Addiction Treatment Under The Mental Health Parity And Addiction Equity Act of 2008 – Expanded Behavioral Health Benefits Bring Risks Of Increased Cost Shifting To Public Funding Sources

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By Gregory B. Heller

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The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
Equity Act of 2008 (the “Parity Act”) promises to do a great deal of good for a lot of families, by making behavioral health benefits more extensive. Under the Parity Act, financial requirements and treatment limitations applicable to behavioral health benefits must be no more restrictive than financial requirements and treatment limitations applicable to physical health benefits; annual and lifetime limits must be the same for behavioral health and physical health; and if a health plan provides out of network coverage for physical health, it must also provide out of network coverage for behavioral health.\(^2\) The Parity Act’s requirements are incorporated into, and are part of, the Patient Protection and Affordable Health Care Act that was recently enacted into law, so tens of millions of the newly insured will have the benefit of the Parity Act.\(^3\)

Managed care techniques, and specialized vendors known as behavioral health carve-out companies, will play a significant role in this expanded coverage. The interim

Victims of Crime. Points of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

\(^2\) ERISA § 712; \textit{see generally} Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

\(^3\) Patient Protection and Affordable Care Act, P.L. 111-148 (2010) at § 1311, to be codified at 42 USCA § 18031.
final rules issued by the federal agencies charged with enforcing the Parity Act – the Departments of Treasury, Labor, and Health and Human Services – impose some important limitations on managed care, but also reflect the Departments’ expectation that “medical management and managed care techniques will help control any major cost impact resulting from the [Parity Act] and [the implementing] regulations,” at least where the managed care techniques are not prohibited or further limited under applicable State laws. The economic case for the Parity Act presumed an active role for managed care. And it scarcely bears mention that the behavioral health managed care industry continues to vigorously assert that the use of managed care techniques is an absolutely essential form of cost control, as the more expansive behavioral health benefits required under the Parity Act become available.

This article reports on a study that should strike a note of caution in the face of what will likely be an expanded use of managed care techniques, at least with respect to addiction treatment. For addiction treatment, the tools and techniques of managed care can result in a significant shift of treatment costs, from private managed care companies onto the public sector.

Our study analyzed payment activity at an adolescent residential addiction treatment facility in Pennsylvania. Addiction treatment is an area that is particularly ripe

\footnotetext[4]{75 Fed. Reg. 5410, at 5422, 5425 (Feb. 2, 2010).}

\footnotetext[5]{See id. at 5424, and articles cited therein.}

\footnotetext[6]{See, e.g., the Memorandum of Law submitted by the Coalition for Parity, Inc., which is a coalition of behavioral health managed care companies, in the action that entity filed in the United States District Court for the District of Columbia.  \textit{Coalition for Parity, Inc. v. Sebelius}, No. 1:10-cv-00527 (D.D.C.).}
for cost shifting, for reasons that are set forth below. Our study documented a significant shift from (a) private insurance companies that should have paid for treatment to (b) public funders of addiction treatment and facilities themselves in the form of unfunded charity. This behavior was indeed a savings for private insurers, but that tells only half the story.

Before turning to the particulars of the study, a prefatory note on terminology is in order. The term managed care covers an extremely wide range of strategies, techniques, and contractual arrangements that govern the financing, organization, and delivery of health care. Preauthorization and concurrent utilization review are two prominent features of managed care that are highly visible and therefore rightly receive a great deal of attention. They are, however, only a small subset of the tools through which managed care companies control and influence treatment services and payment for treatment services. Managed care companies control and influence treatment services by carefully selecting networks; by using a variety of direct or indirect financial incentives; through benefit design; through cost-sharing arrangements; through normative information influences; through interactions with colleagues, provider organizations, and policymakers; by creating, supporting and enabling guidelines, critical pathways, and criteria; and through a “sentinel effect,” in which the very existence of utilization management systems may itself deter care.\(^7\)

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\(^7\) See generally Elizabeth Levy Merrick et al., Managed Care Organizations’ Use of Treatment Management Strategies for Outpatient Mental Health Care, 33 ADMIN. & POL’Y IN MENTAL HEALTH SERV. RESEARCH 104 (2006); see also Robert Rich & Christopher T. Erb, The Two Faces of Managed Care
intentionally broad sense. Most of the discussion below is concerned more with the actual result (namely, the shifting of treatment costs onto the public fisc) than the precise details of how a particular managed care organization managed to achieve that result.

A. Some Background on Cost Shifting

The possibility that private managed care organizations (hereinafter “MCOs”) will shift the costs of care to the public sector has long been recognized. The problem has become more important in recent years, as the reliance on specialized behavioral health carve-out companies has increased. This concern is driven by a recognition that managed care companies have strong incentives to shift the costs of care to others – which, in the case of behavioral health, often means public funding sources.

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8 See, e.g., Zuvekas et al., Cost Shifting Under Managed Behavioral Health Care, 58 Psychiatric Serv. 100, 107 (2007)(“[t]he rapid growth of carveouts to MBHOs in the past two decades heightened long-standing concerns about cost shifting in mental health treatment.”).

9 See, e.g., Norton et al., Cost Shifting in a Mental Health Carve-Out for the AFDC Population, 18 Health Care Financing Rev. 95 (1997)(discussing incentives in contract); see also Frank & McGuire, Savings From a Carve-Out Program for Mental Health and Substance Abuse in Massachusetts Medicaid (Harvard University working paper, 1996); Stoner et al., Expenditures for Mental Health Services in the Utah Prepaid Mental Health Plan, 18 Health Care Financing Rev. 73 (1997).
This problem is particularly acute for addiction treatment. Addiction treatment presents a unique set of opportunities for insurers and managed care companies to shift the costs of care onto the public, for several reasons. First, because there is public funding for addiction treatment (and there should be more), there is frequently a funding source onto which patients can be shifted.\textsuperscript{10} Second, the shame and denial that accompany addiction make it unlikely that individuals and families desperately in need of treatment will enforce their rights against private insurers. Third, the stresses placed on families by diseases of addiction often make it difficult or impossible for individuals and families to successfully pursue their rights even if they are otherwise inclined to do so.\textsuperscript{11}

Cost shifting takes many different forms, and the term cost shift has different meanings in different subsets of the literature. In the helpful taxonomy set forth by Professor Domino, “out-of-plan cost shifting” is cost shifting that occurs when the cost of medical treatment provided to a patient is shifted from a managed care plan to some


\textsuperscript{11} MCOs also take advantage of the strong, informed, and sensible determination to treat addicts that is so often found in the stewards of public treatment dollars, and in personnel who work at facilities that treat these patients. As explained in more detail below, in general a patient does not receive publicly funded treatment unless (a) a public steward concludes, after an assessment, that the patient needs the treatment, and (b) a treatment facility, which conducts its own assessment, concurs. Often these decisions are made after a private MCO has already successfully maneuvered the patient onto a public funding track, or at the same time that the patient is shifted onto a public funding track. Either way it is the MCO, and not the treatment facility or the public steward, that has caused the shift.
other entity or funding source. “Within-plan cost shifting” occurs when costs are shifted from a more expensive treatment to a less expensive one paid for by the same managed care company – for example, by shifting a patient from residential treatment to outpatient treatment.

Within-plan cost shifting has received a great deal of attention in the literature. We know, from this work, that many managed care plans shift patients from more expensive to less expensive forms of treatment.

Out-of-plan cost shifting, by contrast, has received less attention. On the face of it this knowledge gap seems counterintuitive. Policymakers and regulators must understand out-of-plan cost shifting because public money should not be spent doing someone else’s job. Furthermore, public funders of addiction treatment tend to be sophisticated purchasers of health care who are, or should be, well aware that managed health care contracts often include incentives for shifting costs from one category of care (e.g., inpatient) to another category of care (e.g., outpatient).


13 I note, for the sake of completeness, that another form of cost shifting occurs when private insurers (or health plans) pay a higher price for medical care, as a result of lower prices paid by medicare, medicaid, and other public funding sources. See generally Dobson, et al., The Cost-Shift Payment Hydraulic: Foundation, History and Implications, 25 Health Affairs 22 (2006). This form of systemic pricing pressure is not addressed in this article. Similarly, the general societal costs imposed by untreated or inadequately treated addictions, or the treatment costs borne by family, friends, and other similar support systems, are beyond the scope of this article. See generally Shern, et al., Medicaid Managed Care and the Distribution of Societal Costs for Persons with Severe Mental Illness, Am. J. Psych. 165:2 (2008).

14 Id. at 1382.

15 Id.
behavioral health care – and in particular addiction treatment -- presents unique incentives and opportunities for cost shifting. One of the significant opportunities for cost shifting is found in the nature of addiction itself. Diseases of addiction are accompanied by shame and defined by denial, and leave addicts and their families ill-equipped to fight managed care companies. In addition, the very nature of a behavioral health carve-out creates incentives to underutilize care, because behavioral health carve-outs are not responsible for the physical health implications of untreated or inadequately treated mental health disorders. Nor are they responsible for the costs of untreated addiction borne by the criminal justice system.

These dynamics are widely acknowledged and should not be a surprise to any public funder of addiction treatment or to any regulator.

One reason why out-of-plan cost shifting has received less attention may be simply because it is hard to measure. Patients, and information about the care they receive and who paid for the care, can be tracked within a particular insurer or MCO or within a particular public payment system (or even set of systems). Where cost is shifted from private insurance to a wholly separate funding source (say, from private insurance to public treatment dollars), however, it is rarely possible to track the patient across individual patient funding streams without examining individual patient funding records, including records from the criminal justice system. As one careful student of data sources has observed, “[i]t is rarely possible to link administrative information on

16 See, e.g., Zuvekas et al., supra note 14; Domino, supra note 18 (measuring out-of-plan cost shifting for mental health services, from Medicaid managed care plans to jails, based on data allowing patients to be tracked between jail system, county mental health agency and Medicaid).
the same patients in both public and private reimbursement systems to determine the extent to which this [public] safety net is being used."\(^{17}\)

A great deal of information can come from tracking patient care and payment information across the various components of a public reimbursement system. For example, Professor Domino’s study was designed to evaluate the hypothesis that when County mental health services for the Medicaid population were turned over to a capitated managed care plan, the costs of outpatient mental health care (which would be borne by the capitated managed care plan) would decrease and jail costs (which are free to the capitated plan) would increase. Patients were tracked across the King County, Washington jail system, the Medicaid system, and the King County mental health system. Each of these is funded with public dollars. Domino found “a strong increase in the probability of jail use for persons on Medicaid after the introduction of managed care,”\(^{18}\) and estimated a total annual shift of $1.13 million to the jail sector.\(^{19}\) The effects of this shift were “concentrated in the severely mentally ill population.”\(^{20}\) Because the Domino study was limited to public funding sources, however, the study could not have detected or measured any shifting from private insurers to public funding sources. In other words, private insurers enjoy a de facto immunity from this kind of examination.

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\(^{17}\) Garnick et al., Selecting Date for Substance Abuse Services Research, 22 J. OF SUBSTANCE ABUSE TREATMENT 11, 11-12 (2002); see also Shern, supra, at 259 (“In a fragmented human services system, the distribution of costs and benefits is difficult to determine. Agency managers focus on their budgets generally without regard to the effects of their decisions on other payers”).

\(^{18}\) Domino, et al., supra n. 18, at 1392.

\(^{19}\) Id.

\(^{20}\) Id.
The sole example that I am aware of in the published literature that directly measures shifts from private to public funders is a 2001 study by Carole Siegel, Judith Samuels, and Joseph Wanderling. This study used a mental health data set that covered two counties in the Rochester, New York area.\textsuperscript{21} The study classified patients by payor category – private, combined public/private, and wholly public – and measured the number of, and certain characteristics of, patients who changed categories from one year to the next. The study found fairly small shifts between categories. For the first pair of years studied, 1991 and 1992, the study found that 1.7 percent of patients who initially received privately funded services shifted to private/public or wholly public funding. For the second pair of years, 1991 and 1992, the study found that 3.2 percent experienced such a shift.\textsuperscript{22}

While the approach taken in Professor Siegel’s study is obviously helpful, it relies upon a dataset covering all payers and a range of providers. This type of dataset is rare, and creating more of them would be hard, time-consuming, and expensive and may raise significant confidentiality issues. The approach taken by Siegel also has a more fundamental limitation, in that it can only record shifts for patients whose care was funded by private payers in the first place (that is, in the first of the two years studied). If the capitated managed care plan simply refused outright to pay for the care in year 1, there would be no cost shift detected or recorded. This approach measures changes over

\textsuperscript{21} Siegel et al., Cost-Shifting from Private to Public Payers:


\textsuperscript{22} Id. at 22.
time, but does not ask and cannot measure whether there is compliance with or disregard of applicable laws.

B. Cost Shifting at a Residential Adolescent Addiction Treatment Facility

Identifying and quantifying out-of-plan cost shifting becomes straightforward if patients are tracked across funding streams, and if it is possible to make strong claims about whether, and how much, a private insurer (if there is a private insurer) should have paid for the care. Costs that should have been paid for by private insurance, but in fact were paid for by some second source, are costs that have been shifted to the second funding source.

Much of this analysis turned on a particular Pennsylvania insurance law known as Act 106 of 1989, which requires all group health insurance plans to provide (not just offer) an addiction treatment benefit and places access to that benefit in the hands of treating physicians and psychologists, not managed care companies.²³ Act 106 requires all group health plans to include the following addiction treatment benefits. (a) Non-hospital residential alcohol treatment services must be included as a covered benefit for a minimum of 30 days per year. This minimum of 30 days may not be exchanged for outpatient addiction treatment services. (b) In addition, outpatient alcohol treatment services must be included as a covered benefit for a minimum of 30 outpatient, full-

session visits or equivalent partial visits per year. The baseline 30 visits per year may not be exchanged for non-hospital residential addiction treatment services. (c) In addition, a further 30 outpatient visits must be included. This second set of 30 outpatient visits may be exchanged on a two-for-one basis for up to 15 non-hospital residential addiction treatment days, above and beyond the initial 30 days referred to in (a) above. These benefits may be subject to a lifetime cap of 90 days for non-hospital residential treatment services and 120 outpatient, full-session visits or equivalent partial visits. Pennsylvania law also mandates detoxification benefits. The law applies to group health plans, and to insurance provided through the Children’s Health Insurance Program.

Pennsylvania law also spells out, and therefore limits, the prerequisites to a private insurer’s obligation to pay for this treatment. In order for this coverage to apply, “a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.”24 This is the only lawful prerequisite to treatment.25

Parente Randolph, a firm of accountants and consultants with extensive experience in health care work, was asked to help design an analytic approach that would compare actual reimbursement behavior at the Rehabilitation Facility to the reimbursement behavior that one would have expected, had MCOs complied with Act


25 Id.
106. The study examined all payments from all sources (including all public funding sources, all private funding sources including insurance and self-pay, and charity care) at a single residential addiction treatment facility for adolescent males in central Pennsylvania (the “Rehabilitation Facility”), across a period of two fiscal years, spanning the time period from July 1, 2002 to June 31, 2004. The study did so in a way that complied fully with the confidentiality protections that are such an essential part of effective addiction treatment.

Parente Randolph’s analysis found that (a) private insurers were paying for virtually no residential addiction treatment, even though they were required by law to pay for a great deal of such care, (b) public funders were paying for a great deal of care that should have been paid for by private insurers, and (c) the Residential Facility was providing a great deal of scholarship care, for care that could have been paid for by private insurance. Parente Randolph also projected the total number and cost of adolescent non-hospital residential addiction treatment days that should have been paid for by private insurance, but were not, for Pennsylvania as a whole during the two studied fiscal years. When projected across the Commonwealth these cost shifts amounted to $1.6 million to $2.6 million annually transferred to public funding, and $1.2 million to $1.9 million annually transferred to facility scholarship care. These costs shifts represented $2.7 million to $4.1 million annually in financial benefit to private MCOs. These figures are of course for a limited population: for the adolescent population alone, and for Pennsylvania alone.

An adolescent treatment facility was selected for study because children suffering from diseases of addiction are more likely than adults suffering from addiction to have
kept – and not lost – their health insurance coverage. Parents get fired, kids do not. Adolescents are therefore presumably more likely to have insurance at the time they seek treatment.

The study assumed that if patients received treatment and had private insurance, then all the lawful prerequisites for treatment under Act 106 were satisfied. This was a valid assumption. The Rehabilitation Facility’s procedures required physical examination of patients on admission, and physician approval of a treatment plan for the patient. This is consistent with the applicable accreditation standards required by the Joint Commission on Accreditation of Healthcare Facilities. Thus, we know that if the patient received treatment, a physician had determined that treatment was appropriate, and had satisfied all lawful prerequisites to treatment. If the patient received treatment and had coverage subject to Act 106, we know that treatment, up to the limits of the available Act 106 benefit, should have been reimbursed by private insurance.

The empirical study conducted by Parente Randolph proceeded as follows.

Facility personnel reviewed every patient file at the Rehabilitation Facility covering two fiscal years: FY03, which ran from July 1, 2002 through June 30, 2003; and FY04, which ran from July 1, 2003 through June 30, 2004. The actual file reviews were

26 See 2003 Comprehensive Accreditation Manual for Behavioral Health Care Standard LD 1.8.2. Furthermore, Pennsylvania Department of Health regulations that govern residential treatment facilities and programs require extensive documentation for each patient including a physical examination with a detailed history and a treatment plan reviewed and approved by a physician. See 28 Pa. Code §§ 709.51 (freestanding drug and alcohol treatment facilities), 711.51 (drug and alcohol treatment programs that are part of a health care facility). It is fair to assume that similar physician approvals are found in patient charts at all nonhospital residential addiction treatment facilities.
performed by facility personnel, an approach that removed any confidentiality concerns.\textsuperscript{27} Data were entered into spreadsheets, and patients were identified by unique facility tracking identification numbers. For each individual who was a patient during FY03 or FY04, the patient’s clinical/administrative file and medical record file were reviewed. Financial files, monthly billing/funding reports, and daily population reports were also reviewed. Information was also obtained from queries against ledgers in the facility’s financial database.

From these sources, and for every patient who received residential treatment at the facility during FY03 or FY04, the following information was obtained: dates of admission and discharge; the first and last day billed for each month the patient was at the facility; the discharge date; the discharge status (complete or incomplete); total length of stay; home county of residence; the payor (or payors); the number of days billed to each payor; payment status for each payor; whether or not the treatment was Court-Ordered; the parent’s private insurance plan or medical assistance plan; and whether or not the parent’s insurance was privately purchased or provided through CHIP (that is, if the insurance was privately purchased or CHIP the field was marked “yes”; if the insurance was neither privately purchased nor CHIP, the field was left blank). For some patients, if a private insurance card was not found in the patient’s file, an inquiry was made to the entity that had referred the patient for treatment.

\textsuperscript{27} Addiction treatment records are subject to an array of strict confidentiality requirements, under both state and federal law. See, e.g., 42 U.S.C. §§ 1320d-1329d-8; 45 C.F.R. §§ 164.102-534; 71 Pa. Stat. §§ 1690.101 - 1690.112; 4 Pa. Code § 255.5; and 28 Pa. Code § 709.28(c).
Using this approach, it was determined that in 2003, 25 of 81 patients (31 percent) had private insurance or CHIP coverage, and in 2004, 38 of 103 patients (37 percent) had private insurance or CHIP coverage.

This may significantly understate the number of patients who had private insurance or CHIP. A 2004 study commissioned by the Pennsylvania Insurance Department found that 92 percent of Pennsylvania residents had some form of health insurance coverage. For the age group between 0 and 17, 70 percent of children had private health insurance; for the age group between 18 and 64, 77 percent had private health insurance.  

These more general numbers probably apply, because the Rehabilitation Facility is located in the middle of Pennsylvania, in a region that is home to state government and to a large number of skilled workers likely to have insurance. The Rehabilitation Facility treats patients from across the socioeconomic spectrum and it is unlikely that this patient population had significantly less private insurance than the population in Pennsylvania as a whole.

The above-cited figures from the Insurance Department (70% of children) do not precisely establish the general percentage of Pennsylvania children with coverage subject to the requirements of Act 106. In 2004, many children were covered under CHIP; this coverage complied or should have complied with Act 106, and these children would need to be added to the Insurance Department’s figures for private health insurance. Of course the Insurance Department figures also include self-insured plans that are exempt from

28 HC4 “FYI” Report, Issue No. 29, April 21, 2005; see also
http://www.ins.state.pa.us/ins/lib/ins/chip_ab/uninsured_study_web2.pdf;
http://www.ins.state.pa.us/ins/lib/ins/chip_ab/Exec_Summary.pdf.

The Insurance Department’s figures apparently count as insured those individuals who receive benefits through self-insured ERISA plans, and therefore the number of individuals who receive health benefits through self-insured ERISA plans would need to be subtracted from the Insurance Department’s figures.

However the adjustments referred to in the previous paragraph work out, it does seem clear that the percentage documented as having an Act 106 benefit in the Rehabilitation Facility analysis – 31 percent in 2003 and 37 percent in 2004 – is a conservative figure. 30

Because over thirty percent of the patients had private insurance, and because the vast majority of private insurance in Pennsylvania is provided through group health plans that are subject to Act 106, one would have expected a significant percentage of the treatment days to be paid for by private insurance.

That was not the case. In fact, the hard numbers show that virtually no treatment days were paid for by private insurance. The overwhelming majority of treatment days that should have been paid for by private insurance were in fact paid for by the public or by the Rehabilitation Facility in the form of unreimbursed charity care.

29 29 U.S.C. §§ 1001 et seq.; see also, e.g., FMC Corp. v. Holliday, 111 S.Ct. 403, 411 (1990) and its many progeny.

30 It is worth repeating that Parente Randolph was not asked to, and did not, undertake to analyze or evaluate the percentage of Pennsylvania children who have private health insurance or private health insurance with Act 106 benefits. Parente Randolph’s analysis was based on documented insurance information in the patient’s file, as reported by the Rehabilitation Facility.
More precisely, if the addiction treatment benefits required under Act 106 had been provided to all patients at the Rehabilitation Facility identified as having private insurance or CHIP, there were (assuming 30 days of coverage under Act 106) 644 treatment days in 2003 that should have been covered by private insurance. There were 911 treatment days in 2004 that should have been covered by private insurance.

Assuming 45 days of coverage, there were 898 treatment days in 2003 that should have been covered by private insurance, and 1195 days in 2004. Again, these are treatment days that were actually provided to patients, treatment days for care that was appropriate in the eyes of treating clinicians, and treatment days for which all lawful prerequisites to insurance coverage had been satisfied.

These treatment days are a significant percentage of the total treatment days at the Rehabilitation Facility. There were 6,021 total treatment days in 2003, and 6,727 treatment days in 2004. Assuming a 30-day benefit period, 10.6 percent of the treatment days (644/6,021) should have been covered in 2003, and 13.5 percent of the treatment days (911/6,727) should have been covered in 2004. If a benefit period of 45 days is used, 15 percent of the treatment days (898/6,021) should have been covered by private insurance in 2003, and 17.8 percent of the treatment days (1195/6,727) should have been covered in 2004.

In fact, only a fraction of one percent of the treatment days were paid by private insurance. In 2003, 23 treatment days out of 6,021 treatment days were covered by

31 These figures are the total treatment days provided to patients identified as having private insurance or CHIP coverage, limited to the lesser of (a) the actual number of treatment days received, or (b) 30 or 45 days.
private insurance. That works out to .4 percent. In FY04, 54 treatment days out of 6,727 were covered by private insurance. That works out to .8 percent. In other words, in a state that has one of the nation’s strongest laws mandating private insurance coverage for residential addiction treatment, MCOs paid for essentially no residential addiction treatment.

For some of these treatment days, the Rehabilitation Facility never received any reimbursement and the care was provided as scholarship care. Assuming a 30-day benefit period, there were 110 treatment days in FY03, and 256 treatment days in FY04, that should have been paid for by private insurance but were in fact provided as scholarship care. Assuming a 45-day benefit period, there were 162 treatment days in FY03, and 363 treatment days in FY04, that should have been paid for by private insurance but were in fact provided as scholarship care.

The overwhelming majority of the treatment days eligible for private insurance, however, were paid for by public funding sources. Assuming a 30-day benefit period, there were 450 treatment days in FY03 that should have been paid by private insurance but in fact were paid by public funding sources, and 302 such treatment days in FY04. Assuming a 45-day benefit period, there were 665 treatment days in FY03 that should have been paid by private insurance but in fact were paid by public funding sources, and 498 such treatment days in FY04.

Some of the treatment days that should have been paid for by private insurance were paid for by patients and their families. Assuming a 30-day benefit period, these figures are 30 days in FY03 and 63 days in FY04. Assuming a 45-day benefit period, these figures are 37 days in FY03 and 76 days in FY04.
C. The Statewide Implications of the Rehabilitation Facility Data

The Parente Randolph analysis was used as a benchmark to project the total number and cost of treatment days that should have been paid for by private insurance, but were not, for adolescent addiction treatment at Pennsylvania nonhospital, residential addiction treatment facilities for FY03 and FY04 based on the following further assumptions:

- There are 792 adolescent residential addiction treatment beds in Pennsylvania.\(^{32}\)
- Pennsylvania adolescent residential addiction treatment facilities operate at 83 percent program capacity.\(^{33}\)
- The Rehabilitation Facility is fairly representative of adolescent residential addiction treatment facilities in Pennsylvania.
- The Rehabilitation Facility’s utilization rates (number of treatment days divided by maximum annual bed days available), which were 66 percent in 2003 and 74 percent in 2004, are consistent with utilization rates at other residential addiction treatment facilities in Pennsylvania.

\(^{32}\) This number was provided to Parente Randolph and was not independently established by them. The figure was obtained through a survey of Pennsylvania licensing records.

\(^{33}\) The Rehabilitation Facility has 30 beds, and a normal program capacity of 25 beds. These two numbers differ because The Rehabilitation Facility can only exceed 25 patients at a time if they deploy additional staff. Thus, its normal program capacity is 83% (25/30) of available beds. The Rehabilitation Facility does, at times, have more than 25 patients, but these departures from standard capacity are not factored into the projections.
• Public funds pay for adolescent residential addiction treatment at a rate of $170 per day.

• Private insurance companies pay for adolescent residential addiction treatment at a rate of $270 per day.

Based on these assumptions, there were 158,271 adolescent residential addiction treatment days provided in FY03 and 177,455 adolescent residential addiction treatment days provided in FY04. This figure is arrived at by taking the total number of available bed days (792 available addiction treatment beds times 365 days), then multiplying it by 83% (because it is assumed that programs operate at 83% of capacity), and then multiplying it by 66% for FY03 (the utilization rate for that year) and by 74% for FY04 (the utilization rate for that year).

These are straight-line projections. Parente Randolph only reviewed data at one facility which represented a small percentage of the adolescent treatment beds in Pennsylvania -- 25 out 792 available beds, or 3.1 percent. The study did not evaluate the extent to which reimbursement behavior at the Rehabilitation Facility, program capacity, or utilization rates were fairly representative of other residential addiction treatment facilities in Pennsylvania during the time period studied. It is fair to say that there is no direct evidence that the Rehabilitation Facility data present an accurate picture of statewide behavior. It is equally fair to say, however, that there is no evidence that the Rehabilitation Facility data are not fairly representative. Perhaps additional research will uncover a facility or even a set of facilities where private insurers paid for significant nonhospital residential addiction treatment stays during the studied years. But no such facility is known to the author, to treatment advocacy organizations in Pennsylvania, or to
legislative personnel actively engaged in substance abuse and addiction treatment issues. Until such a facility or set of facilities is found, it seems reasonable to explore the projected statewide implications of the data that we do have.

Data from the Rehabilitation Facility established that a significant percentage of treatment days should have been funded by private MCOs but in fact were funded by public funding sources. Assuming a 30-day addiction treatment benefit, these days were 7.5% of the total treatment days in FY03 (450 out of 6,021) and 4.5% of the total treatment days in FY04 (302 out of 6,727). Assuming a 45-day addiction treatment benefit, these figures were 11.0% of the total treatment days in FY03 (665 out of 6,021) and 7.4% of the total treatment days in FY04 (498 out of 6,727).

Parente Randolph applied these percentages to the number of treatment days to establish the number of treatment days that should have been paid for by private insurance, but in fact were paid for by public funding sources, in FY03 and FY04.

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<td>30-day benefit</td>
<td>11,870</td>
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<td>45-day benefit</td>
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Parente Randolph also projected the number of treatment days that should have been covered by insurance but were provided as uncompensated facility scholarship care, in the same way. Using a 30-day benefit, facility scholarship days that should have been funded by private insurance were 1.8% of the total treatment days at the Rehabilitation Facility in FY03 and 3.8% of such treatment days in FY04. Using a 45-day benefit, those figures are 2.7% for FY03 and 5.7% for FY04. Applying these percentages to the statewide figures yields the following:
These projections were also expressed in economic terms. The public reimbursement rates for residential adolescent addiction treatment in Pennsylvania in 2003 and 2004 were at least $170 per day. Using this figure, the total direct cost to the public of care that was paid for by public funding sources but should have been paid for by private insurance is as follows.

<table>
<thead>
<tr>
<th></th>
<th>FY03</th>
<th>FY04</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day benefit</td>
<td>$2,017,900</td>
<td>$1,357,450</td>
<td>$1,687,675</td>
</tr>
<tr>
<td>45-day benefit</td>
<td>$2,959,530</td>
<td>$2,232,270</td>
<td>$2,595,900</td>
</tr>
</tbody>
</table>

The benefit to private insurers was far greater, because the private reimbursement rates that they avoided paying is higher than the public reimbursement rate. If a figure of $270 per day is used, the benefit to private insurers is as follows.

<table>
<thead>
<tr>
<th></th>
<th>FY03</th>
<th>FY04</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day benefit</td>
<td>$3,204,900</td>
<td>$2,155,950</td>
<td>$2,680,425</td>
</tr>
<tr>
<td>45-day benefit</td>
<td>$4,700,430</td>
<td>$3,545,370</td>
<td>$4,122,900</td>
</tr>
</tbody>
</table>

The economic burdens of facility scholarship care are on the same order of magnitude – and are borne by institutions that are often non-profits constantly struggling with limited resources. If this care is valued at the same $270 per day figure assumed to be paid by private insurers, the costs of this care are as follows.

<table>
<thead>
<tr>
<th></th>
<th>FY03</th>
<th>FY04</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day benefit</td>
<td>$769,230</td>
<td>$1,820,610</td>
<td>$1,294,920</td>
</tr>
</tbody>
</table>
While Parente Randolph’s analysis was based on hard data and on assumptions grounded upon solid evidence, the empirical study had a limited scope and there are many areas that would obviously benefit from additional inquiry. One obvious issue is the possibility that the percentage of patients identified as having an Act 106 benefit is not accurate and is either an undercount (a distinct possibility, because private insurance figures appears to be roughly half of generally accepted figures regarding insurance in the population at large) or an overcount (because some of the patients identified as having private insurance did not have group coverage, or had coverage through a self-insured plan that was not required to comply with Act 106).

Furthermore, while the overwhelming majority of patients at the Rehabilitation Facility reside in Pennsylvania, a small number of patients documented as having private health insurance had policies issued in other states. It should be noted, however, that removing out of state insureds from the study group would likely have made the MCOs’ reimbursement behavior more dramatic, not less so. The majority of treatment days reimbursed by private insurers in 2003 and 2004 came from out-of-state insurers (20 of the 23 days in 2003, and 30 of the 54 days in 2004). The Rehabilitation Facility was in all likelihood an out-of-network facility for these patients, and out-of-network benefits are often not subject to managed care utilization review. In all likelihood these treatment days were paid for only because they slipped through this particular chink in the MCOs’ utilization review armor. If these treatment days are removed from the Rehabilitation Facility data, then the number of treatment days reimbursed by private insurance is even closer to zero.

| 45-day benefit | $1,153,710 | $2,731,050 | $1,942,380 |

May 25, 2010
It is also important to note that the stark abrogation of a mandated benefit identified at the Rehabilitation Facility is useful information irrespective of whether or not any particular patient’s claim would, if considered individually, have met all the requirements for reimbursement. In Pennsylvania, Act 106 makes MCO review for medical necessity review inapplicable, but even if an MCO’s judgment on medical necessity were somehow relevant to coverage, that would not disturb the central lesson of the Rehabilitation Facility analysis.

The utter failure to fund residential addiction treatment cannot be defended based on a claimed lack of medical necessity because both the Rehabilitation Facility and the public funder of addiction treatment involved were satisfied that the care was medically necessary and appropriate. Even if this existing evidence of medical necessity were absent, a defense based on medical necessity would not and could not justify the near-complete failure of private MCOs to fund residential treatment unless the asserted medical necessity standard was a standard impossible to meet. The medical necessity defense only works for the MCOs involved if essentially every patient treated at a duly licensed, well-regarded facility over a two-year period failed to meet the asserted standard. The only standard that could justify the MCOs’ failure is a “medical necessity” standard that is not bounded by common sense or accepted standards of practice.

D. Conclusion

As a nation, we spend roughly $21 billion annually treating substance use disorders. Most of this is public money. Public funding accounted for more than three quarters of addiction treatment funding in 2003, and a recent analysis (one that did not
take account of changes worked by the Parity Act) projected that by 2014 public sources would account for 83 percent of all addiction treatment funding.\textsuperscript{34}

The Parity Act and the Affordable Health Care Act promise to have private insurers share more of this burden. In order for this promise to become a reality, regulators must make sure that private insurers comply with their obligations under these federal laws – as well as under the State laws of the more than 38 states that require private insurers to cover treatment for addiction to alcohol or other drugs.\textsuperscript{35} And regulators and policymakers must remain always mindful of the significant opportunities for cost shifting presented where managed care companies control addiction treatment – opportunities that will, according to our data anyway, be fully exploited if left unchecked.


\textsuperscript{35} NAT’L CONF. OF STATE LEGISLATURES, \textsc{STATE LAWS MANDATING OR REGULATING MENTAL HEALTH BENEFITS}, Dec. 18, 2008, http://www.ncsl.org/programs/health/Mentalben.htm. I have not independently verified this figure and there is reason to be skeptical of NCSL’s precise number, if only because NCSL’s nationwide mandate and limited resources, when combined with the remarkable diversity in state approaches to regulating managed care, sometimes make impossible the careful attention required for accurate analysis. A somewhat larger number of states – over 40 – has often been cited by experts involved in nationwide lobbying and advocacy efforts. Whatever the precise number, it is clearly a large majority of the states.