CSSB

363

# HOUSE COMMITTEE REPORT

(11)

Date referred: 4/14/88 FURTHER REFERRALS:

DATE: 4-25-88

The Finance Committee has considered CSSB 363(Fin)

"An Act relating to insurance coverage for treatment of alcoholism or drug abuse; and providing for an effective date."

**RECOMMENDS:**

[ ] replace with _____ [ ] the same title
[ ] attached amendment(s) [ ] a new title

[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

**ADOPTS:** [ ] _____ letter of intent

**ATTACHES NEW FISCAL NOTE(s):**

[ ] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis
[ ] same as previous fiscal note published _____
[X] same as previous zero fiscal note published 3/30/88 (3)

**SIGNING DO PASS:**

Burchett
Brown Tay Brown
Boer Mark Boer
Davis Mike Davis

**SIGNING OTHER RECOMMENDATIONS:**

Larson Ron Larson No Rec.
Rieger Steve Rieger No Recommendation

Chairman's signature

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Bill Version: CSSB 363(FIN)
Publish Date: Senate 3/30/88

# FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act Relating to Insurance Coverage for Alcoholism
Sponsor:
Requestor:

Agency Affected: Dept. of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 0 | 0 | 0 | 0 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 0 | 0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 0 | 0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 0 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 |

POSITIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

The technical changes in this draft do not cause any increase to the anticipated fiscal impact shown in our earlier fiscal note for SB 363.

Prepared By: Robert E. Stalnaker
Phone: 465-4470
Division: Retirement and Benefits
Date: February 22, 1988

Approved by Commissioner: John M. Andrews
Date:
Agency: Department of Administration

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)



Rev: 1/11/88

19/6K2/0222-88/1-2

# STATE OF ALASKA 1987 LEGISLATIVE SESSION
# FISCAL NOTE

Bill Version : CS Senate Bill 363 (Fin)
Publish Date : Senate 3/30/88

REQUEST:

Revision Date:
Title : "An Act relating to insurance coverage for treatment of alcoholism and drug abuse."
Sponsor : Binkley
Requestor :

Agency Affected : Health & Social Services
BRU :
Components :

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

| OPERATING | FY 87 | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | | | | | |
| CONTRACTUAL | | | | | | |
| SUPPLIES | | | | | | |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | -0- | -0- | -0- | -0- | -0- | -0- |
| CAPITAL | -0- | -0- | -0- | -0- | -0- | -0- |
| REVENUE | -0- | -0- | -0- | -0- | -0- | -0- |

**FUNDING:** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | | | | | | |

**POSITIONS:**

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | | | | | | |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

**ANALYSIS :** (Attach a separate page if necessary)

The enactment of SB 363 would have no direct fiscal impact on the Department of Health and Social Services.

Prepared by : Matthew Felix by George Mundell
Phone : 586-6201
Division : Alcoholism and Drug Abuse
Date : 2/1/88

(B) Approved by Commissioner : Mike McMenamin
Date : 2-1-88
Agency :

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CSSB 363 (Fin)
PUBLISH DATE: Senate 3/30/88

# FISCAL NOTE

**REQUEST:**

Revision Date:
Title: Insurance coverage for treatment of alcoholism or drug abuse
Sponsor: Binkley, et al.
Requestor: Senate HESS Committe

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Components: Operations

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

| OPERATING | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | | | | | |
| CONTRACTUAL | | | | | | |
| SUPPLIES | | | | | | |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | -0- | -0- | -0- | -0- | -0- | -0- |
| CAPITAL | -0- | -0- | -0- | -0- | -0- | -0- |
| REVENUE | -0- | -0- | -0- | -0- | -0- | -0- |

**FUNDING:** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | -0- | -0- | -0- | -0- | -0- | -0- |

**POSITIONS:**

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | -0- | -0- | -0- | -0- | -0- | -0- |
| PART-TIME | -0- | -0- | -0- | -0- | -0- | -0- |
| TEMPORARY | -0- | -0- | -0- | -0- | -0- | -0- |

**ANALYSIS:** (Attach a separate page if necessary)

There is no fiscal impact to the Division of Insurance.

Prepared by: John L. George, Director
Phone: 465-2515
Division: Insurance
Date: 1/29/88

Approved by Commissioner: J. Anthony Smith Kathy Newlin for
Date: 1/29/88
Agency: Commerce & Economic Development

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Offered: 3/30/88
Referred: Rules

5-1553B

Original sponsors: Binkley, Halford, Sturgulewski, et al.

IN THE SENATE BY THE FINANCE COMMITTEE

CS FOR SENATE BILL NO. 363 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance coverage for treatment of alcoholism or drug abuse; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, naturopath, physical therapist, or occupational therapist.

* Sec. 2. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.365. COVERAGE FOR TREATMENT OF ALCOHOLISM OR DRUG ABUSE. (a) An insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew a group disability insurance policy for major medical coverage on an expense-incurred basis in the state, or a hospital or medical service corporation authorized under AS 21.87 to offer or renew a group subscriber's contract for medical coverage in the state, shall provide the covered person the following coverage for treatment of alcoholism or drug abuse:

(1) benefits of at least $7,000 over twc consecutive

benefit years; and

(2) lifetime benefits of at least $14,000.

(b) The benefits specified in (a)(1) and (2) of this section shall be adjusted every three years, by the director, to correspond with the change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor. The base year for the computation shall be the first full calendar year for which insurance is obtained under this section.

(c) The insurer or hospital or medical service corporation providing coverage under this section may not

(1) require that the covered person be responsible for a deductible or co-payment that is different for the determination of benefits relating to treating alcoholism or drug abuse than for the determination of benefits for treating another covered illness;

(2) use a different claim payment methodology in determining the benefits relating to treating alcoholism or drug abuse than that used in determining the benefits for treating another covered illness;

(3) require prenotification of treatment or a second opinion unless the requirement is applicable to other covered major illnesses;

(4) limit coverage by provisions of the insurance contract that are not applicable to other covered major illnesses, including but not limited to provisions concerning preexisting illnesses or provisions requiring that the exact date of onset be known;

(5) limit treatment services under the insurance contract to either an inpatient or outpatient service;

(6) exclude from coverage the cost of medically necessary

treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(7) deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

(d) Notwithstanding (a) of this section, if the insured or subscriber is an employer who employs fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, the insurer, hospital, or medical service corporation is not required to provide the coverage specified in (a) of this section to the insured or subscriber but shall offer that coverage to the insured or subscriber as optional coverage.

(e) In this section

(1) "alcoholism or drug abuse" means an illness characterized by

(A) a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances as defined in AS 11.71.900; or

(B) habitual lack of self control in using alcoholic beverages or controlled substances to the extent that the person's health is substantially impaired or the person's social or economic function is substantially disrupted;

(2) "approved treatment facility" means treatment in a facility that is either approved under AS 47.37.140 or located and licensed for treatment of alcoholism or drug abuse in another state;

(3) "catastrophic illness insurance" means a major medical insurance contract or subscriber contract that provides benefits for hospital and medical care with potential lifetime maximum benefits per

insured of at least $250,000 and that has a deductible of at least $5,000;

(4) "co-payment" means the portion of the eligible expenses in excess of the deductible to be paid by the covered person;

(5) "cost" means the least of the following:

(A) the actual charge for the treatment received for alcoholism or drug abuse;

(B) the usual, customary, and reasonable charge for the treatment; or

(C) the charge agreed to by contract between the treatment provider and the insurer, hospital, or medical service corporation;

(6) "covered person" means the insured or subscriber or the insured or subscriber's covered spouse or dependent child;

(7) "deductible" means the portion of eligible expenses for which the covered person is responsible;

(8) "group disability insurance" means a major medical insurance contract or subscriber contract that provides major medical coverage for five or more employees of the employer, but does not include catastrophic illness insurance;

(9) "major medical" means a disability insurance contract, or subscriber contract that provides benefits for hospital and medical care with potential lifetime maximum benefits per insured of at least $10,000;

(10) "treatment" means medical care, including detoxification, as an inpatient or outpatient at an approved treatment facility.

* Sec. 3. AS 21.87.340 is amended to read:

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the

following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) AS 21.42.345 - 21.42.365 [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 2 of this Act, applies to group disability insurance policies and hospital or medical service group subscriber contracts entered into or renewed on or after January 1, 1989.

* Sec. 5. This Act takes effect January 1, 1989.

not offered

AMENDMENT #1

TO: CSSB 363 (Fin)

Page 1, line 25
Page 2, line 10
Page 3, line 10
Page 4, line 11

After the word "hospital," delete any commas and add <u>service corporation</u>

Page 5, line 25

After the word "Hospital," add <u>service group</u>

REASON: Clarifies the intent of the bill making specific references to separate, but statutorily defined, entities...a hospital service corporation or a medical service corporation.

AMENDMENT #2

TO CSSB 363 (Fin)

Page 3, line 6-7
Page 3, line 12
Page 3, line 13

Delete the words [or subscriber]

REASON: This is a technical amendment because the bill deals with group policies, not individual subscribers to a group policy.

AMENDMENT #3

TO: CSSB 363 (Fin)

Page 3, line 9-10

Replace the language [in either the current calendar year or the preceding calendar year] with the following:

<u>during the preceding consecutive 12-month period.</u>

REASON: Because insurance contracts begin in every month of the year, using the most recent 12-month period gives the most current and most accurate experience in the coverage area.

NFIB® National Federation of Independent Business

The Guardian of Small Business

April 25, 1988

TO: HOUSE FINANCE COMMITTEE

FROM: GARY L. JENKINS, DIRECTOR, GOVERNMENTAL RELATIONS

SUBJECT: POSITION ON CSSB 363 (Finance)

This legislation incorporates a concept which is of grave concern to small business across Alaska. The issue is mandating any type of benefit which a business is required to provide for employees and pay the cost. In response to this question on our 1986 ballot, NFIB/Alaska members voted 75% opposed, 15% in favor and 10% no opinion. The mandating of a benefit is in effect a levy of a state tax on those employers who are required to provide the benefit.

Please note that the amended version of the bill which passed the Senate and is now before the committee, represents a compromise which NFIB/Alaska has agreed not to oppose because it minimizes the impact on small businesses in Alaska. However, we urge the committee to look at the goals of this legislation and fashion a solution which will more effectively address the issue and be paid for by those most likely to need the treatment.

We suggest that the committee consider establishing the basic program as set forth in SB 363, however, instead of requiring those businesses who can afford to provide insurance as a benefit to pay the cost, levy a tax on all alcoholic beverages and addictive drugs sold in Alaska to provide funding for the program. A levy of $.75 per gallon on alcoholic beverages brought into Alaska would generate revenue of over $12 million per year. A 5% tax on addictive drugs brought into Alaska for sale would also generate several million dollars. Thus, the people who are buying the products which are the primary causes of the problem being dealt with would be paying for the costs of the treatment. There would be a variety of administrative issues to be resolved in pursuing this concept, however, none of them should prove to be insurmountable.

If any members of the committee have questions regarding our position on SB 363 or our alternative proposal, feel free to contact me at 586-4100.

NFIB/ALASKA
Legislative Office
P.O. Box 210194
Auke Bay, AK 99821
907/586-4100

«DATA senators names»

MEMORANDUM

April 5, 1988

TO: Senator «firstname» «lastname»

FROM: Senator Johne Binkley

RE: Senate Bill 363 - Relating to Insurance Coverage for Treatment of Alcoholism or drug abuse

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Attached is a packet which includes an overview of SB 363 and the issue of including alcoholism and drug abuse coverage in group health insurance plans, the Senate Finance Committee Substitute for SB 363, position papers, research by the Senate Advisory Council relating to health insurance policies of various businesses and other entities in Alaska, and other supportive research.

Working with the National Federation of Independent Businesses, we have forged a committee substitute which would require that the coverage be **offered** to small businesses (those with fewer than 20 permanent, fulltime employees). NFIB inow finds the legislation acceptable, and I am hopeful that small businesses in Alaska will follow the standard established by the legislation and include treatment for alcoholism and drug abuse in their group health insurance policies.

Alcohol and drug abuse costs us all. In 1985 SOADA estimated these costs are more than $170 million, a cost of $12 for every $1 the state received in revenues. In the same study they estimated the loss of income to Alaska families at nearly $55 million. The Municipality of Anchorage recently estimated the economic costs at nearly $200 million. Costs to employers include decreased job performance, increases in absenteeism (4-8 times greater), increased usage of health insurance for medical problems which arise when the primary disease of alcoholism is not addressed, and increased usage of health insurance by family members who develop medical problems caused by living with a substance abuser.

Health insurance coverage which includes alcohol and drug abuse treatment on an equal basis with other diseases benefits all of us. It makes it possible for more substance abusers to receive treatment when needed; it reduces the costs to society from such things as loss of work, automobile accidents, the overuse of insurance for related illnesses, and increased workers' compensation claims.

While a few individuals have voiced their concern over possible increased costs, those states who have forged the path before us (34 states now have enacted similar legislation) have found these costs to very minor. Inquiries we have made have suggest that increases for those who have some type of coverage may be no additional cost whatsoever. DHSS's position paper notes: " . . . evidence suggests that alcohol and drug abuse coverage decreases the use of benefits for related medical conditions thereby offsetting premium increases in the long run."

Pat Jackson of my staff is working on this legislation if you'd like additional information or have questions.

## CS SB 363 (Finance)

"An Act relating to insurance coverage for treatment of alcoholism or drug abuse; and providing for an effective date."

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### Basic Provisions

- Requires providers of *group* health insurance policies to include treatment for alcohol and drug abuses with caps established at $7,000 over two years or $14,000 lifetime. Caps are tied to CPI/Anchorage, adjusted every three years.

- For small businesses, 20 employees or fewer, would require the offer be made.

- Alcoholism and drug abuse must be treated the same as other health coverage in terms of deductibles and co-payments and policies must not discriminate between inpatient (hospitalization) and outpatient (counseling).

- Quality of care for insurance coverage eligibility is provided through facilities certified by the State Office of Alcoholism and Drug Abuse.

- Effective date: January 1, 1989, with grandfathering of existing policies until such time as they are renegotiated or renewed.

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### Rationale

Number one health problem in Alaska.

Health professionals define chemical dependency as a disease of the body, mind, and spirit. It is widely recognized as the number one health problem in the state.

Individuals who have struggled to overcome the denial prevalent with alcoholism and decide to seek treatment are often surprised to learn their health coverage either doesn't cover alcoholism or drug abuse or has limitations that inhibit their ability to utilize it.

A policy may cover, for example, hospitalization (inpatient) at 100% and outpatient (counseling) treatment at $500, if at all. An individual is forced to decide between the two forms of treatment. Hospitalization (30 day program) often means losing their job, family, and support groups.

Outpatient treatment is beneficial for those in the early stages of alcoholism because it allows the individual to their keep job and maintain family support . Additionally, family counseling is a major part of outpatient treatment.

Alcohol and drug abuse costs us all.

- In 1985 SOADA estimated the net cost to the state at more than $170 million, with the loss of income to Alaskan families was nearly $55 million.
- Municipality of Anchorage estimated economic costs related to alcohol abuse at $195.5 million; drug abuse at $62.4 million. Supports legislation.
- Department of Corrections estimates costs to incarcerate individuals charged with DWI: $87.56 per day.
- Decreases in job performance.
- Increase in absenteeism (4-8 times greater).
- **Increased usage of health insurance by alcoholic** for other medical problems which arise when primary disease of alcoholism is not addressed.
- **Increased usage of health insurance by family members** who develop medical problems caused by living with an alcoholic (i.e, ulcers, chronic nausea, sleeping problems, eating disorders, dermatitis).
- Other serious health issues, including
    - children born with Alcohol Related Birth Defects (FAS and FAE). The expenses incurred by infants with ARBD born during 1987 were $1,162,500. This did not include costs while at IHS facilities.
    - children of alcoholics (COA's)
    - suicide (attempts by alcoholics estimated to be 6-15 times greater)

Benefits

- Opens a door to more appropriate and individualized methods of treatment and allows for more alcoholics to receive treatment when needed.
- Mode of treatment for recovery is recommended through certified alcohol and drug facilities. Current provisions in most policies restrict one form of treatment over another, i.e., limits to outpatient, (counseling) no limits to inpatient (hospitalization).
- Reduces costs to society (loss of work, safety problems, automobile accidents, overuse of insurance for related maladies, workers comp claims all depreciate when an alcoholic recovers).
- Reduces costs to insurers. The insurer pays the cost of alcoholism through treatment claims for other medical problems.

> "In the years prior to initial alcoholism treatment, alcoholics incurred gradually increasing total health care costs on the average. These costs rose dramatically in the six months prior to treatment, began to decline after treatment initiation, and continued to fall during several follow-up years."
>
> *Alcoholism Treatment and Total Health Care Utilization and Costs Study*

## State Impact

Current state plan covers $2,500 in outpatient coverage with unlimited coverage for hospitalization (inpatient). Legislation will have little or no impact to the State.

Zero Fiscal Notes

Division of Insurance (Department of Commerce)
Division of Retirement & Benefits (Department of Administration)
Divison of Alcohol and Drug Abuse Services
(Department of Health and Social Services)

Department Positions

Division of Insurance
Philosophically opposed to mandates; technical amendments offered and included in CS.

Divison of Retirement & Benefits
Neutral position on legislation; no fiscal impact to labor contracts due to State's current coverage; increases in usage of outpatient (counseling) will be offset by the "caps" in SB363 which limit costs of hospitalization (inpatient). This shift will result in a net zero cost to the State.

Division of Alcohol and Drug Abuse
Supports legislation; top priority legislation for alcohol and drug abuse treatment efforts statewide. Resolution in support passed by the Governor's Council on Alcohol and Drug Abuse.

## Private Sector Impact

Senate Advisory Council Research (2/16/88)

- small businesses (5 employees or less) typically have no health insurance or individual policies not affected by legislation.
- Random sampling of 14 businesses, 12 of which offered some type of substance abuse coverage in their group health plan (limitations include inpatient/outpatient, limits on consecutive days, one-time/life-time limits, etc.)
- Businesses currently providing group health plans typically have limitiations on the less expensive choice of treatment (outpatient) and no limitation on the more expensive treatment, hospitalization (inpatient).

Alaska General Contractors (per Resa Jarrell, AGC-Juneau)

- Represents 700 general and associate contractors. Health plan includes $5,000/2 years; $10,000/lifetime.
- Estimated impact is $3.00 per month premium increase .

• Supportive of legislation. It will promote alcohol and drug abuse treatment and will promote a positive impact toward reducing workers comp rates in Alaska.

*Effects of Mandated Insurance Coverage*, a study of sources located in six states who mandated coverage found:

•35% had no increase; 11% had increased 1-5%; and 40% increased 5-10%.
• 98% showed no shift to self-insured status due to mandate.
• No indication of elimination of health plans due to mandate.
• 14% experienced measurable health cost reduction.
• States that have *required offer* shift to *mandated* within a few years (i.e., Texas, Vermont).

National Federation of Independent Businesses supportive of legislation with finance amendment that requires the offer be made to businesses of 20 or fewer permanent, fulltime employees.

**Municipal Impact**

Senate Advisory Committee Report (3/14/88)

• 26 groups contacted; major providers: Blue Cross, Aetna
• Typical health plan offered unlimited coverage for hospitalization (inpatient) while restrictions of dollar amounts and lesser percentages of coverage are offered for outpatient (counseling).
• Self-insured municipalities and other entities are not subject to legislation.

**Insurance Companies**

Philosophically opposed to mandates; however, if that policy decision is made, technical amendments have been offered by the two largest health insurance providers in the state (Aetna and Blue Cross). Amendments have been included in current CSSB363(Fin) draft.

Blue Cross of Washington raised rates 2.5% last year, following mandate in Washington.

Division of Insurance contacted top five carriers in Alaska (80% of the market). Responses ranged from **no increase** for those packages which currently have alcohol and drug plans up to $5.50 or $6.00 per month for those with no alcohol or drug treatment. Most estimates were in the $2.00/month range.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

FOR

SENATE BILL NO. 363

"An Act relating to insurance coverage for treatment of alcoholism and drug abuse."

Passage of SB 363 would require providers of health insurance to include treatment for drug and alcohol abuse with benefits of at least $7,000 over two consecutive years and lifetime benefits of at least $14,000. Benefits would be adjusted annually to correspond to the consumer price index. Insurers could not require higher deductibles for the cost of this treatment than for other types of coverage, not require precertification of treatment, a second opinion concerning treatment, a specific form of treatment or limit coverage to either an inpatient or outpatient basis. Insurers could not exclude coverage for medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility. Insurers may not deny coverage for the sole reason that treatment was not completed. A definition is provided for alcoholism and drug abuse. Approved treatment facility is defined as treatment in a facility approved under AS 47.37.140 (Uniform Alcoholism Intoxication and Treatment Act). Treatment would include both inpatient and outpatient services. The effective date on SB 363 is January 1, 1989.

From a public health and public safety perspective alcoholism and drug abuse seriously impact the lives of many Alaskans. These substances contribute to the alarmingly high state rates of accidental personal injury and death. Alaska ranks consistently among the leading states in the per capita consumption of alcoholic beverages. This high level of consumption places Alaskans at risk for related illnesses such as cancer, infectious diseases, and diseases of the liver and pancreas. Living in an alcoholic or drug abusive home can also contribute to a variety of stress related disorders among family members.

Like many preventive approaches to public health problems, the cost versus benefits achieved with the passage of SB 363 will be difficult to measure. However, evidence exists that alcoholism treatment costs can be offset by a reduction in overall health care costs within two to three years following the initiation of treatment.

Holder and Blose studied the impact of alcoholism treatment on health care utilization and costs for health insurance enrollees under the Federal Employees Health Benefit Program (1) Their results indicated that monthly health care costs for families with an alcoholic member were almost twice as high as health care costs for families with no apparent alcoholic member. The results of the study showed that following the initiation of alcohol treatment, the health care costs of alcoholics declined significantly. Total health care costs averaged $294 per month during the six months following the initiation of treatment, but only $194 per month by the third post-treatment year.

Another study, by Holder and Hallan (2) of public employees in California, yielded similar findings, and a five-year follow-up of 90 families of alcoholics showed a reduction in monthly medical expenditures of $72. per person, bringing them to the same level as a comparison group of non alcoholic families.

It has been suggested that following the passage of SB 363, employers' health insurance premiums could increase. We are unable to determine the validity of this claim. However, even though claims may increase initially, and we recognize that this may cause some hardship on some employers, evidence suggests that alcohol and drug abuse coverage decreases the use of benefits for related medical conditions thereby offsetting premium increases in the long run.

Many of the alcohol and drug abuse treatment policies currently in effect in Alaska only cover treatment which is provided in a hospital or by a physician. SB 363 provides for treatment in all programs approved by the SOADA under AS 47.37.140. This provision would make current drug abuse and alcohol coverages more cost-effective by allowing treatment in settings which are less expensive than those provided by physicians or hospitals. This would result in greater access to service and make all coverage more cost-effective.

Presently, 34 states have similar legislation. Under the duties of this department's Office of Alcoholism and Drug Abuse (SOADA), AS 47.37.040(16) mandates that the SOADA shall "encourage all health and disability insurance programs to include alcoholism as a covered illness." At a November 1987 meeting the Review Board on Alcoholism and the Advisory Board on Drug Abuse passed the following resolution: "Resolved that: The State of Alaska should require that medical insurance policies should be required to reimburse for alcoholism and drug abuse treatment services including those that are state approved."

The Department of Health and Social Services is supportive of the approach and intent contained in SB 363.

1. Harold Holder, Ph.D. and James Blose, MPP, Alcoholism Treatment and Total Health Care Utilization and Costs. JAMA, September 19, 1988, Vol. 256, No. 11

2. Harold Holder, Ph.D. and Jerome Hallen, Dr.P.H., Medical Care and Alcoholism Treatment Costs and Utilization: A Five Year Analysis of the California Pilot Project to Provide Health Insurance Coverage for Alcoholism. National Institute on Alcohol Abuse and Alcoholism, (Contract ADM 291-79-0008), December 1981

Myra M Munson 2/9/88

Myra M. Munson Date

2/5/88

Matthew C. Felix Date

PP9

ALASKA NETWORK
ON
DOMESTIC VIOLENCE
AND
SEXUAL ASSAULT

130 Seward, No. 301 • Juneau, Alaska 99801 • (907) 586-3650



# POSITION PAPER
# SUPPORT
## MANDATORY INSURANCE COVERAGE FOR THE TREATMENT OF ALCOHOL AND DRUG ABUSE

The Alaska Network on Domestic Violence and Sexual Assault supports the concept of mandatory insurance coverage for the treatment of alcoho' and drug abuse. While none of the literature on substance abuse and family violence supports the existence of a direct causal relationship between alcohol or drug use and woman battering and child abuse, studies indicate that chemical dependence is an important factor in the frequency and severity of violence.

"Men's substance abuse PRIOR to marriage has been found in one study to be a strong predictor of certain characteristics of family violence IF it occurs in the marriage. These characteristics are:

--higher frequency of violence;
--more probability that alcohol or drug use is involved in the most serious incidents;
--and long duration of violence in the relationship.

There is also research support for the observation that batterers who abuse alcohol inflict more serious injuries on their victims than batterers who do not."

"In yet another study, 85% of batterers with chemical dependence problems admitted that they were also assaultive when sober. ...it seems clear that we cannot predict an individuals' violent behavior by his alcohol consumption, either as a pattern or in particular incidents. However, these findings also suggest that battering is even more dangerous if the batterer drinks at all, whether or not he is intoxicated at the time of an incident."

In one study of battered women and alcohol abuse, the majority of the women developed their problems with alcohol after being in an abusive relationship for some time.

Finally, there is evidence that alcohol or drug use by a batterer increases the potential that the violence will end in death.

In light of this research, the Network feels strongly that the availability of substance abuse treatment should be increased and is an important aspect of assisting families where there is violence.

(Research excerpted from an address presented by Melissa Eddy at the Sixth Annual Texas Council on Family Violence Conference, October 28, 1987, Austin Texas.)

Municipality of Anchorage

P. O. BOX [illegible]
ANCHORAGE, ALASKA [illegible]
(907) 264-4111

Tom Fink
MAYOR

MUNICIPAL HEALTH & HUMAN SERVICES COMMISSION

Pat

March 9, 1988

RECEIVED MAR 14 1988

Senator Johne Binkley
Senate Finance Committee, Chair
Alaska State Legislature
POB V
Juneau, Alaska 99811

Dear Senator Binkley,

The Municipal Health and Human Services Commission would like to lend their full support to the passage of SB363. In 1984, the economic cost related to alcohol abuse was $195.5 million; the economic cost associated with drug abuse was $62.4 million. Absenteeism among alcoholics and problem drinkers is 4-8 times greater than the average. Problem drinkers and alcoholics attempt suicide 6-15 times more than the general population.

Substance abuse is ranked as the second highest behavioral and mental health priority in the Anchorage Health and Human Services Plan (January 1988). There are countless statistics which quantify the social, economic, and psychological devastation attributable to substance abuse. The provision of insurance coverage for substance abuse is an important measure in Alaska's effort to control alcoholism and drug abuse. It is a measure long overdue.

If I can answer any questions, I would be happy to. You can reach me at 562-2828, or you can call our staff at 343-4674.

Sincerely,

Gari B. Andreini, Chair
Municipal Health and Human Services Commission

cc: Senate Finance Committee
Anchorage Municipal Assembly
Tom Fink, Mayor, Municipality of Anchorage
Ron Garzini, Manager, Municipality of Anchorage
Robert A. (Bert) Hall, Director, Health and Human Services, Municipality of Anchorage

SJ18/dPD20

RESOLUTION

Family Recovery Center
Advisory Committee
of the
Central Penninsula General Hospital
Soldotna, Alaska

Whereas drug and alcohol abuse has an economic, social, and morally debilitating effect on the community and;

Whereas the economic cost of alcohol and drug abuse in Alaska is estimated to be $175,000,000 annually and;

Whereas drug and alcohol abuse is a treatable disease and services can be provided through community based treatment programs and;

Whereas the Family Recovery Center of the Central Peninsula General Hospital provides such services and;

Whereas the Family Recovery Center is reliant upon client fees for services provided to support its operations;

Now Therefore Be It Resolved:

The Advisory Committee of the Family Recovery Center is fully supportive of the mandatory insurance coverage for the treatment of alcoholism and drug abuse as is contained in the provisions of House Bill 403 and Senate Bill 363.

Sharon Jean
Sharon Jean, Chairperson
Advisory Committee
Family Recovery Center

March 1, 1988
Date

# Alaska State Legislature

Senate Advisory Council

PO Box
State Capitol
Juneau, Alaska 9981
Phone: (907) 465-3114

MEMORANDUM

TO: Senator Binkley
Alaska State Legislature

FROM: Carol R. Vandor CRV
Senate Advisory Council

DATE: February 16, 1988

RE: Private Businesses that Provide Employee Coverage for Substance Abuse Treatment: IR# 88-003230

February 8, 1988, Pat Jackson, of your staff, verbally requested that the Senate Advisory Council determine if major businesses operating in Alaska provide medical coverage to employees for substance abuse treatment. Pat requested that the information be provided for a committee meeting scheduled February 9, 1988. Following is the information I verbally provided to Pat for the February 9, meeting.

I contacted six major firms operating in Alaska; Fred Meyer, Pay N Save, Nordstrom, ARCO, Chevron, and Standard Alaska Production Company. All six companies provide coverage to their employees for substance abuse treatment. Each policy, however, does have internal limits. The limits vary with in-patient/out-patient treatment, limitations on consecutive days of treatment, one-time/life-time limits, etcetera.

February 9, 1988, Pat verbally requested that the Senate Advisory Council survey several local small businesses to determine what, if any, type of coverage was provided to employees for substance abuse treatment. Pat wanted this information for a committee meeting scheduled February 17, 1988. Following are the businesses I contacted and the information I obtained.

Elgee & Rehfeld, CPA's. Elgee & Rehfeld employ 7 people. Their medical plan covers treatment for alcohol abuse but does not cover abuse of drugs, or complications from drug use, for drugs that have not been approved by the Food and Drug Administration.

Lyle's Hardware. Lyle's employs 22 people. Their current medical plan includes coverage for alcohol and drug abuse treatment.

Foodland Super Drug. Foodland Super Drug employs 12 people. Their plan states specifically that there is coverage for alcohol abuse treatment; they assume there is coverage for drug abuse treatment also.

Ace Hardware. Ace Hardware employs from 8 to 12 people. They provide no employee group health plan. They have liability insurance and workmen's compensation only.

Juneau Drug. Juneau Drug employs 4 full-time people and 2 to 3 part-time people. The full-time employees have individual policies and the part-time employees have no medical coverage.

Alaska Federal Savings & Loan (AFS&L). AFS&L employs approximately 60 people. Part-time employees and employees who have been employed less than 6 months have no medical coverage. All other employees have medical coverage that includes provisions for treatment of substance abuse.

Channel Sanitation. Channel Sanitation employs approximately 35 people. Their medical plan provides coverage for treatment of substance abuse.

Don Abel Building Supply. Don Abel employs approximately 20 people. Their medical plan provides coverage for treatment of substance abuse.

Each policy for the above-mentioned small businesses does have internal limits. The limits vary with in-patient/out-patient treatment, limitations on consecutive days of treatment, one-time/life-time limits, etcetera.

If you have any questions, please let me know.

## SUMMARY

| *Company* | *Type of Insurance* | *Drug and Alcohol Included?* | *Notes* |
|---|---|---|---|
| Fred Meyer | Different Types . . . -union/non-union | Yes, in Alaska | with limitations |
| Pay & Save | M. E. T. | Yes | with limitations |
| Nordstroms | Self-insured | Yes | with limitations |
| ARCO | | Yes | with limitations |
| Chevron | M. E. T. | Yes | with limitations |
| Standard Alaska | Different Types | Yes, in Alaska | with limitations |

| **Business** | **Number of Employees** | **Medical Plan** |
|---|---|---|
| Elgee & Rehfeld, CPA | 7 | includes alcohol abuse but not drug abuse |
| Lyle's Hardware | 22 | includes alcohol and drug abuse treatment |
| Foodland Super Drug | 12 | alcohol abuse |
| Ace Hardware | 8-12 | no group health plan |
| Juneau Drug | 4 full-time<br>2-3 part-time | individual policies<br>no medical coverage |
| Alaska Federal Savings and Loan | 60 | includes substance abuse (part-time and those less than 6 months--no medical coverage) |
| Channel Sanitation | 35 | includes substance abuse |
| Don Abel Building Supply | 20 | includes substance abuse |

*Each policy does have internal limits . . . (in-patient/out-patient treatment, limitations on consecutive days of treatment, one-time/life-time limits, etc.)*

# Alaska State Legislature

Senate Advisory Council

PO Box
State Capitol
Juneau, Alaska 99811
Phone (907) 465-3112

MEMORANDUM

TO: Senator Binkley
Alaska State Senate

FROM: Carol R. Vandor
Senate Advisory Council

DATE: March 25, 1988

SUBJECT: Addendum to IR#88-003250; Insurance Coverage for Substance Abuse

My March 14, 1988, memorandum listed 26 groups of employers in Alaska and outlined the health benefit they provide to their employees for alcohol and drug abuse treatment. You also requested that we indicate whether or not the employer is self-insured. The information is as follows.

Groups that are Self-Insured

Health Provider - Great West Life

Fairbanks North Star Borough
Fairbanks North Star Borough School District
City of Fairbanks
North Slope Borough School District

Groups that are Fully Underwritten Experience Rated

Health Provider - Blue Cross

Kodiak Island Borough School District
City and Borough of Juneau
City and Borough of Juneau School District
Nome Public Schools
City of Ketchikan

Health Provider - Aetna

Nenana School District
Dillingham City School District
Ketchikan Gateway Borough School District

Groups that are Pooled

Health Provider - Blue Cross

Alaska Gateway School District
Annette Island School District
Bristol Bay Borough and School District
Wrangell General Hospital
Klawock City School District
Southwest Region School District
Lower Yukon School District
Cordova Public Schools
Galena City Schools
City of Kotzebue
City of Wrangell
City of Yakutat
Valdez Public Schools
City of Valdez

If you have any questions about the groups under these definitions, please contact the appropriate health provider and ask for the following individual(s). They will be able to provide you with detailed information about how each policy is written.

| | | |
|---|---|---|
| Nita Schaerer | Steven LeBrun | Ellen Kariya |
| Blue Cross | Aetna | Great West Life |
| (907) 561-5065 | (206) 441-2803 | (206) 822-5575 |

# Alaska State Legislature

Senate Advisory Council

PO Box
State Capitol
Juneau, Alaska 99811
Phone (907) 465-3704

MEMORANDUM

TO: Senator Binkley
Alaska State Senate

FROM: Carol R. Vandor
Senate Advisory Council

DATE: March 14, 1988

SUBJECT: Alcoholism and Drug Addiction Treatment Benefit in Selected School District and Municipalities in Alaska; IR# 88-003250

Your memorandum of February 25, 1988, requested that the Senate Advisory Council determine the amount of medical benefit for alcoholism and drug addiction treatment that school districts and municipalities in Alaska provide for their employees. Following is a selection of school districts and municipalities and the type of coverage they have for substance abuse.

Name of Group

Alaska Gateway School District
Annette Island School District
Bristol Bay Borough & School District
Wrangell General Hospital
Klawock City School District
Southwest Region School District
Lower Yukon School District
Cordova Public Schools
Galena City Schools
City of Kotzebue
City of Wrangell
City of Yakutat
Valdez Public Schools
City of Valdez

Health Provider

Blue Cross

Alcoholism Treatment Benefit

In-patient treatment provided in a legally operated hospital or a Blue Cross participating alcoholism treatment facility will be covered under major medical at 90%* as any other condition.

In-patient treatment at a non-participating alcoholism treatment facility will be paid under major medical at 90%* up to a maximum of $1,000 each calendar year.

Hospital out-patient treatment, treatment on an out-patient basis in an alcoholism treatment facility and physician services are not covered.

Drug Addiction Treatment Benefit

Hospital in-patient treatment incurred at a legally operated hospital and all non-institutional treatment is paid under major medical at 90%*.

*Paid after a $100 per member, $300 per family, calendar year deductible has been satisfied. Major medical co-insurance is 90%/10% of the first $1,955 in covered expenses then 100% for all other covered expenses for the remainder of the calendar year. Once a member has received $50,000 in major medical benefits that member no longer is required to satisfy a calendar year deductible and reimbursement will be at 100% thereafter up to a maximum of $250,000.

**********

Name of Group

Kodiak Island Borough School District

Health Provider

Blue Cross

Alcoholism Treatment Benefit

In-patient treatment provided in a legally operated hospital or a Blue Cross participating alcoholism treatment facility will be covered under major medical at 90%* as any other condition.

In-patient treatment at a non-participating alcoholism treatment facility will be paid under major medical at 90%* up to a maximum of $1,000 each calendar year.

Hospital out-patient treatment, treatment on an out-patient basis in an alcoholism treatment facility and physician services are not covered.

Drug Addiction Treatment Benefit

Hospital in-patient treatment incurred at a legally operated hospital and all non-institutional treatment is paid under major medical at 90%*.

*Paid after a $50 per member, $150 per family, calendar year deductible has been satisfied. Major medical co-insurance is 90%/10% of the first $1,955 in covered expenses then 100% for all other covered expenses for the

remainder of the calendar year. Once a member has received $50,000 in major medical benefits that member no longer is required to satisfy a calendar year deductible and reimbursement will be at 100% thereafter up to a maximum of $250,000.

All payments are based on customary and reasonable charges.

**********

Name of Group

City and Borough of Juneau

Health Provider

Blue Cross

Alcoholism Treatment Benefit

Combined in-patient and out-patient expenses incurred in a legally operated hospital, or Blue Cross participating alcoholism treatment facility and all non-institutional treatment is covered at a constant 80%* up to a maximum of $2,000 each calendar year.

Drug Addiction Treatment Benefit

Hospital in-patient expenses incurred at a legally operated hospital and all non-institutional treatment expenses are paid at 80%*.

*Paid after a $150 per member, $300 per family, calendar year major medical deductible has been satisfied. Major medical co-insurance at 80%/20% of the first $5,000 in covered expenses then 100% of other covered expenses for the remainder of the calendar year.

All payments are based on customary and reasonable charges.

**********

Name of Group

City and Borough of Juneau School District

Health Provider

Blue Cross

Alcoholism Treatment Benefit

Hospital in-patient and out-patient expenses incurred at a legally operated hospital are paid at a constant 85%* up to a maximum of 30 days each calendar year.

Treatment provided at a state approved alcoholism treatment facility on an in-patient and out-patient basis is paid at 85%* up to the maximum of $2,500 each calendar year.

Note: Each day of in-patient care will be charged as one day of in-patient hospital care against the maximum days available. Each day of out-patient care in an alcoholism treatment facility or a detoxification center will be charged as one-half day of in-patient hospital care.

Drug Addiction Treatment Benefit

Hospital in-patient expenses incurred at a legally operated hospital are paid under major medical at 85%* up to a maximum of 30 days each calendar year.

Treatment of non-institutional services is paid at 85%*.

*Paid after a $50 per member, $150 per family, calendar year major medical deductible has been satisfied. Major medical co-insurance is 85%/15% of the first $1,875 in covered expenses for the remainder of the calendar year.

All payments are based on customary and reasonable charges.

**********

Name of Group

Nome Public Schools

Health Provider

Blue Cross

Alcoholism Treatment Benefit

In-patient and out-patient expenses incurred at a legally operated hospital, or Blue Cross participating alcoholism treatment facility and all non-institutional treatment is covered at a constant 80%* up to a maximum of $2,000 each calendar year.

Drug Addiction Treatment Benefit

Hospital in-patient expenses incurred at a legally operated hospital are paid in full (no deductible) up to a maximum of 120 days each calendar year for combined treatment of mental and nervous conditions and drug addiction.

Treatment for non-institutional services is paid at 80%*.

*Paid after a $100 per member, $300 per family, calendar year major medical deductible has been satisfied. Major medical co-insurance is 80%/20% of the first $1,875 in covered expenses then 100% of all other covered expenses for the remainder of the calendar year.

All payments are based on customary and reasonable charges.

**********

Name of Group

City of Ketchikan

Health Provider

Blue Cross

Alcoholism Treatment Benefit

Combined expenses for in-patient and out-patient treatment at a legally operated hospital or an approved alcoholism treatment facility are paid at 80%* up to a maximum of $2,000 each calendar year.

Drug Addiction Treatment Benefit

Hospital in-patient expenses incurred at a legally operated hospital are paid in full (no deductible) up to a maximum of 30 days each calendar year. Treatment after 30 days is paid under major medical at 80%*.

Treatment for non-institutional services is paid at 90%*.

*Paid after a $100 per member, $300 per family, calendar year major medical deductible has been satisfied. Major medical co-insurance is 80%/20% of the first $1,875 in covered expenses then 100% of all other covered expenses for the remainder of the calendar year.

All payments are based on customary and reasonable charges.

**********

Name of Group

Nenana School District

Health Provider

Aetna

Alcoholism Treatment Benefit

"Standard Coverage" as described on the attached letter is available for in-patients, subject to a $100 deductible, 20% individual co-payment (plan pays 80%), and a $500 per person co-payment calendar year limit after which benefits are paid at 100% by the Plan for the rest of the year. Alcoholism abuse charges for out-patients are included as part of the psychiatric benefit, payable at 50% after the deductible up to $1,000 per person per year.

Drug Addiction Treatment Benefit

"Standard Coverage" as described on the attached letter is available for in-patients, subject to a $100 deductible, 20% individual co-payment (plan pays 80%), and a $500 per person co-payment calendar year limit after which benefits are paid at 100% by the Plan for the rest of the year. Drug abuse charges for out-patients are included as part of the psychiatric benefit, payable at 50% after the deductible up to $1,000 per person per year.

**********

Name of Group

Dillingham City Schools

Health Provider

Aetna

Alcoholism Treatment Benefit

There is an "Optional" 45 day in-patient treatment benefit included subject to a $100 deductible, 20% individual co-payment and $500 per person co-payment out-of-pocket calendar year limit. Out-patient treatment is included in psychiatric benefit at 50% after the deductible to $1,000 per year.

Drug Addiction Treatment Benefit

There is an "Optional" 45 day in-patient treatment benefit included subject to a $100 deductible, 20% individual co-payment and $500 per person co-payment out-of-pocket calendar year limit. Out-patient treatment is included in psychiatric benefit at 50% after the deductible to $1,000 per year.

**********

Name of Group

Ketchikan Gateway Borough School District

Health Provider

Aetna

Alcoholism Treatment Benefit

In-patient treatment is covered under "Standard Coverage" subject to a $50 deductible, 10% individual co-payment and a $400 per person calendar year out-of-pocket limit. Out-patient treatment is included in psychiatric benefit at 50% after deductible (no calendar year dollar limit).

Drug Addiction Treatment Benefit

In-patient treatment is covered under "Standard Coverage" subject to a $50 deductible, 10% individual co-payment and a $400 per person calendar year out-of-pocket limit. Out-patient treatment is included in psychiatric benefit at 50% after deductible (no calendar year dollar limit).

**********

Name of Group

Fairbanks North Star Borough
Fairbanks North Star Borough School District

Health Provider

Great West Life

Alcoholism Treatment Benefit

Treatment for alcoholism is covered in the same way as any other illness. However, for in-patient or out-patient care provided in a regular hospital or in an approved alcoholism treatment facility, benefits will be

paid under the Plan for 80% of reasonable and customary expenses up to the Lifetime Maximum benefit of $6,500.00 per person.

There is an annual $50.00 deductible per person, $150.00 deductible per family. The Plan will pay 80% of the first $1,500 annually and 100% thereafter.

Drug Addiction Treatment Benefit

Drug addiction treatment benefits are not specifically addressed. However, for in-patient care provided in a legally operated hospital or in an approved treatment facility, benefits will be paid under the Plan as comprehensive/major medical.

Out-patient treatment for drug addiction is not specifically addressed, however, it would likely be considered psychiatric care. Out-of-Hospital Psychiatric Coverage is as follows:

| | |
|---|---|
| Co-Payment | 100% |
| Maximum Payment Per Treatment | $ 50 |
| Maximum Benefit Per Year | $1,000 |

There is an annual $50.00 deductible per person, $150.00 deductible per family. The Plan will pay 80% of the first $1,500 annually and 100% thereafter.

**********

Name of Group

City of Fairbanks

Health Care Provider

Great West Life

Alcoholism Treatment Benefit

Treatment for alcoholism is covered in the same way as any other illness. However, the patient must be confined as an in-patient in a regular hospital or in an approved alcoholism treatment facility. For treatment in an alcoholism treatment facility, benefits will be paid under the plan for only one such confinement in any 12-month period and the plan will not pay more than a total of $1,500 under the plan for all expenses incurred and all services rendered during such confinement.

Out-patient treatment for alcoholism is considered psychiatric care. Out-of-Hospital Psychiatric Coverage is as follows:

| | |
|---|---|
| Co-Payment | 80% |
| Maximum Allowance Per Treatment | $ 25 |
| Maximum Payment Per Year | $1,000 |

Drug Addiction Treatment Benefit

Drug addiction treatment benefits are not specifically addressed. However, for in-patient care provided in a legally operated hospital or in an approved treatment facility, benefits will be paid and will be considered under the Plan as comprehensive/major medical.

Out-patient treatment for drug addiction is not specifically addressed, however, it would most likely be treated as psychiatric care. Out-of-Hospital Psychiatric Coverage is as follows:

| | |
|---|---|
| Co-Payment | 80% |
| Maximum Allowance Per Treatment | $ 25 |
| Maximum Payment Per Year | $1,000 |

**********

Name of Group

North Slope Borough School District

Health Provider

Great West Life

Alcoholism Treatment Benefit

Treatment for alcoholism is covered in the same way as any other illness. However, the patient must be confined as an in-patient in a regular hospital or in an approved alcoholism treatment facility. For treatment in an alcoholism treatment facility, benefits will be paid under the plan for only one such confinement in any 12-month period and the plan will not pay more than a total of $1,500 under the plan for all expenses incurred for all services rendered during such confinement.

Out-patient treatment for alcoholism is considered psychiatric care. Out-of-Hospital Psychiatric Coverage is as follows:

| | |
|---|---|
| Maximum Allowance Per Treatment | $ 25 |
| Maximum Payment Per Year | $1,000 |

There is an annual $50.00 deductible per person, $150.00 deductible per family. The Plan will pay 90% of the first $3,000 annually and 100% thereafter.

Drug Addiction Treatment Benefit

Treatment for substance abuse is covered for confinement in an approved treatment facility or a psychiatric hospital. During a calendar year the plan will not pay more than $1,500 for all expenses incurred and all services rendered during confinement.

Out-patient treatment for drug abuse is not specifically addressed, however, it would most likely be considered psychiatric care. Out-of-Hospital Psychiatric Coverage is as follows:

| | |
|---|---|
| Maximum Allowance Per Treatment | $ 25 |
| Maximum Payment Per Year | $1,000 |

There is an annual $50.00 deductible per person, $150.00 deductible per family. The Plan will pay 90% of the first $3,000 annually and 100% thereafter.

If you have any questions, please let me know.

SB363

IN 1986 THERE WAS $173,723,000 OF GROUP A+H COVERAGE WRITTEN IN ALASKA. MARKET SHARE AND WRITTEN PREMIUMS FOR THE TOP 5 CARRIERS WAS:

| COMPANY | % MARKET SHARE | ($000) WRITTEN PREMIUM |
|---|---|---|
| 1. AETNA LIFE INS. CO. | 41.0 | $ 71,232 |
| 2. BLUE CROSS ALASKA-WASHINGTON | 29.6 | $ 51,113 |
| 3. TRAVELERS INS. CO | 3.8 | $ 6,592 |
| 4. GREAT WEST LIFE ASSUR. CO. | 3.0 | $ 5,277 |
| 5. PRUDENTIAL INS. CO. OF AMERICA | 2.6 | $ 4,470 |
| TOP 5 TOTALS | 80.0 | $138,684 |
| REMAINING | 20.0 | $ 35,039 |
| TOTAL ALL COMPANIES | 100.0 | $173,723 |

Don Koch
[illegible]
1-25-87

Employee Benefits Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

March 4, 1988

Mr. Jim Jordan, Officer in Charge of A & H
Department of Commerce, Division of Insurance
P.O. Box D
Juneau, Alaska, 99811

Subject: Estimated Small Business Rates for Alaska's Proposed Alcoholism and Substance Abuse Legislation

Dear Mr. Jordan:

If the proposed legislation is enacted, the following figures represent Ætna's estimated adjustment to manual rates before adjustment for census. These numbers apply to our standard small business policies.

General Assumptions:

(1) $100 Deductible; and

(2) Maximums apply to inpatient and outpatient treatments combined.

The estimated adjustments per person under a Major Medical plan with a 100% feature are:

$1.51 per month for adult males and females;
.18 per month for dependent children; and
.57 per month for Medicare eligibles.

The estimated adjustments per person under a Major Medical plan with an 80% feature are:

$1.21 per month for adult males and females;
.15 per month for dependent children; and
.46 per month for Medicare eligibles.

Hopefully, this information will be of some help to you, and if anything further is needed please do not hesitate to call.

Sincerely,

Austin H. Soares

Austin H. Soares
Contract Counseling
Employee Benefits Division
Ætna Life Insurance Company
(203) 636-5037

MEMORANDUM. . .

DATE: March 3, 1988

TO: Jim Jordan
Alaska Division of Insurance

FROM: Erin R. Glynn, Sr. Vice President, Operations
Blue Cross of Washington and Alaska

SUBJECT: SB 363 - ALCOHOL AND DRUG ABUSE BILL

Jim, as you requested, we've developed cost projections relating to the impact of SB 363 on group health insurance rates. In determining these numbers, we assumed that the group is a standard risk small group. For a group that currently has no alcoholism or drug abuse benefits, costs would range from $5.50 to $6.00 per employee per contract month. Adding the provisions of SB 363 to a group that has a typical drug and alcohol benefit would cost between $2.35 and $2.80 per employee per contract month.

If you need any additional information or would like to discuss these figures in greater detail, I will be in the office on Friday.

ERG:jo

TheTravelers

The Travelers Companies
One Tower Square
Hartford, CT 06183

Raymond J. Marra, FSA, M.A.A.A.
Assistant Actuary
Actuarial & Financial Division
Employee Benefits Department
NATIONAL ACCOUNTS GROUP

March 3, 1988

Mr. J. Jordan
Alaska Division of Insurance

Senate Bill #363

This bill provides for Alcohol and Drug Abuse coverage as follows:

> Inpatient and Outpatient Care in Treatment Center covered same as any other illness. Maximum benefit in any two consecutive years = $7,000, with lifetime maximum of $14,000.

Our standard Small Group package, offered to groups of 2 - 50 lives, already provides:

> 45 days Inpatient and 100% of Outpatient charges (up to $1,000 annually) for alcohol and drug abuse treatment.

At your request, we have estimated that benefits specified under Senate Bill #363 are approximately equal in cost to our current alcohol and drug abuse benefits.

As such, no additional rate is required.

The full cost of Senate Bill #363, i.e. in the absence of our standard alcohol and drug abuse treatment benefit, would be approximately $2.50 per adult per month, and $.75 per insured child-unit per month. On a composite basis, this is slightly over 1% of total case premium.

This letter should be considered merely informational. We reserve the right to reevaluate our expected liability with regard to Senate Bill #363 in either its present or revised form. As the information provided is proprietary, we would request that you not divulge company specific results.

Ray Marra

Raymond J. Marra

# Great-West Life

Great-West Life Center
9505 East Orchard Road
Englewood, CO 80111 Tel. (303) 889-3000
Address mail to: P.O. Box [illegible], 80150

Jim Jordan
Division of Insurance, State of Alaska
3601 C Street Suite 722
Anchorage, AK 99503

Dear Mr. Jordan:

I have been asked to respond to you with a comparison of Great-West Life's alcoholism and drug abuse provision, and Alaska's Senate Bill 363.

Our current inpatient benefits more than meet the criteria set in the bill. We pay the claim using the same deductible and copayment as the other covered items in the policy. We do have a $10,000 annual maximum and a $25,000 lifetime maximum on these benefits. This does comply with the stated $7,000 over two years and $14,000 lifetime as stated in the bill.

Our outpatient benefits, however, would have to be increased to comply with the bill. Currently, the policyholder can choose a $25, $50, $75, or $100 office visit maximum. The office visit amount is only covered at a 50% coinsurance level and is subject to an annual 50 visit maximum. This coverage is optional.

To comply with Bill 363, I analyzed the results of changing the coinsurance level on outpatient benefits to 80% and also changing the annual and lifetime maximums. I used the following policy to do my analysis:

- 80% coinsurance, $100 deductible, $2000 breakpoint, 3X family
- 30 employees, 9 dependents
- Average Age = 30
- Zip Code = 995
- Health Care Review Service included
- Industry Code = E (10% load)
- No other options

This policy produced a monthly rate of $5,440.17. When I add the current optional outpatient benefit to this policy using a $50 office visit maximum, the premium increased to $5,471.22. This is a .6% increase. At this point I used our actual claims data base and forced the system to pay outpatient claims at the higher level. This produced a monthly premium of $5,525.74. This is a 1% increase over the current outpatient option.

In summary, Senate Bill 363 would only affect the payment of outpatient substance abuse claims. It would involve a 1.6% increase over a policy with no outpatient substance abuse coverage.

If you need any further information, please feel free to call me at (303)889-3296.

Sincerely,

Kimberly Heier
Actuarial Assistant
Group Insurance Products

KH:gls

# Alcoholism Treatment and Total Health Care Utilization and Costs

## A Four-Year Longitudinal Analysis of Federal Employees

Harold D. Holder, PhD, James O. Blose, MPP

This study examines the effect of alcoholism treatment services on overall health care utilization and costs for health insurance enrollees under the Federal Employees Health Benefit Program with Aetna Insurance Company, 1980 through 1983. Claims filed by 1697 treated alcoholics (and their family members) continuously enrolled with Aetna during the study period were examined. In the years prior to initial alcoholism treatment, alcoholics incurred gradually increasing total health care costs on the average. These costs rose dramatically in the six months prior to treatment, began to decline after treatment initiation, and continued to fall during several follow-up years. For alcoholics less than 45 years of age, costs eventually declined to a point comparable with the lowest pretreatment levels.

(*JAMA* 1986;256:1456-1460)

EARLIER studies have established that alcoholics have lower life expectancies and thus higher mortality rates at younger ages than nonalcoholic populations.[1-3] Regular heavy ingestion of ethanol increases the chances of physical illness and early death.

On the average, alcoholics consume medical care resources at a much higher rate than nonalcoholic individuals.[4,5] There have been few studies, however, of the way that alcoholism treatment affects overall health care utilization and costs. This relationship has become an important issue during the past decade as more insurance carriers, self-insured companies, and health maintenance organizations (HMOs) have covered and/or provided alcoholism treatment. Several studies have examined the impact of alcoholism treatment on medical care cost and utilization using data from prepaid plans or HMOs (H. Hunter, unpublished data, November 1978).[6-9] These have generally found a reduction in health care utilization or cost following alcoholism treatment. Holder and Hallan[9] report similar findings in a study of alcoholics in a fee-for-service population. Research in this area has been more thoroughly reviewed by Jones and Vischi[10] and Saxe et al.[11] While these studies consistently show decreases in overall health care utilization following alcoholism treatment, the generalizability of the findings can be questioned because of the possibility of self-selection in enrollment with HMOs.[12,13] Further, most of this research is based on relatively small numbers of cases concentrated in specific geographic areas.

The study reported herein provides further evidence regarding changes in general medical care utilization and costs following initiation of alcoholism treatment. This research sought to avoid several limitations of many prior studies[10] by the use of several design features: (1) a large, continuously enrolled treated alcoholic population (about 1,700 subjects), (2) a geographically diverse population including cases from all 50 states, (3) longer pretreatment and posttreatment time periods, (4) use of multiple cost and utilization measures to corroborate any observed effects, and (5) use of a comparison group.

In addition to providing an opportunity to corroborate the findings of previous small regional studies with a sizable national data base, this research has the capacity to extend our knowledge in two directions: (1) The large number of cases permits some exploratory analyses to be conducted on alcoholics of differing ages; and (2) the long time period examined provides a longer and more detailed picture of the pretreatment cost patterns of alcoholics than has been possible.

### RESEARCH APPROACH

The data for this study were derived from a review of all claims filed with the Aetna Life and Casualty Company during the calendar years 1980 through 1983 by all persons insured under the Federal Employees Health Benefit Program. As of September 1983, the Aetna plan covered 390 000 enrollees (federal employees and retirees) and about 980 000 beneficiaries in all. About half of all enrollees were aged 60 years or older. During the four-year

From The Human Ecology Institute, Chapel Hill, NC (Dr Holder and Mr Blose), and the School of Public Health, University of North Carolina at Chapel Hill (Dr Holder).

Reprint requests to The Human Ecology Institute, 211 N Columbia St, Suite B, Chapel Hill, NC 27514 (Dr Holder).

study period, 2324 individuals filed claims for alcoholism treatment.

An alcoholic was defined as any person who had received medical treatment under a primary diagnosis of alcoholism. Aetna utilized a limited classification system for coding types of illnesses but did identify alcoholism diagnoses as a single group. Aetna did not utilize International Classification of Diseases codes during the time period covered by the study.

Since the primary purpose of the study was to examine longitudinal patterns of medical care, only those families that had continuous health insurance coverage with Aetna during the study period were used for analysis. Of all families with at least one alcoholic member, 1645 (57%) were continuously enrolled. Those dropped from the longitudinal analysis were demographically similar to the continuously enrolled families, and no temporal patterns in enrollment discontinuity were evident.

A randomly selected group of continuously enrolled families that had filed no claims for alcoholism treatment during the study period was chosen. This random sample was stratified by age to ensure that the age distribution matched that of families with alcoholic members. The sample size (N=3598) was twice that of the alcoholic family group. This group was used only to make comparisons with the alcoholic families regarding general medical care utilization patterns. It would be inappropriate to utilize such a comparison group for making inferences regarding the impact of alcoholism treatment.[14]

No statistically significant differences in demographic characteristics ($P<.01$) were found between the two family groups. Both had a mean family age of approximately 50 years. This similarity in age was the result of selecting an age-stratified comparison group. Mean family size was 2½ persons. Family composition was similar as well.

All medical care claims for both groups for services rendered during the period from January 1980 through September 1983 were analyzed. Claims for medical services received during the final quarter of 1983 were incomplete because many such claims would not be filed until early 1984. Costs were defined as unique charges for services submitted to Aetna by medical care providers. Although the cost measures used here are limited to services for which claims were filed with Aetna, the Aetna plan is rather inclusive, and these measures thus serve as fairly comprehensive indicators of overall health care utilization. Federal employees and annuitants can be insured under only one government-sponsored plan, including HMOs approved under the Federal Employees Health Benefit Program. While membership by Aetna enrollees or members of their families in other HMOs is possible, we consider it unlikely given the high average age of Aetna enrollees and the large number of retirees enrolled. All charges were adjusted to control for inflation during the study period using the Medical Care Index developed by the US Department of Labor as part of the Consumer Price Index. All cost figures cited herein are stated in January 1980 dollars.

Under the Federal Employees Health Benefit Program with Aetna, alcoholism treatment is explicitly covered under the surgical and medical expenses for mental disorders. There are two annual inpatient treatment benefit limits: $20 000 (high-option coverage) and $15 000 (low option). About 80% of the families in both the alcoholic and nonalcoholic study groups retained high-option coverage throughout the four-year period. Inpatient treatment is covered only if part of a program of therapy supervised by a physician who certifies that a follow-up program has been established. Inpatient care for detoxification alone without an associated therapy program is not covered by the plan. Outpatient treatment coverage includes the services of a physician or clinical psychologist. Services rendered by other providers are covered if they are supervised by a physician specializing in psychiatry. Annual outpatient treatment benefits are limited to $1000 (high-option coverage) and $750 (low option).

## RESULTS

The total medical care utilization and costs of the two family groups were examined by calendar year. This family-based comparison ensures the broadest frame of reference, ie, all insured individuals are included. No statistically significant differences were found across calendar years within either group. The four-year average per capita monthly health care costs for families with an alcoholic member were $209.60, or almost 100% higher than comparable costs ($106.54) for families with no apparent alcoholic members (statistically significant at $P<.01$) (Fig 1). Most of this difference resulted from higher monthly inpatient costs ($164.50 per person) for the families with an alcoholic member. These figures include both general medical care and alcoholism treatment costs. When alcoholism treatment costs are omitted, the average per capita monthly health care cost of the alcoholic families was $180.88.

The mean age for the 1697 treated alcoholics was 51 years. The age distribution is shown in Fig 2, which shows that 85% were 35 and older and that more than 50% were more than 54 years old. About 65% were male. Treated alcoholics were located in all 50 states. Two thirds of those receiving alcoholism treatment were enrollees (employees or annuitants), 24% were spouses, and 11% were dependent children.

The primary form of alcoholism treatment was inpatient care, with an average length of stay of 21.7 days. Inpatient alcoholism care was received by 77% of the treated alcoholics and accounted for 95% of all alcoholism treatment costs. The utilization rate of the alcoholism benefit was low—less than 1% of covered individuals were treated for alcoholism in any given year. The estimated benefit cost for Aetna's alcoholism treatment coverage was $1.34 per covered individual per year. About 65% of all charges were paid under the plan.

Most of the inpatient care was concentrated in general hospitals (82% of inpatient admissions). Other forms of inpatient or residential care, such as specialized alcoholism hospitals (9.2%) and hospital-affiliated inpatient or alcoholism care centers (6.3%), were used less frequently. Outpatient care was concentrated in physicians (66.4%) and general hospitals (13.7%). Other outpatient providers included clinical psychologists (5.7%), specialized alcoholism hospitals (2.8%), and psychiatric social workers (3.0%).

No individuals exceeded the annual benefit limits for inpatient alcoholism treatment and the outpatient benefit limits were exceeded only rarely—in less than 1% of the cases. Benefit limits thus did not result in any significant underestimation of alcoholism treatment cost or utilization.

The pattern of overall medical care for treated alcoholics was analyzed using the first known alcoholism treatment event as a reference point. The date of first alcoholism treatment was determined based on the available claims data. While it is possible that some individuals had previously received alcoholism treatment, this is unlikely to be a significant problem.

Since alcoholics began treatment during each month of the study period, individuals had varying amounts of pre- and post-alcoholism treatment initiation data available for analysis.

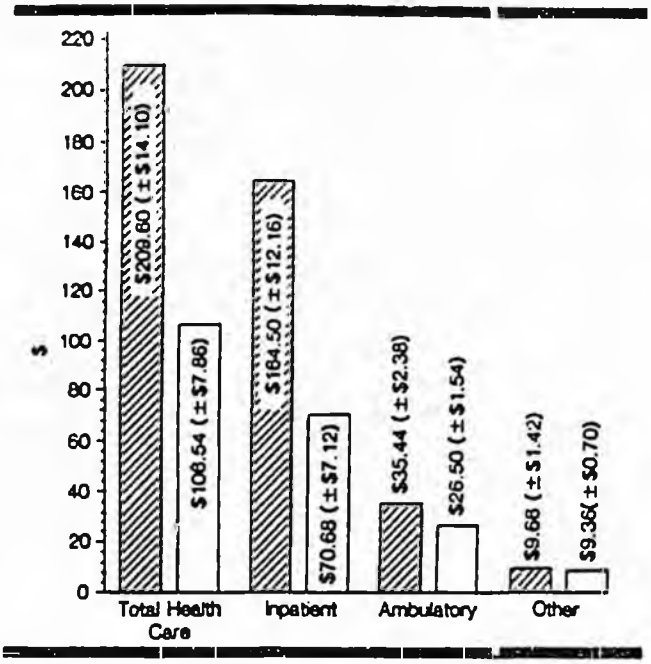


Fig 1.—Family health care costs (per capita monthly average), 1980 through 1983, for alcoholic (slashed bars) and nonalcoholic (solid bars) groups. Ninety-five percent confidence limits are given in parentheses.

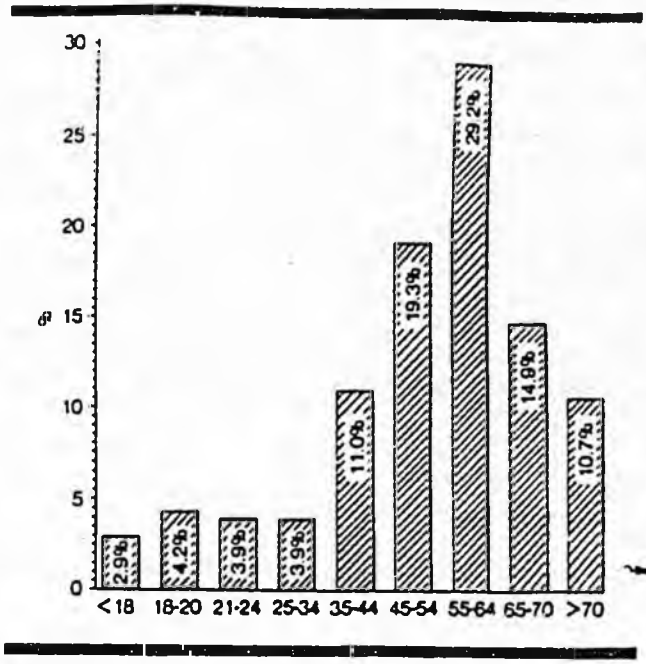


Fig 2.—Age of persons receiving alcoholism treatment.

Table 1.—Longitudinal Patterns in Total Health Care Cost and Utilization for Individuals With Available Data for 24-Month Pretreatment Period and 12-Month Posttreatment Period*

| Variable | 13-24-mo Pretreatment Mean | 1-12-mo Pretreatment Mean | 1-12-mo Posttreatment Mean | F | P |
|---|---|---|---|---|---|
| Total cost | $247 | $398 | $251 | 4.76 | <.01 |
| Inpatient cost | $192 | $316 | $191 | 4.11 | .01 |
| Ambulatory cost | $41 | $49 | $47 | 0.49 | .61 |
| No. of inpatient days | 0.7 | 1.6 | 0.7 | 9.98 | <.01 |
| No. of inpatient treatment events | 0.03 | 0.07 | 0.05 | 13.60 | <.01 |

*N=344. First alcoholism treatment claim and its associated cost and utilization have been excluded.

Table 2.—Longitudinal Patterns in Total Health Care Cost and Utilization for Individuals With Available Data for 12-Month Pretreatment Period and 24-Month Posttreatment Period*

| Variable | 1-12-mo Pretreatment Mean | 1-12-mo Posttreatment Mean | 13-24-mo Posttreatment Mean | F | P |
|---|---|---|---|---|---|
| Total cost | $290 | $242 | $192 | 3.85 | .02 |
| Inpatient cost | $225 | $188 | $150 | 2.55 | .07 |
| Ambulatory cost | $48 | $45 | $35 | 2.31 | .09 |
| No. of inpatient days | 1.2 | 1.0 | 0.6 | 4.73 | <.01 |
| No. of inpatient treatment events | 0.06 | 0.05 | 0.04 | 6.46 | <.01 |

*N=338. First alcoholism treatment claim and its associated cost and utilization have been excluded.

We tested for statistically significant changes in medical care cost and utilization using two groups of individuals having pretreatment and posttreatment periods of similar length: (1) persons for whom a full 24 months of pretreatment data and 12 months of posttreatment data were available and (2) persons with 12 months of pretreatment and 24 months of posttreatment data. Mean monthly cost and utilization for specific 12-month intervals were examined. Costs associated with the first alcoholism claim have been excluded from these and all subsequent analyses reported herein. Since initial alcoholism treatment usually involved an expensive inpatient stay, including these costs in the analysis tended to obscure the pattern of general medical care utilization. All subsequent costs for alcoholism treatment were included, however.

The total health care costs of group 1 (24 months of pretreatment and 12 months of posttreatment data, N=344) averaged $247 per month during the period from 13 to 24 months prior to treatment initiation and rose to $398 per month during the year immediately prior to treatment. This declined to an average of $251 per month during the year following treatment initiation (Table 1). Those in group 2 (N=338) had an average monthly total health care cost of $290 per month during the 12 months prior to treatment (Table 2). This declined to $242 per month during the first year following treatment initiation and then declined further to a monthly average of $192. Each of the mean comparisons was statistically significant at $P<.02$. These changes in overall monthly medical care are primarily the result of changes in inpatient utilization (Tables 1 and 2). While the longitudinal cost patterns of the two groups are similar, they appear to differ in average monthly costs for the 12-month pretreatment period. Some differences between groups should be expected due to stochastic variation.

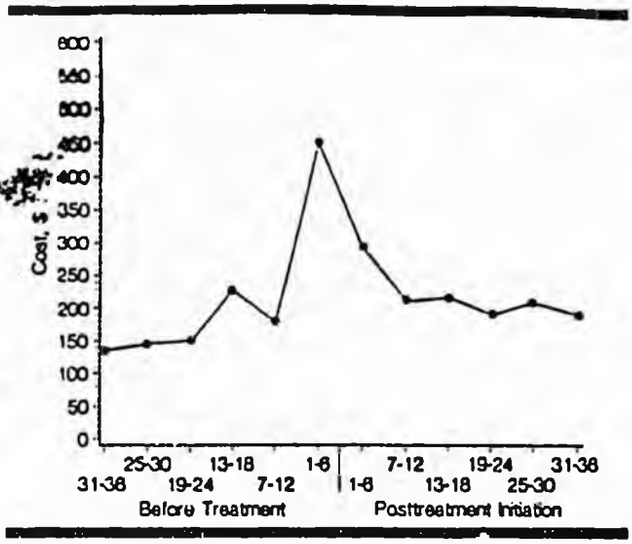


Fig 3.—Average monthly total health care costs for alcoholic individuals by six-month intervals (total population). Costs associated with first alcoholism treatment encounter were excluded.

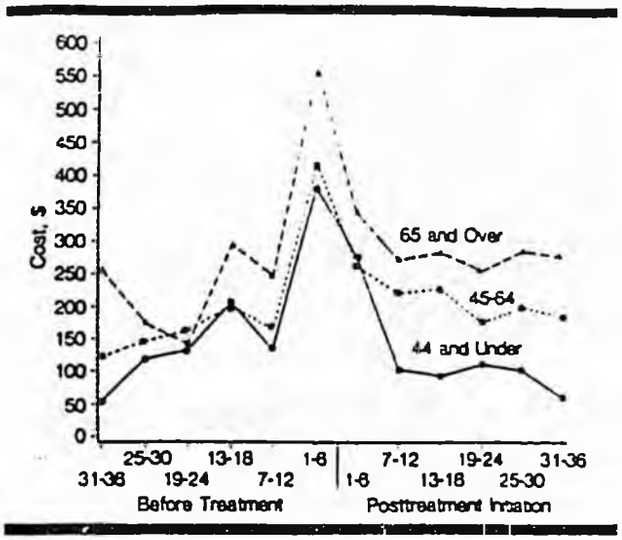


Fig 4.—Average total health care costs for alcoholic individuals by six-month intervals, by age group. Costs associated with first alcoholism treatment encounter were excluded.

Although the precise reasons for this particular difference are unclear, it is fairly certain that it is not due to a systematic discrepancy between individuals beginning treatment at different times. A comparison of the demographic characteristics of each of the four-year cohorts found no statistically significant differences. A cross-cohort comparison of average monthly costs also found no significant differences.

Taken as a whole, these results clearly indicate that mean monthly total medical care costs gradually increase before the initiation of alcoholism treatment, decline immediately following treatment initiation, and continue to decline at least into the second year.

These statistical analyses of specific subgroups were necessary to ensure that individuals were compared across similar time periods. However, overall patterns in monthly total medical care costs can also be examined by pooling the pretreatment and posttreatment data from all 1697 treated alcoholics to obtain a distribution of average monthly costs per individual during a six-year period (36 months before and after treatment initiation). A plot of this distribution is shown in Fig 3, using means for 12 different six-month intervals, where the midpoint on the horizontal axis is the start of alcoholism treatment. Monthly cell sizes always exceed 300 individuals.

This plot shows that, on the average, from 36 to 12 months before alcoholics begin alcoholism treatment their medical care costs gradually increase, with average monthly costs per person rising from approximately $130 to $179. During the year before treatment begins, however, total medical care costs rise much faster. The average monthly medical care cost rose to $452 in the six-month period before alcoholism treatment and to $1370 in the final month.

After treatment begins, total medical care costs drop fairly rapidly for about 12 months. This drop continues, though more slowly, during the next two years. Total health care costs averaged $294 per month during the six months following treatment initiation, but only $190 per month by the third post-treatment initiation year.

While this pattern of overall medical care costs was almost identical for both men and women, alcoholics of different ages showed distinct medical care cost patterns. We examined three age groups: less than 45 years, 45 to 64 years, and 65 years and older. Alcoholics in each age group followed the general patterns of the total group (Fig 4). Yet there was a clear association between age and the extent of the drop in medical care costs following the start of alcoholism treatment. By 36 months after the start of treatment, the average monthly total costs of those less than 45 years (N=440) had dropped to a level comparable with that experienced 36 months prior to treatment.

The middle age group (45 to 64 years old, N=823) is most like the model age of groups typically represented in previous studies of treated alcoholics. The health care costs of this group also dropped significantly following the start of alcoholism treatment, although they did not reach levels as low as those existing several years prior to treatment. The oldest group (N=434), which consisted primarily of retirees, experienced the highest overall medical care costs and showed the least convergence to the levels that existed prior to initiation of alcoholism treatment.

## COMMENT

The results presented herein provide important confirmation of the findings of previous studies showing a decline in the health care costs of alcoholics following the initiation of treatment. No study of a single enrolled population can be definitive, given both the diversity of the alcoholic population and the diversity of populations enrolled under employee health benefit plans, as well as variances in types of coverage and services available in different regions of the United States. Nonetheless, this research is probably more generalizable than many previous studies based on smaller regional samples. Additionally, the long time period available for analysis allowed us to examine the pretreatment medical care cost patterns of alcoholics more thoroughly than has been possible in prior research. This examination identified more clearly the nature of the rapid increase in costs that occurs in the year immediately preceding initial alcoholism treatment. It appears that within the six months prior to the start of alcoholism treatment, the emotional and physical problems of the average alcoholic escalate. These worsening problems manifest themselves in the use of additional health care services. This sharp upward ramp is not unique to alcoholism but also occurs for other chronic diseases.[15]

Further, the large sample size permitted for the first time an exploration

of the possibility that the effects of alcoholism treatment on health care could vary by age. Indeed, the findings indicate that this may be the case. Only for persons less than 45 years of age did posttreatment health care costs eventually decline to a level as low as that experienced several years prior to alcoholism treatment. While persons in older age groups also experienced declining costs after starting treatment, these costs did not decline to a point comparable with the lowest pretreatment levels. This is likely a result of the increasing medical care costs that accompany aging,[16] as well as potentially more serious alcohol-related health problems due to a longer period of chronic abuse.[17-19]

It is possible that some of the posttreatment decline in total medical care costs resulted from factors other than the treatment itself, particularly statistical convergence to the mean. While this factor may be operating for some individuals in the period immediately following treatment initiation, the longer-term decline in posttreatment costs is more likely the result of alcoholism treatment.

The effects of specific forms of treatment cannot be evaluated using these data. Rather, the findings are relevant to an actuarial concern for the extent of risk for increased benefit payments by a health insurance company, a self-insured employer, or an HMO. From this perspective, the aggregate reductions in total health care costs associated with alcoholism treatment in a situation where there is no direct control of the quality or type of alcoholism treatment are most relevant.

Random assignment to treatment and "no treatment" conditions to control for motivation to seek care is not possible in studies of this type. In any case, it is unlikely that a "no treatment" alcoholic group randomly selected from the same enrolled population could be diagnosed and ethically denied care. Further, enrollees who are motivated to seek alcoholism treatment are the ones most likely to experience reductions in health care utilization and cost. The health policy question is not whether alcoholism treatment can bring about a reduction in total health care under controlled conditions but whether such treatment as actually rendered to a large population that is motivated to seek care can result in reduced overall health care costs. The results of this study provide further evidence that this question should be answered affirmatively.

This research was conducted under a contract from the National Institute on Alcohol Abuse and Alcoholism, US Department of Health and Human Services, contract ADM 281 83 0011.

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STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF ALCOHOLISM AND DRUG ABUSE

POUCH H 05F
JUNEAU, ALASKA 99811
PHONE: 586-6201

January 29, 1987

Lois R. Irvin, President
Cook Inlet Council on Alcoholism and Drug Abuse
167 West Bayview Avenue
Homer, Alaska 99603

Dear Lois:

It was good to talk with you yesterday and learn of your board of directors interest in legislation requiring that insurance companies operating in Alaska cover alcoholism and drug addiction treatment costs as they do other medical conditions. Information available to me from our state directors association indicates that 34 states have enacted such legislation.

The statute by which this agency operates contains a provision that we should pursue this idea.

> "A.S. 47.37.040 Duties of office. The office shall... (17) encourage all health and disability insurance programs to include alcoholism as a covered illness;"

About six years ago we were successful in obtaining Senate approval of an insurance bill but it died in the House of Representatives and was not enacted.

I have enclosed material related to this issue for your review. We are told the Nevada law has proven to be quite workable.

Again, thank you for your inquiry and please extend our best wishes to your Board members. We really appreciate the time all of you volunteer to improve upon the present alcohol and drug abuse situation.

Sincerely,

George Mundell

George E. Mundell
Regional Program Coordinator

Enclosure

cc: Kevin Murphy, Director
Cook Inlet Council on Alcoholism and Drug Abuse

M34

06-F74LH

fewer accidents, less workmen's compensation and health insurance expense (and lower insurance rates); and for the employee: better health and greater career opportunity.

Employer-sponsored EAPs cost the taxpayer no dollars. They deserve wide support.

State agencies, businesses, and other organizations interested in reducing alcohol abuse should support establishment of more EAPs. State legislatures and governors can and should focus attention on EAPs, encouraging their implementation throughout industry.

The Alcohol Policy Council believes that every possible effort should be made to expand the workable and proven EAP effort. This is a primary instrument in reducing alcohol abuse. It is a tool, however, that is greatly underused.

# Insurance Coverage for the Treatment of Alcoholism

Strides toward improved health care have come about because most Americans have hospital or medical insurance — either private carrier or public sponsor — that covers much of the expense of health care.

Health insurance companies too often exclude from coverage the treatment of alcoholism under the rationale that it is too expensive to cover.

Studies disprove this rationale. Alcoholics tend to have multiple medical problems that *are* covered under most insurance programs. Thus, debilitating physical results of alcoholism are treated many times, requiring large expenditures without ever treating alcoholics with the correct diagnosis.

Twenty states have mandated that alcoholism be covered under all medical insurance policies. An additional fourteen states require that the option for such coverage be offered at the discretion of the group to be insured as follows:

| States with Mandatory Insurance Coverage (20) | States Requiring Option of Coverage at Discretion of Group to be Insured (14) | States and Territories without Mandatory Coverage or Option Requirement (23) |
|---|---|---|
| Connecticut | Alabama | Alaska |
| Hawaii | California | American Samoa |
| Illinois | Colorado | Arizona |
| Maine | Florida | Arkansas |
| Maryland | Kansas | Commonwealth of the Northern Marianas |
| Massachusetts | Kentucky | Delaware |
| Michigan | Louisiana | District of Columbia |
| Minnesota | Montana | Georgia |
| Mississippi | Nebraska | Guam |
| Missouri | South Dakota | Idaho |
| Nevada | Tennessee | Indiana |
| New Jersey | Texas | Iowa |
| New York | Utah | New Hampshire |
| North Dakota | Vermont | New Mexico |
| Ohio | | North Carolina |
| Oregon | | Oklahoma |
| Rhode Island | | Pennsylvania |
| Virginia | | Puerto Rico |
| Washington | | South Carolina |
| Wisconsin | | Trust Territories of the Pacific |
| | | Virgin Islands |
| | | West Virginia |
| | | Wyoming |

Source: National Association of State Alcohol and Drug Abuse Directors (NASADAD)

Alcoholism is an illness, so recognized by the major medical organizations. Thus, expense for its treatment should be covered under health insurance.

*Some benefits of health insurance coverage are:*

- *Makes it possible for more alcoholics to receive treatment when needed.* Without insurance treatment is, too often, put off.
- *Reduces the costs to society caused by alcoholics.* Loss of work, safety problems, automobile accidents, overuse of insurance coverage (for related maladies), workman's compensation claims, etc., are minimized when an alcoholic recovers.
- *Reduces costs to insurers.* Insurers pay the cost of alcoholism through treatment claims for other medical problems associated with alcoholism. Coverage allows the patient to be admitted for *alcoholism*, so that the *cause* of the patient's medical problems are treated — not just the physical effects.
- *Encourages families of alcoholics to urge treatment without fear of increased added financial burden.*

The benefits of insurance coverage are considerable, both to the state, employers, family and patient. The Alcohol Policy Council believes insurance coverage for the treatment of alcoholism should be available in *all* states, as a matter of state law or regulation.

EXECUTIVE SUMMARY

# MEDICAL CARE AND ALCOHOLISM TREATMENT COSTS AND UTILIZATION: A FIVE-YEAR ANALYSIS OF THE CALIFORNIA PILOT PROJECT TO PROVIDE HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

December 1981

By

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and

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Chapel Hill, N.C. 27514

*Report prepared for the National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-79-0008.*

A variety of conclusions may be drawn as a result of this study. It appears that inpatient care has not gained in popularity as a modality of service; indeed, it now appears as if inpatient care is leveling with respect to the number of inpatient admissions per client. It further appears that upon admission to an inpatient facility clients are now staying for much shorter periods of time than the three years previously. This perhaps may be attributable to the use of hospitals for detoxification only. Surprisingly the outpatient care in terms of visit per person had dropped during the fourth year of the study. It is not clear at this time whether such a drop protends a true trend, or whether it is merely an artifact in the data. Finally, the study findings continue to demonstrate that a uniform comprehensive set of insurance benefits for the treatment of alcoholism is feasible and generally inexpensive. Utilization continues at a relatively low rate and projection of insurance premiums necessary to finance this program indicate that only a modest increase above normal insurance cost would be necessary. This observation does not take into account the potential off-setting costs likely to be achieved and the reduction of costs associated with other forms of health care.

Conclusions which may be drawn about the potential impact of the treatment of alcoholism as a specific diagnosis include: (See Figure I-7.)

- o Utilization and costs of all forms of inpatient care for both nonalcoholic family members as well as alcoholic family members can be expected to drop.

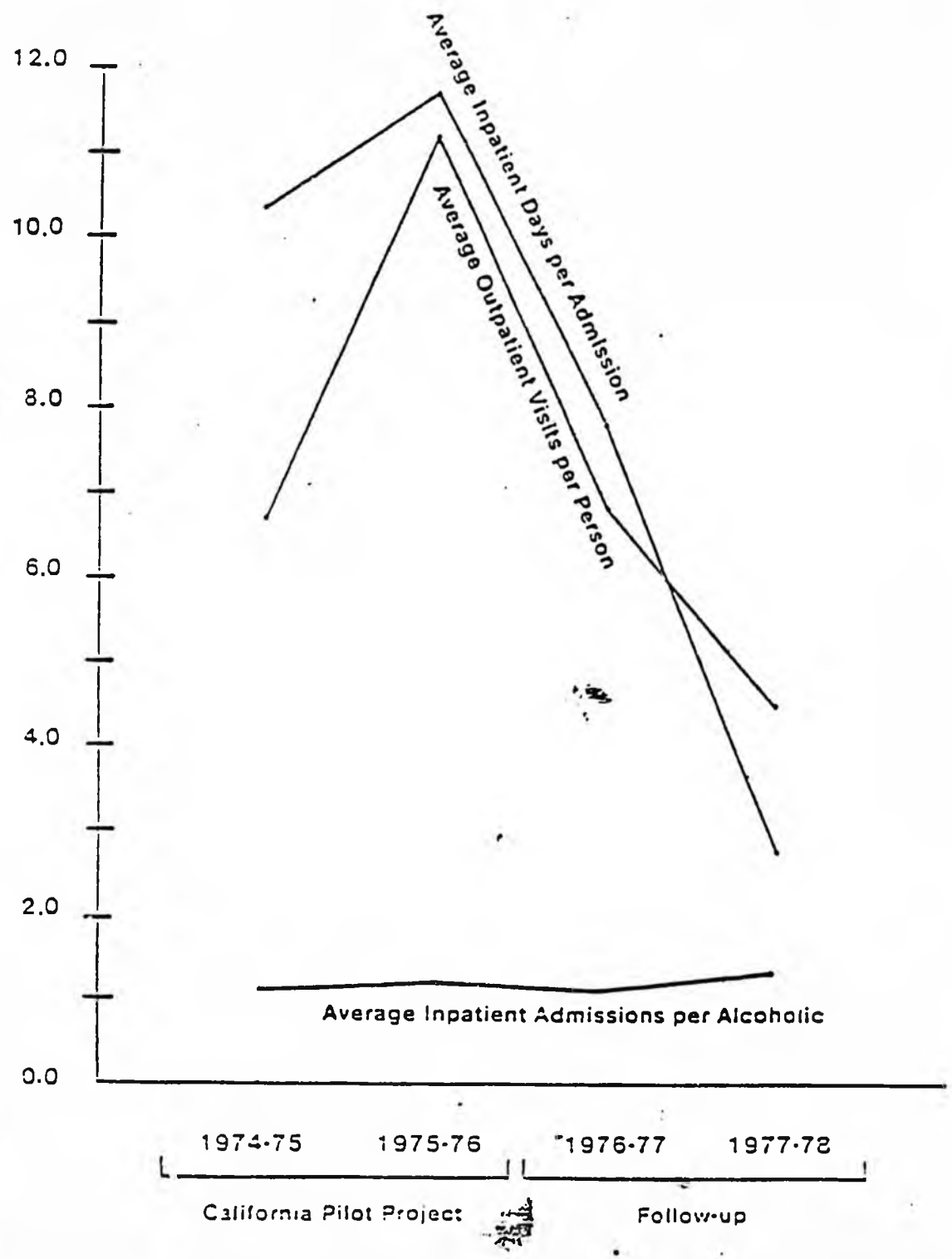
- o Outpatient care will also decrease in frequency and will represent a higher percentage of the family health care costs.

- o Total medical care costs per family member (both inpatient and outpatient care) will decrease substantially over time as the effect on the family of treatment of its alcoholic member occurs.

The conclusions are supported when compared with the nonalcoholic matched control group of families. At the end of the study, the inpatient costs per person per month of both the control families and the alcoholic families were similar and the outpatient costs of the control families were actually higher. Therefore, one can conclude that the changes in health care costs and utilization among the study population are most likely a result of alcoholism treatment and not a result of natural changes (e.g., aging or family composition) as demonstrated in the control population over time. It would appear that the treatment of alcoholism has a significant effect in reducing not only the utilization and costs of all health care for alcoholic family members but for nonalcoholic family members as well.

FIGURE I-1

## Alcoholism Treatment Utilization, 1974-78
### California Pilot Project and Follow-up

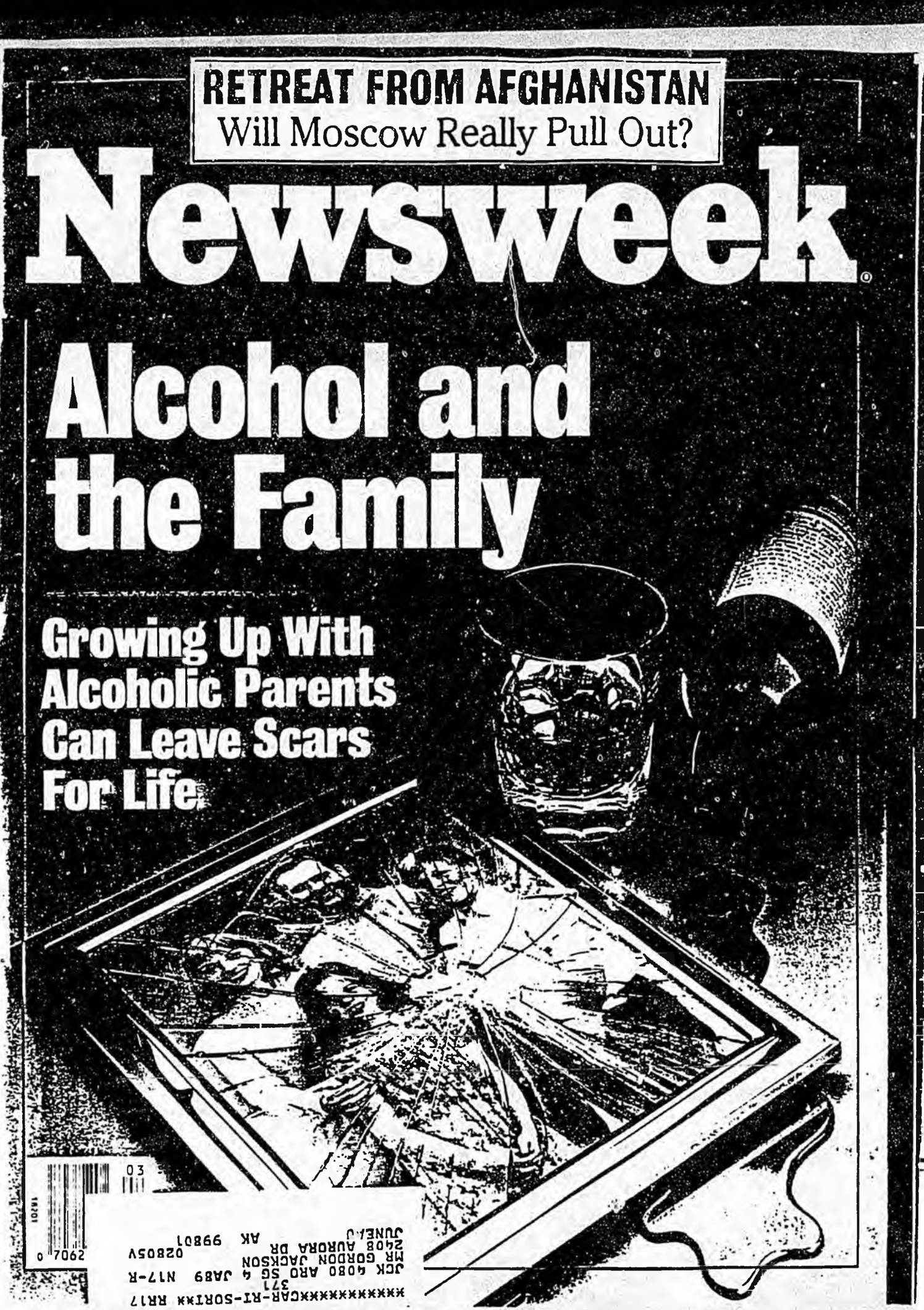


**RETREAT FROM AFGHANISTAN**
Will Moscow Really Pull Out?

# Newsweek

## Alcohol and the Family

**Growing Up With Alcoholic Parents Can Leave Scars For Life**



# Alcohol and the Family

## The children of problem drinkers are coming to grips with their feelings of fear, guilt and rage

Believe it or not, there are still people who think that the worst thing about drinking is a hangover.

*Oh, yeah, on New Year's Day I had a hangover that . . .*

No. Forget hangovers.

*Huh? So what should we talk about? Cirrhosis?*

If you wish, but the liver, with its amazing powers of regeneration, usually lasts longer than the spouse, who tends to fall apart relatively early in the drinker's decline.

*You're making it hard for a man to drink in peace.*

Sorry, but even if spouses do not abuse alcohol, they can come to resemble drunks, since their anger and fear are enormous: way beyond what you'd find in a truly sober person.

*I know, I know, it's terrible what goes on behind closed doors.*

You make it sound like there are no witnesses. You're forgetting the children. They grow up watching one out-of-control person trying to control another, and they don't know what "normal" is.

*I suppose it's hard for the kids, until they move out.*

They may move out, but they never leave their parents behind.

*Hmm. Listen, can we talk?*

We already are. A lot of people already are.

We are, just now, learning more about heavy drinking, and, simultaneously, putting behind us the notion that what alcoholism amounts to is just odd intervals of strange, and sometimes comic, behavior: W. C. Fields, Dean Martin, Foster Brooks. Since 1935 the members of Alcoholics Anonymous have been telling us, with awesome simplicity, that drinking made their lives unmanageable; Al-Anon brought us the news that relatives and friends of drinkers can suffer in harmony; and then came Alateen and even Alatot, where one picture of a stick person holding a beer can is worth a thousand slurred words. The Children of Alcoholics (COAs)—loosely organized but rapidly growing throughout the United States—reaffirm all of the previous grass-roots movements and bring us new insight into alcoholism's effects on the more than 28 million Americans who have seen at least one parent in the throes of the affliction. The bad news from COAs: alcohol is even more insidious than previously thought. The good news: with the right kind of help, the terrible damage it does to nonalcohol-

**Exorcising old demons:** *Gill (rear) undergoes grief therapy at Caron Family Services*

SAATCHI COLLECTION, LONDON, COURTESY MARY BOONE GALLERY

■ Shame, embarrassment and sadness: Fischl's 'Time for Bed'

## There's a Problem in the House

In "Adult Children of Alcoholics," Janet Geringer Woititz discusses 13 traits that most children from alcoholic households experience to some degree. These symptoms, she says, can pose lifelong problems.

Adult children of alcoholics . . .

- guess what normal behavior is.
- have difficulty following a project from beginning to end.
- lie when it would be just as easy to tell the truth.
- judge themselves without mercy.
- have difficulty having fun.
- take themselves very seriously.
- have difficulty with intimate relationships.
- overreact to changes over which they have no control.
- constantly seek approval and affirmation.
- feel that they are different from other people.
- are super-responsible or super-irresponsible.
- are extremely loyal, even in the face of evidence that the loyalty is undeserved.
- tend to lock themselves into a course of action without giving consideration to consequences.

[illegible] need [illegible]

Imagine [illegible] a chaotic house, rides around with a drunk driver and has no one to talk to about the terror. Don't think it doesn't happen: more than 10 million people in the United States are addicted to alcohol, and most of them have children. "I grew up in a little Vietnam," says one child of an alcoholic. "I didn't know why I was there; I didn't know who the enemy was." Decades after their parents die, children of alcoholics can find it difficult to have intimate relationships ("You learn to trust no one") or experience joy ("Hide in the closet"). They are haunted—sometimes despite worldwide acclaim, as in the case of artist Eric Fischl—by a sense of failure for not having saved Mommy or Daddy from drink. And they are prone to marry alcoholics or other severely troubled people because, for one reason, they're willing to accept unacceptable behavior. Many, indeed, have become addicted to domestic turmoil.

**'Hurting so bad':** Children of alcoholics are people who've been robbed of their childhood—"I've seen five-year-olds running entire families," says Janet Geringer Woititz, one of the movement's founding mothers. Nevertheless, the children of alcoholics often display a kind of childish loyalty even when such loyalty is clearly undeserved. They have a nagging feeling that they are different from other people, Woititz points out, and that may be because, as some recent scientific studies show, they are. Brain scans done by Dr. Henri Begleiter of the State University of New York College of Medicine in Brooklyn reveal that COAs often have deficiencies in the areas of the brain associated with emotion and memory. In this sense and in several other ways—their often obsessive personalities, their tendency to have a poor self-image—the children of alcoholics closely resemble alcoholics. In fact, one in four becomes an alcoholic, as compared with one in 10 out of the general population.

The anger of a COA cannot be seen by brain scans. But at a therapy session at Caron Family Services in Wernersville, Pa., Ken Gill, a 49-year-old IBM salesman, recently took a padded bat and walloped a couch cushion hard enough to wake up sleeping demons. "I came because I was hurting so bad and I didn't know why," he says. "A lot of things were going wrong. I


COURTESY CLAUDIA BLACK

■ A nine-year-old's nightmare: Living in denial

was a workaholic, and I neglected my family." It took Gill only a few hours of exposure to the idea that he might be an "adult child," he says, to realize that his failings as a parent may be if not excused, then at least explained. Like a lot of kids who grew up in an alcoholic household, Gill, who is also a recovering alcoholic, never got what even rats and monkeys get: exposure, at an impressionable age, to the sight and sound of functioning parents. Suzanne Somers, the actress and singer, spent years working out her anger in the form of a just published book called "Keeping Secrets." "I decided that this disease took the first half of my life, and goddam it," she says, "it wasn't going to take the second half of it."

**'Control freak':** Not every COA has all of the 13 traits (chart, page 63) ascribed to them by Woititz in her landmark work, "Adult Children of Alcoholics" (*1983, Health Communications, Inc.*), and not all have been scarred. President Reagan, who has written of sometimes finding his father passed out drunk on the front porch, does not appear, from his famous management style, to suffer from any tendency to be a "control freak," a most common COA complaint.) Some children of alcoholics are grossly overweight from compulsive eating while others are as dressed for success as, well, Somers. A few COAs are immobilized by depression. Another runs TV's "Old Time Gospel Hour." What these people *do* have in common is a basic agreement with George Vaillant, a Dartmouth Medical School professor who says that it is important to think of alcoholism not as an illness that affects bodily organs but as "an illness that affects families. Perhaps the worst single feature of alcoholism," Vaillant adds, "is that it causes people to be unreasonably angry at the people that they most love."

The movement is only about six years old, but expanding so rapidly that figures, could they be gathered for such a basically unstructured and anonymous group, would be outdated as soon as they appeared. We do know, though, that five years ago there were 21 people in an organization called the National Association for Children of Alcoholics; today there are more than 7,000. The 14 Al-Anon-affiliated children-of-alcoholics groups meeting in the early '80s have increased to 1,100. With only word-of-mouth advertising, Woititz's book has sold about a million copies; indeed, "Adult Children of Alcoholics" reached the number-three spot on The New York Times paperback best-seller list long before it was available in any bookstore—at a time, in other words, when getting a copy meant collaring a clerk to put in an order and *saying the title out loud*.

"We turned on the phones in 1982," says Migs Woodside, founder and president of the Children of Alcoholics Foundation in New York, "and the calls are still coming in 24 hours a day." The COAs Foundation sponsors a traveling art show that features the work of young and adult COAs; often, says Woodside, an attendee will stand mesmerized before a crude depiction of domestic violence or parental apathy ("Mom at noon," it says beneath the picture of someone huddling beneath the bedcovers)—and will then go directly to a pay phone to find help. "The newcomers all tend to say the same thing," says Woodside. "'Wait a minute—that's my story, that's *me*!'"

"It's private pain transformed into a pub-

[illegible] president of the [illegible] vanced Study in Child [illegible] Chicago, "a fascinating movement [illegible] when you consider that denial is the primary symptom of alcoholism and that COAs tend by nature to take on more than their share of blame for whatever mess they happen to find themselves in, the rapid growth of the COAs movement seems just short of miraculous—something akin to a drunken stockbroker named Bill Wilson cofounding AA, now *the* model for a vast majority of self-help programs throughout the United States. After all, who would want to spill the family's darkest secret after years of telling teachers, employers and friends that everything was fine? "A child of an alcoholic will always say 'Fine'," says Rokelle Lerner, a counselor who specializes in young COAs. "They get punished if they say otherwise.") Who would voluntarily identify themselves with a group whose female members, according to some reports, have an above-average number of gynecological problems, possibly due to stress—and whose men are prone to frequent surgery for problems, doctors say, that may be basically psychosomatic?

The answer is, only someone who had, in some sense, bottomed out, just the way a drinker does before he turns to AA.

The concept of codependency is at the center of the COAs movement. Eleanor Williams, who works with COAs at the Charter Peachford Hospital in Atlanta, defines codependency as "unconscious addiction to another person's dysfunctional behavior." Woititz, in a recent Changes magazine interview, referred to it more simply as a tendency to "put other people's

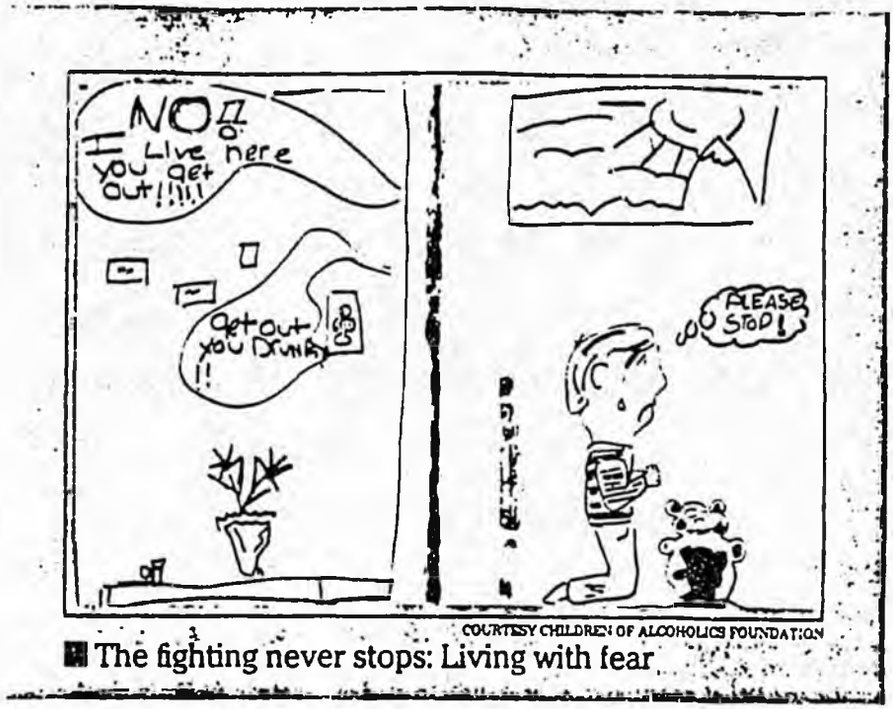
**Talking and playing their way to a healthy state of mind**

needs [illegible] family member may suspect that he has driven the alcoholic to drink (though that is impossible, according to virtually all experts in the field) he almost certainly thinks that he can cure or at least control the drinker's troublesome behavior. "I actually thought that I could make a difference by cooking my husband better meals and by taking the kids out for drives on weekends so he could rest," says Ella S., a Westchester, N.Y., woman. "For all I know, it's a deeply ingrained psychological, and possibly genetic, disease, and here I am going at it with a lamb chop."

**Mental movies:** Obsessed with her husband's increasingly self-destructive behavior, Ella's next step, in typical codependent fashion, was to hide Bob's six-packs, which made him, to put it mildly, angry. Soon they were fighting almost daily and Ella was running mental movies of their scenes from a marriage all night long. "I was wasting a lot of time and energy trying to change the past, while he kept getting worse," she says. "There was a kind of awkward violence between him and me all the time; our hearts weren't really in it, but it wasn't until he had an affair with an alcoholism counselor *that I got him to* that I left." If you're wondering about children, Ella has a seven-year-old daughter, Ann. Her omission is significant. If life were a horse race, then Ann has been, as they say on the past performance charts, "shuffled back" among the also-rans.

What COAs—all people affected by alcohol—need to learn is that the race is fixed: when there is no program of recovery—either through the support of a group or the self-imposed abstinence of an individual—the abused substance will always win, handily, no matter what the competition. The first step of AA begins, "We admitted we were powerless . . ." But what will become of Ann, who is codependent on *two* people? Perhaps, sensing that she is not exactly the center of attention, she will reach adulthood with a need for constant approval, a common COA symptom. Or maybe she will, even as a child, react to the chaos by trying to keep everything in her life under control, and thus give the impression that she is, despite everything, quite a trouper, a golden child.

"[Some] don't fall apart until they're in their 20s or 30s," says Woititz, and in some cases, especially those marked by violence or incest and sexual abuse (three times more common in alcoholic households than in the general population), that's the wonder of it all. One eight-year-old patient at Woititz's Verona, N.J., counseling center woke up in the middle of the night to see her alcoholic mother shoot herself in the head. "The child called the 911 emergency number, got her mother to the hospital and basically saved her mother's life," says Woititz. "When I saw her she was having



COURTESY CHILDREN OF ALCOHOLICS FOUNDATION

■ The fighting never stops: Living with fear

*The board game Sobriety (left), Brooks with a father and son at her California counseling center*

TOM IVES

RICK RICKMAN


COURTESY CHILDREN OF ALCOHOLICS FOUNDATION

■ Out of control: Remembering hurts

nightmares—that she wouldn't wake up and witness this suicide attempt. This is not a normal nightmare. The child had become mother to her own mother."

Each unhappy family, as Tolstoy said, is unhappy in its own way. Artist Eric Fischl, 39, in a short videotape he made for the COAs Foundation called "Trying to Find Normal," speaks of stepping over his passed-out mother, in their comfortable-looking (from the outside) Port Washington, N.Y., home and seeing her "lying in her own piss." His work, which has been the subject of a one-man show at the Whitney Museum in New York, is not autobiographical, he says, and yet "the tone [of it] has everything to do with my childhood." His painting "Time for Bed" (page 63) "re-

[illegible] loose," he says. "I [illegible] boy is me and his shame, embarrassment and sadness is mine as well. The little boy's Superman pajamas are on backwards, so it's like looking in a mirror. I painted the woman standing on a glass table with spiked heels on to give it a sense of fragility and danger. The man only has one arm because I wanted a sense of impotence."

Alcohol leaves every alcoholic and codependent who does not admit his powerlessness over the substance in a constant state of longing. Fischl didn't realize how sad he'd been until his mother died, in an alcohol-related car accident, in 1970. "The thing about having a sick parent is that you think it's your problem," he says. "You feel like a failure because you can't save her." Even when there is no interest, there is seduction. Fischl's mother kept "signaling," he says, "that if you could just come a little bit further with me in this, you can save me."

Some of the other things that alcohol ruins, before it gets to the liver: family meals ("Alcohol fills you up. My father was never interested in eating with us"); gloriously run-of-the-mill evenings around the hearth ("Alcohol makes you tired. My father was in bed most nights at 8"). When enough $C_2H_5HO$ is added to a home, vases may start to fly across the room and crash

# Heredity and Drinking: How Strong Is the Link?

Research on the genetics of alcoholism took a curious turn a few weeks ago when Lawrence Lumeng analyzed his DNA to demonstrate why he can't tolerate liquor. Lumeng, a biochemist at the Indiana University School of Medicine, is among the 30 to 45 percent of Asians whose response to spirited beverages is a reddened face, headaches or nausea. This "Oriental flush," past studies have shown, arises in those who have an inefficient version of a liver enzyme that is crucial to the body's breakdown of alcohol; this "lazy" enzyme allows the buildup of an alcohol product, acetaldehyde, which is sickening and leads many Asians to shun alcohol. Working with biochemist Ting-Kai Li, Lumeng says that he pinpointed the gene that instructs cells to make the odd enzyme. The experiment offers dramatic evidence that a bodily response to alcohol is genetically dictated—and is thus inherited as surely as eye color.

There is no evidence for the opposite proposition: that a specific gene makes a person *crave* alcohol. Considering the wide variety of reasons why people consume the stuff, it seems unlikely that a "drinking gene" exists. But researchers have firmly established that, compared with other children, an alcoholic's offspring are around four times more likely to develop the problem, even if they were raised by other, nonalcoholic parents. In families with a history of alcoholism, explains C. Robert Cloninger, a psychiatrist and geneticist at Washington University in St. Louis, "what is inherited is not the fact that you are destined to become an alcoholic but varying degrees of susceptibility" to the disorder. So real is the predisposition that many researchers advise adult children of alcoholics (COAs) to drink no alcohol whatsoever.

Even the brains of COAs show faint signs of unusual activity, according to controversial studies by psychiatrist Henri Begleiter of the State University of New York in Brooklyn. Begleiter has found that young boys who have never consumed alcohol produce the slightly distorted brain-wave patterns typical of their alcoholic fathers. Such signature brain waves, he says, may mark the son of an alcoholic as likely to develop a drinking problem and perhaps alert him to the risk. However, it

MARY ANN CARTER

**Probing for genes:** *Lumeng*

COURTESY CHILDREN OF ALCOHOLICS FOUNDATION

■ Trauma: Parental neglect

into walls. All kinds of paper—court-issued Orders of Protection, divorce decrees, bounced checks—come fluttering down. The lights go on and off. Does that mean Daddy's forgotten to pay the bill again, or that the second act is starting?

Every alcoholic household is, in fact, a pathetic little play in which each of the members takes on a role. This is not an idea that arrived with the COAs movement: a 17-page booklet called "Alcoholism: A Merry-Go-Round Named Denial" has been distributed free of charge by Al-Anon for almost 20 years. Written by the Rev. Joseph L. Kellerman, the former director of the Charlotte, N.C., Council on Alcoholism, "Merry-Go-Round" takes note of the uncanny consistency with which certain characters appear in alcoholic situations. These include the Enabler ("a 'helpful' Mr. Clean . . . [who] conditions [the drinker] to believe there will always be a protector who will come to his rescue"); the Victim ("the person who is responsible for getting the work done if the alcoholic is absent") and the Provoker (usually the spouse or parent of the alcoholic, this is "the key person . . . who is hurt and upset by repeated drinking episodes, but she holds the family together . . . In turn, she feeds back into the marriage her bitterness, resentment, fear and hurt . . . She controls, she tries to force the changes she wants; she sacrifices, adjusts, never gives up, never gives in, but never forgets").

Some of the earliest books in the COAs movement explored the drama metaphor more deeply and defined the roles that children play. Sharon Wegscheider-Cruse in her 1981 book, "Another Chance . . . *Science and Behavior Books, Inc. Palo Alto, Calif.*), wrote about the Family Hero, who is usually the firstborn. A high achiever in school, the Hero always does what's right, often discounting himself by putting others first. The Lost Child, meanwhile, is withdrawn, a loner on his way to a joyless adulthood, and thus, in some ways, very different from the Scapegoat, who appears hostile and defiant but inside feels hurt and angry. (It is the Scapegoat, says Wegscheider-Cruse, who gets attention through "negative behavior" and is likely to be involved in alcohol or other drugs later.) Last and least—in his own mind—is the Mascot, fragile and immature yet charming: the family clown.

**'Good-looking' kids:** Virtually no one was publishing those kinds of thoughts when Claudia Black, a Laguna Beach, Calif., therapist, began searching for literature on the subject of the alcohol-affected family in the late '70s. "Half of my adult [alcoholic] patients had kids my age and older," she remembers, "but all I found was stuff on fetal alcohol syndrome and kids prone to juvenile delinquency." One thing that fascinated her about young COAs, she says, was that despite their developmental problems "they were all 'good-looking' kids"—presentable and responsible albeit

remains to be seen whether such brain scans are sufficiently reliable and informative to distinguish potential social drinkers from future alcoholics. The technique, comments psychologist Robert Pandina, scientific director of the Center of Alcohol Studies at Rutgers University, is "at this time not any more valuable" as a predictor of future drinking behavior "than collecting a good family history on an individual."

Other studies show that many COAs respond uniquely to booze. Marc Schuckit, a psychiatrist at the Veterans Administration Hospital in San Diego, has found that college-age sons of alcoholics often react less to a few drinks than other college men; in his studies, the drinkers' sons were generally not as euphoric or tipsy after three to five cocktails. Schuckit believes that this lower sensitivity makes it harder for the alcoholics' sons to know when to stop drinking, starting them down the road to alcohol problems. Preliminary experiments by Barbara Lex of McLean Hospital in Belmont, Mass., confirm that daughters of alcoholics respond similarly. Women from families with a history of alcohol abuse tend to keep their balance better on a wobbly platform after having a drink. Apparently women, too, can inherit traits that might predispose them to addiction, although there are far fewer female than male alcoholics.

**Half a beer:** The key unresolved issue, of course, is why some individuals from alcohol-scarred families succumb to alcoholism while others don't. Genes play some role in the development, most notably in abstinence. "People say that whether you drink or not has to do only with willpower," explains Indiana's Lumeng, "but the reason I can drink only half a beer is biological."

Yet heredity alone obviously isn't to blame for alcoholism's appalling toll. In fact, about 60 percent of the nation's alcohol abusers are from families with *no* history of the disorder. How much people drink is influenced by factors as prosaic as cost; partly to curb consumption, the National Council on Alcoholism is lobbying to raise federal excise taxes on beer and wine, which haven't changed since 1951. Social influences like cost and peer pressure "are just as important as genes," says Dartmouth psychiatrist George Vaillant. "All the genes do is make it easier for you to become an alcoholic." For now, the value of genetic studies is to warn COAs that they may well have a real handicap in the struggle against the family trouble.

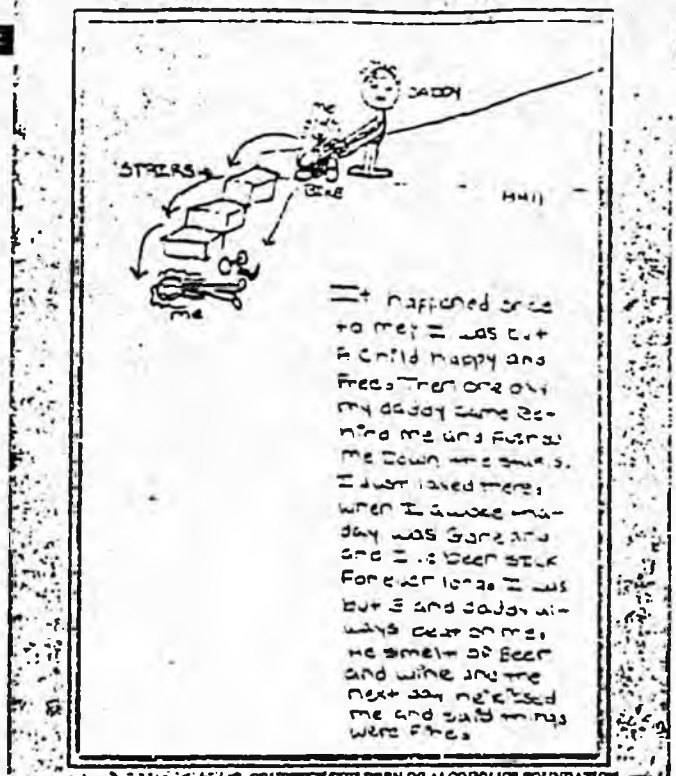
TERENCE MONMANEY *with* KAREN SPRINGEN *in New York and* MARY HAGER *in Washington*


RICHARD SOBOL

**Tipsy?** *Lab demonstration*

not terribly verbal. They had friends but weren't honest with them. Everything was "fine and dandy."

The title of Black's important 1981 book, "It Will Never Happen to Me" (*M.A.C. Denver, Colo.*), reflects the typical codependent's mix of denial and false bravado. In it, she makes the point that the children in an alcoholic household never have an environment that is consistent and structured, two of the things they need most—and she, too, talks of such stock juvenile "roles" as the Responsible One and the Adjuster. Her unique warning was that children who survive a parent's alcoholism by displaying unusual coping behavior often experience "emotional and psychological deficits" later on. They are also likely to become alcoholics, says Black, because "alcohol helps these persons become less rigid, loosen up and relax. When they drink, they aren't quite so serious." Though those things happen to almost everyone who imbibes, Black says that "for those who are stuck in unhealthy patterns, alcohol may be the *only* thing that can provide relief."



COURTESY CHILDREN OF ALCOHOLICS FOUNDATION

**Physical abuse: An adult remembers**

Well, she guessed wrong there: a movement, manifested by often joyous meetings, has come along in the interim. At hundreds of COAs gatherings around the country tonight, people will talk and listen to each other's stories, to cry, to laugh and generally, as Ken Gill says, "recharge their batteries." "This program kept me from being an alcoholic myself," said a woman named Heather at a gathering in an affluent section of San Francisco last week. "Because I was the oldest, everything was always my fault. It's like when you make your parents breakfast and you bring them one scrambled egg and one fried egg—in my house I always scrambled the wrong egg." Heads bobbed in agreement. Who else but COAs could identify with a story about what happens when kids cook for their own mother and father?

**Discovering self-esteem:** Talking and listening: this is the way we've learned to deal with problem drinking. And though it sounds wimpy, don't knock it; it's the surest way to alleviate not just the imbibing but the whole range of symptoms we call alcoholism. A woman named Nina stood up at a meeting in Boston last week, practically glossed over the fact that both her parents were alcoholics—and proceeded to speak about how well she was feeling and doing. COAs meetings and literature, she said, had allowed her to discover self-esteem. At another meeting, Carolyn told a story of complaining to her doctor about depression—and hearing the doctor shoot back a question about whether one of her parents was an alcoholic. "I was shocked," she said, and well she might be. Doctors, as a group, have yet to play a major role in helping mitigate the effects of alcohol, perhaps because the average medical-school student spends a grand total of between zero and 10 hours studying the affliction that kills 100,000 people annually.

An avalanche of information is coming, nevertheless, from another kind of M.D.—call them the Masters of Disaster, the people who've lived with alcoholism or worked with alcoholics so closely that they might as well be their sons. [illegible] man, a professor at [illegible] Indiana University of Pennsylvania, has been studying the children of alcoholics for an exceedingly long time by the standards of the movement—since the early '70s. In his recent book "Let Go and Grow" (*Health Communications, Inc.*), he reports on a survey he took to test the validity of Woititz's 13 generalizations about COAs, as well as seven more observations of his own. What he found was that "adult children of alcoholics identified about 20 percent more with these characteristics" than did the general population. Other professionals are reporting success with therapies involving hugging, acting out unresolved scenes from long ago and even playing one of several board games for children of alcoholics called Family Happenings and Sobriety. Cathleen Brooks, executive director of a program called Next Step in San Diego, reports that her clients often make life-changing strides after six to 18 months of primary treatment and make the decision never to drink or take drugs.

**A founding mother of the movement: *Woititz***
BERNARD GOTTFRYD—NEWSWEEK

The 7 million COAs who are under the age of 18 are harder to help, if only because their parents' denial tends to keep them out of treatment. For these children who never know what to expect when they come home from school each day, life, says Woititz, "is a state of constant anxiety." Some pediatricians think there is a link between such anxiety and childhood ulcers, chronic nausea, sleeping problems, eating disorders and dermatitis. Migs Woodside, from the COAs Foundation, says that the trained teacher can pick the child of an alcoholic out of a crowded classroom. "Sometimes you can tell by the way they are dressed or by the fact that they never have their lunch money," she says. "Sometimes you can tell by the way they suddenly pay attention when the teacher talks about drinking, and sometimes you can tell by their pictures."

Someday, 20 or 30 years from now, those children may feel a vague sense of failure or depression and be hard pressed to explain why. In the meantime, it's their Crayolas that are hard pressed. Beer cans—and not liquor or wine bottles—form a leitmotif in the work of young children of alcoholics. Occasionally, Woodside says, looking a little sad, the big stick figures can be seen tipping the cans into the mouths of the little stick figures.

CHARLES LEERHSEN *with* TESSA NAMUTH
[illegible]

NFIB® National Federation of Independent Business

The Guardian of Small Business.

April 4, 1988

TO: The Honorable Johne Binkley
Alaska Senate

SUBJECT: SB 363-KEY SMALL BUSINESS VOTE

FROM: Gary L. Jenkins, Director
Governmental Relations
NFIB/Alaska

We urge you to carefully consider the impact of this issue on the businesses in your district when you vote on this bill. Your vote on this very important issue will be reported to our membership in your district. Our position is based on the vote of our Alaska members. There are currently 4,000 NFIB members in Alaska.

ISSUE: Mandated alcohol and drug abuse health insurance coverage for companies with 20 or more employees.

NFIB POSITION: The Finance Committee CS includes amendments which mitigate the impact of this legislation on small businesses throughout Alaska and is acceptable to NFIB/Alaska. However, many of our members strongly oppose the concept of the legislature mandating any type of coverage since this bill will open the door to many other mandated coverage bills. Thus, if we had our preference, we would rather have the legislation specify the levels of coverage but make it optional regardless of the number of employees. With regard to the issue of the legislature mandating any type of health insurance coverage, our Alaska membership voted 75% opposed, 15% in favor and 10% no opinion.

SUMMARY STATEMENT. We can accept this legislation for the following reasons:

1. It will mandate reasonable levels of coverage for those policies which provide coverage for treatment of alcohol and drug abuse problems.

2. It will limit the required coverage to those businesses who have 20 or more employees and which typically are providing alcohol and drug abuse coverage in existing group health insurance policies.

For further information, feel free to contact the NFIB/Alaska office.

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