Substance abuse coverage provided by employer medical plans

BLS' Employee Benefits Survey shows that in 1989, 96 percent of health plan enrollees had some coverage for substance abuse treatment

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There are currently about 13 million substance abusers in the United States,[1] and it is estimated that substance abuse cost the U. S. economy $229 billion in 1990.[2] (Substance abuse is defined as the use of illicit substances or misuse of controlled substances, alcohol, or other psychoactive drugs.)

Recent data clearly suggest a major problem facing American employers. More and more dollars are spent on employee substance abuse treatment costs while work time is lost and productivity is reduced because of an employee's incapacity induced by substance abuse. To help counter this trend, employers have been adding benefits to their medical care plans to treat the acute effects of substance abuse and to assist individuals in altering their behavior.

According to data from the Bureau of Labor Statistics' Employee Benefits Survey, participation in plans providing substance abuse coverage has grown dramatically since 1983, the first year for which data are available. In that year, a little more than one-half of all participants had coverage for some form of alcohol abuse care. By 1989, approximately 97 percent were covered for alcohol abuse services. Similarly, 43 percent of health plan enrollees had drug abuse coverage in 1983; in 1989, the figure had risen to 96 percent. (See chart 1.)[3]

Benefits provided for this type of care are, however, less comprehensive than those for other illnesses. Plans typically impose limits on the duration or cost of coverage, beyond those applicable to other illnesses. For example, a plan may impose a 30-day per year limit on inpatient substance abuse treatment or restrict expenses for all substance abuse care to $10,000 per lifetime.

The Employee Benefits Survey in medium and large private industry establishments provides a vast amount of detail on benefits provided for substance abuse treatment. In addition, the survey provides extensive data on other health care benefits such as hospitalization, surgical care, and physician's services. The 1989 survey studied full-time employees in a sample of 2,047 establishments, which represented more than 109,000 establishments employing 32 million full-time employees. These data cover private industry establishments with 100 or more employees in all States except Hawaii and Alaska.[4]

Substance abuse in the workplace

Data on substance abuse in the workplace indicate the cause of employer concern and action. The National Institute on Drug Abuse 1985 Household Survey showed that among the 20- to 40-year-old employed population, 29 percent responded that they had used illicit drugs within the past year and 19 percent, within the past month. Of those respondents reporting current drug usage, 16 percent used marijuana and 5 percent admitted cocaine usage.[5] Some experts estimate that up to 20 percent of all employees have used illegal drugs in the workplace.[6] In addition, 1984 alcohol abuse data indicate that 1 in 5 male workers had a serious drinking problem and 1 in 10 male workers displayed alcohol dependence. Alcohol abuse among female employees is lower, but recent medical studies suggest that women may experience more severe alcohol dependency as the result of metabolic differences in the initial absorption process. Finally, the incidence of multiple drug use must not be over-

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looked. It is estimated that 15 to 20 percent of alcohol abusers are "polydrug abusers."[7]

Employees who are substance abusers can represent either a direct or indirect cost to employers. Substance abuse and related mental health treatment cost the Nation $38 billion in 1988, and accounted for 7 percent of total health care expenditures. Costs for such care are increasing at approximately twice the rate of medical inflation, and faster than any other component of health care expenses. More than one-half of this cost is paid by employers through private health insurance premiums. According to employers who were surveyed nationwide, their direct costs for the treatment of substance abuse problems increased by 18 percent from 1988 to 1989, while the average cost per employee rose from $207 to $244. Recent surveys of public and private employers show that substance abuse treatment averages 5 to 15 percent of total employee health plan costs.[8]

Indirect business costs resulting from employee substance abuse are equally startling. Comparisons drawn between abusers and non-abusers reveal that:

- Employees who tested positive for drugs were absent 2.5 times more often than non-abusers.
- Job productivity was 25 to 33 percent lower for substance abusers.
- The probability of off-the-job accidents was 4 to 6 times greater for substance abusers.
- Claims for worker compensation were three times greater for abusers.

Other indirect costs to business by substance abusing workers include higher turnover rates,

Table 1. **Percent of full-time participants in medical care plans with alcohol and drug abuse treatment benefits by extent of benefits, medium and large establishments, 1989**

Coverage limitation	Alcohol abuse			Drug abuse		
	Inpatient detoxification[1]	Inpatient rehabilitation[2]	Outpatient care[3]	Inpatient detoxification[1]	Inpatient rehabilitation[2]	Outpatient care[3]
Total	100	100	100	100	100	100
With coverage	[4]100	68	61	[4]100	64	58
Coverage the same as other illnesses	43	9	8	45	8	7
Covered the same as mental illness	(5)	(5)	(5)	(5)	(5)	(5)
Subject to separate limitations[6]	56	59	53	55	55	51
Limit on days	42	46	22	40	42	20
Per year	27	31	20	26	28	18
Per confinement	15	12	2	15	12	2
Per lifetime	11	14	6	11	13	5
Limit on dollars	23	23	36	23	23	35
Per day	(5)	1	6	(5)	1	6
Per year	7	6	25	7	6	24
Per confinement	(5)	(5)	—	(5)	(5)	—
Per lifetime	19	18	18	19	18	18
Per other period	1	1	2	1	1	2
Coinsurance limit[7]	6	6	18	6	6	18
Ceiling on out-of-pocket expenses does not apply	9	8	18	9	8	18
Separate copayment of deductible	1	1	6	1	1	6
Other limitations	(5)	(5)	(5)	(5)	(5)	(5)
Without coverage	(5)	32	39	(5)	36	42

[1] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[2] Rehabilitation is designed to alter behavior in patients once they are free of acute physical and mental complications.

[3] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, doctor's office care was tabulated.

[4] There were a few plans that covered inpatient rehabilitation, but not inpatient detoxification.

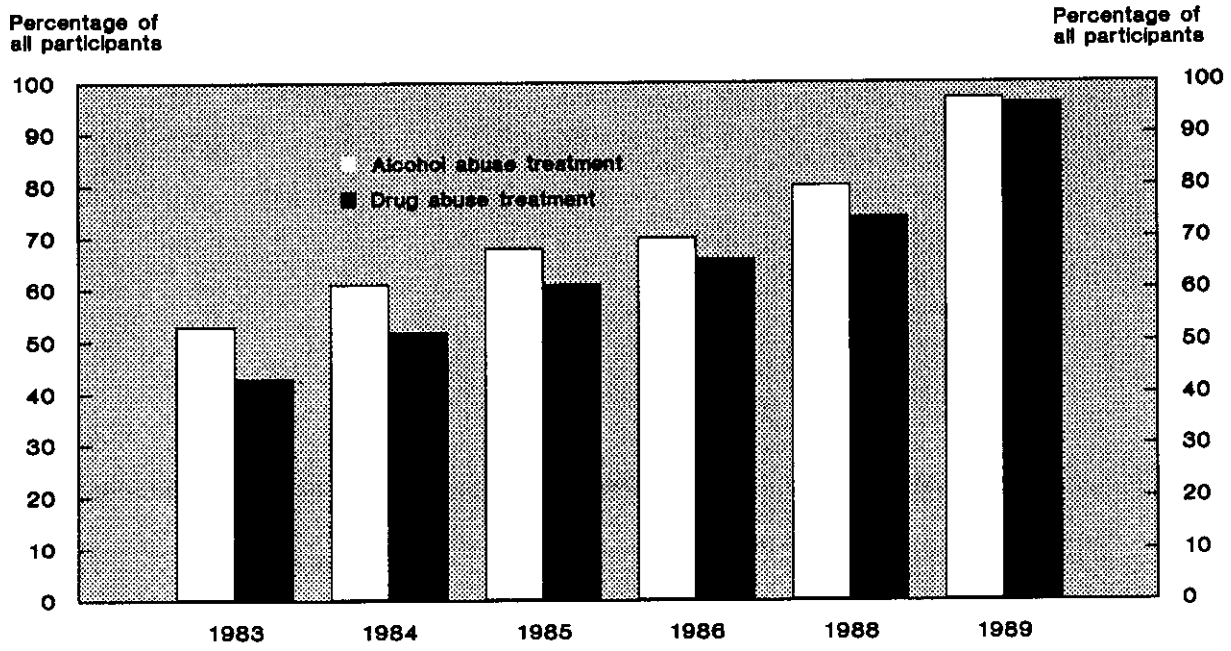
[5] Less than 0.5 percent.

[6] The total is less than the sum of the individual items because many plans had more than one type of limitation.

[7] Coinsurance rate is lower than that applying to other medical services.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no employees in this category.

Chart 1. **Percent of full-time participants in medical care plans by coverage for alcohol and drug abuse treatment, medium and large establishments, 1983-89**



Note: Private industry data are not available for 1987 because the Employee Benefits Survey examined only State and local government benefit plans that year.

increased workplace theft, lower office morale, and increased behavioral problems.[9]

In addition to the direct and indirect cost to employers of substance abusing workers, there is also the cost of *not* treating substance abuse. The health insurance costs associated with the treatment of AIDS (Acquired Immune Deficiency Syndrome)[10] are enormous, and with a new generation of infants born with Fetal Alcohol Syndrome or as "cocaine babies," the ultimate cost to employers in particular and society in general is staggering. Future costs to employers of not effectively treating substance abusers may also include payment of premature life insurance benefits, long-term disability income payments, and pension plan disability, death, and survivor payouts. The costs of abuse can be a serious threat to the competitiveness, profitability, and quality of American business.[11]

Employer response. Prior to the 1970's, it was standard practice for private insurance policies specifically to exclude coverage under the heading of substance abuse treatment. Instead, health insurance plans typically covered specific symptoms of alcohol and drug abuse, such as cirrhosis, pancreatitis, heart disease, and ulcers.[12]

During the mid- to late 1960's, however, limited coverage of treatment specifically for alcohol abuse began to appear. In 1964, the Kemper Insurance Companies added alcohol treatment coverage to the health plan for their own employees. Blue Cross-Blue Shield began offering a similar benefit to their subscribers by 1969.[13] Such benefits were limited, however, as policies typically restricted the availability of coverage through exclusions and limitations.

Mandates enacted. Efforts to improve access to medical care benefits for employees with substance abuse problems have led, in recent years, to State-legislated mandates, requiring insurers to provide coverage. Currently, 24 States and the District of Columbia require private insurance plans to provide some type of coverage for alcohol-related treatments, while 16 other States have mandated coverage for both alcohol and drug abuse.[14] Mandates vary between States—some providing for a specified number of days or treatment sessions to be covered, others establishing a minimum dollar amount of coverage that must be provided, while others merely require insurers to offer

substance abuse treatment benefits as an option to those purchasing medical care policies.[15]

Types of treatment. In 1989, substance abuse treatment benefits were widespread. Benefits for alcohol and drug abuse treatment are provided for both detoxification and rehabilitation. (See the appendix for details on types and locations of substance abuse treatment.) Table 1 describes the incidence of benefits for detoxification and rehabilitation for those participants with some form of alcohol and drug abuse treatment coverage; it also compares coverages of substance abuse treatment with that of other illnesses.

Virtually all participants in plans with alcohol and drug abuse benefits were covered for inpatient (in-hospital) detoxification. Detoxification is generally considered to be a medically necessary health benefit and is therefore rarely excluded from coverage. In contrast, rehabilitative care is often not considered medically necessary by the insurer, and is thus covered less frequently than treatment for detoxification. Two-thirds of the participants with some type of alcohol coverage had provisions in their plan for inpatient rehabilitation treatment. Coverage for outpatient alcohol treatment, generally rehabilitative care, was slightly less common than inpatient rehabilitation. Coverage patterns were similar for inpatient and outpatient drug abuse benefits.

Table 2. **Percent of participants in medical care plans with substance abuse benefits by limitations on days of coverage, 1989**

[Full-time participants in medium and large establishments]

Coverage[1]	Fee-for service plans	Health maintenance organization plans
Total	100	100
With inpatient care, total[2]	100	100
Separate limit on inpatient days	44	44
Limit on days also covers outpatient care	1	(3)
No limit on days	55	56
Without inpatient care, total	—	(3)
With outpatient care, total[2]	60	62
Separate limit on outpatient days	17	33
Limit on days also covers inpatient care	1	(3)
No limit on days	42	29
Without outpatient care, total	40	38

[1] Includes plans in which inpatient and outpatient day limits are combined with mental health care.

[2] The total is less than the sum of the individual items because some participants were in plans that had separate limits for one category of care and limits that applied to multiple categories of care.

[3] Less than 0.5 percent

NOTE: This table describes plans that treat both alcohol and drug abuse care in the same manner. Because of rounding, sums of individual items may not equal totals. Dash indicates no employees in this category.

Table 3. **Percent of participants in medical care plans with substance abuse benefits by limitations on days of coverage for inpatient and outpatient care, 1989**

[Full-time participants in medium and large establishments]

Coverage[1]	Fee-for service plans	Health maintenance organization plans
Total inpatient[2]	100	100
Maximum days per year	62	90
Less than 30	5	9
30	28	65
31–44	8	2
45	9	6
46–59	1	—
60	8	1
More than 60	3	7
Maximum days per illness	34	7
Maximum days per lifetime	32	17
Total outpatient[2]	100	100
Maximum days per year	86	98
Less than 20	—	—
20	3	64
21–29	2	6
30	20	10
31–34	—	—
35	17	3
36–49	5	3
50	22	1
51–59	5	—
60	4	9
More than 60	7	1
Maximum days per illness	9	6
Maximum days per lifetime	34	4

[1] Plans in which combined day limits applied to inpatient and outpatient coverage were excluded because there were few plans in this category.

[2] The total is less than the sum of the individual items because some plans had more than one type of limitation.

NOTE: This table describes plans that treat both alcohol and drug abuse care in the same manner. Because of rounding, sums of individual items may not equal totals. Dash indicates no employees in this category.

Limitations

In virtually all plans, provisions for alcohol abuse treatment were the same as those for drug abuse treatment. Thus, the remaining discussion

will cover alcohol and drug abuse treatment as one benefit, substance abuse care.[16] For example, a plan may impose a limit of 20 days per year for all outpatient substance abuse treatment and 30 days per year for all inpatient care.

The following tabulation indicates the percent of plan participants with alcohol abuse treatment coverage by how their plan covers drug abuse treatment:

	All plans
Total	100
Drug abuse treated the same	92
Drug abuse treated differently	7
No coverage for drug abuse	1

Note that drug abuse treatment is nearly always covered under plans that also covered alcohol abuse treatment; no plans were found that solely covered drug abuse.

Benefits for substance abuse treatment have traditionally been more limited than benefits for other illnesses. Coverage for inpatient detoxification, however, is more likely to be treated the same as other conditions than either inpatient rehabilitation or outpatient care. Slightly more than 40 percent of the participants with substance abuse coverage had inpatient detoxification benefits covered the same as other illnesses. In contrast, fewer than 10 percent of participants had provisions for inpatient rehabilitation and outpatient care that were identical to those for other illnesses.

Table 4. **Percent of participants in *fee-for-service plans* with substance abuse benefits by limitations on dollars paid by the plan, 1989**

[Full-time participants in medium and large establishments]

Coverage[1]	Fee-for-service plans
Total	100
With inpatient care, total[2]	100
Separate dollar limit on inpatient care	9
Dollar limit also covers outpatient care	23
No dollar limit	70
Without inpatient care	—
With outpatient care, total[2]	60
Separate dollar limit on outpatient care	27
Dollar limit also covers inpatient care	23
No dollar limit	18
Without outpatient care	40

[1] Includes plans in which inpatient and outpatient dollar limits are combined with mental health care.

[2] The total is less than the sum of the individual items because some participants were in plans which had both separate limits for one category of care and limits that applied to multiple categories of care.

NOTE: This table describes plans that treat both alcohol and drug abuse care in the same manner. Because of rounding, sums of individual items may not equal totals. Dash indicates no employees in this category.

Table 5. **Percent of participants in fee-for-service plans with substance abuse benefits by limitations on maximum dollar amounts coverage, 1989**

[Full-time participants in medium and large establishments]

Coverage[1]	Fee-for-service plans
Inpatient care only[2]	100
Maximum dollars per year	27
Maximum dollars per lifetime	77
Other period[3]	6
With outpatient care only[2]	100
Maximum dollars per year	96
Less than $500	—
$500	12
$501–$999	5
$1,000	24
$1,001–$1,499	1
$1,500	8
$1,501–$2,499	18
$2,500	11
$2,501–$4,999	14
$5,000 or more	1
Maximum dollars per lifetime	11
Other period[3]	1
Inpatient and outpatient care combined[2]	100
Maximum dollars per year	31
Maximum dollars per lifetime	83
Less than $9,999	15
$10,000	9
$10,001–$24,999	12
$25,000	17
$25,001–$49,999	5
$50,000	18
$50,000 or more	6
Other period[3]	3

[1] Includes plans in which inpatient and outpatient dollar limits are combined with mental health limitations.

[2] The total is less than the sum of the individual items because some plans had more than one type of limitation.

[3] Includes participants in plans in which the maximum dollar amount applied to a specified period other than that shown (such as per 24-month period).

NOTE: This table describes plans that treat both alcohol and drug abuse care in the same manner. Because of rounding, sums of individual items may not equal totals. Dash indicates no employees in this category.

There appear to be several reasons why insurers provide more restrictive coverage for substance-abuse benefits than for other illnesses. First, there are still strong social beliefs holding that substance abuse is not a legitimate illness, but rather a self-inflicted condition for which treatment should not be covered under medical care benefits. Second, it is difficult to determine an actuarially based premium for substance abuse benefits.[17] It is also difficult to estimate the incidence of the disease, the responsiveness to treat-

ment, or the ultimate cost and duration of treatment. Finally, some commercial insurers question the various nontraditional treatments currently in vogue, such as that delivered by nonmedical counselors and case managers without physician supervision.[18]

Typically, medical care plans impose limitations that apply just to substance abuse treatment. Such separate limitations frequently included restrictions on the annual number of days of inpatient care, the number of outpatient visits per year, and the maximum dollar amounts of benefits to be paid by the plan per year or per lifetime.

Benefit limitations vary significantly. One important factor in determining benefit limitations is the type of medical care plan. Traditional fee-for-service plans, which reimburse patients or providers after care is received, typically limit available inpatient substance abuse treatment to a maximum number of days per year. (To a lesser extent, limits are placed on the number of days of coverage per illness or per lifetime.) In contrast, prepaid health maintenance organizations (HMO's) are more likely to impose an annual limit on inpatient days, but less likely to limit days per illness or per lifetime than fee-for-service plans.[19]

Table 6. **Percent of participants in health maintenance organization plans with outpatient substance abuse benefits by copayment provisions, 1989**

[Full-time participants in medium and large establishments]

Coverage	Participants
Total[1]	100
Copayment required	44
Copayment per visit	34
$1–4	5
$5	6
$6–$9	1
$10	6
$11–$19	4
$20	6
$25	5
Greater than $25	1
Copayment varies by days	9
Copayment per year	1
Other[2]	(3)
Copayment not required	56

[1] The total is less than the sum of the individual items because some plans had more than one type of limitation.

[2] Includes participants in plans in which the copayment limits applied to a specified period other than that shown (such as per 24-month period).

[3] Less than 0.5 percent.

NOTE: This table describes plans that treat both alcohol and drug abuse care in the same manner, and are for full-time participants in medium and large establishments.

A high percentage of participants in all types of plans providing outpatient substance abuse benefits had restrictions placed on the annual number of treatment days available. Traditional plans frequently specified the maximum dollar amount the plan would pay for substance abuse treatment over some time period, while HMO's did not generally impose such limits. However, HMO's tended to apply copayment provisions, requiring subscribers to pay a nominal fee before receiving services for outpatient care; traditional plans rarely had such features.

Generally, HMO's cover inpatient and outpatient substance abuse treatment in full, but limit the annual number of days; such plans cover outpatient substance abuse care up to an annual number of days while imposing a copayment per visit. In comparison, substance abuse coverage in fee-for-service plans typically is subjected to overall plan limitations, that is, limitations applying to several medical procedures and services. The three main overall limits are: deductibles, coinsurance, and maximum dollar coverages. A deductible is the dollar amount of initial medical costs that the plan enrollee must pay before the policy will begin reimbursing expenses. In 1989, the individual deductible usually was $100 or $200 per year with a family limit of 2 or 3 times the individual amount. Under coinsurance, covered expenses are shared between the individual and the plan, with the insurer typically paying 80 percent of the total. Finally, most medical plans impose a lifetime dollar maximum on health insurance coverage, commonly $500,000 or $1,000,000.

Beyond these general provisions, limitations on days of coverage is one means by which insurers restrict benefits provided for substance abuse treatment. Tables 2 and 3 describe the incidence and duration of such limitations.

For participants with inpatient coverage, 44 percent had day limitations imposed. There was no difference in the incidence of such limits between HMO and fee-for-service plan participants. Day limitations for inpatient care were nearly always separate from those imposed on outpatient coverage in both types of health care providers.

Fee-for-service plan participants most commonly had policies limiting inpatient days for substance abuse on a per year basis, frequently to 30 days. Restrictions on inpatient days per illness and per lifetime were less frequently observed.

Coverage patterns for HMO participants were similar to those fee-for-service participants, although when day limits applied, they were nearly always covered subject to an annual maximum. Illness and lifetime restrictions were less common. A limit of 30 days per year for inpatient care was by far the most common feature. This mirrors

typical treatment patterns, which frequently include a 28- or 30-day inpatient detoxification and rehabilitation program.

Slightly more than half of HMO enrollees with outpatient benefits had ceilings on days of coverage, while fewer than one-third of fee-for-service plan participants with outpatient benefits had such ceilings imposed. In HMO's, these limits were usually 20 days annually. Rarely were there outpatient day limits on a per illness or per lifetime basis for HMO's. In fee-for-service plans, the most frequent provision was an annual outpatient limit of 30, 35, or 50 days.

Plans may further restrict coverage for substance abuse treatment benefits by placing ceilings on the maximum dollar amount paid by the plan. Tables 4 and 5 illustrate these limitations. As previously noted, HMO's seldom limit coverage for substance abuse treatment benefits through maximum dollar restrictions.[20] Consequently, the discussion of dollar limitations is confined to those found in fee-for-service plans.

Seventy percent of the fee-for-service participants with uniform substance abuse benefits had no limitations on the dollar value of inpatient care. Where inpatient dollar maximums were imposed, they were generally combined with outpatient treatment. This is in contrast to day limitations, where combined inpatient and outpatient maximums were rare. Dollar maximums of $25,000 or $50,000 per lifetime for all substance abuse treatment were commonly observed provisions.

Outpatient care was more likely to be restricted by a dollar maximum than inpatient care. This includes plans that impose an overall dollar maximum on all substance abuse care plus those with a separate outpatient dollar maximum. In addition, some plans had both an outpatient substance abuse dollar maximum, for example, $2,000 per year, and a total substance abuse dollar maximum, such as $50,000 per lifetime. Treatment must fall within each of those restrictions to be paid for by the plan.

As a rule, HMO's place restrictions on outpatient care through employee copayments per visit rather than on maximum dollar payments. Table 6 shows the percent of participants in HMO plans with outpatient substance abuse copayment provisions. Just over two-fifths of enrollees had outpatient services subject to a copayment, generally $5, $10, $20, or $25 per visit.

IN SUMMARY, substance abuse is a serious problem in America. In fact, a Gallup poll ranked drug use as the Nation's number one problem.[21] As a rapidly accelerating component of health care costs, charges for alcohol and drug abuse treatment are helping to drive up medical care expenses. The substance abuse crisis is also affecting employers, both public and private, who are struggling to provide needed health benefits while controlling spiraling plan costs.

Despite the upward pressure on health costs, the problem is so serious that there has been a steady increase in the incidence of coverage for substance abuse treatment in employer-provided medical care plans, to the point that virtually all plans now provide some benefits. Nevertheless, health plans typically cover substance abuse treatment on a more restrictive basis than other illnesses. This may change, however, as the interest in, and the need for, comprehensive substance abuse treatment benefits grows. □

Footnotes

[1] *National Household Survey on Drug Abuse*, 1990.

[2] *Substance Abuse Issues* (Marsh and McLennan Cos., Winter 1990).

[3] The relatively large increase in the incidence of substance abuse benefits between 1988 and 1989 is due not only to the greater extent of such benefits in health insurance plans, but also to improvements made in the survey's methods for tabulating detoxification benefits. Private industry data are not available for 1987, because the survey examined only State and local government benefit plans in that year. The extent of substance abuse coverage and details of plan provisions among government employees in 1987 was similar to the private industry data.

[4] The Employee Benefits Survey is an annual study of the incidence and characteristics of employee benefits. The survey provides data for the following employee benefits: health care, life and disability insurance, retirement and capital accumulation plans, paid and unpaid leave and a variety of other benefits. Data are presented for all full-time workers and separately for three broad occupational groups: professional and administrative, technical and clerical, and production and service workers. The results of the most recent survey are available in *Employee Benefits in Medium and Large Firms, 1989*, Bulletin 2363 (Bureau of Labor Statistics, 1990).

[5] *National Household Survey on Drug Abuse*, NIDA Capsule (National Institute on Drug Abuse, October 1986).

[6] National Drug Control Strategy, September 1989, The White House, p.56.

[7] Polydrug abuse refers to the misuse of two or more controlled or illicit substances. "Addressing Addiction Through Employee Benefit Plans," *Employee Benefits Practices*, International Foundation of Employee Benefit Plans, Second Quarter 1990, pp.1–2.

[8] *Ibid.*, p. 5.

[9] Peter B. Bensinger and Susan B. Fitzpatrick, "Creating a Substance Abuse Policy That Works," *Health Cost Management*, March/April 1987, p. 11.

[10] The Centers for Disease Control report that as of

September 1987, 14 percent of all reported cases of AIDS are transmitted through the sharing of contaminated needles by intravenous drug users. See Robert P. Galea, Ph.D., Benjamin F. Lewis, Ed.D., and Lori A. Baker, M.A., *AIDS and IV Drug Abusers–Current Perspectives* (Owings, MD, National Health Publishing, 1988), p. xxvi.

[11] *Employee Benefits Practices*, pp. 5–6.

[12] Michael A. Morrisey and Gail A. Jensen, "Employer Sponsored Insurance Coverage for Alcoholism and Drug Abuse Treatments," *Journal of Studies on Alcohol*, Vol. 49, No. 5, 1988, pp. 456–57.

[13] *Broadening the Base of Treatment for Alcohol Problems*, report of a study by a committee of the Institute of Medicine, Division of Mental Health and Behavior Medicine, 1990, p. 424.

[14] "Health Technology Case Study 22: The Effectiveness and Costs of Alcoholism Treatment," Congress of the United States, Office of Technological Assessment, p. 69.

[15] It should be noted that these mandates only apply to employer-sponsored health plans. Under the Employee Retirement Income Security Act of 1974 (ERISA), self-insured plans are exempt from coverage mandates for all types of care, including alcohol and drug abuse treatment.

[16] Plans in which substance abuse benefits differed often had varying limits on coverage between alcohol and drug abuse care. For example, when inpatient alcohol detoxification and rehabilitation were restricted to 30 days per year, inpatient drug benefits were covered for only 20 days annually. Also, there were some plans that covered alcohol detoxification and rehabilitation services but only provided drug detoxification treatment.

[17] An actuarially based premium uses insurance mathematics and the application of statistics to determine an appropriate level of benefit funding, based on the projected use of certain benefits.

[18] *Broadening the Base of Treatment for Alcohol Problems*, pp. 424–25.

[19] A traditional fee-for-service plan reimburses enrollees or providers for expenses, subject to various limitations, incurred in connection with illness or injury. Few, if any, restrictions are placed on the choice of providers or facilities. Preferred Provider Organizations are a specialized type of fee-for-service arrangement in which participants may use providers and facilities of their choice, but are reimbursed at higher rates when using designated providers. For tabulation purposes in this article, Preferred Provider Organizations are included with fee-for-service plans.

Health Maintenance Organizations function on a prepaid basis by providing a predetermined set of benefits for a fixed cost to enrollees. The choice of providers and facilities is generally limited to those affiliated with the organization.

[20] Because HMO's provide services on a prepaid basis, and patients are not charged for individual services, dollar limitations have little effectiveness in controlling the use of services. Instead, HMO's typically limit the number of times a patient can receive services, or control usage by requiring that certain treatment be recommended by a primary physician.

[21] Nancy L. Hodes, "Drugs in the Workplace: New York State is meeting the challenge," *Employee Benefits Journal*, March 1990, p. 21.

APPENDIX: Approaches to substance abuse treatment

The treatment of substance abuse involves a wide range of approaches and settings, with wide variations in cost. For example, it can cost as little as $8 per visit to an outpatient substance abuse clinic in California and more than $450 per day for acute care in a general hospital in the Midwest.

The following describes the most common types of substance abuse treatment providers, the approaches involved, and their costs.

Inpatient hospital care

Typically, both general and psychiatric hospitals provide detoxification and other substance abuse services, including rehabilitation, on an inpatient basis. Detoxification involves supervised medical care designed to reduce or eliminate systematically the symptoms of substance abuse, with treatment occurring in a hospital or other short-term facility. Rehabilitation generally follows detoxification and entails a variety of services intended to alter the behavior of chronic abusers. Treatment in hospital facilities is usually more expensive than in most other settings. A 9-day detoxification stay can cost $3,000 or more. For a standard 28-day inpatient rehabilitation program involving patient counseling, group therapy, and other services, costs can range from $6,000 in a public treatment center to $30,000 in a private specialized psychiatric hospital.

Day/night treatment centers

These facilities offer outpatient detoxification and rehabilitation care on a much less costly basis than in hospitals. Outpatient detoxification typically averages 6.5 days at a cost of between $175 to $388 per treatment. Outpatient rehabilitation lasting 2 weeks can average between $1,000 and $2,000.

Specialized inpatient treatment centers

These settings focus almost exclusively on the rehabilitation of abusers. Detoxification is usually required before admittance. Residential treatment centers are nonmedical facilities where substance abusers are provided residential support along with ambulatory care, such as counseling, group therapy, and other related services. Residential treatment facilities typically charge about $125 per day. However, more expensive programs can charge $25,000 to $100,000 per 28-day stay.

Organizations such as Phoenix House and Second Genesis provide nontraditional approaches to substance abuse treatment. These providers use encounter group confrontation and what some critics call "scare tactics" to achieve behavior modification in abusers, hopefully resulting in a lifelong abstinence from substance abuse. (Information on the various types of substance abuse treatment providers can be found in *Substance Abuse Issues* (Marsh and McLennan Cos., Summer 1990).)