Should health insurers have the final say about your care?

“We're the ones treating the client. We know how they're doing. We feel that we've made the correct assessment for them to be at this level of care. Somehow the insurance companies have a say over the provider. *‘No, they need to step down. They've had enough of that level of care’” - Arlene Stanich-Prince*

911. What's your emergency?

America's healthcare system is broken and people are dying.

Welcome to Code WACK!, where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on **Code WACK!** How do insurance companies put up barriers to addiction treatments? How does this affect treatment programs and their clients? To find out, we spoke to **Arlene Stanich-Prince**, executive director of **Ohlhoff Recovery Programs** in San Francisco, one of the longest standing treatment programs in the city. This is the second of two episodes with Stanich-Prince.

Q: Welcome back to Code WACK! Arlene. You're the executive director of Ohlhoff Recovery Programs in San Francisco. How do clients generally pay for their services and what challenges do they face when it comes to dealing with insurance companies?

Stanich-Prince: Ohlhoff is a nonprofit, private organization. Okay? We get no funding, no money from the city or the county and we're small. We're a small organization. We accept private health insurance or private pay, and we really try to keep our prices affordable. As a nonprofit, we are able to, well, I am as executive director, able to work with certain clients, perhaps (at) a sliding scale at times with some people. Also, we have a scholarship fund and we'll make that decision if we feel that somebody deserves that scholarship. That's been wonderful as well. And then we just get grants. The revenues are number one income from the services. And then we have some grants and some donations. Some come from alumni, some are just grants or foundations that we apply for, but no extra funding and we do not accept Medicare/Medi-Cal, and we don't have a contract with Kaiser (Permanente) Not because it's a competitive thing. It's sort of, you know, they have an outpatient, sometimes they'll refer people to us, but it's a kind of a, it's not a straight contract with them. They'll have to refer.

Q: Got it. So what challenges have you had in dealing with insurance companies?

Stanich-Prince: Ooh, where do I start? It's interesting. I like to think of the insurance companies as we are, that we collaborate together. We want the best for the client so we're supposedly working together. However, it does feel like insurance companies really are about the money. So I spent many years trying to simplify how we work with the companies. We've got inpatient, the residential, we have partial PHP hospitalization level of care, and we have intensive outpatient. That's only three levels of care contracted with insurance companies. Okay. I don't know if that makes any sense to you, but what that does is straight across the board, it's like they're either gonna be in our inpatient, they were gonna be in an outpatient setting and maybe in a sober house. Okay? We know what level of care our clients are in. We have wonderful care managers that work with their care managers.

They have to call. We get all the clinical information. When a person comes in, we've screened the person, we've assessed, we've diagnosed what level of care they should be in, and we start treatment. We call to get the authorization, which will be the reimbursement. They give us the numbers, all of that. It's all done in our accounting office. All this. We bill the claims and guess what? It'll come back and say they're not paying. They've authorized, but they won't pay or trying to get the authorization – somebody's here for 30 days, they'll give you authorization for seven days. You gotta call back and get seven more days. And that's not so much the problem. The problem is we're the ones treating the client. We know how they're doing. We feel that we've made the correct assessment for them to be at this level of care. Somehow the insurance companies have a say over the provider. *'No, they need to step down. They've had enough of that level of care...'* and it just does not make sense to me.

And I don't wanna put it out there that sometimes they do things that I just don't understand how someone in residential can all of a sudden in seven days be stepped down to one of those other levels of care that I talked about. That obviously is only about money - paying us less - and then yet they know that we're still providing the residential treatment or the top level of treatment. It's just you don't talk about it and I can't go back to the clients and say, 'oh, your insurance isn't covering you at residential, so you have to pay the difference.'

I can't do that. I could go to them and say, 'Hey, this is what happened. We want you to stay. We'll take whatever we get.' It just seems that they get the upper hand, they get to make the decision. I don't understand how that works. Why? We're professionals, too. Our clinicians, our doctors are making these decisions.

Q: Right. So then if that happens, like somebody's in a residential program and all of a sudden the insurance says, no, sorry, they need to go step down to a lower level of treatment, like an outpatient. I guess, what are your options at that point? And you know, have people actually had to leave in the middle of their treatment?

Stanich-Prince: Not at Ohlhoff. I know it happens though, because people do come to us saying, 'I can't finish at this other place because my insurance won't cover.' So I'll find out what they're covering and say, 'look, okay', sometimes I could

ask for a sober living fee if it's very small, but this is why we have scholarships. This is why we do the work that we do. I'd rather somebody come in here (on) their last week, we don't really get paid much, but that person has got the best treatment that I promised them and that they are leaving here satisfied and safe. So I feel better. I can sleep at night. Right? If I had to step somebody down and say, 'oh, you're gonna have to leave it now you have to go home,' where maybe they don't have that safe home to go to and go to our outpatient.

When I know they're not ready, what's gonna happen is they're gonna relapse. It's gonna cost more money because now they're gonna have to come back. So it really doesn't make sense. Is this something I've been dealing with and I just, like I said, I've made that decision and everybody here at Ohlhoff, including the finance director and the billing people do not argue it because they see it. They understand it.

We have a full team that just works on claims with insurance day long, just calling and saying, you authorized this, and why does it have to go into appeal? It's really insane. It's sad. It affects the client. The insurance will send them a statement too, saying, 'you stepped down, we're not authorizing' and I'll get family members running over here going, 'oh my God, they're not, oh, we're gonna have to pay this' and I'll go 'slow down, slow down, no, no, no, no. This is how we're doing it. Here's your statement. There's nothing on here.' They are responsible for their deductible and copay, but ;we're not asking you to make up the difference. Let's just get through treatment here. Okay.'

But it does put a lot more pressure on us. If the client finds out, you know, they make become very distraught and wanna leave. Many times, there's a client knocking on my door going, 'can I talk to you for a minute about my insurance?' And I see the stress that it puts on them and they're ready to just go, 'I have to go home. I gotta leave. I can't afford this.' 'Nobody's asking you for anything. We want you to stay. It's okay.'

Q: I imagine that you can, you can do that maybe because you have the scholarship fund and the nonprofit money or, or you, you prioritize it. You don't have to by any means.

Stanich-Prince: Or you write it off <laugh>, you write it off.

Q: You write it off. How have these challenges then affected your business?

Stanich-Prince: Yeah, I'm gonna say it hasn't ever come to the point where we have to close the doors, but we've had to make sure that the people that are working on this side, the case managers working with the insurance companies are not being taken advantage of. That they can speak up and they feel comfortable saying, you know, rarely do I have to step in, but I will if I feel like they're really, somebody's being told they're not gonna be covered completely, I'll fight it. We'll go into appeals and things like this. But you have to expect it. It's just the way it is.

Q: Has this gotten worse over time?

Stanich-Prince: Yes. It used to be when I started, that's why one time in the beginning when you asked me some of the hats that I was wearing, I stepped in and I realized they were just submitting claims ... after 30 days and hoping for the best, what they would, you know, how they'd be paid. And Ohlhoff was in trouble back then. So I said, 'wait a minute, you guys, let's look at each person's policy. Let's work with these insurance companies. Let's change our contracts here. Don't leave it up to them. You may never see anything.' Right? And so some of the programs were struggling. You're right. But I think also enough programs and people like myself, we don't just sit back. There was about probably seven years ago, one insurance company was trying to drop somebody after three days of inpatient to outpatient.

And this person is horribly detoxing still. It was unethical and I called them, I said, I want outta my contract. This is it. I got people to sign petitions. We went to Sacramento. We fought this. And I ended my contract for like a couple of years. And then they finally came back. And that is when I started to see a big change where, you know, the communication got better with the care managers and we work on something called ASAM where there's certain dimensions, better screening tools so that insurance companies and providers are kind of talking the

same language. It was like, that's the collaboration that did get a little bit better. But the part that's unfair is they get to have the final say in the end. You know, sometimes it goes to what's called a peer-to-peer or a doc-to-doc.

And we can fight it right then and there. And still it's like our doctor's given a very, very small window of when he needs to be available and on the call and if he misses it, then they just deny it. So there's a lot of things that are just very stressful, you know, but you just have to not accept it and you really, we gotta make change. And I think that enough of us providers getting together and saying, 'we're not gonna take this anymore. And you know, if you're gonna pay for, you pay hospitals for a certain procedures with no question, not everything, but you know what I mean, you'll pay them. Why don't you pay us? What's so different about addictions, you know, substance abuse addiction or disorders and mental health that you get to say, 'oh, it's, you know, we're not, we're not covering it.' People are dying. You hear that, you know that.

Q: Are certain plans better than others? Is it easier to work with, like PPOs versus HMOs for example?

Stanich-Prince: It varies. And this is the thing where you have to educate a person as well. A lot of people will come to me and go, 'what's the best insurance company? I can't make that decision for you. What can you afford? What do you need? What are you looking for? What is your medical status at this point besides just coming into treatment here? You know, are you diabetic also? Do you foresee being on medications and things?' Everybody's policy or plan is different. HMOs and PPOs are no different. But what happened through the years is that it used to be you know, our deductibles were a lot lower in the beginning or there were no deductibles at all. A deductible is what you have to pay upfront because it's take it off the top of the provider's reimbursement before they kick in to pay anything.

And then you have a percentage after that. 80%, 90%, a hundred percent. What the insurance companies don't really explain this. They'll say, 'oh, you're covered a hundred percent,' but they also don't say what level of care they've authorized that it's a hundred percent. Then sometimes they forget to say 'you have a $6,000 deductible.' So imagine going into outpatient where, you know, the lowest level of care three days a week, maybe the total amount the insurance company is paying

is $600 a week, but you have a $6,000 deductible before they start authorizing. So that gets taken off of, you know, what they'd be paying us and then we have to collect it from the client, you know, so they're actually paying out of pocket until they hit that. It's horrible. I can't ask somebody, you know, it's like, pay your 6,000 up front. It's terrible. So you have to really just tell people, 'look, yes, this is what you're signing up for. Is that worth it?' Sometimes private pay is a better solution, you know, right? But also if you need help and you need treatment and you are in the in-patient. It's like we give people time to pay that down and it is worth it.

Q: Wow. How much would private pay be for like 30 days of treatment?

Stanich-Prince: $15,000. So that is very reasonable. I mean, we do medical detoxes here, very individualized. We meet our clients where they're at. I do a lot of the couples and family counseling you know, wonderful safe community here, great food, you know, wonderful clinicians. You can talk to a counselor anytime you want, you know, the doctor's available. My door's always open. So the quality I think is wonderful here at Ohlhoff and also just the environment is really special. And like I said, it's a community and a family of its own.

Q: Is there another story that you wanna share that really struck you, that kind of illustrates these problems with insurance?

Stanich-Prince: A client comes in, they're on medical leave from work. Their employer is, they're still on the plan. All of this has been checked. They come in, should be covered at a hundred percent. All right, so this person really has no funds. We know that they're coming in – no deductible. We get the authorization. We keep getting the authorization, the 28th day, two more days before graduating and leaving. The care manager goes, 'oh, they're telling us that this plan, that the employer terminated the plan at the beginning of the month.' So this client nearly just fell apart two days before graduation. 'Now my employer's involved. Does it mean I'm fired? Does it mean I have no healthcare for a month? And nobody told me?' Do we not get paid? Right. We're still just, and so I just really feel for this person, you know, it was like, are you gonna be safe enough to go home at this point? And they, yeah. So we're still dealing with it. Yeah.

Q: So if everybody had comprehensive health care that included substance abuse treatment like most Medicare for All bills, what would that mean for you and your clients?

Stanich-Prince: If everybody (had it?)

Q: Yes, universal single-payer, single payer Medicare for All. If everybody had comprehensive health insurance that included substance abuse treatment?

Stanich-Prince: Then it would change everything. Yes. We would still have the discretion to be able to assess. It would make no difference, I'm sure. Yes. And people probably wouldn't feel so hopeless. Maybe they would feel like I have a chance, maybe I will go to treatment. If the person, the individual themself had the choice to say, ;this is what I want, this is where I wanna go.' Absolutely. Absolutely. Then it could work. Yes, it's a win-win – not just for who gets paid, but also for the person who needs the treatment.

Thank you Arlene Stanich-Prince of Ohlhoff Recovery Programs.

Do you have a personal story you'd like to share about our wack healthcare system? Contact us through our website at heal-ca.org.

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