

WHY MEDICAL INSURANCE SHOULD NOT PAY FOR CHEMICAL DEPENDENCY TREATMENT

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Employers have many financial, liability and human resource reasons for providing employees purchase substance abuse treatment programs. However, using medical insurance to facilitate the purchase of this service does not make sense. This column explains why insurance is not the best vehicle for providing treatment for chemical dependency and how the purchasing of such a service can be better managed.

An appropriate package and distribution channel is required for any seller to sell a product and for the buyer to buy the right service or item at the right price. Without a viable packaging and distribution system, the buyer and seller both suffer. A basic principle of marketing is that the lack of an appropriate distribution channel, or changes in distribution channels, account for more product failures than the product not being needed or the product not working. This is definitely true in today's marketplace for alcoholism treatment.

There is no doubt that treatment for substance abuse works. Research has confirmed recovery rates of about 65 percent for all severity levels for people completing a treatment program appropriate for their situation. The costs for such treatment can be recovered in medical cost savings alone within twelve to thirty-six months, depending upon the study. There are also savings in decreased absenteeism and turnover, increased product liability and employee efficiency, and reduced need for community services.

The need for treatment is prevalent. Very few studies find an incidence of less than 8 percent of any population having serious problems with mood altering chemicals, not counting nicotine and caffeine. Patterns in the drug of choice change. Cocaine use for most populations is now less prevalent than it was. Alcohol and nicotine remain the principle drugs of abuse in terms of any measure of morbidity and mortality. The need for treatment has not evaporated.

What has changed are the purchasing mechanisms. The treatment industry grew rapidly during the 80's, primarily as a result of medical insurance providing coverage and payment. The rapid growth was not primarily a result of new treatment technologies or of a rapid increase in incidence, both of which were not that different in the 80's than the 60's. It was the change in the distribution system and the funds available through medical insurance which facilitated the diffusion of the Minnesota Model of treatment, and supported increased communications about the need for treatment and its benefits.

Despite the clear benefits of and ongoing need for treatment, utilization management has produced a precipitous decrease in the number of people entering both inpatient and outpatient

chemical dependency programs. The survival of nearly all treatment programs regardless of price or quality is being seriously threatened. Conditioned by the bonanza of medical insurance, many treatment trade groups are trying to mandate coverage or criteria to reinstitute medical insurance as a payer of chemical dependency treatment. However, such an effort is shortsighted, and does not serve the interests of treatment centers, employers or chemically dependent people.

Hallmarks of an Effective Substance Abuse Treatment Program

Employers should become involved in all phases of program design to ensure that it fulfills the following requirements:

1. *Provides control over aggregate costs.*

2. *Assures the purchase of quality services.*

If quality is conformance to requirements, employers need to become involved in defining requirements. If one requirement is that dollars buy actual services rather than merely coverage or the possibility of service, employers should define the amount of services they want to buy.

3. *Provides member satisfaction and equity.*

If a purpose of the substance abuse treatment benefit is to attract and retain valued employees, employers should ensure that the benefit has real value and is administered fairly.

4. *Offers choice.*

Choice is a prerequisite for competition to do the micromanagement of assuring optimum value and quality. This only works if there is informed choice. Consumers and their case managers need detailed information on the satisfaction and outcome of previous customers with each provider, matched for similar situations.

5. *Simplify administration.*

Benefits proliferated into too many plans with too many administrative requirements become a nightmare to administer and administer efficiently.

6. *Protects the employer from liability concerns.*

The plan and provider must deliver what is promised.

7. *Allows employers and employees to pay for treatment with pretax dollars.*

An employee denying the need for treatment will not decide at the beginning of the benefit year to set aside monies in a flexible benefit plan in anticipation of being pressured to enter treatment. Section 125 of the Internal Revenue Code regulating flexible benefits needs to be changed so that an employee having completed treatment can pay for the treatment in subsequent plan years through a pretax, flexible spending account. Given the costs of chemical dependency to everyone involved, especially the government, it is hard to see who would not benefit from such a provision.

Contradictory Purchasing Systems Lack Measurable Objectives

In purchasing treatment, employers need to become involved in designing and implementing viable systems for the packaging, pricing, and purchase of treatment services. Each employer should specify total desired spending, expected volume for various services, and required results. Despite the costliness of providing treatment for substance abuse, rarely are any measurable objectives established. *An expenditure of this magnitude would never escape detailed performance requirements if it were in the production part of an organization.*

The accompanying sidebar lists seven common employer goals for health benefits that can also be applied to chemical dependency treatment programs. This list should be refined by each individual employer. Once the objectives have been established, the next step is to begin defining specific performance measurements for each of these objectives.

It is crucial that there be agreement on these objectives by different parts of the organization. Typically, each department or entity in the organization is concerned with its own needs with regard to substance abuse treatment. For example, a goal of benefits managers is to control rapidly escalating costs. Benefits managers seldom receive bonuses for helping to reduce turnover or enhance product reliability through the benefits they manage. Their reward system is focused on controlling costs. This is accentuated by their framework of insurance. Under insurance - whether indemnity, self-insurance or capitated arrangements such as health maintenance organizations (HMOs) - every claim is a loss and the goal is to reduce losses to the lowest possible number. This is accomplished by restrictive plan design and various forms of utilization management. Insurance administration and claims adjudicators would never think of trying to increase claims.

Use of chemical dependency treatment programs is also restricted by the denial inherent in the condition. The incidence of alcoholism and other serious addictions to mood altering substances is estimated at no less than 8 percent for most company workforces. Yet very few medical plans provide treatment for even 1 percent of the workforce in any given year, with most plans providing treatment for 5 per thousand or less. If treatment were only provided for a similar 5 percent of the people who have heart disease and cancer, mortality might go up but medical costs would certainly not be a serious problem. The point is that controlling costs and outcomes is very different for late-stage heart and cancer conditions where access approaches 100 percent of incidence, than it is for alcoholism in which denial is literally a condition of the diagnosis.

Opposing these dynamics for minimizing costs are employer programs designed to encourage treatment. These programs include employee assistance, health promotion, occupational health and safety, fitness for duty and drug testing. Without some unified agreement on realistic objectives, the parts of an organization wanting to encourage treatment and the parts wanting to discourage treatment are going to be working against each other. Generally each works from different data. Many benefits administrators see numbers while employee assistance program (EAP) counselors see clients and ignore the numbers. Often they function with different values, and obviously different goals. Efforts to smooth over the differences by encouraging "all appropriate treatment" are too ambiguous to resolve the conflicts in which clients are frequently caught in the middle. While a balance of powers may be appropriate in a political context, the effect of these forces pulling against each other does not result in an efficient delivery system.

Packaging chemical dependency treatment as an insurance product creates systems that work against each other rather than toward efficiently achieving the employer's objectives. Employers thus find it difficult to make coherent decisions about the purchase of substance abuse services.

The Search For Realistic Norms

To give some indication of the variances that exist, Larry Tucker, a Hewitt managed care consultant, suggests that in terms of charges per employee per year for mental health and substance abuse, "a reasonable level is about \$375" with about 170 days per 1,000 employees.¹ Chrysler appears very pleased with costs (not charges) of \$338 per employee per year and hospitalization rates of 280 per 1,000 employees.² Contrast these with Milliman and Robertson in their Healthcare Management Guidelines suggesting 28 days per 1,000 members which at 2.3 members per employee would be 64 days per 1,000 employees.

Figure 1 COST COMPARISONS FOR MENTAL HEALTH AND SUBSTANCE ABUSE

Larry Tucker of Hewitt, "A reasonable level"	\$375
Chrysler Costs in Managed Plan	338
HMO average	62

Figure 2 DAYS PER 1,000 EMPLOYEES FOR MENTAL HEALTH AND SUBSTANCE ABUSE

Chrysler in managed plan	280
Larry Tucker of Hewitt, "A reasonable level"	170
HMO average ³	93
Minnesota commercial plans average ⁴	82
Milliman & Robertson recommendation	64

State Department of Health reports show that major HMO's in Minnesota have admission rates for chemical dependency ranging from .8 to 2.4 per 1,000 members. A large staff model HMO has cited combined inpatient and outpatient access of 5 per 1,000. The state-wide average for mental health and substance abuse is 35.52 days per 1,000 members for commercial plans for persons under 65. At 2.3 members per employee, that would be 82 days per 1,000 employees.

Milliman and Robertson suggest an admission rate of .27 per 1,000 for substance abuse rehabilitation. Michael Q. Ford, President of National Association of Treatment Providers (NAATP), reports that MEDSTAT data on a base of 3 million privately insured members in 1989, the admission rate is about 3 per 1,000 members.⁵ This would be about 10 times the Milliman and Robertson standard, but still only 3% of probable incidence.

Figure 3 PREVALENCE AND ADMISSION RATES PER 1,000 LIVES

Prevalence according to US government studies	86.3
MEDSTAT 3 million privately insured in 1989	3
Milliman & Robertson recommendation	.27

¹ Nancy N. Bell, "Packaging a Better Brand of Mental Health," Business and Health, Vol 9, #6, June 1991, p 75.

² Stacy Gordon, "How Chrysler Floored Mental Health Costs," Business Insurance, May 11, 1992, p25.

³ Maureen Shadle Peterson, Jon B. Christianson and Douglas Wholey, National Survey of Mental Health, Alcohol and Drug Abuse Treatment in HMOs: 1989 Chartbook, Interstudy: Center for Managed Care Research, January, 1992.

⁴ Reports on file at the State Department of Health.

⁵ Michael Q. Ford, "The Dismanteling of Our National Treatment System," Hazelden Newsletter, p 3.

The balance between mental health and substance abuse also shows wide variations. The Milliman and Robertson recommendation has 8% of the total admissions for mental health and substance abuse being for substance abuse rehabilitation. From the employer's perspective, paybacks to the employer are much more dramatic for substance abuse treatment than for most mental health services or even other medical services. Personally, I would suggest a third of mental health and substance abuse days be for substance abuse, and a third of outpatient expenditures before substance abuse.

The point of the numbers is that even when looking at the ideal rather than the real, wide variations exist.

Do employers want to provide for treatment or don't they? If so, a coordinated and concerted approach is required, not unlike developing a marketing plan for most products.

Employers vary in how much they spend for training and development, staffing and travel. Similar variations are evident in the purchase of chemical dependency services. What is disconcerting is that the variances are seldom the result of any overt business planning. Evidence suggests that the utilization rate and costs of treatment have little relationship to the incidence of substance abuse.

The cost and service volume numbers can be managed to any level desired by the aggregate purchaser. The technology of the volume control switch is readily available. Traditional employee assistance technologies such as employee communications, performance management programs, health promotion programs and drug testing can achieve whatever rate of discovery and treatment the employer desires.

Very few employers have undertaken the management process of:

- 1) Setting measurable objectives in line with a defined statement of purpose,
- 2) Allocating an appropriate budget,
- 3) Assigning responsibility to meet those objectives within that budget.

Chemical Dependency Is Uninsurable

Why is chemical dependency not an insurable risk?

An insurance product is designed to compensate for or restore a loss resulting from an event over which the insured has no control. To be effective, insurance must meet four prerequisites:

1. A definable event must occur.
2. The insured has no control over the event.
3. The event requires definable compensation.
4. The compensation must be able to be economically and feasibly administered.

Life insurance is a classic example of a product that meets these prerequisites. Death is the definable event documented by the presentation of a death certificate to match the insurance policy that will then produce a claim. Death is rarely chosen as a way to collect insurance benefits, and most policies exclude suicide because of the moral hazard. The definable compensation is specified in the policy. No one asks if the beneficiary needs more or less than the face value of the policy. And life insurance can be economically and feasibly administered: actuaries determine the premiums, sales costs are structured and most beneficiaries file a claim that is promptly and efficiently paid.

An assessment of chemical dependency insurance based on the four prerequisites demonstrates that insurance is not an efficient instrument for providing education, assessment, referral or treatment for chemical dependency.

1. Defining and Controlling Chemical Dependency

Chemical dependency comes closest to meeting the first prerequisite - that of being a definable condition. Health care professionals can accurately determine whether an individual is chemically dependent. However, there are many variations of chemical dependency that are not easily categorized for the purposes of insurance administration. *Significant discrepancies exist in defining chemical dependency. For example, to my knowledge the Center for Disease Control does not list alcoholism or chemical dependency as one of the 10 leading causes of death, although it is a leading contributor to 6 of the 10 leading causes of death and was defined in 1954 by the medical community as a primary disease.* Although research shows that 8 percent or more of the population has a serious problem with mood altering drugs, the insurance industry uses very different criteria in determining rates and eligibility for treatment. Most insurance companies would have to increase their rates at least by a factor of 10 in order to financially cover the risk of treating all chemically dependent people, even to achieve a recovery goal of 50 percent.

2. Is There a Moral Hazard?

As to the second criteria of moral hazard, does the person control the catastrophic event which the insurance policy is to financially cover? Alcoholics Anonymous and treatment is based on acceptance of a paradoxical position stating that a person does not have control over their being chemically dependent and can gain control over using the substance by acknowledging their inability to control the use of the substance.

For chemically dependent persons to use and abuse chemicals is a very serious and catastrophic risk. Such persons are very much at risk to lose their health, their jobs, their families and their lives. Surely the risk of such a catastrophe would be insurable. Employers are at serious risk of having impaired employees do all kinds of very dangerous things, such as drive an oil tanker into a reef or fly a commercial aircraft from Fargo to the Twin Cities. One would think people and employers could buy chemical dependency insurance. For example, an individual buying a \$20,000 policy would collect \$20,000 if and when it could be verified that the person was abusing chemicals. A claims administrator would verify that the person was drunk or under the influence of a chemical, and issue a check to cover the serious consequences resulting from this action.

Obviously, such coverage is not available because of the attendant incentives and moral hazards. *We would argue that the same dynamics applying to this lack of coverage are equally applicable to including chemical dependency coverage in medical plans.* Do people have control over their being chemically dependent? Probably not. Do they have control over managing their disease? Very definitely, given the appropriate education and support systems. However, the difficulty lies in determining the amount of education and support needed. One should not leave the decision of how much education and support is needed to a claims adjuster, who applies arbitrary criteria without having to meet outcomes requirements.

3. Defining Compensation for Chemical Dependency

In much of medicine, decisions to invest in expensive procedures are based upon outcome probabilities. It is not uncommon to invest \$20,000 in a procedure that increases the probabilities of living another five years from 50 percent to 70 percent. Yet medical insurance for chemical

dependency is administered in a binary fashion. Treatment is considered medically necessary or unnecessary with little attention or data related to outcome. It is quite likely, however, that extended services would result in better outcomes. Therefore, the focus should really be on determining at what point is the increased benefit of additional treatment for substance abuse is not worth the added investment. Is it worth \$10,000 to increase the probabilities of someone's successful sobriety from 50 percent to 70 percent? How would insurance make that decision?

A \$100,000 life insurance policy pays \$100,000. Collision insurance pays the value of the car or the cost to repair the car. What does it cost to cure an alcoholic or other chemically dependent person? A knowledgeable addiction professional knows that there is no cure for chemical dependency, only maintenance-based recovery. In general, the aim of medical insurance is to pay for services that cure illness, and there are limited benefits for ongoing care. *In spite of all the care words attached to contemporary medical insurance products, medical insurance in general provides very limited benefits for care rather than cure.* For example, an Alzheimer's patient receives very little compensation from insurance for the continued care necessary to manage the disease. Should the recovering alcoholic expect anything different?

The financial liability or cost of providing treatment for a chemically dependent person is not definable in an insurance contract. This stems from the fact that treatment is not a defined package or entity that, when applied to a defined situation, produces a uniform result. This kind of mechanical application of solutions is inherent in the insurance paradigm, and has consequently influenced the orientation of medicine as getting rid of illness or disease rather than striving for health. *The striving for a positive outcome is inherent in education and any business venture, but is antithetical to insurance which is designed to compensate or restore in the event of loss but never to make things better.* The goal of treating substance abuse, on the other hand, is not to get people to stop using the chemical, but to help them put their lives in order with abstinence being an important side-effect.

The treatment process itself is an intensive educational experience rather than a medical technology. While medical services are an important adjunct, most treatment is designed, managed and implemented by people who do not have a license to practice medicine and are not under the direction of a physician. *The medical role in most treatment programs (American Society of Addiction Medicine [ASAM], Levels I, II, & III) is not unlike that in a school where medical services are important but ancillary and the school is not considered a medical institution.* Generally, the goals are to help people think more clearly, see reality more accurately, develop new skills and make important decisions about their lives. These are educational goals. *When we look at managing educational services, it is very difficult to objectively define who needs services. If need were to be defined in education as capable of reading at an eighth grade level, should we do concurrent review and place all third graders in the textile factory when they can read at the eighth grade level? Who needs a Ph.D.? Is the Ph.D. the recidivist who needed more education to be able to cope in the world?*

As an educational process, treatment for substance abuse should entail an initial assessment of the situation, including obstacles to recovery, followed by placement of the individual in *a multi-level sequence of programs which an expert expects to be useful and cost-effective.* *The person going to a 10 day course learns more than the person attending a 5 day course, and while people occasionally drop out of seminars and courses or are even expelled, that is not the norm.* Such a program should be built upon a known process that has been proven successful. To be effective, the program must have a distinct beginning, a middle and an end. A person who is sent to a twenty-one day program should stay for the full twenty-one days unless there are major indicators that the program is not working. No one should daily review the situation to determine if the person is cured yet or not. *Treatment is an educational process. We cannot insure against ignorance or lack of skills.*

The decision to enter any treatment program of any length or intensity of care is not a decision based on what is necessary but rather a decision based on what is prudent in view of desired goals. *Who needs a seminar in chemical dependency plan design which is what this article is about? Who needs a college degree? The answer is not objectively determined by assessing the individual, but by comparing the present status to the desired goal.* Sobriety is not the absence of substance use so much as creating a *desirable life, responsive, warm, energetic and productive.* Insurance puts the criteria and focus in the wrong place.

4. Administration of Insurance for Chemical Dependency

Of people with medical insurance who have heart attacks, close to 100 percent access their medical benefits. Of people with medical insurance who are actively chemically dependent, less than 10 percent use their medical benefit plan for treatment. This is due to the denial dynamics associated with chemical dependency. People who are substance abusers rarely admit that they have a problem, and it is therefore not that difficult for an insurance adjuster, or precertification reviewer, to talk such a person out of the need for treatment. *Family members, too, are often only too anxious to agree. Could you imagine a life insurance company complaining about costs if less than 10 percent of eligible claimants filed a claim?* It is hard to imagine a claims adjuster talking a life insurance claimant out of claiming \$100,000 of benefits.

The fewer than 10 percent of chemically dependent people who do use their medical benefits frequently encounter a benefits schedule for copayment and caps that differs from that for other medical conditions. There is considerable variance in administration as to what is considered medically necessary treatment. Indeed, if the criteria of the American Society of Addiction Medicine indicates that only severe detoxification warrants medically managed treatment, why should the 95 percent requiring other levels of treatment be covered by the medical plan?

From Insurance To Management

For these and other reasons, chemical dependency treatment should not be purchased or administered through an insurance mechanism. It is the wrong package or distribution system. Covering substance abuse through insurance does not work well for chemically dependent people and their families, for employers and other payers, for employee assistance programs, for providers or for insurance companies. *Most systems problems are a result of previous solutions. As is usually the case, intensifying the efforts of old solutions only makes the problems more acute.* Intensifying standard insurance procedures such as utilization review and capitated pricing, only accentuates the problems inherent in the system.

A defined benefit plan should not be expected to efficiently administer an undefinable benefit like recovery services. *For someone with a career in benefits, to think about something other than a defined benefit plan is a very difficult transition. It requires a paradigm shift which is the more difficult the more one has been immersed in the paradigm.* Fortunately, other, more appropriate options are available. Pension plans, for example, are moving fairly quickly from a defined benefit to a defined contribution. Under a management process of setting specific goals and budgets, chemical dependency services can be efficiently and effectively purchased through a defined aggregate contribution. Contributing to this trend is the shift from quality assurance, which focuses on inspection, to total quality management, which emphasizes defining and reaching objectives.

The focus on management and quality is antithetical to insurance. One should manage that which is controllable *and insure against those catastrophes which are uncontrollable.* The incidence of chemical dependency is common and predictable, and the cost of chemical

dependency treatment is highly controllable. An employer should identify what percentage of its work force is chemically dependent, the optimum number of those people who need treatment, the type of treatment, and how much treatment will cost. Will it be necessary to spend \$50, \$100 or \$200 per employee per year on chemical dependency to get an optimum return on investment? Every treatment center sales person should be able to answer that question by providing research data based on the demographics of the employer's work force.

A successful system design must work for every part of the system. It must work for consumers, for the employee's management, for the employer as payer, for case managers, for treatment providers and for other essential parties. A successful system requires looking at what do each of these parties need and need to contribute to make the system work.

The first and basic customer is the chemically dependent person and his or her family. Services should be convenient and supply what is predictably needed for a successful outcome. Second, the employee's manager and human resources manager need appropriate policies and skills to aid them in identifying, referring, and continuing to manage the individual. The employer as payer needs to define objectives and budgets. Case management must be done, for example, through an EAP, to oversee assessment, referral, workplace integration, follow-up and payment to providers. The case management and payment functions should be integrated and administered by one person who is the contact for the consumer. Case management and payment should operate on one integrated software system. *Providers are needed to provide treatment at various levels of care.* An independent research function is required to evaluate outcomes and thus assist in realistic budget setting. Finally, a consultant is required to help design, implement and manage the system.

Those are the players. The difficulty is that people generally think in terms of the functions that they should do given where they are in the structure, rather than to think comprehensively as to overall functional requirements, and then design the structure accordingly. Function follows structure whereas the structure needs to follow function. The governor of Maryland has been rotating department heads as a way to help managers see the overall functional requirements. If procurement officers managed benefits and benefit managers worked in procurement, a change in paradigms might be easier to achieve.

The Difference Between Insurance and Managed Procurement

Unlearning is more difficult than learning. Seeing the inappropriateness of insurance clears the way to begin developing appropriate administrative structures and product distribution systems. Insurance and procurement are distinct systems. Attempts to gradually shift from insurance to procurement inevitably creates severe problems because the respective components are not interchangeable and the equilibrium and homeostasis of systems maintains the original state. Insurance and managed procurement are distinct in purpose, point of sale, payout decisions, expected results, payment mechanism and costs controls.

The purpose of procurement is to buy a product or service to create some improvement, reach some goal or generally create some positive result. A purchase is made when the anticipated benefits outweigh the costs. In contrast, insurance focuses not on the results but on meeting contractual requirements. *The purpose of insurance is to provide coverage which compensates in the event of loss. Insurance is never there to make things better, only to pay in the event of catastrophe. The purpose of home owners insurance is not to give a better house, but to provide financial protection in the event of loss.* The purpose of medical insurance is not to create health but to pay for medical services to cure illness.

The point of sale in procurement occurs with the decision to acquire a product or service, such as buying twenty-one days of chemical dependency treatment. The point of sale in insurance

occurs with the purchase of a policy. Filing and paying a claim merely execute the contract that was purchased. A claim is just that - a claim rather than a decision or point of sale.

In procurement the payout decision is based on whether the goods or services are more valuable than the cost. The decision also depends on whether the product or service is perceived as the best one available and on the availability of funds at the time payment is due. For insurance, payment is strictly determined by the provisions of the policy. Payment decisions are not based on cash flow; indeed the purpose of insurance is to assure payment in the event of catastrophe no matter what the cost.

In purchasing, one buys services or products. In insurance one buys coverage. The typical capitated, at-risk mental health plan offered by an HMO has much better coverage than the typical indemnity insurance plan, but provides 25 percent or less of the services. Given this fact, *why would any union wanting services for its membership negotiate coverage rather than services?* Why would any employer focus on coverage rather than services for substance abuse services? Coverage is no better than its translation into services, which is heavily influenced by financial incentives.

Purchasing focuses on specifications while insurance focuses on schedules. The buyer of insurance does not have a legitimate basis to expect any services unless the terms of the insured catastrophic event are met. *Last year I spent \$400 on a term life insurance policy, which turned out to be wasted money. That is fine with me and with the insurance company.* Technically within a properly administered insurance contract, if an employer received no chemical dependency services under the insurance contract, there may be actuarial concerns regarding pricing of the premium but there should be no reason for complaint as to lack of services.

One alternative to either buying coverage or buying services according to specifications for volumes and levels of care is to base the purchase on required outcomes. For example, a carrier or health plan might be required to ensure that 1.5 percent of the eligible people per year enter treatment and receive sufficient treatment and continuing care services to achieve an overall success rate of 65 percent. *The plan might collaborate or subcontract with the EAP so as to find and involve the right people and would have to contract with treatment providers for specific performance.* Clinical criteria would be important insofar as they relate to outcomes requirements, and would not be relevant to other insurance requirements, as is presently the case. Research experts in chemical dependency indicate that the probable outcome is very predictable given demographic data, severity indicators and known obstacles to recovery.

Adding such a requirement for performance to an insurance contract may seem like a fairly obvious way to assure quality, yet would it still be an insurance product? How would such a product fit with all the other characteristics distinguishing insurance from managed purchasing? Adaptations for cash flow would be required in that most providers want payment prior to the end of two years when the research results might come in. If the results control payment, the definitions of success might need to be more rigid than in current research and the costs of reliably determining outcome could be significant. There are some data to indicate that the context for admission to a treatment program as framed by the employer and the case manager has more to do with outcome than anything that happens at the treatment center. If this were confirmed, it would be important to find valid ways of correlating responsibility for outcome with financial compensation.

To continue with the contrasts between insurance and procurement, purchasing and insurance can also be distinguished by their payment procedures and cost-control methods. The purchasing process is expedited by purchase orders and invoices. There are no claims in managed health care. Claims are for the administration of insurance.

For procurement, cost control is achieved by basing each purchasing decision on the immediate situation, general policies or guidelines, overall objectives, and budget. Cost control for insurance is primarily the responsibility of the underwriting actuary who calculates the risks involved. Second, insurance costs are controlled during claim administration by requiring strict conformance to the contract before payment is made. For insurance, every claim is a loss, and the goal is to reduce losses and maximize the loss ratios. For purchasing the goal is to optimally buy services that meet specific goals.

Two Radically Different Systems

The point of this somewhat detailed comparison between insurance and purchasing is to demonstrate that there are two radically different paradigms and systems. One cannot subtly shift year by year from one to the other any more than a car designed as a rear wheel drive car can gradually over the years become a front wheel drive car. Engineers in manufacturing calculate in detail the system requirements. Yet in social systems, we expect that the intuitive and political process of a few committees will design a workable system.

While there are models that try to combine an insurance and procurement product (e.g., benefit incentives for those employees going through the EAP before accessing benefits), they result in confusion over objectives and conflicts for clients and staff. The insurance part says that less is better and the managed part seeks cost effective services. Most implementers of such incentive options have determined whether substance abuse services are needed, and if so, in what amounts, at what cost and with what required outcomes.

It takes very different competencies to design a car, to build a car, to prudently buy a car, to drive a car and to manage a rental car business. Providers of chemical dependency treatment have not designed an appropriate delivery system for their product. They cling to the medical payment system, and many take financial advantage of the inabilities of that system to prudently purchase services. The medical payment system is now in crises and it is time for the substance abuse treatment industry to create a more appropriate vehicle marketing its product.

Employers have traditionally purchased coverage rather than services and have not involved themselves in designing an appropriate delivery system. The result has been excessive consequences of chemical dependency in the workplace. The problem for employers has usually not been so much that they have been spending too much, but that what has been spent has not been realistically managed so as to achieve the best results for the most people.

Hopefully this discussion has made it clear that chemical dependency is a clear example of how we need a different packaging and distribution system for at least this type of health service. Trying to improve the way the system operates without understanding the basic paradigms structuring the marketplace is not going to work. In the same way, to move to national health insurance is not changing the paradigm or distribution system, merely who pays the bill. A move from insurance to procurement is the only way to cost effectively provide for chemical dependency services, if not the majority of health services for chronic conditions.