problem, less than 1/3 of 1 percent are receiving treatment.³ In a recent audit of 3 million claims, substance abuse accounted for less than 4 percent of insurance payments.⁴

And even if CD treatment is costing a bundle, proponents of easy-access care say that the sum doesn't begin to approach what untreated alcoholism alone costs society. According to a report by the National Institute on Alcohol Abuse and Alcoholism, the costs of illness, lost productivity and early death due to alcohol added up to more than \$85 billion in 1985.⁵ In California, the societal costs of alcohol and drug

problems totals more than \$15 billion. Less than 8 percent of that is for treatment costs.⁶

Is there any logic to thinking that boosting the funding for treatment would decrease overall costs? General Motors--which claims that substance abuse sets the company back \$1.5 billion a year--found that providing treatment, no matter how expensive it seems, saves 3 times what it costs.⁷

Seen another way, while treating Roger M. for his alcoholism in a residential program could cost an average of \$400 a day, the cost of treating his cirrhotic liver down the line will cost more than \$1200 a day.⁸ As one program director put it, denying treatment isn't a cure; it's just a delay.

And treating Roger M. now might still be saving bucks a generation down the road. Children of alcoholics and substance abusers are four times more likely to seek inpatient hospitalization for chemical dependency--and spend about 60 percent more time there--than children of non-abusers, according to a study of more than one-and-a-half million insurance claims in Pennsylvania.

It all adds up to billions potentially saved. But with business managers trained to focus on this month's bottom line, there's little hope that a more enlightened long-term view of alcoholism treatment will be guiding the decisions of major indemnity companies anytime soon. The name of the game is cutting disbursements.

REDUCING COSTS. There are four ways employers and insurance companies seek to reduce their costs for CD treatment. First, they simply cut down on the available

benefits. It's not uncommon these days for a policy to allow a \$5,000 or even \$1000 lifetime benefit for CD. According to one benefits consulting firm, nearly 90 percent of employers impose limitations on substance abuse benefits.⁹ And limitations often translate into a shorter stay. Although some people claim a shorter stay can accomplish everything a person needs, research indicates that length of stay is directly related to continued abstinence. According to figures compiled by MEDSTAT Systems, nearly half the patients who stay for a week or less at an inpatient/residential treatment program come back into treatment within a year. Less than a third of the patients who stayed 3 to 4 weeks returned within a year.¹⁰ Tragically, however, the length of stay for addicts and alcoholics in psychiatric hospitals declined over 15 percent in the last 2 years, from nearly 27 days to 23 days.¹¹

A second way that insurance companies reduce their CD benefits is by putting up barriers to admission with cumbersome procedures and unrealistic criteria. "Workers are being hoodwinked," says Harold Swift, Chairman of the Board and President of Hazelden Foundation in Minnesota. "They read their benefits brochure and see they have CD coverage, then they find they can't access it because of a case manager's decision." And one hospital intake coordinator put it like this: "It's not unusual to be one hold for an hour or so trying to verify someone's benefits only to be told that you'll have to wait for a call back. Or the patient could be given the runaround until they decide it's not worth the hassle."

Unrealistic criteria may include demands that a would-be inpatient has already failed an outpatient program, or is actively suicidal or homicidal, or has actually used

within the past 24-hours. Clearly, these demands keep lots of addicts on the street. It's good business, but it's lousy medicine. According to NAATP's president Michael Ford, 60 to 70 percent have coverage for alcohol treatment but "it doesn't matter how big the door is, if you ain't got the key you don't get in." In the words of another intake specialist, "Red tape shouldn't be an acceptable mode of treatment." And even if the addict does get in, it's not uncommon for the treatment provider to be told by a utilization reviewer, "Take the patient if you like, but don't construe this permission to mean that we've agreed to pay the bill."

Third, employers contract with counseling firms to supply their workers with counseling sessions prior to considering any other care. A cocaine user, say, will be sent to a counselor for a couple of sessions before treatment is even considered. Critics of this procedure say that individual counseling may work for an emotional problem, but for substance abuse the success rate is negligible. A recent study in the American Journal of Psychiatry of 168 cocaine addicts randomly assigned to weekly sessions of family, group or individual psychotherapy found that only 20 percent were abstinent 6-12 months later, and even these subjects were probably sample of "spontaneous remission."¹² An even worse case scenario involves patients being told they simply don't have a CD problem at all. According to Hazelden's Swift, "Chemical dependency is easy to defer. Sometimes you don't see harmful consequences for one or two years. And telling someone they don't have a problem feeds into the addicts denial. They want to hear it. They'll just say, 'Thank you.'"

And fourth, insurers are increasingly putting patients on a tight leash, and

yanking them out of treatment whenever they like. As Betty Ford recently testified before the Subcommittee on Health and Long-Term Care, "Once a patient gets into...treatment, utilization review organizations...want the patient discharged at the earliest possible moment. This discharge is demanded with no regard for informed, clinical judgement to the contrary."¹³

WHAT GOES AROUND. For some observers, the cut in CD treatment funds is a karmic act of divine proportions. For the past decade or so insurance companies were billed exorbitant amounts of money for care that was sometimes overprescribed. Patients who could have done well in an outpatient setting were corralled into a waiting bed--at \$800 a day. Some hospital chains advertised shamelessly for CD patients, and it became something of a bromide among intake coordinators that if someone called for information, it meant they needed help. Billing practices were invented to get the last drop of coverage from a patient's claim, such as billing separately for various group activities rather than including it in a comprehensive rate.

But if it's true, as insurance companies claim, that it was overutilization by CD programs that killed the golden goose, are insurance companies in turn cooking their own goose? Insurance companies have increasingly turned to managed care professionals to act as gatekeepers, and the administrators who run these operations now make up one of the fastest growing--and with expected revenues of \$7 billion, one of the most profitable--segments of health care. Estimates are that within 30 years, administration will account for half the nation's health care budget.¹⁴ Medical care has

become so overburdened by managed care and utilization review that the Journal of the American Medical Association recently wondered whether the army of cost-containment experts cost more than they contain.¹⁵

Some, like Dr. Stone feel that managed care plays a useful role in monitoring the ethics of treatment providers who, he says, are under pressure to keep the census high. But there's little doubt that managed care professionals are under a similar pressure, to keep census low. And who who's monitoring their ethics? One former utilization reviewer, who wished to remain anonymous, put it this way, "When I first began reviewing care and costs, the emphasis was on making sure patients got what they needed at a reasonable price. But then things changed and I was under increasing pressure to just save money any way I could." And as Paul Lubben, past president of the National Association of Alcoholism and Drug Abuse Counselors has put it, "At one time, there was money to be made by providing treatment. Today the real money is to be made in setting up systems to deny treatment."¹⁶

Furthermore, doctors and counselors are concerned that, with a cadre of case managers deciding who gets treatment, how long they can stay, and whether or not the bill will even be paid, their own time will increasingly be spent in satisfying the needs of the insurance companies and their middle men, rather than the addicts'.

And if insurance companies cite treatment centers for needlessly inflating CD treatment bills, treatment professionals point their fingers at the insurance companies' legendary inefficiency. Blue Cross/Blue Shield of Massachusetts, for instance, employs more than 6,500 hundred workers to cover 2.7 million subscribers. Compare that to the

entire country of Canada, where 6,5000 workers cover 25 million subscribers.¹⁷ Given the enormous expense of running inefficient insurance companies, and the staying power of an entrenched bureaucracy, no wonder these companies claim to have no choice but to save money on patient care.

INTO THE FUTURE. Although the future may seem bleak for those who are trying to get inpatient care, treatment centers and concerned professionals aren't giving in without a fight. In Georgia, one legislature has introduced a bill that would mandate addiction coverage in any new insurance policy in that state.¹⁸ In New York, more than a dozen CD treatment providers have banded together to effect changes in treatment law and to force insurance companies to either provide treatment for the disease or to reveal their reasons for refusing treatment. Some national organizations, like the American Society of Addiction Medicine, composed of more than 3,500 physicians specializing in chemical dependency, are bringing all their influence to the struggle for reimbursement.

And in response to the charge that admission criteria for inpatient care have been somewhat vague, The National Association of Addiction Treatment Providers, a national group representing more than 600 private substance abuse facilities, has proposed a set of standards that will keep the guesswork out of who needs what kind of treatment. If these are accepted, insurance companies and treatment providers may have a bridge across which they can reach each other. Another bridge may be built when case reviewers themselves come under review. At present, some reviewers are

making decisions for which they lack even the most rudimentary training. According to Hazelden's Swift, "In most parts of the country, anybody with an LCSW or a PhD can open up a managed care organization, but that will change. In Minnesota we passed a law that says a CD reviewer has to be trained in CD issues. Even if you're an MD case manager, you have to show proof of training."

In the final analysis, the changes being wrought in CD treatment look different depending on where you're standing. If you think about CD care as a business that needs to be run efficiently even if it does cost some lives, then what's happening amounts to a long-needed overhaul that will help all consumers in the end. And optimists like Cornerstone's Dr. Stone feel that the insurance crunch is going to force hospitals to do things better and faster and to give patients the level of care that really suits their needs.

But if you're someone who thinks treatment for anyone who wants it should be one of nation's top priorities, then all the changes will seem to amount to, in Betty Ford's eloquent phrase, a "forced dismantling" of our treatment system "to a point of no return."

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SIDEBAR MATERIAL:

HARD TIMES TALLY. Half the beds in the nation's more than 2,000 treatment centers are currently empty.¹⁹ So, many hospitals are doing what the St. Luke Medical Center in Pasadena has done: restructured their chemical dependency treatment unit into outpatient and day care treatment, which is typically half the cost of inpatient care. But offering cheaper outpatient care is no guarantee that insurance companies will come across. Even the prestigious Betty Ford Center is, in the words of its founder, "struggling to keep our center open."

Other large providers of CD care have taken more drastic measures. Parkside Medical Services plans to shut down half its freestanding CD units. Charter Hospital posted a yearly loss of \$70 million and it seems certain that at least some of their treatment centers will be axed. Addiction Recovery Group in Maryland has placed its 500-bed treatment center up for sale. Milwaukee-based DePaul is reducing staff and services. And CompCare, described by some as "the flagship of U.S. addiction treatment," has all but ceased to exist as an inpatient provider on the West Coast. Harold Swift of Hazelden Foundation reports that for the first time in 20 years, Hazelden has empty beds. In order to adopt to the new situation, Hazelden is offering "financial incentives" for its employees to resign or change careers. According to Michael Ford, president of the National Association of Addiction Treatment Providers, 200 private sector programs have closed in the last year and a half and about 150 are up for sale.

SIDEBAR MATERIAL:

WHO PROVIDES INPATIENT CARE?

There are four basic modes of inpatient treatment: programs based in a psychiatric hospitals, like Community Psychiatric Centers; non-acute care hospital programs, such as the Betty Ford Center; free-standing programs that have no hospital affiliation, such as Father Martins Ashley in Maryland, or the world famous Hazelden program in Minneapolis; and residential programs in a home setting. Each of these models can offer good care. The trick is finding the right mix of patient with placement.

Psychiatric Hospitals: With daily costs of up to \$800, this is by far the most expensive way of getting CD treatment. What distinguishes these programs is round the clock nursing care and the supervision of the addicts case by a psychiatrist. While critics contend that psychiatric care--which routinely includes daily session with the doctor at an average cost of about \$150 a session--is overkill, proponents of this mode argue that a substantial proportion of addicts and alcoholics are found to be dual diagnosed, that is, in addition to their drug abuse, they also suffer from an emotional or personality disorder. More than half of admits to some mental hospitals are substance abusers.²⁰ And while the cost is high, most hospitals offer contract rates to insurance companies that are only a fraction of the posted rates.

Non-acute Care Hospital Programs: These programs offer nursing care and medical supervision, which for many addicts going through detox is essential. Average cost per day is about \$400. Proponents of these programs contend that in the early stages of abstinence, many people have a host of medical problems that need

attending. Critics maintain that the vast majority of addicts are physically okay, and at most may need some common sense nutritional guidance.

Free-standing Programs: These programs stress social, rather than medical, recovery. Counseling staff tends to be composed of other recovering addicts and a high degree of rapport between staff and clients is the norm.

Residential Treatment Centers: These are therapeutic communities suitable for people who do not need any detox. Advantages? The cost is relatively small. Addicts learn lifestyle changes in a "real-world," familiar setting. Counselors are almost always other recovering addicts. Primary disadvantage is the possibility that some patients may really need more intense psychiatric or medical supervision.

SIDEBAR MATERIAL:

WHO NEEDS INPATIENT CARE?

A recent study in the New England Journal of Medicine has added fuel to the inpatient vs outpatient treatment controversy by finding that in a randomly selected group of 227 alcoholics, those receiving inpatient care had a better success rate than those getting outpatient care. Previous studies have found little difference in inpatient-outpatient care outcome, data which insurance companies have used to justify cut-backs for the more expensive inpatient care. But, given the greater need for post-treatment hospitalization for the outpatient group, the real savings are negligible: after 2 years, the outpatient group had spent only 10 percent less.

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