

***Drug and Alcohol Service Providers Organization of Pennsylvania***  
***dasdbeck@hotmail.com***

**HR590 Public Comment**  
**Addiction Treatment Access – Agency/Stakeholder Survey**

Please describe the major barriers you encounter when attempting to assist someone in accessing care.

We routinely handle many calls for help throughout the week. The calls come from individuals as well as addiction treatment programs – all trying to figure out how to access health plan coverage for all levels of care.

Most people now have coverage for the treatment of addiction through PA's state addiction treatment insurance law (Act 106 of 1989), through PA's Medicaid laws (Act 152 of 1988 and Medicaid Expansion), through self-insured health plans (Affordable Care Act), through federal programs such as the Federal Employee Health Benefit Program, the VA, Medicare, etc.

The problem is how to access the coverage already paid for by the public, by the employer or by the individual. In this regard, the two attached documents (Remove Barriers to Addiction Treatment and Insurance/Health Plan Matters) were shared at a hearing of the PA Senate Democratic Policy Committee in Pittsburgh this past April and elsewhere. These documents may be of some help with this discussion.

In addition, here is an unedited list of the types of problems routinely encountered.

- Insurers/health plan materials on addiction and how to access treatment are hard to understand
- Pre-authorization and authorization processes delay treatment and fail to reflect the urgency of the illness
- Calls are not returned by health plans in a timely fashion
- Denials of addiction treatment are common
- Non-denial, denials of treatment are also common through such means as simply not getting back to the patient or the treatment program

- Odd, made-up criteria governing admissions
- Denial of detoxification for certain drugs
- One day or one unit of service authorizations for treatment
- Emails and paperwork lost repeatedly
- Requirements to fail at a lower level of care than recommended or requirements to fail several times at a lower level of care
- Requirements to fail recently at a lower level of care than recommended
- High co-pays
- Health plan lack of awareness of and compliance with PA's Act 106 of 1989
- Health plan lack of awareness of and compliance with the Mental Health Parity & Addiction Equity Act of 2008
- Health plan lack of awareness of and compliance with provisions of PA's Act 106 of 1989, specifically family and intervention services
- Lack of a simple appeal process and an appeal process that is timely for addiction (currently could take months)
- Need to develop enforcement provisions of the Mental Health Parity & Addiction Equity Act of 2008
- Lack of detox and rehab beds
- IMD Exclusion barrier
- Treatment funding cuts
- Patients seeking help who have no personal identification
- Illegal case rates
- Lack of experience by treatment programs in handling self-insured health plans

- Lack of a clear pathway to enforcement of self-insured plans and government health plans
- Lack of comprehensive addiction treatment coverage under Medicare
- Denials of court-ordered treatment
- Exclusion of specific levels of care by health plans
- Limits on lengths of treatment in outpatient and inpatient

Deb Beck  
Drug & Alcohol Service Providers Organization of Pennsylvania  
717-652-9128  
[dasdbeck@hotmail.com](mailto:dasdbeck@hotmail.com)

**Remove Barriers to Addiction Treatment**

Addiction can't wait.

Our state is in the middle of a deadly heroin epidemic heavily driven by the marketing of and increased access to powerful prescription opiates. As a result in 2013, 2,525 Pennsylvanians lost their lives to drug overdoses with the number dying expected to increase over the next few years.

The demand for addiction treatment services has never been higher and PA's addiction treatment system is overwhelmed. Demand for addiction treatment services is soaring with desperate families crying out for help. At the same time, the treatment effort has lost ground with funding for addiction treatment reduced by \$11.5 million since FY08-09, a 22% reduction.

We urge the leaders of our state to come together, bring laser focus on this problem and bring relief to the 1 in 4 families in PA wrestling to help an addicted loved one.

Even with budget stalemates in Washington and Harrisburg, there is much that can be done to address the crisis.

Here's the issue. Most Pennsylvanians now have coverage for addiction treatment through assorted health plans and county drug and alcohol systems. However, access to the addiction treatment benefit has been made outrageously, punishingly difficult for our desperate families.

The difficulty in accessing the addiction treatment benefit is heartbreaking for families and practically guarantees that costs are shifted to the public sector.

Individuals unable to access addiction treatment already paid through premiums and other sources end up cost shifted to limited public funding, to jails, to hospital emergency rooms and as we know, some lose their lives.

PA must ensure that health plans and health payers already in place and already funded through premiums and other sources are easy to access by families and are also held accountable to the General Assembly.

Addiction can't wait. Addiction is a disease of both urgency and of denial. For this reason, we cannot expect to solve this problem through individual complaints.

DASPOP urges the state to provide ongoing, systemic review of all health plans and payers to ensure that current laws and rules are fully enforced and that barriers to care are stripped away for individuals and families seeking help for loved ones.

We have made some preliminary recommendations here knowing that the Departments have additional tools that can be mobilized in the service of addressing Pennsylvania's epidemic drug problem and ensuring help for suffering families. (Some of these tools are funded by the health plans themselves.)

Each of the laws listed below require coverage for treatment of alcohol and drug addiction in some fashion. Each also is in need of strong, consistent enforcement and the establishment of accountability provisions and reporting on compliance to the General Assembly.

## **Federal Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA)**

MHPAEA requires insurers to cover the treatment of drug and alcohol addiction and/or mental illnesses in parity with med/surgical problems. States are required to be the first line of enforcement of the Federal Parity Act. If properly utilized, this Federal law should work with our state drug and alcohol insurance and health laws (Act 152 of 1988 and Act 106 of 1989) and enhance care for people in need of treatment.

New York state has taken lead in the enforcement of the Parity Act and there are templates that could be used here in Pennsylvania.

The New York State Department of Financial Services issued guidance to insurers delineating the requirements of MHPAEA and conveying the expectation of compliance.

In addition, New York state's Attorney General has been vigorously enforcing MHPAEA violations such as: more restrictive, more frequent utilization and review for drug and alcohol and mental health than for other illnesses, outpatient fail first schemes, discriminatory limits on units of service, more frequent denials of addiction treatment than for other illnesses, etc.

California insurance regulators require managed care companies working with drug and alcohol to expressly certify their compliance with MHPAEA.

Why wouldn't the PA Insurance Department and/or the Attorney General's Office follow these templates and examples and immediately begin review of the health care plans in relationship to addiction treatment? (See attachments from the NY State Department of Financial Services and the NY State Attorney General.)

### **Federal Employees/Federal Blue Cross**

In Pennsylvania, there are over 200,000 Federal employees, retirees and dependents. Although Federal employees can select health coverage from over 130 different plans, we estimate that about 60% sign up with Federal Blue Cross.

After enactment of the federal Mental Health Parity & Addiction Equity Act, in 2011, Federal Blue Cross reduced coverage for addiction treatment by dropping treatment in licensed, residential non-hospital addiction treatment facilities. When people are unable to get help, costs of treatment are shifted to precious and limited public funding and as the person deteriorates, to the criminal

justice and health care systems. Effective January 1, 2016, Federal Blue Cross reinstated this coverage.

However, the authorization process imposed by Magellan/Federal Blue is making it nearly impossible for individuals to obtain help in this needed level of care. (See attached.)

The authorization process drives costs to be shifted to the state as Federal employees needing this treatment for themselves or loved ones end up losing their jobs or seeking public funding.

Through state and federal advocacy, Pennsylvania must insist on a simpler authorization process and lead the national effort on behalf of federal employees and families.

### **Institution for Mental Diseases Exclusion (IMD)**

The IMD is a Federal statute that bars federal Medicaid match for treatment in facilities with more than 16 beds. Facilities with 17 or more beds are considered IMDs and are excluded from Medicaid match. The IMD Exclusion has caused serious gaps in the availability of non-hospital, residential addiction treatment services for adolescents, for pregnant addicted women, addicted women with dependent children and criminal justice populations. Many individuals, organizations and elected officials have worked for years to eliminate the IMD Exclusion's application to addiction treatment. (See attached letters from Peter Edelman, former Counselor to Secretary of Health & Human Services during the Clinton Administration and from 18 U.S. Senators, including Senator Robert Casey, Jr. and the DASPOP Briefing on IMD)

Addiction treatment efforts in all states have been damaged by the erroneous application of the IMD Exclusion to addiction treatment facilities. This harmful policy can be eliminated through administrative action by the executive branch.

Pennsylvania should lead advocacy efforts in Washington to eliminate the application of the IMD Exclusion to alcohol and drug addiction treatment programs.

### **Act 106 1989 (Act 64 of 1986)**

Act 106 of 1989 requires all group health plans, HMOs, some self-insured plans and the Children's Health Insurance Program to provide comprehensive treatment for alcohol and other drug addictions. After a ruling by the state

Supreme Court, this law is now generally followed. However, we are struggling with the Affordable Care Act/Health Exchanges in this regard. Pennsylvania declined to set up a state Health Exchange and the Federal government selected an Aetna plan for PA – one of the three largest group plans in the state.

This health plan falls under the provisions of Act 106 of 1989. In some parts of the state, insurers are following the law and in other parts of the state, insurers are claiming that Act 106 does not apply to the Health Exchanges.

A letter from the Insurance Department directing insurers to comply with Act 106 of 1989 in regard to the Health Exchanges would quickly settle the issue and improve access to addiction treatment across the Commonwealth.

### **Act 152 of 1988**

Act 152 of 1988 adds licensed non-hospital residential detoxification, non-hospital residential rehabilitation and halfway house to the services already covered by state Medicaid to treat alcohol and other drug addiction. Prior to the enactment of Act 152, state Medicaid only covered limited outpatient and limited hospital services. Medicaid administers addiction treatment through Behavioral Health Managed Care Organizations (BHMCOs) across the state using the PA Client Placement Criteria (PCPC) established by statute in the Department of Drug and Alcohol Programs. Accountability provisions are needed to ensure that the proper lengths of stay and levels of care are provided to these more deteriorated patients. We are hearing of very, very short lengths of stay in rehab – too short to support recovery. Oversight and accountability is needed.

The Department of Drug and Alcohol Programs, with the assistance of the Department of Human Services, should be directed to conduct PCPC compliance reviews with each behavioral health managed care organization.

Behavioral health managed care organizations should be required to report the number of people receiving addiction treatment, levels of care and lengths of stay in a transparent fashion made available to the General Assembly and to the public at least annually.

Similar transparency and public reporting should be required of all health plans operating in the state, not just Medicaid.

### **Health Plan Benefit Booklets**

Managed care organizations are required to send their sample consumer benefit books and other consumer materials to the Department of Health. (PA

Title 28, Chapter 9. Managed Care Organizations, Section 9.604. Plan reporting requirements.) Insurance policies are also subject to review by the Insurance Department.

Periodically, we have checked the materials in the Department of Health. Rarely are the provisions of Act 106 of 1989 correctly depicted by the health plans. In addition, we've seen no clear description of how to access addiction treatment through the Mental Health Parity & Addiction Equity Act of 2008.

The managed care organizations are also required to file an Annual Status Report with the Department of Health that includes a section on substance abuse (#21) that asks for information such as number of members treated at each level of care, average length of stay, etc. This section is typically incomplete or reveals that for the most part, not much treatment is occurring.

The reports are filed with the Department of Health but do not appear to be used to ensure compliance with state and federal addiction treatment laws.

Let's use these tools in the two Departments.

### **Insurance Department and Office of the Attorney General**

Finally, because of the nature of addiction, waiting for individual complaints to trickle through the consumer complaint process of the Insurance Department is unrealistic and is unhelpful in this time of epidemic need.

The Insurance Department and Office of the Attorney General should mobilize their regulatory tools and conduct systematic reviews and investigations of MHPAEA compliance and barriers to addiction treatment across the Commonwealth.

In addition, the Insurance Department and Office of the Attorney General should take active roles in assisting consumers in filing complaints and should also meet regularly with the Department of Drug and Alcohol Programs and addiction treatment programs to help identify patterns of delay and denial.

### **All Health Plans**

All health plans providing addiction treatment in the state of Pennsylvania should be required to report the number of people receiving addiction treatment, levels of care and lengths of stay in a transparent fashion made available to the General Assembly and to the public on at least an annual basis.

## Emergency Addenda

We are in the middle of an epidemic drug problem in the state and must ensure subscribers of health plans know how to get help. Insurers should be required to prepare and issue emergency addenda to all subscribers describing how to access drug and alcohol addiction treatment coverage in the health plan. To ensure clarity for the consumer, the materials should be reviewed by the Department of Drug and Alcohol Programs, the Department of Health, the Department of Insurance, addiction treatment programs and people impacted by the illness.

\*All attachments are available at [dasdbeck@hotmail.com](mailto:dasdbeck@hotmail.com)

April 2016

Drug and Alcohol Service Providers Organization of Pennsylvania  
[dasdbeck@hotmail.com](mailto:dasdbeck@hotmail.com)

## Insurance/Health Plan Matters

Some beginning steps to improve access to addiction treatment in Pennsylvania through existing health plans that are already required to provide this treatment. There are many other steps that could be taken, but here is a start.

### Health Exchanges

The ACA requires establishment of Health Exchanges by the state or Federal government for individuals who are ineligible for other insurance, have no employer-based insurance or who choose to purchase coverage through an Exchange.

States could decline to set up a health exchange or could select an existing health plan to define the items and services to set the benchmark for services included in the ACA's Essential Health Benefits. States could select from: one of the three largest small group plans in the state; one of the three largest state employee health plans; one of the three largest federal employee health plan options or the largest HMO plan offered in the state's commercial market.

PA declined to set up a state Health Insurance Exchange and the federal government moved on to select an Aetna plan for PA – one of the three largest small group plans in the state.

This health plan falls under the provisions of Act 106 of 1989. In some parts of the state, insurers are following the law. In other parts of the state, insurers are claiming Act 106 does not apply.

### Remedy

A letter from the Insurance Department directing insurers to comply with Act 106 of 1989 in regard to the Health Exchanges would settle the issue.

### Sample Benefit Material

Managed care organizations are required to send their sample consumer benefit books and other consumer materials to the Department of Health. (PA Title 28, Chapter 9. Managed Care Organizations, Section 9.604. Plan reporting requirements)

Periodically, we have checked these materials. Rarely are the provisions of Act 106 of 1989 correctly depicted. In addition, we've seen no clear description of how to access addiction treatment through the Mental Health Parity & Addiction Equity Act of 2008.

Someone should be routinely reviewing all these consumer materials to ensure that they accurately reflect the provisions of Act 106 of 1989 and the Mental Health Parity & Addiction Equity Act and that the materials are written so families in crisis can read and utilize them.

In addition, the managed care organizations are required to file an Annual Status Report with the Department of Health that includes a section on substance abuse (#21) that asks for information such as number of members treated at each level of care, average length of stay, etc. This section is typically incomplete or reveals that for the most part, not much treatment is occurring.

These reports should be used by the Insurance Department and other departments as tools to ensure compliance with Act 106 of 1989 and the Mental Health Parity & Addiction Equity Act.

### Remedies

- IMMEDIATELY require managed care organizations to work with the Department of Drug & Alcohol Programs to prepare an emergency addendum to go out to all subscribers describing how to access drug and alcohol addiction treatment coverage during this time of crisis
- Require routine review of sample benefit books and consumer materials to ensure compliance with Act 106 of 1989, the Mental Health Parity & Addiction Equity Act and other rules
- Require routine review of benefit books and consumer materials on addiction treatment to ensure that the materials are clear and uncomplicated to read
- Require routine follow-up by the Insurance Department, Office of the Attorney General and the Department of Drug & Alcohol Programs on the Annual Status Report, question #21

## Mental Health Parity & Addiction Equity Act of 2008

New York state's Attorney General has been vigorously enforcing MHPAEA violations such as: more restrictive, more frequent utilization and review for drug and alcohol and mental health than for other illnesses, outpatient fail first schemes, discriminatory limits on units of service, more frequent denials of addiction treatment than for other illnesses, etc.

Why wouldn't PA's Attorney General or the Insurance Department follow this template and immediately begin review of these and other practices by all the health care plans in relationship to addiction treatment?

September 2015