Model Addiction Costs Reduction Act (ACRA)

Table of Contents

Model Addiction Costs Reduction Act Policy Statement

HISTORICAL PERSPECTIVE AND SUMMARY

During the time period from 1973 to 1989, 43 states and the District of Columbia enacted laws requiring health insurance policies to cover treatment of alcohol and drug problems. Eight states have no such coverage.

As a result of these laws, in 26 of the states inclusion of addiction treatment coverage is automatic in health insurance policies. In another 17 states, laws mandate that coverage for drug and alcohol problems be offered to purchasers of insurance.

In 26 of the states, the coverage includes both alcohol and drug problems. In another 17, only alcohol is included.

Reflecting the time of origin, local politics and the evolution of the treatment field, the coverages vary widely. Some provide for the treatment of alcoholism only, some mandate only outpatient, some exclude individual policies and some attempt to cover a continuum of treatment services. In 15 states, Health Maintenance Organizations are excluded from the requirements established for health insurance.[1]

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 months before treatment, the alcoholic's costs are close to 300% higher than costs of comparable nonalcoholics."[2]

(b) High health care utilization by the families of untreated alcoholics and addicts prior to addiction treatment of the addicted individual.

- "Policyholders in alcoholic families used roughly twice the (health care) services of non-alcoholic families."[3]
- One study compared these expenditures in monthly dollar amounts for families of addicted individuals and families without an addicted member. Families with an addicted member used inpatient health services at a cost of $27.00 a month compared to $6.50 a month for families without an addicted member.[4]

(c) High rates of accidents, absenteeism and sick benefit claims by untreated alcoholics and addicts in the workforce prior to addiction treatment.

- "The average alcoholic, it was found, lost 32 days to illness per year, almost one day in ten, prior to intake.[5]
- Another study found prior to addiction treatment, "... sick benefit claims 120% the normal level, days absent 335% of normal, disciplinary actions 235% of normal ... "[6]

On the other hand, after addiction treatment occurs, study after study finds:

(a) Marked reductions in health care use by the now treated addicted individual.

- In one study, "In general, rates of hospitalization for treated alcoholics declined by nearly 50% at three of four sites ..."[7]
- Another study found a 49% reduction in health care claims after addiction treatment.[8]
- In another study, health care expenditures by the now treated addicted person dropped from about $100.00 a month prior to treatment to $13.34.[9]

(b) Marked reductions in health care use by the family members.

- One study found the decline in health care utilization by the family after treatment of the alcoholic or addict was just over 50%.[10]
- Before treatment, health care utilization by the family of an addicted person is two to three times higher than for comparison families. After treatment of the addicted person occurs, health care utilization by their families drops to the same as the control group.[11]

(c) Marked reductions in workplace accidents, absenteeism and sickness claims.

- In one study, after treatment - workplace reprimands declined by 75% after six months and days lost to illness declined by 50% at the 18 month follow-up.[12]
- In another study describing after treatment work and health records, "Days sick or absent from work declined by fifty percent throughout this period..."[13]
- And still another study found after treatment reductions in disciplinary actions of 56%, absenteeism of 55%, days on disability of 53%.[14]

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, 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 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 here 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.

Similar cost benefit and cost offset data is available for criminal justice populations. Studies and research with narcotics and criminal justice populations show similar results. Criminal justice activity is markedly reduced after treatment of the alcohol / drug addiction.

The cost benefits for health care and other data on cost offsets presented here and in "Socioeconomic Evaluations of Addictions Treatment" prepared for the Commission by the Center of Alcohol Studies at Rutgers University, clearly establish alcohol and other drug treatment as a key component vital to any serious state strategy to contain health care costs or to address alcohol and other drug related crime.[15]

The data are clear - treatment of the alcohol and other drug problem is cost beneficial with any cost for addiction treatment more than offset by savings in other health care spending, accidents, welfare and criminal justice costs.

RELATIONSHIP TO NATIONAL HEALTH INSURANCE PROPOSALS

Along the way to passage of drug and alcohol insurance laws, 43 states have developed carefully crafted compromises between many competing interests. As noted, over the last 15 years, these compromises have resulted in coverage for addiction treatment in 43 states.

The federal debate over national health insurance has just begun. In the meantime the laboratory of the states goes onward. The daily devastation of families wrought by addiction will continue unless states quickly implement effective treatment policies.

Fifteen years of delicate political negotiations provide a solid foundation on which to build national health insurance proposals. Individuals developing national health insurance proposals can significantly benefit from the state experience. Accordingly, they will want to draft proposals which complement rather than detract from the compromises found in existing state laws.

MANDATED INSURANCE COVERAGE VERSUS MANDATED OPTION

Of the 43 states with mandated insurance laws, 26 provide coverage for drug and alcohol problems automatically with the policy. Since alcohol and other drug problems are among the top 5 leading disease killers in the United States, exclusion from the basic matrix of health care would seem illogical.

However, another 17 states require insurers to offer the coverage to the purchaser of insurance. Given the level of stigma and denial about alcohol and other drug problems, it is unrealistic to expect individuals or companies to anticipate having the problem personally or in the workforce.

Over the years, there has been some movement on this issue. Some mandated option states have switched to mandated coverage automatic in the policy. There has been no shifting in the other direction.

Key Components

Throughout the process of gathering treatment ideas, the need to update and further refine existing insurance laws was brought repeatedly to our attention.

With these goals in mind, states without insurance coverage for drug and alcohol problems may wish to put these laws in place. States with laws already on the books may wish to ensure that the full continuum of treatment services is available. Some of the treatment services needed to fill out many of the existing insurance laws include: drug treatment, family and co-dependency treatment, intervention services and intensive outpatient.

These coverages, in combination with workplace alcohol/drug education, alcohol/drug policies and employee assistance programs (EAPs) are critical in early intervention with chemical dependence. Intervention while the individual still has a job and a family is humane but also pays dividends in reduced workplace accident claims and high health insurance utilization for other related illnesses and injuries. Without such intervention, families and jobs are lost and additional health care dollars are expended. Many addicted people find themselves trapped on welfare and dependent on limited public funding for treatment. Some get involved in crime. At this point, the treatment needs of the individual are more intense and more extensive. In general, the longer the individual deteriorates, the longer and more intense the treatment will need to be to break the cycle of chemical dependence.

Full Continuum of Treatment

The continuum is usually defined as including at least the following treatment coverages:

Alcohol and Other Drug Intervention

Intervention includes services such as drug and alcohol assessment, diagnosis, family intervention, employee assistance and student assistant services and referral.

Alcohol and Other Drug Detoxification

Detoxification is "The process whereby a drug or alcohol intoxicated or dependent patient is assisted through the period of time necessary to eliminate by metabolic or other means, the presence of the intoxicating substance, while keeping the physiological or psychological risk to the patient at a minimum. This process should also include efforts to motivate and support the patient to seek formal treatment after the detoxification phase."[16]

This service is provided in a hospital or non-hospital residential setting.

Lengths of stay vary depending on the drug or combinations of drugs and alcohol in use, severity of addiction and an array of physical complications.

Many state insurance laws provide 7 to 15 days coverage.

Alcohol and Other Drug Inpatient Rehabilitation

Rehabilitation often follows detoxification or referral from an outpatient program. Many of these intensive programs are based on a therapeutic community model. Everything in the patient's living environment is organized and arranged to assist in the patient's therapy. The programs also

typically involve extensive education on alcohol and drug abuse and addiction, group and individual counseling and work with the family.

This service is provided in a hospital or a non-hospital residential setting.

Depending on the needs of the patient, inpatient rehabilitation can be short or long term. "In general, for employed individuals who are not in a deteriorated condition, the length of stay is about 30 days. Longer stays can be anticipated for young people, for the more deteriorated and for those with more attendant life trauma and complications. These individuals may need a year or more in residential treatment to deal successfully with the addiction. Patients leaving inpatient rehabilitation will generally be expected to continue treatment in an outpatient clinic."[17]

Many state insurance laws provide for 30 to 45 days in short term rehabilitation. Most of these insurance laws do not provide coverage for long term rehabilitation or for halfway houses.

Alcohol and Other Drug Outpatient Treatment and Intensive Outpatient

Addicted individuals access outpatient and intensive outpatient services in several ways: "A number of addicted individuals will first go to inpatient detoxification programs and, upon completion of that treatment, will move on to an outpatient setting...Many people go to outpatient clinics to explore a potential drug and alcohol problem or to discuss the problem of a loved one."[18] Enrollment in outpatient or intensive outpatient treatment often follows these exploratory first steps toward help. "Inpatient facilities also routinely refer program graduates to outpatient treatment as the next step in the continuum of healing."[19]

"Lengths of treatment will vary greatly for this modality and depend on the patient. In general, the outpatient involvement can be expected to last for up to a year. Programs typically involve educational and therapeutic components, group and individual counseling and work with the patient's family."[20] Some programs provide counseling coupled with methadone maintenance.

> "Frequency of appointments is worked out on an individual basis, although a typical pattern may involve one to three hour sessions a week in the beginning of the process. Some programs and states offer intensive outpatient approaches that run two to five hours during the day or after work, several times a week."[21]

Vigorously developed early intervention programs such as family intervention, student assistance programs (SAPs) and EAPs can reach people with addictions earlier in the disease progression and can lessen the need for inpatient treatment services. Sadly, intervention often comes so late in the disease progression that both outpatient and inpatient treatment are necessary.

State insurance laws typically provide coverage of 30 to 60 outpatient sessions but do not provide for the more recently developed intensive outpatient benefit.

Family and Co-Dependency Treatment

These programs can be provided on an outpatient or inpatient basis and are intended to address the needs of children of alcoholics and addicts, adult children of alcoholics and addicts, families and others significantly impacted by the alcohol and other drug abuse or addiction in the family. These programs are key in breaking the multi-generational cycle of addiction.

These services are rarely covered under state insurance laws. Where they are covered, they are usually listed under the general outpatient or inpatient benefits.

Other Treatment

There are other components in the continuum of services not listed here. These services tend to be less utilized by people who are still employed and who have health insurance coverage. These include quarterway houses, halfway houses, therapeutic communities, pharmacotherapeutic interventions, case management, etc. These components are generally not covered under state insurance laws.

SUMMARY

The Model Addiction Costs Reduction Act reflects a full continuum of treatment services for alcohol and other drug abuse and addiction. Many components of the continuum are already in place around the country however, most are missing both intensive outpatient coverage and family treatment.

ENDNOTES

1. All data in this subpart has been taken from: Goldman, Marshall, and Muszynski, P.C., STATE REQUIREMENTS ON PRIVATE HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AND/OR DRUG DEPENDENCY TREATMENT SERVICES (National Association of Addiction Treatment Providers (NAATP), 1989).
2. 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).
3. *Id.* at 19.
4. *Id.* at 26.
5. *Id.* at 13.
6. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at *Addictions Treatment in Workforce Populations, Chapter 5,* at 13.
7. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at 13. 7.
8. *Id.* at 25.
9. *Id.* at 26.
10. *Id.* at 26.
11. *Id.* at 27.
12. *Id.* at 13.
13. *Id.* at 14.
14. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 6.
15. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTION TREATMENT (Center of Alcohol Studies, Rutgers University, 1993).
16. Pennsylvania Office of Drug and Alcohol Programs, PENNSYLVANIA LICENSING STANDARDS FOR DRUG AND ALCOHOL SERVICES, Chapter 157, 157.2 (February 13, 1990).
17. *The War on Drugs,* NATIONAL CLEARINGHOUSE REVIEW, Special Issue (1990).
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.*

Highlights of the Model Addiction Costs Reduction Act

- Requires all group health insurance and health maintenance organizations providing health care coverage in the state to provide coverage of a full continuum of alcohol and other drug abuse and addiction treatment services including:
  1. Detoxification
  2. Inpatient rehabilitation
  3. Outpatient
  4. Intensive outpatient
  5. Family treatment
- Establishes minimum levels of coverage within each modality of treatment.
- Limits provision of service to facilities and programs licensed by the single state authority on alcohol and other drugs.
- Allows deductibles and copayments if applied similarly to other physical illnesses in the policy.
- Disallows deprivation of coverage in the event of identification and referral from the legal or criminal justice system.

Model Addiction Costs Reduction Act

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Addiction Costs Reduction 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 many babies whose future lives are compromised by being born exposed to alcohol and other drugs will also use many times more medical benefits in their lifetimes than their more fortunate counterparts. Failure to provide sufficient insurance coverage for the complete continuum of alcohol and other drug addiction treatment leads to higher health insurance costs for all health insurance consumers.

(c) The cost of 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.[3] 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.[4] One out of four families in American are impacted by alcohol and other drug abuse.[5]

(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) Health insurance that fails to cover a sufficient level of alcohol and other drug treatment to provide a reasonable prospect of recovery is medically and fiscally unsound, and inconsistent with general insurance practices in other areas of coverage.

COMMENT

The high cost of untreated alcohol and other drug abuse and addiction to the nation is reflected disproportionately in the health care system as people repeatedly seek medical treatment for a wide array of addiction related accidents and illnesses. This spending can be markedly reduced by providing a full continuum of alcohol and

[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.

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

[5] 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).

other drug treatment services. Expenditures made on treating the disease directly are generally recouped in savings in health care alone within a one to three year period. For this reason, early intervention and referral of untreated alcoholics and addicts is a sound investment in both workplace safety and in the health of employees. If savings in reductions in workplace accidents and absenteeism and increases in productivity are factored in, dollars spent on treatment are offset even more rapidly.[6]

Where intervention and appropriate treatment is not provided, for many the result is loss of job and a process of deterioration devastating to both the addicted individual and the family. For many, damage to health progresses with accelerating health care utilization and eventual dependency on the welfare system and other public funding streams. Some become involved with crime.

At this point of deterioration, longer term and more intensive treatment will be needed to break the cycle of addiction. The treatment services described in the [Model Medicaid Addiction Costs Reduction Act] reflect precisely this reality. Like other chronic progressive illnesses, failure to intervene early or failure to provide sufficient treatment early in the disease progression leads to more expense than proper treatment of the illness in the first place.

Until such treatment is provided, the alcohol and other drug problem will stand in the way of restoring the individual to re-employment and self-sufficiency.

Section 3. Purpose.

The purpose of this [Act] is to ensure that medical insurance beneficiaries are provided a level of alcohol and other drug treatment benefits sufficient to meet the minimum requirements of care necessary to provide effective alcohol and other drug treatment for health insurance policy subscribers and their families. This will increase the rate of successful treatment and reduce the disproportionately high utilization of medical insurance benefits by untreated alcoholics and other drug addicts.

COMMENT

Over the last 30 years, many states have passed insurance laws requiring some form of coverage for addiction. Treatment provided under these statutes varies greatly. Some include drug and family treatment. Some require treatment only for alcoholism. Others provide only inpatient care and exclude intensive outpatient services. Treatment requirements vary depending on local politics and when in the evolution of drug and alcohol treatment they became law.

The purpose of this statute is to delineate and provide for a full continuum of treatment services for alcohol and drug abuse and addiction. Provision of the full continuum will maximize recovery of alcohol and other drug abusers and maximize cost savings in health care.

Section 4. Definitions.

As used in this [Act]:

(a) "Alcohol and other drug abuse" means any use of alcohol and/or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

(b) "Drugs" means addictive substances, and substances of abuse scheduled in the [state controlled substances act].

(c) "Detoxification" means the process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the [single state authority on alcohol and other drugs] through the period of time to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.

(d) "Hospital" means a facility licensed as a hospital by the [state health department], the [state welfare department], or operated by the state and conducting an alcoholism and other drug addiction treatment program licensed by the [single state authority on alcohol and other drugs].

(e) "Inpatient care" means the provision of medical, nursing, counseling or therapeutic services 24 a day in a hospital or non-hospital facility, according to individualized treatment plans.

[6] Langenbucher, J.W., McCrady B.S., Brick, J., Esterly, R., *supra* note 2, at *Addictions Treatment in Workforce Populations, Chapter 5.*

(f) "Non-hospital facility" means a facility, licensed by the [single state authority on alcohol and other drugs] for the care or treatment of alcohol and other drug abusing and addicted persons, except for transitional living facilities.

(g) "Non-hospital residential care" means the provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol and other drug abuse or dependency in a short-term or long-term residential environment, according to individualized treatment plans.

(h) "Outpatient care" means the provision of medical, nursing, counseling or therapeutic services in a hospital or non-hospital facility on a regular and predetermined schedule, according to individualized treatment plans.

(i) "Partial hospitalization or intensive outpatient care" means the provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility or intensive outpatient program licensed as an alcoholism and other drug addiction treatment program by the [single state authority on alcohol and other drugs], designed for a patient or client who would benefit from more intensive care than is offered in outpatient treatment but who does not require inpatient care.

COMMENT

To ensure quality, accountability and proper use of health care dollars, any treatment service provided under the terms of this statute must be licensed by the [single state authority on alcohol and other drugs].

Section 5. Mandated Policy Coverages and Options.

(a) All group health or sickness or accident insurance policies providing hospital or medical/surgical coverage in this state and all group subscriber contracts or certificates issued by any entity subject to this [Act], [cite statute relating to hospital plan corporations] or [cite statute relating to professional health services plan corporations], [cite state Health Maintenance Organization Act] or [cite state fraternal benefit society code] providing hospital or medical/surgical coverage in this state, shall in addition to other provisions required by this [Act] include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in Sections 6, 7, 8, 9, and 10.

(b) The benefits specified in subsection (a) may be provided through a combination of such policies, contracts or certificates.

(c) The benefits specified in subsection (a) may be provided through prospective payment plans.

(d) The provisions of subsection (a) shall not apply to Medicare or Medicaid supplemental contracts or limited coverage accident and sickness policies, such as, but not limited to, cancer insurance, polio insurance, dental care and similar policies as may be identified as exempt from this section by the insurance commissioner.

(e) No individual insured by a policy, group subscriber contract or certificate described in subsection (a) shall be deprived of alcohol and other drug treatment or coverage due to identification of an alcohol and other drug problem that occurs as a result of contact with the criminal justice or legal system.

COMMENT

As described in subsection (a), the policy coverages outlined in the statute are required for all group health insurance plans including those provided by health maintenance organizations.

In subsection (e), few people with alcohol and other drug problems reach a decision to seek help on their own without some kind of intervention. Typically, an accumulation of outside pressure drives 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 language in subsection (e) will ensure that the type of intervention employed is not used as grounds to deny treatment and that criminal justice interventions are welcomed as an opportunity to assist the individual, to reduce health care costs, to cut crime and to meet other goals consistent with both the needs of managed care and the needs of society.

Section 6. Inpatient Detoxification.

(a) Inpatient detoxification as a covered benefit under this [Act] shall be provided either in a hospital or an inpatient non-hospital facility which has a written referral agreement with a hospital for emergency, medical and psychiatric or psychological support services, and is licensed by the [single state authority on

alcohol and other drugs] as an alcoholism and other drug addiction treatment program.

(b) The following services shall be covered under inpatient detoxification:

(1)Lodging and dietary services;

(2)Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3)Diagnostic X-ray;

(4)Psychiatric, psychological and medical laboratory testing; and

(5)Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered for a minimum of 15 days in any calendar year unless medical complications require additional days.

COMMENT

This section delineates the services that are reimbursable within an inpatient detoxification setting licensed by the [single state authority on alcohol and other drugs].

The process of detoxification can be life threatening and requires medical monitoring. At the point of admission, it is often impossible to discern who will have a problem free withdrawal and who will experience severe medical complications. Often, the individual is unable to remember or provide medical history or information on types and quantities of alcohol and other drugs consumed.

The length of detoxification typically depends on such factors as: the types, quantities and combinations of alcohol and other drugs consumed over a specific period of time, length and severity of addiction, age of onset of addiction and general physical health. Uncomplicated detoxification generally ranges from 1-7 days in duration with detoxification from certain kinds of prescription medications taking 15 days or longer.

The detoxification process is similar to stabilizing a diabetic in crisis. For both illnesses, failure to provide treatment after initial stabilization will result in an additional medical crisis and expenses as the individual is admitted for additional detoxification or other medical problems.

During the course of detoxification, an assessment of the need for ongoing alcohol and other drug treatment is made and preparation for referral to treatment occurs. Assignment to, or length of stay in outpatient or inpatient care will vary with the needs of the individual and is dependent on the degree of chronicity, deterioration of the individual's health, strength of support systems such as the family, the employer and others and many other factors. Sophisticated patient matching to care is critical to this process. This is accomplished by use of alcohol and other drug diagnostic criteria combined with personnel skilled in making these determinations.

An additional factor affecting patient matching to level of treatment and length of care, is the degree of denial by the patient. In fact, denial of the alcohol and other drug problem by both the patient and the family is one of the symptoms of alcohol and other drug problems. Like patient and family denial of other serious illnesses, denial must be addressed vigorously as part of the treatment recommendation and process. Dealing with denial is critical to opening the patient and family up to full participation in the recovery process. In general, the more severe the denial, the more intense the level of treatment will need to be and the longer the length of that treatment.

Other factors influencing treatment recommendations are public safety, high suicide rates of untreated alcohol and other drug abusers and high utilization of health care if the primary illness is left unaddressed.

Given the cost to society of untreated or inadequately treated alcohol and other drug problems, provision of and access to the full continuum of treatment services is essential and in the interest of the national economy. Failure to intervene or undertreatment at this point is likely to result in the alcohol and other drug addicted person returning to the health care system without a job, and now dependent on public funding.

No part of the continuum of treatment services described below can fill the role of the other. Some individuals will need every component of the entire continuum while others may not. However, some generalities can be made. As with other illnesses, where intervention occurs late in the addictive disease process, the individual is more likely to need longer and more intense levels of care. Early interventions result in less intense care over shorter periods of time.

Unfortunately, denial and the lack of understanding of this problem by the individual, the family, the employer and even the physician is such that intervention, if it occurs at all, tends to be late in the progression of the disease.

A companion bill in this package, the [Model Health Professionals Training Act] is intended to address this issue. Since untreated addicted people enter the health care system repeatedly for alcohol and other drug related accidents and illnesses, training of health care professionals to do early intervention and treatment is a key starting point. Such early intervention should assist in reducing health care utilization and could reduce some of the need for more intensive alcohol and other drug treatment.

Section 7. Non-Hospital Residential Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility which is appropriately licensed by the [single state authority on alcohol and other drugs] as a non-hospital residential alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Rehabilitation therapy and counseling;

(4) Family counseling and intervention;

(5) Psychiatric, psychological and medical laboratory tests; and

(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this [Act], for a minimum of thirty (30) days per calendar year for residential care.

COMMENT

This section delineates the services that are reimburseable within a residential rehabilitation setting. Nothing in this section bars provision of the services in an inpatient hospital setting. In fact, many insurers already provide such treatment in hospital settings.

Inpatient residential treatment ranges commonly from 28-32 days, depending on patient need. Many who do well in this form of treatment are still employed or may be unemployed but have been identified early in the disease progression, have some remaining support systems and good health. More deteriorated individuals will generally need more intensive, longer term care.

Throughout the 3-5 week treatment cycle, the individual is immersed in intensive patient education about addiction, in therapy and is exposed to support tools such as Alcoholics Anonymous and Narcotics Anonymous. As with other chronic life threatening illnesses, denial is normal and must be handled as part of the treatment process. Denial is often quite intense in the first weeks of treatment and must be approached with care. For this reason, program staff work to develop strong relationships with the individual and to create an environment where it is safe to move out from behind the walls of denial. As denial diminishes, patient therapy and education intensify. Inappropriately confronted, denial can lead to the development of psychological problems or drive the individual to leave the treatment program prematurely.

Education on addiction and other work with the family and support system occur while the addicted individual is in treatment. At the appropriate time, therapy and education with the individual, family, support system and others is combined as the individual is prepared to re-integrate with his/her family and community.

From the inpatient setting, the individual and family is referred to outpatient and self-help groups such as Alcoholics Anonymous and Narcotics Anonymous to continue the growth process and to maintain and reinforce recovery.

As with other illnesses, the more deteriorated alcohol and other drug abusers and addicts will generally need longer lengths of stay than provided here in short term rehabilitation. Programs specializing in treatment of the more deteriorated patient are prepared to handle an array of complex medical, psychological, interpersonal, vocational and socioeconomic problems. The treatment needs of many of these individuals can be provided under the provisions of the [Model Medicaid Addiction Costs Reduction Act].

Section 8. Outpatient Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an outpatient alcohol and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency, and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 outpatient, full-session visits per calendar year.

Section 9. Intensive Outpatient or Partial Hospitalization Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by [single state authority on alcohol and other drugs] as an intensive outpatient or partial hospitalization alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 intensive outpatient, full-session visits or days of partial hospitalization per calendar year.

COMMENT

Sections 8 and 9 delineate the services reimburseable under outpatient, intensive outpatient or partial hospitalization alcohol and other drug treatment services.

Many addicted individuals enter outpatient or intensive outpatient and in group and individual sessions, learn about addiction and develop the skills to stay sober. In general, these are individuals for whom intervention and referral occurs relatively early in the disease progression.

In addition to the group cited above, other addicted people require detoxification or detoxification and inpatient care. Upon completion of the inpatient programs, they will progress to an outpatient setting for ongoing treatment.

Outpatient or intensive outpatient or combinations of the two are generally recommended for at least a year. Intensive outpatient is recommended for those in need of a more structured treatment experience than can be provided in a traditional outpatient setting but who are not in need of inpatient treatment.

Here too, the more deteriorated alcohol and other drug abusers and addicts will generally need more intense levels of outpatient services over a longer period of time.

Outpatient and intensive outpatient as well as inpatient treatment programs encourage involvement with self-help groups such as Alcoholics Anonymous and Narcotics Anonymous as well.

Section 10. Family Codependency Treatment.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed

physician or licensed psychologist must certify the insured as a family member suffering from codependency as a result of an alcohol and other drug abuse or dependency within the family, and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests;

(5) Prevention services for children; and

(6) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 outpatient, full-session visits per calendar year.

COMMENT

This section delineates the services reimburseable under the family codependency treatment section.

Treatment for the families of addicted people has only become available in the past decade. Until recently, newly recovering individuals returned from outpatient and inpatient treatment to families made dysfunctional by the addiction, anger and blame.

In addition, there is emerging research demonstrating that families of addicted individuals also use health care at rates higher than found in the general population. After treatment of the addicted individual, health care spending by the family members is reduced.[7] **Direct treatment of the overall family in distress may well have additional positive and measurable benefits for the emotional and physical health of all concerned.**

Family treatment increases the likelihood of recovery by the alcohol and other drug abusing individual and addresses the needs of family members and children at risk of developing alcohol and other drug problems.

Section 11. Deductibles, Copayment Plans and Prospective Pay.

(a) Reasonable deductible or copayment plans, or both, after approval by the insurance commissioner, may be applied to benefits paid to or on behalf of patients during the course of alcohol and other drug abuse or dependency treatment. No deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.

(b) Under a prospective payment plan, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy.

COMMENT

This section bars discriminatory practices in regard to chemical dependency and the use of deductibles, copayments and prospective payment plans. It ensures that addictive diseases will be handled on the same basis as other illnesses.

Section 12. Liberal Construction.

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

Section 13. 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 14. Effective Date.

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

[7] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 2, at 42-43, 48-50.

Appendix A

Bibliography

Abel, E.L., and Sokol, R.J., *Incidence of Fetal Alcohol Syndrome and Economic Impact of FAS-Related Anomalies*, 19 DRUG AND ALCOHOL DEPENDENCE 51-70 (1987).

An Effective Approach to Employee Alcoholism, THE PERSONNEL ADMINISTRATOR (July-August 1972).

Beck, F.W., and Sanders, B.K., THE ILLINOIS MEDICARE/MEDICAID ALCOHOLISM SERVICES DEMONSTRATION;MEDICAID COST TRENDS AND UTILIZATION PATTERNS, Managerial Report (Center for Policy Studies and Program Evaluation, Sangamon State University, September 1984).

Barnes, D.M., *Drugs: Running the Numbers*, 240 SCIENCE 1729-1731 (1988).

Blue Cross/Blue Shield Association, SUBSTANCE ABUSE TREATMENT BENEFITS: A GUIDE FOR PLANS (1983).

Blue Cross of Greater Philadelphia, 1986 COMMUNITY DATA REPORT (July 1986).

Brown University Digest of Addiction Theory and Application, Announcement of National Video Teleconference (December 7, 1988).

Butynski, W., ECONOMIC COSTS TO SOCIETY OF ALCOHOL AND DRUG ABUSE AS COMPARED TO ALLOCATIONS FOR ALCOHOL AND DRUG PREVENTION AND TREATMENT PROGRAMS (National Association of State Drug and Alcohol Directors, Research Triangle Institute, 1984).

CATOR: Comprehensive Assessment and Treatment Outcome Research, *Majority Abstain One Year: Prolonged Relapse Rare*, CATOR CONNECTION (1990).

CATOR: Comprehensive Assessment and Treatment Outcome Research, *Hospital Use Dramatically Reduced After Treatment*, CATOR CONNECTION (1990).

De Leon, G., *Therapeutic Community Treatment Research Facts: What We Know*, TCA NEWSLETTER (Fall 1988).

EAP DIGEST (November-December 1988).

Esterly, R., Goodman, D., Meglen, T., Smith, J.I., Wagonhurst, A.H., Governor's Council on Drug and Alcohol Abuse, and Capital Blue Cross, TASK FORCE ON SUBSTANCE ABUSE AND INSURANCE BENEFITS (Pennsylvania Blue Shield, March 1981).

Fein, R., ALCOHOL IN AMERICA: THE PRICE WE PAY (Care Institute, 1984).

Fitzgerald, K.W., ALCOHOLISM, THE GENETIC INHERITANCE (1988).

Freeland, M. S., Jackson-Beeck, M., Madlen, L., McGuire, T., Thexton, P.M., ALCOHOLISM TREATMENT IMPACT ON TOTAL HEALTH CARE UTILIZATION AND COSTS: ANALYSIS OF THE FEDERAL

EMPLOYEE HEALTH BENEFIT PROGRAM WITH AETNA LIFE INSURANCE (U.S. Department of Health and Human Services, February 1985).

Gilligan, E.F., Campbell, J.C., Cetron, H.M., NEW JERSEY HEALTH CARE FINANCING ADMINISTRATION ALCOHOLISM PROJECT (Division of Medical Assistance and Health Services, New Jersey Department of Human Services, April 1986).

Goldman, Marshall and Muszynski, P.C., STATE REQUIREMENTS ON PRIVATE HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AND/OR DRUG DEPENDENCY TREATMENT SERVICES (National Association of Addiction Treatment Providers (NAATP), 1989).

Harwood, H.J., and Napolitano, D.M., *Economic Implications of the Fetal Alcohol Syndrome*, 10(1) ALCOHOL HEALTH AND RESEARCH WORLD (1985).

Harwood, H.J., Napolitano, D.M., Kristiansen, P., and Collins, J.J., ECONOMIC COSTS TO SOCIETY OF ALCOHOL AND DRUG ABUSE AND MENTAL ILLNESS: 1980 (Research Triangle Institute, 1980).

Holder, H.B., and Hallan, J.B., MEDICAL CARE AND ALCOHOLISM TREATMENT COSTS AND UTILIZATIONS: A FIVE YEAR ANALYSIS OF THE CALIFORNIA PILOT PROJECT (December 1981).

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

Legal Action Center, ALCOHOLISM AND DRUG DEPENDENCIES TREATMENT BENEFIT (December 1992).

Manisses Communications Group, Alcoholism and Drug Abuse Week, Inc. (January 25, 1989).

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

National Association of Addiction Treatment Providers (NAATP), THE SUBSTANCE ABUSE TREATMENT FACTBOOK: A PRACTICAL GUIDE FOR HEALTH CARE PURCHASERS.

National Association of Addiction Treatment Providers (NAATP), THE TRUTH ABOUT SUBSTANCE ABUSE TREATMENT.

National Association of State Alcohol and Drug Abuse Directors, THE COST EFFECTIVENESS OF ALCOHOL AND OTHER DRUG TREATMENT, ALCOHOL AND OTHER DRUG ABUSE AND THE LINK TO CRIME.

National Coalition on Alcohol and Other Drug Issues, THE ECONOMIC COSTS OF ALCOHOL AND OTHER DRUG ABUSE (1991).

NCADD, FACT SHEET:ALCOHOLISM AND ALCOHOL-RELATED PROBLEMS (12 West 21 Street, New York, NY).

Pennsylvania Chamber of Commerce, ALCOHOLISM (June 1974).

Pennsylvania Department of Health, OFFICE OF DRUG AND ALCOHOL PROGRAMS FY 1984-85 MANAGEMENT PLAN.

Pennsylvania Department of Health, PRESCRIPTION ABUSE DATA SYNTHESIS PROJECT, EXECUTIVE SUMMARY, PENNSYLVANIA REPORT (April 1986).

Pennsylvania Office of Drug and Alcohol Programs, Pennsylvania Licensing Standards for Drug and Alcohol Services, Chapter 157, 157.2 (February 13, 1990).

Porter, S., *Employee Counseling Pays Off For Firms*, in *Your Money's Worth* column, Harrisburg Sunday Patriot News, November 23, 1986.

Private Health Insurance Coverage for Alcoholism and Drug Dependency Treatment Services: State Legislation that Mandates Benefits or Requires Insures to Offer Such Benefits for Purchase, THE ALCOHOL AND DRUG ABUSE REPORT, Special Report 23-25 (January-February 1986).

Rice, D.P., Kelman, S., Miller, L., and Cunmeyer, S., THE ECONOMIC COSTS OF ALCOHOL AND DRUG ABUSE AND MENTAL ILLNESS: 1985 (Institute for Health andd Aging, University of California, U.S. Department of Health and Human Services, 1990).

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 (July 13-14, 1992).

THE ALMACAN (April 1989).

The War on Drugs, NATIONAL CLEARING HOUSE REVIEW, Special Issue (1990).

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

U.S. JOURNAL OF DRUG AND ALCOHOL DEPENDENCE (October 1988).

VOICE OF MADD, Tri-County Chapter, Enola, Pennsylvania (April 1989).

X(5) THE ALCOHOL REPORT (December 31, 1981).