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SPECIAL ISSUE: Psychiatric/Substance Abuse/Alcoholism

HOW TO EXPAND BENEFITS AND NOT INCREASE OVERALL COSTS

By Edward T. Gluckmann, M.S.

Fund Managers and their Consultants agree that new approaches and better controls are needed to curb soaring costs generated by psychiatric and substance abuse cases. But not all agree on the best approach for achieving more effective and lasting care while lowering total benefit claims.

The old advertising slogan: "*You can pay me now or you can pay me later*" would have to be altered when applied to psychiatric and substance abuse illness, to read: "*Without adequate coverage, the Fund can pay now and just keep paying and paying and paying*".

Studies, however, indicate that the expansion of benefits to cover mental illness and substance abuse treatment can reduce overall benefit costs over a period of time.

These studies show that particular families, where substance abuse and/or mental health problems exist, require outlay of greater than average health dollars than families without similar problems.

In the current issue of JOURNAL, published by the International Foundation of Employee Benefit Plans, Grant D. Lawless reports that these studies reveal that "*the presence of an addicted member will more than double the overall utilization for all health care services in a given family.*"

This finding is also confirmed in the 1985 study on Alcoholism by the U.S. Department of Health and Human Services which found: "*On the average, alcoholic families used health care services and incurred costs at a rate about twice that of similar families with no known alcoholic members. Average monthly costs for the two groups over the 1980-83 period were $210 per person and $107 per person, respectively.*"

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Blue Cross and Other Studies

Blue Cross of Western Pennsylvania conducted a four-year study which showed a monthly reduction in medical costs of $9.41 per patient after a psychiatric component was added. Kaiser-Permanente studies showed that after five years, there was a continuing decrease in outpatient medical utilization by individuals provided with access to psychotherapy.

A study of McDonnell-Douglas of the impact of its Employee Assistance Program (EAP) showed that patients who had psychiatric and/or substance abuse problems utilized their hospital insurance benefits up to almost ten times as much as employees in similar groups who did not have such problems. The study also revealed that employees who used the Company's EAP program experienced much lower substance abuse/psychiatric treatment costs than employees who sought their own sources of care.

The Need for Expanded Care

Insurance coverage for psychiatry and substance abuse lags behind insurance benefits provided for other specific illnesses. This is true despite mounting evidence that such coverage is both controllable and can result in reductions in the overall costs of providing health care.

Health funds often decide to limit hospital benefits to acute general hospitals or to the patient *only*. Many

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will cover detoxification or provide limited benefits—in either days or dollars—for psychiatric or substance abuse treatment. Comprehensive coverage should include free-standing facilities, partial hospitalization and ambulatory programs, family coverage and continuing care. This creates a benefit package that allows patients and family members to receive care at the appropriate level, and often at a lower cost.

Free-standing facilities, as a general rule, charge anywhere from 20% to 60% less than acute general care hospitals. Outpatient services and partial hospitalization, more recent developments, are even less costly. Combined with the discounts that can be obtained through a *Preferred Provider Organization* (PPO), the savings of the fund can be even greater.

KEY POINTS TO CONSIDER WHEN SELECTING A PPO FACILITY

- Does it accept payment from providers?
- Does it accept quality reviews?
- Does it provide alternate levels of care?
- Does it provide special programs for women and adolescents?
- How long has the PPO been in existence?
- How much experience does the PPO have with hospitals and free-standing facilities?

It's a Family Affair

In most cases requiring medical care, the patient is easy to identify: the patient is the one who is sick and manifests recognized symptoms and is admitted for specific treatment, which could include hospitalization, surgery or medication. In most cases the treatment is of limited duration. Presently, treatment is almost exclusively limited to the patient.

In the case of psychiatric illness and/or substance abuse, while the patient is the one who shows certain behavioral patterns, in almost all cases the illness directly affects others. Family members, friends and employers will go out of their way to rationalize, deny or accommodate the illness. This type of behavior does not make the problem go away—*it merely postpones the day of reckoning!*

In most cases we are dealing with family illness, and treatment limited to the individual patient will almost always result in failure. Family illness requires family treatment in order to achieve family recovery.

Continuing and Varied Care Needed

The admission of a patient to a psychiatric or substance abuse treatment facility calls for multi-faceted therapy and treatment modalities and varying levels of care.

In the area of psychiatric care, the patient is often admitted because of an acute crisis; the patient acts out, becomes destructive, dysfunctional or threatening. The first step is to stabilize the patient and then rehabilitation can begin; and rehabilitation can be a lifelong effort. It requires continuing care and support mechanisms needed to minimize relapses.

In the case of substance abuse, detoxification usually lasting three-to-five days, needs to be followed by rehabilitation in a controlled setting and with continuous follow-up. Without proper support programs and structured aftercare the chance of relapse is significant.

What Are the Options?

The answers, as in the case of many health problems, include various options. The first is to review present cost allocations by diagnosis, type of provider and individual participant. It should not be surprising to discover a high correlation between inpatient care costs for treatment related to mental illness and substance abuse, at acute care general hospitals and individuals who amass a disproportionate amount of health care expenditures.

If the fund does not cover mental illness and substance abuse it may find a higher incidence of accidents, upper GI bleeding, liver problems, broken bones, metabolic disturbances, gastrointestinal problems, neurological disorders, cardiac arrhythmias, allergic reactions as well as a host of non-specific complaints.

In many cases the provider will mask the real diagnosis by using a diagnosis which stands a better chance of obtaining coverage by the fund's benefit program.

The providers are quite familiar with health insurance limitations, and when presented with a patient in obvious need of treatment they often work within the framework of the fund's benefit structure to assure admission to a hospital and payment for their services.

The fund can take positive steps by expanding its

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benefits to provide comprehensive psychiatric and/or substance abuse treatment, in cluding inpatient and outpatient care, partial hospitalization and aftercare. These benefits should include family members who may also need support and treatment.

Finally, the fund can limit benefits to those facilities which become part of its PPO. Many facilities offer discounts that can range from 10% to 30% off regularly posted charges when the PPO facilities are free-standing and not part of an acute care medical center. Their charges will be anywhere from 20% to 60% below the acute care hospitals to begin with. Many, because of their special knowledge and experience, provide comprehensive family care, special programs for adults as well as adolescents and various aftercare programs.

Management, Review and Direction

With expansion of benefits and arrangements for referral to PPOs a fund must undertake several managerial responsibilities. For example, many funds directed by labor-management trustees have benefited by the establishment of EAPs (Employee Assistance Programs). By agreement between the Union and Company, these programs can identify employee problems before they become full blown and extremely costly.

EAP programs can be the advisory and guiding factor in the selection and referral to an appropriate facility for treatment and can be most effective in assisting the affected family members in coping with fallout created by the illness of the employee.

Another aspect of an overall program would include
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Many funds provide SPD language as follows:

Psychiatric/Substance Abuse Treatment

Benefits include: *(describe days or dollars available to participants and covered dependents)* at PPO psychiatric and PPO substance abuse facilities. Benefits are *(not payable or paid at 50%)* when a participant or covered dependent uses a non-PPO facility, service or program.

Benefits cover inpatient, partial hospitalization, intensive outpatient, week-end and ambulatory care up to (insert days or dollars per benefit year).

To obtain approval for your admission or information about PPO facilities care, you must call (Fund Office, TPA, etc.).

INDIRECT COSTS OF MENTAL HEALTH PROBLEMS

- **Indirect costs typically 10-12 times direct costs**
- **Medical/Surgical costs 2-3 time higher if family member has mental health problem.**
- **Over 50% medical/surgical costs relateds to mental health**
- **Approximately 50% medical/surgical costs lifestyle related**
- **Workers comp 5 times higher if substance abuse problem**
- **Disability claims 5 times higher if substance abuse problem**
- **Productivity at 50% if substance abuse problem**
- **Turn over 2-6 times higher if mental health problem**
- **Absenteeism 2-6 times higher if mental health problem**

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case management. This involves special programs to identify those who will need extended care and insure that the system is conducted so that the patient obtains the right level of care at lower costs. Case management also provides mechanisms to insure that the anticipated outcome is achieved and that the relapse syndrome that goes with the illness is minimized.

Case management also requires utilization review, which can be done retrospectively. The prospect of utilization review in itself will deter providers from abusing benefits. This is known as the 'sentinel effect' and informs all concerned that the case is being monitored.

Whether it be through an Employee Assistance Program, under the guidance of a fund employee or a retained consultant, control of all referrals and follow through must be vested in a person who will act as a 'Gatekeeper' for the program.

Finally, a fund can limit benefits to those facilities which become part of its PPO, some examples of these may be seen in the box on Page 2.

CREDITS

In preparation for this article I have drawn from the opinions, comments and statistics reported in the following publications, as well as others not listed, and I acknowledge this with great appreciation. E.G.

Employee Benefits Journal (The International Foundation of Employee Benefit Plans)

Trends (Published by Cost Care, Inc.)

ALCOHOLISM (A study written by Barry Liskow, M.D. and Donald W. Goodwin, M.D.

Alcoholism Treatment Impact On Total Health Care Utilization and Costs (A study reported by the U.S. Department Of Health And Human Services)

Drugs in the Workplace (Employee Benefits Journal)

MENTAL HYGIENE: 'The Law And The Mentally Ill' (A report issued by the National Association for Mental Health, Inc.)

THE EFFECTS OF OUTPATIENT PSYCHIATRIC UTILIZATION ON THE COSTS OF PROVIDING THIRD-PARTY COVERAGE: (A Study sponsored by Blue Cross of Western Pennsylvania. Prepared by John Jameson, M.D., Larry J. Shuman, Ph.D. and Wanda W. Young, Sc.D.

LAW AND THE MENTALLY ILL, a quarterly journal of the National Association for Mental Health, Inc.

Perspective, BNA Pension Reporter and others.

SOME SIGNIFICANT CITATIONS

". . . Substance abusers use five to eight times as much medical care, have five times as many compensation claims, have three to four times the absentee rate and are four times more likely to have job-related accidents than nonabusing employees. Half of all industrial accidents are drug or alcohol related. . ."

—Nancy L. Hodes, Executive Deputy of State of New York Governor's Office of Employee Relations

* * *

". . .There is a gradual rise in the overall health care costs and utilization for alcoholics during the three years preceding alcoholism treatment, with the most dramatic increase incurring in the six months before treatment. . . After alcoholics start treatment, their health care costs drop significantly and eventually reach approximately the level that existed several years prior to treatment. . . Using a variety of forecasting techniques, the project estimated that the average alcoholism treatment costs can be recovered within three years after treatment initiation. . ."

—U.S. Department of Health and Human Services, Public Health Service

* * *

Between 1983 and 1988, total covered costs per person for mental disorders increased 18.8 percent, while total costs for substance abuse increased almost 25 percent. . . in 1988, the average charge per admission for hospitalization due to mental disorders was $9,430 for employees, $9,431 for spouses, and $18,036 for dependents. The average charge per admission for hospitalization due to substance abuse was $8,160 for employees, $7,104 for spouses, and $12,364 for dependents. . . the average cost per admission to a special facility due to substance abuse was slightly lower; $6,394 for employees, $5,994 for spouses, nad $8,834 for dependents. . ."

—David Renaldo, director of Employer Health-Care Data Center Westport, Conn.

WHY N.J.'S DRG'S MUST GO

The New Jersey DRG legislation was intended to promote the welfare of the citizens and to control health care costs by controlling hospital charges.

That's not how things turned out. **DRG's have not saved money for ERISA funds**, but rather have caused a substantive increase in hospitalization costs for union health funds. The system was heralded as the most efficient and cost-effective in the nation. The results of that system looks like a windfall for the hospitals, a fiasco for cost containment and trouble for ERISA funds.

DRG's must go. Connecticut ended its DRG program last October because the system didn't work and led to DRG bills that were outrageous. Trade Unions must mobilize their strength and end this system in New Jersey. The governor and state legislators must be told to get this program off the backs of the unions.

The DRG law in New Jersey is flawed. First, Blue Cross gets discounts which must be made up by other payers. Second, ERISA funds are thrown into the same payer factor as commercial insurance companies. Third, HMO's are allowed to negotiate discounts. Last, self-insured funds which are neither regulated by the State Insurance Department or State Health Department are forced to make up the difference. This is a back-handed and back-door attempt to control ERISA funds which are under federal jurisdiction.

It is ironic that the State of New Jersey, long known for its union tradition and history, has developed a law which places harsh burdens on employers and unions which seek to be self-insured and cost conscious. The draconian measures used to force ERISA funds to comply with the onerous DRG law include harassment and threats and the loss of homestead rebates or tax refunds of union members.

The State's taxes are underwriting a vast bureaucratic harassment and collection effort. Multiple phone calls and letters from hospitals are followed by similar efforts by collection agencies and lawyers. Citizens of New Jersey are forced to endure incredible harassment, all of which the State pays for with your taxes.

Unions must have the right to negotiate with New Jersey hospitals for discount rates. Hospitals are now being pressured by the New Jersey Health Department not to negotiate discounts to ERISA funds. This pressure must stop.

Why DRG's must go! When a patient is admitted to a hospital, his or her illness or injury is assigned a DRG. All that a hospital has to do to receive a higher revenue is to find a way for the diagnosis to "creep" into a more expensive DRG category, or into multiple categories. Some hospitals have encouraged doctors to code the patient's condition in a DRG category that generates a higher economic return for the hospital. Many people are hospitalized for more than one reason. A different DRG code on the claim form submitted to the insurance carrier or the self-insured fund allows a higher charge for the admission.

Another method hospitals have used to maximize their income is to pressure doctors to discharge patients at the earliest possible moment. The DRG system was intended to discourage prolonging hospital stays beyond medical necessity. Now hospitals are tempted to cut stays dangerously short in order to keep more of the DRG

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SAMPLE OF COLLECTION FORMS USED BY NEW JERSEY HOSPITALS

THIS URGENT NOTIFICATION IS YOUR LAST OPPORTUNITY TO RESOLVE YOUR ACCOUNT

Did you know that the hospital is mandated by New Jersey law to use all of the following remedies to settle patient accounts?

- Collection Agency
- Legal Action
- Homestead Rebate Attachment
- TAX REFUND ATTACHMENT

Within (10) days your account will be transferred for these recovery actions. You may deal with a collection agency, an attorney, or the NJ State Treasurer after 11/30/89.

WHY N.J.'s DRG's MUST GO

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allowance and to admit as many patients as possible. Many patients now feel they are being prematurely discharged before adequate home care or other alternatives to hospitalization can be arranged.

If the patient has not fully recovered, early discharge can lead to prompt readmission. This situation, called "churning" means hospitals can bill twice for treating one illness or injury.

The DRG system has been an economic bonanza for some hospitals, while patients have suffered through premature discharge and self-insured ERISA funds have experienced excessively high bills. *The New York Times* was exactly right in its April 2, 1984 editorial:

> "If hospitals have a new incentive, it's to manipulate the system to keep the money flowing, not to reduce costs."

Purchasers must have the right to negotiate the best price for the product that they can. In almost every other aspect of our economy, this is a right we all enjoy. The most restricted area in New Jersey is the purchase of hospital care. A hospital giving negotiated discounts to a health fund is penalized by the State in its reimbursement formula. Hospitals giving discounts are threatened by the State. The law that permits these tactics must be changed.

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