Research Report

Workplace Solutions

Treating Alcohol Problems Through Employment-Based Health Insurance

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Ensuring Solutions to Alcohol Problems
THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Ensuring Solutions to Alcohol Problems (Ensuring Solutions) at the George Washington University Medical Center seeks to increase access to treatment for individuals with alcohol problems. Working with policymakers, employers and concerned citizens, Ensuring Solutions will provide research-based information and tools to help curb the avoidable health care and other costs associated with alcohol use and improve access to treatment for Americans who need it. The project is supported by a grant from The Pew Charitable Trusts.

Ensuring Solutions strives to improve access to alcohol treatment by:

- Educating policymakers, business leaders and the general public about the extent and costs of untreated alcohol problems;
- Educating policymakers, business leaders and the general public about ways to increase access to alcohol treatment.

 For more information, please visit the Ensuring Solutions Web site, http://www.EnsuringSolutions.org, or contact:

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About This Study

This study looked at how well employment-based insurance benefits cover the services needed by people with alcohol problems. Alcoholism treatment experts developed detailed recommendations for treating four hypothetical but representative people with serious alcohol problems. Each has an alcohol problem and other health issues that could bring them into contact with different parts of the health care system – an adolescent with serious depression, a young pregnant woman, a middle-aged person who crashes her car after drinking, and a man with poorly controlled diabetes.

The consensus recommendations of the expert panel were compared with the alcohol treatment benefits of health plans representing two types of insurers – self-insured plans which are exempt from state laws and health plans that must conform to state laws. Thirty-two health plans covering the largest number of workers and their families in a sample of 25 states were compared with the health plans of 16 large self-insured employers. A detailed explanation of the methodology is in the complete report.

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Executive Summary

Alcohol treatment is the neglected stepchild of health benefits. Americans with serious alcohol problems face enormous hurdles getting the treatment they need, even if they are lucky enough to have health insurance. For most people, the type of care they can get depends on where they live and work – not on what they need

Lynn Cooper, 47, has been sober for 13 years. What saved her – and ultimately inspired a new career – was a 90-day intensive outpatient treatment program tailored specifically for her. It included intensive therapy, four hours a day, four times a week, and integrated additional individual, group and family therapy several times a week.

"I got exactly what I needed, and it worked," she says. Most importantly, her health insurance, obtained through her job, made it all possible.

"There's no question about it," she says. "Having the right insurance coverage absolutely made the difference for me."

Major Findings

State insurance laws make a difference. In states where insurance laws require that alcohol treatment coverage be the same as that for other illnesses, people are much more likely to get the services they need. Only seven states have such requirements. In states without laws or with nominal requirements, there are huge gaps in the care that employees and their family members can expect to be covered.

There are great gaps in the coverage offered by large, self-insuring employers. One-half of the 177 million Americans who have employment-based insurance work for employers who "self-insure" or administer their own health plans. The plans these employers (mostly large companies) offer their workers and their family members do not cover critical parts of the alcohol treatment services that would be recommended based on scientific evidence.

The costs of untreated alcohol problems are enormous. About one of every 13 adults has a serious problem with alcohol and more than half of all American adults have a close family member who is alcohol dependent or has a history of alcoholism. Alcohol problems cost each man, woman and child in the U.S. $683 each year.

The cost of significantly improving health coverage for alcohol problems is very small. The overwhelming majority of employment-based health insurance plans cover some type of alcohol treatment services, but usually with serious limitations and restrictions. The cost of removing these barriers amounts to only pennies per month according to a RAND Corporation study. The benefits to individuals, families and society are significant. Actuarial estimates by the Substance Abuse and Mental Health Services Administration (SAMHSA) suggest that upgrading employment-based health insurance coverage would increase premiums by 0.2 percent.

Other Findings

Access to treatment is restricted by limits on the number of days that patients can receive inpatient care and the number of outpatient visits. Many health plans charge higher copayments for alcohol treatment than they do for the treatment of other illnesses, particularly in states with no laws or nominal requirements. One-fourth set maximum dollar amounts that they will pay for alcohol treatment, much lower than for mental or other illnesses. A small number of plans cover only one or two episodes of treatment.

Intensive outpatient treatment is not covered by many plans. Typically a person participates in 2- to 4-hour sessions several times a week for a month or more during the early period of sobriety. People covered by self-insured health plans, or living in states with no laws or nominal laws, generally would not have any insurance coverage for the intensive outpatient treatment recommended by experts.

There is very little coverage to coordinate care. Successful treatment often depends on educating and involving patients and families in the management of their illness. Treatment also needs coordination of care between specialty addictions providers and primary care physicians and also between treatment providers, schools and other community supports.

Some employers voluntarily offer their employees equal coverage for alcohol treatment even though it is not required. Some large companies that self insure (one-fourth of the self-insured plans in this study) and some individual health plans already provide equal coverage for alcohol treatment services.

Workplace Solutions: Treating Alcohol Problems Through Employment-Based Health Insurance

Even if they are lucky enough to have health insurance, most Americans with serious alcohol problems face enormous hurdles obtaining enough treatment to take care of themselves over the long haul. Their care usually depends not simply on what they need, but on where they live and work. In the complicated structure that characterizes this country's health insurance system, alcohol treatment is the neglected stepchild.

Lynn Cooper's experience is the exception, not the norm. Unlike most heavy drinkers who start drinking at a young age, Cooper was a late bloomer, not taking her first drink until she was an adult. Dealing with the stress of a divorce at 25, she turned to wine for solace.

"It was instant love," she recalls. "I fell in love with alcohol. It made me feel wonderful."

Evenings, she would settle in with half-gallon jugs. On Saturdays and Sundays, she would start drinking as early as 10 a.m., and continue throughout the day.

Soon, it stopped feeling so wonderful. She began suffering from constant, horrible hangovers, and debilitating stomach problems. But for nearly a decade, she kept drinking.

"I felt like I was going to die," she says. "I knew I had a serious problem. But I couldn't stop."

Today, Cooper, 47, has been sober for 13 years and declares, "I love life. I can't begin to tell you how wonderful it is to be free of alcohol."

What saved her – and ultimately inspired a new career as an advocate for drug and alcohol treatment providers – was a 90-day intensive outpatient program that she describes as "absolutely terrific."

Tailored specifically for her, it included intensive therapy four hours a day, four times a week, and integrated additional individual, group and family therapy several times a week.

Most importantly, her health insurance, obtained through her job, covered it all.

"There's no question about it," she says. "Having the right insurance coverage absolutely made the difference for me."

Not everyone is so fortunate.

The Impact of Alcohol

An estimated 100,000 American lives are lost every year to the effects of alcohol use, either through diseases directly associated with alcohol consumption or through accidents, such as car and boat crashes, falls, fires and drowning. Domestic violence, child abuse, homicide, and rape are also frequently associated with alcohol problems. The federal government estimates that alcohol costs the nation $184.6 billion each year in avoidable deaths, illnesses, medical treatments, criminal justice, and lost productivity.[1] Alcohol contributes directly to the injury or trauma of at least 20% of persons entering hospital emergency departments, and as many as 45% of persons admitted to trauma centers.[2]

Alcohol problems range from missing a day of work due to a hangover to serious accidents and alcoholism. In the year 2000 an estimated 12.6 million people in the U.S. were heavy drinkers – drinking five or more drinks on the same occasion on at least five different days in the last 30 days. **Nearly 14 million Americans, seven percent of the population, have problems with alcohol; almost 15 million adults are dependent on alcohol or have alcohol-related problems.**[3] More than half of all American adults have a close family member who is alcohol dependent or has a history of alcoholism. One in every four children in this country lives in a household with someone who drinks to excess.[4]

Moreover, alcohol problems are a major workforce issue. Problem drinkers are concentrated in the 15-44 age group, when people are getting an education and working – and are in the years regarded as those of their greatest potential. Working men are more than twice as likely as working women to be dependent on alcohol or have problematic alcohol use.[6]

One way to reduce the toll alcohol is taking on families and in the workplace is to provide effective and affordable treatment. For most people, the type of care they can get does not depend on what they need. It depends on where they live and work.

Health Insurance: How It Works

To pay for health care, Americans rely on a complex patchwork of private health insurance, government-funded health care for the elderly, disabled and the poor; charity; out of pocket payment, and subsidies.

Most Americans who have health insurance typically get it through their employers. The US Census Bureau estimated that 59% of US residents received health insurance through their place of work in 2000.[6]

About two-thirds of all employers – from the very small to the very big – offer their workers health insurance benefits. According to the 2002 Kaiser Family Foundation survey of employer health benefits,[7] 55% of firms with 3-9 employees, 74% of firms with 10-24 employees, 88% of firms with 25-49 employees, 96% of firms with 50-199 employees and 98% of firms with more than 200 workers offer health benefits to their workers.

Employers and workers share the costs of health insurance. Employers pick up on average 84 percent of the premium for single coverage and 73 percent for family coverage. Most workers (62%), especially those who work for larger companies, have more than one health plan to choose from.[8] One-third has no choice, as there is only a single health plan offered.

Plans vary dramatically. Health insurance companies offer different levels of services under a variety of options. Employers who provide health insurance can choose from among insurance companies and among the plans offered by individual insurance companies. And from state to state, the range of available options is closely linked to the state laws that govern health coverage.

In addition to limitations placed on visits and hours of treatment, health plans use other approaches to manage benefits to save money, just as they often do for other conditions. But, in many cases, controls on alcohol treatment can be more restrictive. In the short term, health plans may reduce the use of alcohol treatment services by charging higher copayments, setting maximum dollar amounts that they would cover, or limiting the number of treatment episodes that they will pay for. By restricting use of alcohol treatment, plans can cut costs. But the costs of untreated or under-treated alcohol problems on the health of employees and their families and on the workplace, coupled with the reduced likelihood of sustained recovery, ultimately make this a very expensive choice.

Does Health Insurance Coverage Mean Treatment?

Even when companies offer their employees alcohol treatment coverage and even when states require that coverage be available, people like Lynn Cooper may not get the help that they need.

Sometimes the benefits described in a plan aren't enough. In other cases high co-pays and deductibles make actually using the benefit very expensive, erecting high hurdles to getting needed treatment. *A "one size fits all" benefit which can't be tailored to an individual situation makes it impossible for physicians and others to provide appropriate treatment services.*

Getting health plans to approve payment for treatment services that appear in the plan's benefit description can be difficult. A benefit on paper may be very different from what is available in a specific situation. Managed care controls such as a medical necessity criteria and limited numbers of treatment providers in the company's network of approved providers can be hurdles for many needing treatment, and may discourage them from getting help. But the lack of care coordination in fee-for-service plans can create challenges in getting the right combination of treatments needed. Sometimes alcohol treatment services are just not accessible in every geographic area. Sometimes, success in getting the right treatment depends on where an individual lives.

In addition, people in need of alcohol treatment services are not always ready to ask for treatment. This study does not address the barriers that may prevent people who could benefit from treatment and who have sufficient health insurance coverage from getting that coverage. Rather, it examines how employment-based health insurance covers treatment for alcohol problems in the context of government regulation.

Regulating the Employment-Based Health Insurance Marketplace

More than 1,400 federal and state laws regulate health insurance companies and their offerings.[9] Regulations set standards for consumer protections, financial solvency and coverage requirements. Forty-three states require health plans to cover alcohol treatment in some fashion, with some laws requiring more expansive coverage than others.[10] State laws directly impact coverage requirements for half of all people with employment-based health insurance. States vary tremendously in their requirements. For example, the 18 states that set floors for the dollar amount for alcohol treatment or number of treatment episodes that plans must cover are utterly inconsistent:[11]

Alaska	$9,600 lifetime
Arkansas	$12,000 lifetime
Florida	$2,000 lifetime
Hawaii	2 episodes of treatment lifetime
Kansas	$7,500 lifetime
Michigan	$2,968 annual
Mississippi	$1,000
Missouri	lifetime maximum = 4 times the annual limit
Montana	$2,000 lifetime
Nevada	$9,000 inpatient, $1,500 detoxification, $2,500 outpatient
Nebraska	2 episodes of treatment lifetime
New Hampshire	$10,000 lifetime
North Carolina	$16,000 lifetime
Ohio	$550 annual
Oregon	various amounts based on age and diagnosis
South Carolina	$2,000
Texas	3 episodes lifetime
West Virginia	$10,000 lifetime

Alcohol benefit laws require that in a given state, private health insurance companies must provide some type of alcohol treatment services. This study examines insurance that falls into five categories of mandates. Throughout this report, these categories will be referred to as **self insured, parity, mandated minimum, mandated offering** and **no mandate**.

Self-Insured

The federal Employee Retirement Income Security Act (ERISA) exempts those businesses that write and administer their own health plans from state insurance laws, including laws that require health plans to cover some alcohol treatment services. Such businesses are said to be self-insured – that is, rather than purchasing insurance through a separate entity, the businesses insure themselves. These are usually large companies; more than two-thirds of large companies have self-insured health plans. Slightly less than half of Americans who have employment-based health insurance are covered by self-insured plans, nearly 87 million people.[12] Only a handful of small companies with fewer than 100 employees are self-insured.

Parity

Parity laws require insurers to provide the same level of benefits for treating substance abuse as for other illnesses. Seven states require parity. They are Connecticut, Delaware, Indiana, Minnesota, New Jersey, Vermont and Virginia. Health insurance companies operating in these states must sell health plans that cover alcohol treatment to the same degree as other illnesses. State government employees in North Carolina and South Carolina have parity coverage, as do all federal employees.

Mandated Minimum

Mandated minimum benefit laws require a minimum level of coverage for chemical dependence and mental disorders, although most times it is less than that of physical illnesses. These benefits differ considerably among the various states. Currently, 21 states require that all group health insurance plans sold in their states include some minimum alcohol treatment benefit, although many of these states allow exemptions for very small companies. (Usually, businesses with fewer than 25 or 50 employees are considered small companies.) These states are Alaska, Hawaii, Illinois, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, and Washington.

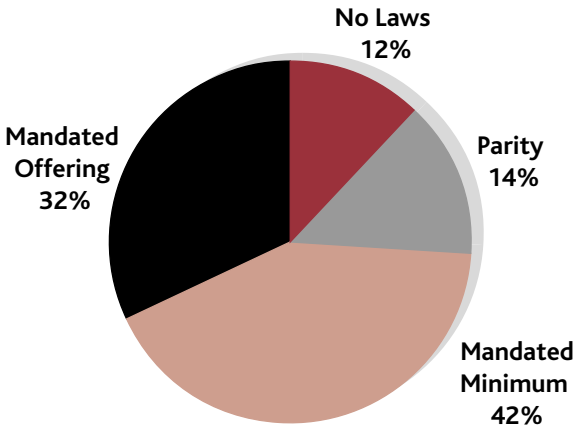
Mandated Offering

Mandated offering laws do not require that any benefit be provided at all. However, they do require the insurer to offer companies the option of selecting a plan that includes alcohol treatment. Sixteen states require health insurance companies must include at least one plan with a minimum alcohol benefit among the choices that

employers can buy – or can decide not to buy. These states are Alabama, Arkansas, California, Colorado, Florida, Georgia, Louisiana, Nebraska, New Mexico, New York, North Carolina, South Carolina, South Dakota, Tennessee, Utah, and West Virginia.

No Laws

Six states have no alcohol treatment benefit requirements at all. They are Arizona, Idaho, Iowa, Oklahoma, Wisconsin and Wyoming.



How This Study Was Conducted[13]

This project developed four hypothetical cases of representative individuals who might seek treatment. For each, nationally prominent treatment experts developed a set of recommended treatments that could be reasonably expected to help the individual recover from his or her alcohol problem, as well as other illnesses. These recommendations were compared to the benefits available from health plans offered under the full spectrum of insurance regulations. The summary plan descriptions (SPDs) of those plans were compared with the treatment recommended by the experts for each of the four cases.[14]

Health plans were solicited from each of the five categories of regulation. Researchers collected benefits descriptions from a number of self-insured health plans offered by large employers. In addition, the study examines a sample from states with the remaining categories of alcohol treatment health insurance laws – parity, mandated minimums, mandated offerings and no laws. In each of the states surveyed, the health insurance company that covered the greatest number of beneficiaries in a managed care or health maintenance organization (HMO) plan was asked to provide its SPD of the benefit package most frequently purchased by small- and mid-sized employers. The health insurance company in each of these states that covers the greatest number of beneficiaries in an indemnity (fee-for-service) or preferred provider organization (PPO) plan was asked to provide an SPD for its most popular benefit package.

Prominent experts in alcohol treatment studied the cases and came to a consensus on treatment recommendations for each case. The expert panels included, among others, Loretta P. Finnegan, M.D., David Mee-Lee, M.D., and Norman Hoffman, Ph.D.

These experts have chaired federal advisory and professional panels developing practice guidelines which are regarded as current standards of care (*see Appendix*).

The researchers based the hypothetical cases on real-life scenarios.[15] Using the best current practices based on scientific research, the treatment experts recommended services that would be necessary to treat the individuals' alcohol problems. Because there are tremendous variations in the real-life problems individuals with alcohol problems bring to treatment and in their responsiveness to treatment, some people who seem similar to the four hypothetical cases may need substantially more treatment or more intensive treatment. Others may need substantially less. The detailed case descriptions, treatment recommendations and references to practice standards are described in greater detail at http://www.EnsuringSolutions.org.

Examining Health Benefits: Four Cases

Case Study 1: Robert

Robert, 56, began drinking in his teens and continues to drink daily. He's in the fourth year of his third marriage. Robert has a history of changing jobs, and currently works as a salesman with frequent travel. He tells himself that he needs to drink with his customers at lunch.

Feeling tired and continuously exhausted, he makes an appointment with his physician. His doctor asks about Robert's drinking. Robert admits he is worried, particularly since he and his wife fight about his drinking – among other things – constantly. Also, his employer has warned him to "get it together" if he wants to keep his job. His sales numbers are at the low end among the company's sales representatives. His employer knows that, given the amount of driving Robert is required to do, he is at very high risk for a DUI arrest. Robert says that he has tried to cut back on his drinking on his own, but failed. He says he needs a drink by lunchtime to cope with the stresses of his job, and if he doesn't have one, he feels "shaky and anxious." He hasn't experienced any period without drinking in several years.

Robert's One-Year Treatment Course

Robert's physician conducts a physical examination and orders lab work, including liver function tests. The results show that Robert has type II diabetes, elevated liver enzymes, and a slight enlargement of his liver. His doctor prescribes oral medications for the diabetes, nutritional counseling and diabetes education, and recommends an assessment at an alcohol treatment facility.

During the initial interview at the facility, Robert experiences tremors, sweating, and his heart is beating fast, typical symptoms of alcohol withdrawal. He immediately is transferred to an inpatient detoxification unit, where he stops drinking under medical supervision. After two days, his withdrawal symptoms have decreased and he is transferred to a less intensive inpatient detoxification service for an additional day. His oral diabetes medication is continued throughout this initial treatment, and his blood sugar seems to be under control.

Robert is discharged from the hospital and is taken directly to the hospital's intensive outpatient treatment program, where he enrolls.

Robert cooperates. He does not drink, and admits he is frightened about his diabetes and about the detoxification experience. He now understands that drinking can worsen his diabetes – another incentive to stay sober.

In addition to seeing the therapists in his outpatient treatment program, he goes to Alcoholics Anonymous (AA) meetings, and has a sponsor. But he still craves alcohol, and tells his counselor he isn't sure if he can continue his abstinence. After consulting with Robert's primary care physician, the program's consulting physician prescribes Naltrexone, a medication that can help curb his craving for alcohol.

He is regularly monitored for any drug interactions with his oral hypoglycemic agents and for blood glucose levels. His diabetes remains under control with oral medications and diet. His elevated liver enzymes return to normal with no further drinking. His wife – who has made it clear she will leave him if he quits treatment and starts drinking again – attends his treatment program's family education sessions, and begins going to Al-Anon meetings. Al-Anon is a support group for alcoholics' family members structured much like AA.

Robert attends and completes his treatment program's continuing care program. His treatment counselor refers Robert and his wife for continued couples counseling.

Robert's Alcohol Service Needs

- Two days of medically managed inpatient detoxification
- One day of medically monitored inpatient detoxification
- Five weeks of intensive outpatient substance abuse treatment 5 times per week
- Detoxification medications and Naltrexone
- Eight months of continuing care/relapse prevention counseling

Robert's Mental Health Service Needs

- Six months of couples counseling

Robert's Diabetes Service Needs

- One 30-minute primary care physician visit
- Four 15-minute primary care physician visits
- Routine lab work
- Two 30-minute visits with a nutritionist
- Supplies for managing and monitoring diabetes

How would Robert fare under existing plans?

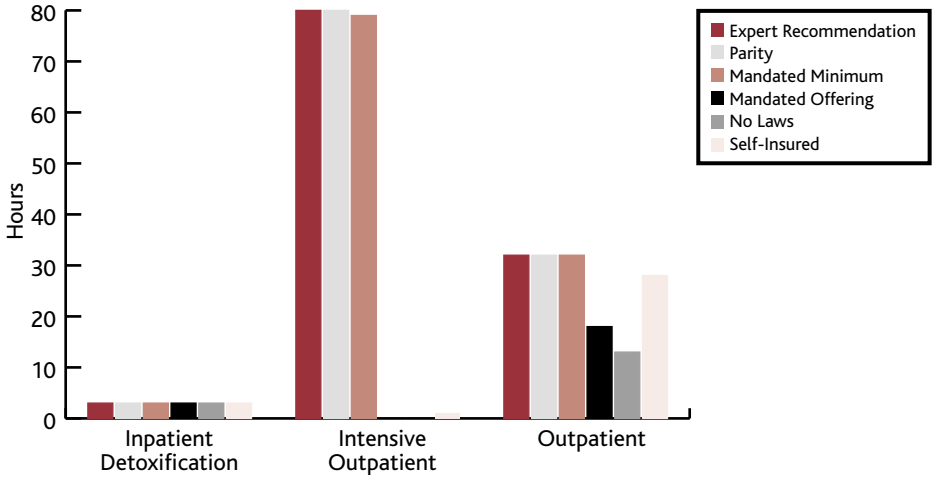
Robert has two chronic diseases, alcohol dependence and type II diabetes. Heavy drinking over one's life substantially increases risks of liver disease, various cancers, stroke, and trauma. But heavy drinking also makes the treatment of other, unrelated illnesses more difficult, more expensive, and less effective.[16] The challenge of coordinating care between his primary care practitioner, who needs to treat the

diabetes, and the therapists at specialty substance abuse treatment programs, who will focus on his alcohol addiction, will be significant. Treating two serious illnesses at the same time can be very difficult. Interactions are complicated between the underlying illnesses and the medications used to treat them.

In none of the summary health plan descriptions was case coordination, care management, or consultation between treatment providers identified as specifically covered benefits. The benefit descriptions also were silent about patient and family education for the management of these chronic illnesses. The table and chart below show how Robert's treatment needs would be met by plans that operate in the four types of state insurance laws, and in self-insured health plans.

MEDIAN HEALTH PLAN COVERAGE OF RECOMMENDED TREATMENTS FOR ROBERT[17]

ROBERT	Expert Recommendation[18]	Parity	Mandated Minimum	Mandated Offering	No Laws	Self-Insured
Inpatient Detoxification (days)	3	3	3	3	3	3
Intensive Outpatient (hours)	80	80	79	0	0	1
Outpatient treatment (hours)	32	32	32	18	13	28



Intensive outpatient treatment is poorly covered in states with mandated offering laws or no laws. The average health plans from these states and from the self-insured plans cover no intensive outpatient treatment, and only about half of the recommended outpatient treatment for Robert's alcohol addiction. Coverage for intensive outpatient and outpatient treatment in the parity and mandated minimum states is good. All but one of the health plans would cover all of

Robert's inpatient medical detoxification. The one exception covers two of the three recommended days. This reflects the very common practice in health plans to cover some specified number of inpatient treatment days for substance abuse.

Even though benefits in plans in states with mandatory minimum coverage appear to be close to equal to those offered by states in plans with parity laws, there were four plans that met their state requirements but still left gaps of 66-96 hours of intensive outpatient treatment.

Case Study 2: Beth

Beth is a 28-year-old full-time receptionist for a construction company, divorced with two children, ages three and five, and 16 weeks pregnant with her third. The father abandoned her upon learning she was pregnant. She has been drinking regularly since she was a teenager.

Beth has missed some work days, and her boss has confronted her several times after smelling alcohol on her breath after lunch. He has told her that he will give her time off for treatment, but that otherwise she will be terminated if her drinking continues. The problems are mounting at home as well. Beth lives with her sister and brother-in-law, but it is a stressful arrangement. Beth's sister has warned her repeatedly about her drinking, and threatens to kick her out if she doesn't quit, even though she needs Beth's rent money.

Beth has tried to quit, especially after learning she was pregnant again. But she hasn't been able to stay sober for more than a few days at a time. She seeks help from her obstetrician.

Beth's One-Year Treatment Course

Beth's obstetrician refers her to a substance abuse treatment facility for evaluation. Beth goes to the appointment, and is diagnosed as alcohol dependent.

The assessment counselor recommends intensive outpatient treatment, and Beth is admitted to the program. She attends the sessions, but says little, and refuses to go to self-help meetings. She doesn't really think she has a problem. She abstains from drinking for three weeks. But in the fourth week, she gets very drunk. When she returns home in this condition, her brother-in-law kicks her out of the house and threatens to have her children taken away.

She passes out on the front lawn, where she spends the night. She wakes up scared.

After arranging to stay with a friend, she decides to take treatment seriously. She stops drinking, attends Alcoholics Anonymous meetings, and begins to make progress. Her sister and brother-in-law participate in the program's family education sessions and, after one month, Beth moves back in with them.

Beth completes primary treatment and attends continuing care sessions. Her counselor there recommends that Beth see a therapist for individual counseling to help with the other stresses in her life. She keeps all the prenatal appointments. By her delivery date, she has abstained from alcohol for 5 months. She delivers a healthy baby girl.

Beth's Alcohol Service Needs

- Sixty sessions of intensive outpatient substance abuse treatment sessions over five months until delivery
- Fifty continuing care sessions after delivery for at least six months
- Medication (Naltrexone) was considered, but not indicated at this time

Beth's Mental Health Needs

- Fifty individual therapy sessions

Beth's Obstetrical and Gynecological Service Needs

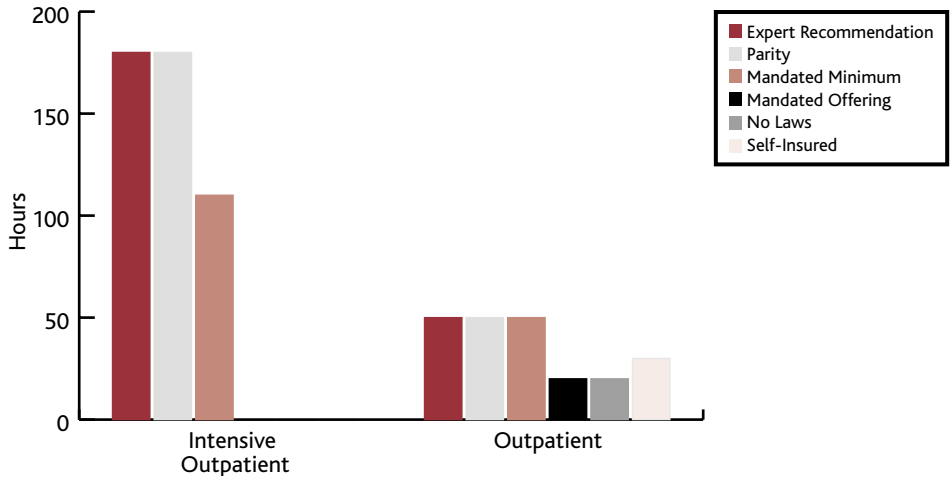
- Eight OB/GYN visits
- Two Ultrasonagraphic exams
- Lab work
- Inpatient hospital stay for delivery
- Prenatal vitamins

How would Beth fare under existing plans?

Beth would have received nothing – no coverage at all – for intensive outpatient treatment during her pregnancy under the average benefit of a self-insured plan provided by an employer or if she lived in a state with weak or no mandates.

MEDIAN HEALTH PLAN COVERAGE OF RECOMMENDED TREATMENTS FOR BETH

BETH	Expert Recommendation[19]	Parity	Mandated Minimum	Mandated Offering	No Laws	Self-Insured
Intensive Outpatient (hours)	180	180	110	0	0	0
Outpatient (hours)	50	50	50	20	20	30



In states with parity laws, health plans would cover virtually all the recommended levels of intensive outpatient treatment. On average two-thirds of these services would be covered by health plans in states with a mandatory minimum coverage requirement.

After her delivery, she would find a similar pattern of little or no outpatient coverage in states without mandates or with weak mandates, or under self-insured plans for outpatient treatment to help her stay sober. If she lived in parity or mandated minimum state, these services would be covered – at least according to the health plan descriptions.

Fetal alcohol syndrome (FAS) is the leading known cause of preventable mental retardation and birth defects. FAS affects between 4,000 and12,000 infants annually[20] and it costs taxpayers $2.1 billion to treat individuals with FAS disorders for just one year, according to a federal report.[21]

Those costs include $1.2 billion annually for special education and residential treatment services for all alcohol-affected children.[22] Continued drinking during pregnancy increases the risk of delivering a baby with the disorder. Treating Beth's alcohol addiction would be more cost effective than treating the consequences of her child's FAS.

Case Study 3: Catherine

Catherine, 52, is a real estate broker with a husband and grown children who live outside their home. She has a troubled history of driving under the influence (DUI). She continues to drink, despite having attended alcohol education classes three years earlier as part of a plea agreement with law enforcement authorities to reduce DUI charges to reckless driving.

One evening after a dinner with colleagues during which Catherine drinks several glasses of wine, she collides with a parked car, breaking her leg. She is taken to the emergency room of a local hospital, where she appears disoriented and workers there notice a strong alcohol odor. Police issue a citation for driving under the influence of alcohol.

She has a fracture of her left tibia. Hospital policy requires blood alcohol level testing on emergency room trauma patients suspected of drinking. The tests show a blood alcohol level of 0.13 one hour after the accident. Doctors set and cast her leg, treat minor cuts and lacerations, and examine her for further injuries. She is discharged with enough pain medication for two days, with a recommendation to follow up with an orthopedist. Catherine sees the specialist, who recommends physical therapy after the cast is removed.

This is not the first time that Catherine has had to miss work, but the broken leg is the most serious. Catherine is a good broker and a valued employee at her agency, but driving is a must. If her license is suspended, she will not be able to maintain her success and the agency will suffer.

Meanwhile, anxious about the DUI citation, she calls her attorney, who, mindful that this is her second such citation, advises her to get into an alcohol treatment program before her court appearance. She makes an appointment for evaluation,

and goes with her husband. However, once there, she makes it clear she is there only because she has to be.

She admits that she should probably "cut down," and acknowledges her recklessness in drinking and driving, but insists that she doesn't think she has a problem with alcohol. Her husband disagrees, and urges her to enter the treatment program.

Catherine's One-Year Treatment Course

Based on a full assessment, Catherine is diagnosed as alcohol dependent. Outpatient treatment is recommended. Reluctantly, she enters the program and initially participates very little. She also resists the idea of joining a self-help group.

Nevertheless, she abstains from drinking. In the midst of her initial weeks in treatment, she goes to court, where she is fined and told that her treatment will be monitored. Gradually, she becomes more involved with her outpatient treatment, and also begins to attend regular Alcoholics Anonymous meetings. At the same time, her husband participates in the program's family education sessions and in Al-Anon meetings.

Catherine completes intensive outpatient treatment and, as recommended, attends continuing care sessions. She stays sober, and declares that she intends to stay that way.

Catherine's Alcohol Service Needs:

- Twenty-five outpatient substance abuse treatment visits over 4 months
- Three family education sessions
- Three family counseling sessions
- Twenty-four continuing care sessions over 4 months

Catherine's Orthopedic Service Needs:

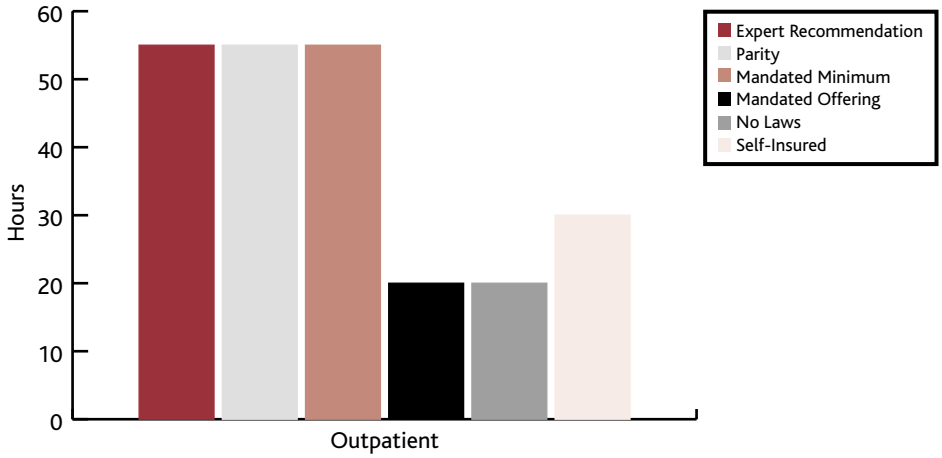
- One Emergency room visit for trauma assessment
- Three 15-minute visits to orthopedist
- Two days of pain medication
- Six weeks of physical therapy

How would Catherine fare under existing plans?

All of the health plans would cover the emergency treatment for Catherine's traumatic car crash. Only a small number of emergency departments and trauma centers "screen" or test to see if a patient has been drinking when they arrive in the emergency department. An even smaller number treat the alcohol problem on the spot when alcohol screening tests are positive.[23] As few as 15% of emergency patients with obvious alcohol problems ever have their drinking behavior addressed while in the emergency department or through a referral to an addictions specialist for problem drinking.[24]

MEDIAN HEALTH PLAN COVERAGE OF RECOMMENDED TREATMENTS FOR CATHERINE

CATHERINE	Expert Recommendation[25]	Parity	Mandated Minimum	Mandated Offering	No Mandate	Self-Insured
Outpatient (hours)	55	55	55	20	20	30



Catherine could find herself in the peculiar position of having the treatment for her broken leg covered by her health insurance plan, but not the underlying cause of the accident, her alcohol problem. Failure to identify and treat her alcohol problem is also likely to cause future crashes, trauma and emergency department use.[26] About half of the outpatient treatment recommended for Catherine by the experts is covered by health plans in states with weak or no alcohol mandates, and in self-insured plans. Health plans in all of the parity states would cover all of the recommended treatment. All of the mandatory minimum laws would cover some of Catherine's outpatient treatment, but in four plans there is a gap of 25 hours or more.

Case Study 4: John

John, 16, has been drinking steadily since he was 14. Often, he comes home drunk after his mother and stepfather are asleep. His drinking has been spotted by his two siblings, ages 13 and 19. His biological father, who has no contact with his son, is an active alcoholic. John's mother and stepfather both work hard at full-time jobs. His mother has a history of depression, but is on medication and doing well. John rarely eats at home and stays out late with his friends. His school performance is suffering, and he has abandoned his extra-curricular activities.

One evening, while John is out, his mother searches his room and finds poems and writings that suggest her son is fantasizing about suicide. She also finds a stash of empty half-pint liquor bottles hidden under the bed. She takes John to the family doctor, where he admits to excessive drinking and feelings of intense depression, though he denies any suicidal plans. The doctor refers him for a psychiatric evaluation.

John's One-Year Treatment Course

The evaluating psychiatrist diagnoses John as alcohol dependent and as having a major depressive disorder. He prescribes antidepressant medication and refers John to an intensive outpatient substance abuse treatment program for adolescents. At his mother's insistence, John agrees to enter treatment. John continues to see the psychiatrist for his depression. During the first month of treatment, John misses several sessions, and comes home smelling of alcohol twice.

He continues to experience symptoms of depression, and his psychiatrist changes his medication after four weeks. Meanwhile, several members of his family begin to participate regularly in the family counseling sessions and attend Al-Anon meetings.

After four weeks on the new antidepressant, John's symptoms of depression decrease; he begins to get more involved in his program and starts to make progress in treatment. He completes the intensive outpatient program, and attends continuing care sessions and AA meetings regularly. John's substance abuse counselor strongly recommends continued family counseling and individual counseling for John's depression. John's mother has already racked up many sick days from dealing with John's crisis, and additional counseling will mean missed work for his stepfather as well. But with John's improvement apparent, his stepfather agrees to begin attending family counseling sessions. Eventually, the family is referred to a family therapist. Although worried about their jobs, John's parents are eager provide him with the support he needs.

John's Alcohol Service Needs:

- Twenty three-hour sessions of intensive outpatient treatment 3-5 times per week for 10 to 12 weeks
- Thirty outpatient visits for continuing care/relapse prevention counseling
- Ten sessions of family education
- Three case management meetings at John's school

John's Mental Health Service Needs:

- One psychiatric evaluation
- Twenty-five 15-30 minute visits for psychiatric treatment and medication follow-up
- Antidepressant medication
- Nine months of individual therapy

John's Primary Health Service Needs:

- Three primary care physician visits

How would John fare under existing plans?

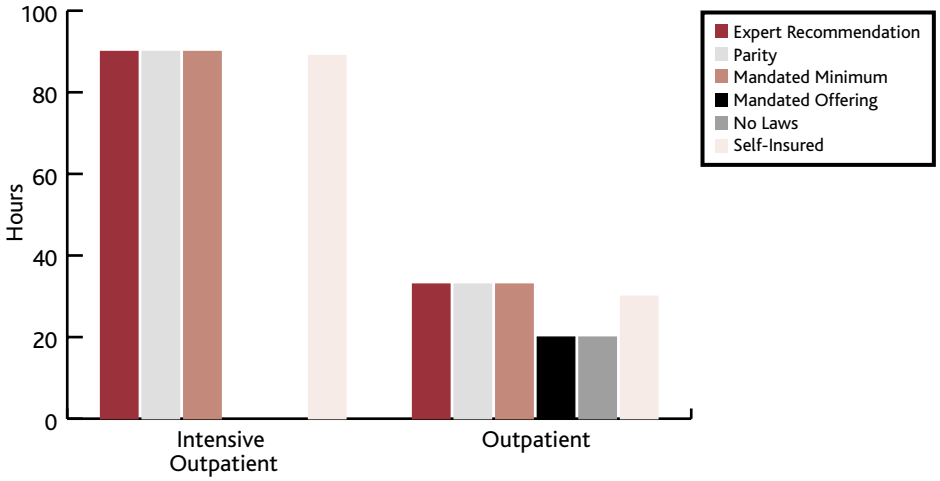
Many people with alcohol problems also suffer from depression. A nationwide study of mental illness and addictions in the general public found that 42 percent of people with alcohol disorders also had a major depressive disorder.[27] There are

ten million Americans who have both addiction and mental illness, the most common pairing being depression and alcoholism. This mix can be particularly deadly among adolescent boys.[28]

John likely would encounter serious coverage roadblocks. Health plans in states with weak or no insurance mandates and in self-insured health plans typically have no coverage benefit for intensive outpatient treatment.

MEDIAN HEALTH PLAN COVERAGE OF RECOMMENDED TREATMENTS FOR JOHN

JOHN	Expert Recommendation[29]	Parity	Mandated Minimum	Mandated Offering	No Laws	Self-Insured
Intensive Outpatient (hours)	90	90	90	0	0	90
Outpatient (hours)	33	33	33	20	20	30



Moreover, they would cover only about half the outpatient treatment recommended. Not surprisingly, the outlook brightens under health plans that operate in states with parity and mandated minimums. Plans in parity states would cover all of the treatment recommended by the experts. In the mandated minimum states, all cover the recommended amount of outpatient treatment. Although over half cover all of John's recommended intensive outpatient treatment, four of the ten plans have gaps of 40-90 intensive outpatient hours.

Findings Across the Four Cases

Beth, Catherine, John and Robert – if they are lucky enough to live in one of the 28 states that require parity or in a mandatory minimum state with ample coverage requirements for alcohol treatment – likely would do pretty well in getting the services they need. If they lived somewhere else or were members of self-insured health plans, they would face significant barriers and limitations to treatment.

Their plight would be far different if they lived in one of the 22 states that lack mandates, or who simply require mandated offerings. Although most health plans in these states had some limited inpatient and outpatient benefits for alcohol treatment, the absence of coverage for intensive outpatient, case management, family education, and other needed care put patients and their families in a painful dilemma: pay out-of-pocket for the uncovered services, or forego the needed care. Out-of-pocket payments for such services are far beyond the resources of most working families. Similarly, alcohol treatment providers would have to decide whether to deliver unpaid treatment, refer these patients to publicly funded programs – or simply refuse to treat them.

Finally, self-insured coverage isn't necessarily better coverage. All four probably would not receive all of the services they needed if they were covered by large companies with self-insured health plans. Alcohol treatment benefits in self-insured health plans are nearly indistinguishable from coverage by health plans that serve small- and mid-sized companies in states with mandated offering laws or no laws. Most companies choose to offer benefits with limited inpatient and outpatient coverage for alcohol treatment.

Mandates Aren't Destiny

Generally, laws do make a difference. There are systematic differences in how health plans operating under different types of state laws and health plans that are exempt from state laws are covering alcohol treatment.

Despite the general obstacles that many individuals face, the study uncovered some bright spots where coverage is good. The study found health plans purchased by small, medium and large employers in each of the four types of states and among the self-insured plans that offer more comprehensive alcohol benefits than required by law.

For example, in one of the states with no laws governing alcohol coverage, the most popular health plan serving small and mid-size companies is a parity plan. Out of the 32 state-based plans studied, ten have equal or parity benefits. Five are offered in states that require it by law, but five are in states where there are no requirements or less comprehensive mandates. There are eleven plans in this study with alcohol treatment benefits that are more generous than required by law.

A similar pattern exists among the self-insured plans. Although self-insured plans have no requirements to cover alcohol treatment, all did so. One-fourth had equal coverage.

However, a substantial number of plans are not following the law. They simply do not meet the states' legal standards. As shown on the table below, nine plans – each offered by the largest employment-based health insurance provider in their state – have alcohol benefits substantially below state requirements. The nine plans cover, on average, only one-fourth of outpatient visits and two-thirds of inpatient days required by their state laws. All but one is in a state with mandatory offering requirements. In these states, insurance companies must offer at least one health plan that meets a state mandated minimum. Should an employer choose to purchase such a plan, the plan must then meet the state's mandatory coverage standard. That does not appear to be happening.

	Plans Same as or Better than State Requirements	Plans Worse than State Requirements
Parity	4	1
Mandated Minimum	11	0
Mandated Offering	3	8
No Laws	5	0
Total	23	9

Coverage for Recommended Care Can Be Very Limited

The plans generally cover two types of alcohol treatment – inpatient and outpatient – and are inconsistent in covering intensive outpatient treatment, family education, and case management.

All but one has sufficient inpatient treatment coverage for the three days of inpatient medical detoxification that Robert requires. The sole plan that does not cover the three days has a two-day benefit. More than two-thirds (69 percent) of the outpatient treatment visits recommended for Beth, Catherine, John and Robert would be covered within the plans' benefit limits.

Of the 48 plans reviewed in this study, however, only 14 plans have equal coverage for alcohol treatment. (Four of the 14 plans were self-insured, with five each in parity and nonparity states.) All of the recommended treatment for all four cases could be covered by the plans. In other health plans – particularly in states with no coverage requirements or mandatory offerings – the gap between outpatient therapy needs and plan coverage is substantial. Median coverage of outpatient treatment in these two groups is less than half the amount recommended by the experts for the four hypothetical cases.

The greatest gaps between need and coverage are in intensive outpatient treatment. Only 43 percent of recommended number of substance abuse intensive outpatient treatment sessions is covered by the plans. Gaps of 60 to 180 hours between the recommended amount of intensive outpatient treatment and plan benefits are common. The absence of any intensive outpatient treatment coverage is the norm in health plans in states without laws, and in states with only mandatory offering laws, as well as in the self-insured plans studied.

Few health plans included family education and case management. For persons with medically complex, chronic illnesses, these services are the essential "glue" that ties together the specialized treatments that patients receive.[30] Research across a wide range of chronic illnesses has shown that outcomes improve when patients and families are taught to control chronic illnesses, including ways to reduce the risk of complications, relapse and symptoms.[31] Treatment experts recommended family education for both Catherine and John. Yet, not one of the health plans included family education as a covered benefit – another example of health plans failing to catch up to current standards of practice.

Nearly all of the health plans require patients to pay part of the cost of treatment, either a specific copayment per session, or a percentage of the charges. This is not unusual by itself – but the charges borne by patients for alcohol-related services are often higher than for other treatments. In one-third of the plans studied overall, patients are charged higher copayment for substance abuse outpatient treatment than for outpatient treatment for other illnesses. More than half of the plans in states with no mandates and those with mandatory offerings require higher copayments for alcohol treatment.

This practice could seriously undermine treatment. One large national health care insurance company that serves self-insured and state-based health plan purchasers found that when the outpatient copayments for alcohol treatment were more than $20 per session, patients did not come or failed to return.[32] A sizable group of plans set maximum dollar amounts they are willing to pay for substance abuse treatments that were lower than for other treatments; six had lower maximum amounts for substance abuse inpatient treatment than for other illnesses and ten had lower benefit maximums for substance abuse outpatient treatment than for outpatient treatment for other illnesses. Five limit their coverage for substance abuse to a specific number of treatment episodes during a patient's lifetime, typically two. No other illnesses were singled out for restrictions of this kind. None of the 14 plans with parity coverage has these restrictions and limitations.

Conclusion

Significant gaps in coverage are common. Only 14 of the 48 plans in this study would cover the treatment recommended by experts. Among the other plans, most cover less than half of the recommended intensive outpatient and outpatient treatment needed.

State and federal health insurance laws strongly affect health benefits and the levels of alcohol treatment services available to individuals. Where state laws require equal coverage, health plans comply. But only seven states require equal coverage for alcohol treatment in employment-based health insurance. Two states require it for state government employees but not for other workers. The federal government, similarly, requires equal coverage for all nine million federal workers, retirees, and their dependents. In states that have lower requirements or no laws, health plans generally have less generous benefits. The gap between treatment recommended and treatment covered is substantial.

The cost of comprehensive coverage of alcohol treatment is very small. Actuarial estimates by the Substance Abuse and Mental Health Services Administration (SAMHSA) suggest that upgrading employment-based health insurance coverage would increase premiums by 0.2 percent.[33] State legislative committees in Maine, Oregon and North Carolina have projected premiums for employment-based insurance would increase by about the same amount in their states.[34] When insurance for North Carolina's government employees was moved to full parity, the actual increased costs for alcohol treatment was five cents per employee per month, or 60 cents per year.[35]

This study found evidence that comprehensive coverage is possible. States and employers can make it happen. In each of the four types of state insurance mandates – parity, mandated minimum, mandated offering, and no mandates – and in self-insured plans, there is at least one example of a health plan that provides comprehensive alcohol treatment coverage that is equal to other illnesses. Equitable coverage is not only possible, it is being offered by many small, mid-size, and large employers right now.

The cost of comprehensive coverage of alcohol treatment is small. The costs of not treating alcohol abuse are staggering, both to the workplace and to individual families. Alcohol is the third leading cause of disability and premature death in developed countries, including the United States, according to the World Health Organization.[36] Alcohol is eclipsed only by tobacco use and high blood pressure. The overwhelming majority of employment-based health insurance plans cover treatment for alcohol, but characteristically, with serious limitations and restrictions. The evidence is mounting that the costs of removing these barriers amount to only pennies per month – while the benefits are significant. Even in a time of escalating health insurance costs and tight budgets, employers and public officials should consider updating and simplifying alcohol coverage – a move that would cost little, and may save money over the long haul.

"I was so sick, and I must've tried 100 times to stop," says Lynn Cooper, whose workplace health plan paid for her treatment. "I kept telling myself: 'I can't do this anymore.' My daughter started seeing a counselor when she was 17 and complained that she hadn't seen me in ten years. That started it – my need to get help. But I could not have done it without the right insurance."

For her, the right insurance included the flexibility to design a largely outpatient treatment plan and allowed her to keep working and live at home with her family. She relearned how to live her daily life without alcohol, an approach that bolstered her chances of staying sober permanently.

"I got exactly what I needed – and it worked."

Appendix

The following experts reviewed this study's four hypothetical cases:

Michael Dennis, Ph.D., Senior Research Psychologist, Chestnut Health Systems

Marc Fishman, M.D., Assistant Professor, Department of Psychiatry, Johns Hopkins University School of Medicine

Loretta P. Finnegan, M.D., Medical Advisor for the Director, Office of Research on Women's Health, National Institutes of Health

Norman Hoffman, Ph.D., President, Evince Clinical Assessments

Robert Mathieu, M.D., Anchor Medical Associates

David Mee-Lee, M.D., President, DML Training and Consulting

David Oslin, M.D., Assistant Professor, University of Pennsylvania

Susan Sampl, Ph.D., Research Associate, University of Connecticut Health Center

Gerald Shulman, MA, MAC, FACATA, Consultant and Trainer

Cassandra Vieten, Ph.D., Principal Investigator, UCSF Family Study, University of California, San Francisco

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[13] Detailed methodology available at www.EnsuringSolutions.org/

[14] There were no differences in the extent of alcohol treatment coverage between the 25 HMOs and 23 PPOs in the study. All subsequent analyses pooled data for the 25 HMOs and 23 PPOs. HMOs were somewhat more likely to offer parity coverage for alcohol services than were PPO/indemnity plans: nine of 25 HMOs offered parity coverage of substance abuse inpatient and outpatient treatment, four of 23 PPO/indemnity plans offered parity coverage.

[15] Treatment needs of actual cases require continuous reassessment and adjustment based on changing clinical presentation, problems that arise, and treatment response. The treatment plan for the four hypothetical cases used in this study should not be considered recommendations for any individual with similar alcohol-related problems.

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