Curbing the High Cost of Opioid Abuse Treatment

by Andy Johnson

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As the opioid epidemic worsens, health plans are getting hit with large bills from out-of-network substance abuse treatment facilities. Plan sponsors can take steps to control these costs but must be mindful of mental health parity requirements when enacting changes.

The opioid crisis has been one of the most prevalent and consistent news items for the last decade. Sadly, despite the daily appearance of the opioid abuse epidemic in public discussion and the billions of dollars spent to address the issue, the problem has only gotten worse, and its outcome has become more deadly. In fact, at the end of 2017, the Centers for Disease Control and Prevention (CDC) released a report showing that, for the first time since the 1960s, life expectancy in the United States had declined for the second year in a row.\textsuperscript{1} The CDC directly attributed the decline in life expectancy to the rising death rate among younger Americans due to drug overdoses.\textsuperscript{2} And more recently, the CDC issued a Vital Signs report showing that emergency department visits due to opioid overdoses had surged upward nationwide by approximately 30\% from July 2016 to September 2017.\textsuperscript{3}

Researchers agree on the grim mortality figures of the crisis and on the tremendous financial costs of this epidemic. Last year a White House report\textsuperscript{4} estimated that the cost was more than $500 billion annually, and a report earlier this year stated that the total cost since 2001 had exceeded $1 trillion.\textsuperscript{5}

The financial cost to health benefit plans has not been thoroughly researched or documented. However, a quick glance at recent history would make it safe to assume that health plans have suffered huge losses related to the opioid abuse epidemic. A major contributing factor was the passage
of two landmark federal laws affecting health plans at the same time the opioid crisis began to emerge.

First, the Affordable Care Act (ACA) mandated coverage for a variety of medical services, removed annual and lifetime dollar limits, and added a new population (those aged 19-25) of participants to health plans. At the same time, this age group is the most likely to abuse prescription opioids, stimulants to treat attention deficit hyperactivity disorder (ADHD) and antianxiety medications.6

Next, the Mental Health Parity and Addiction Equity Act (MHPAEA) removed significant financial limitations that plans had applied to behavioral health benefits and mandated that plans cover services provided by out-of-network facilities and providers if the plan’s medical benefit rules allowed out-of-network coverage. These changes all occurred in the midst of the unprecedented surge in opioid prescribing, with sales of prescription opioids in the U.S. nearly quadrupling from 1999 to 2014.7

News of an opioid abuse epidemic began to appear at the same time these two laws went into effect and, almost immediately, new substance abuse treatment programs began to open across the country. Many of these programs were in destination regions like Florida and southern California. These program sites frequently appeared at the top of search engine results, with attractive websites promising to “accept your insurance” and emphasizing comfortable, luxurious accommodations.

Many of the new treatment programs frequently used high-cost urine drug screens and tested patients several times a week at a cost of hundreds or even thousands of dollars for each test. Health plans began to see drug testing bills that were nearly equal to, and in some cases greater than, the cost of treatment. The author’s fund has witnessed charges as high as $12,000 for a single drug test, and there have been news reports of charges as high as $17,000.

In 2016, two reports by FAIR Health quantified the costs of opioid abuse to health plans. The first report revealed that from 2007 to 2014 there was a 3,000% increase in the volume of insurance claims related to opioid dependence diagnoses.8 The second report found that from 2011 to 2015 professional charges for opioid abuse and dependence diagnoses rose by more than 1,000%, from $71.66 million to $721.80 million.9 This report also noted that the allowed amounts, that is, the amount that an insurer would actually pay for a covered health service, had risen at an even higher rate during that time, from $32.42 million in 2011 to $445.74 million in 2015, an increase of 1,375%.

These major cost increases continue to severely impact health plans of all sizes. However, while plans may feel vulnerable to the high-dollar billing tactics of unethical substance abuse treatment programs, there are several steps plan sponsors can take to limit the access of these programs to plan assets.

**Review Plan Rules for Weak Points**

It is important for plan sponsors to review plan rules and procedures to determine whether there are weak points that are allowing easy access to their benefits. These weak points can vary from areas like how incoming calls are handled to how certain claims are being processed by the payment system. Once the review is complete, the sponsor then needs to initiate changes to close those gaps in the plan.

One major weak point that may go unnoticed is how out-of-network claims are repriced. This is particularly true when the repricing is left up to the plan’s insurance company and that company uses a Medicare-based repricing model. Insurance carriers may base their allowable rate for out-of-network carriers on a multiple of a Medicare rate (e.g., 150% or 250%).

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**takeaways**

- Passage of the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) have left health plans open to higher costs for the treatment of substance abuse at the same time the number of unethical treatment centers grew.

- The number of health insurance claims related to opioid dependence has skyrocketed over the last decade.

- Some plans have placed limits on substance abuse coverage by refusing to cover treatments in out-of-network treatment facilities, but such limits also must be applied to medical treatment in order to avoid violating MHPAEA.

- Directing incoming communication from treatment facilities and plan participants to a gatekeeper helps plans clearly explain benefits available and avoid miscommunication.

- Plan sponsors should address drug testing, considering issues such as whether out-of-network tests will be covered and placing limits on frequency and allowable reimbursement rates.
While Medicare-based repricing can be a valuable tool, it is often exploited by unethical treatment programs and results in high-dollar payments to the treatment program. The Medicare rate pricing may reimburse out-of-network providers at a higher rate than the negotiated rates for in-network providers. Another issue can occur when claims are passed through to the payer at full charges. This can happen if there is no Medicare rate for a service in that area. In-network rates also tend to be all-inclusive, while out-of-network providers often are reimbursed for each billed service. For example, if a patient is in an inpatient setting, attends a group session and then is drug-tested, the out-of-network provider may bill for each separate service, while the in-network provider is reimbursed at a daily rate for all services rendered.

This is one reason many treatment programs elect to not contract with health plans—There is too much money to be made out of network. Plans should review their reimbursement policies for out-of-network claims as well as the actual claims to make sure they are not being overbilled.

Some plans have placed limits on coverage to reduce their exposure to unethical treatment programs, including refusing to cover any treatments in Florida, any out-of-network treatment facilities, etc. However, if these rules are not also applied to medical treatment, the plan would be in violation of MHPAEA. Another problem with these types of limits is that there are many excellent and ethical treatment programs in Florida, and every other state in the U.S., and plan participants should be allowed to find the right program for their condition.

Control Incoming Communications

Plans may regularly receive inquiries from both treatment facilities and plan participants regarding their behavioral health benefits. It is good practice to direct all of these calls to a gatekeeper—either a specific employee or department within the plan or the employee assistance program (EAP) and/or behavioral health management company. This will ensure that all incoming calls are handled according to plan policies and procedures and will avoid miscommunication by a staff member who is not familiar with these practices.

Another important benefit of controlling incoming communication is that it allows the plan to clearly explain the benefits available and the plan rules and to direct participants in need of substance abuse treatment to either the EAP, a list of in-network treatment providers or both.

Address Drug Testing

Routine urine drug testing is an important component of substance abuse treatment. However, health plans do not have to tolerate excessive use of those tests and frequent use of higher cost confirmatory testing. Trustees may be hesitant to address limits on drug test reimbursement because of concerns of violating MHPAEA, but the law does not include any language regarding limitations on drug testing. Plans also should note that drug testing is a procedure that is not limited to substance abuse treatment. Medical providers also drug-test patients to check the presence of certain substances. Therefore any rule applied to drug testing would apply to both medical and behavioral benefits.

Plans should decide whether they want to cover out-of-network drug testing. Plan sponsors also may elect to establish their own reimbursement schedule for drug testing with limits on frequency and allowable reimbursement rates. A plan could elect to limit reimbursement to the Medicare rate, usual and customary rates, or simply a set cap of $100 per drug test, regardless of how many substances are checked on the test. The goal would be to adequately cover lab costs and reduce the likelihood that the lab will balance bill the patient. If the plan sets limits on the number of tests, a limit of one test per week for residential and partial hospitalization levels of care and five tests per month for outpatient and intensive outpatient treatment would be reasonable.

Participant Communications Are Critical

Regardless of what steps plan sponsors enact to protect themselves from unethical substance abuse treatment providers, it is important to regularly communicate the what and why of these changes to their participants. Participants should be warned about the unethical behaviors of some treatment programs and encouraged to get help through plan-approved providers and services.

Signs of Change

In February, Purdue Pharma, in the midst of mounting lawsuits over its marketing practices, announced that it would stop marketing its opioid medications to physicians.10 Also in February, a California jury awarded more than $7 million in a wrongful death suit to the widow of a patient who died at a treatment facility due to staff negligence.11 Another California court found a “rehab mogul” who operated more than 13 drug treatment centers guilty of 31 criminal
counts of rape and drug dealing. These events all point to society’s growing intolerance for those people and companies that seek to profit from America’s opioid addiction.

Conclusion

Federal legislation affecting health plans and the opioid abuse epidemic opened a Pandora’s box that resulted in huge costs for benefit plans. Plan sponsors have a fiduciary responsibility to take action in the best interests of the plan and protect financial assets. However, it is critical that they never lose sight of the fact that families who are experiencing the crisis of drug addiction are often desperate for help and looking for answers. With proper policies and procedures in place and frequent, clear communication with participants, plans can reduce their financial exposure to the opioid epidemic and encourage their membership to turn first to their health plan and its behavioral health partners when looking for assistance.

Endnotes

2. Ibid.
7. See www.cdc.gov/drugoverdose/data/prescribing.html.
8. The Opioid Crisis Among the Privately Insured: The Opioid Abuse Epidemic as Documented in Private Claims Data. Fair Health. 2016.

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