HB

403

5-1683B
Ford
2/22/88

Original sponsors: Boyer, Davis,
Ulmer, et al.

IN THE HOUSE

CS FOR HOUSE BILL NO. 403 ( )

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."

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 subscriber's contract for medical coverage in the state, shall provide the insured or subscriber the following coverage for treatment of alcoholism or drug abuse:

(1) benefits of at least $7,000 over two 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 yearly, 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 service corporation providing coverage under this section may not

(1) require that the insured or subscriber pay a higher deductible or co-payment for the cost of treating alcoholism or drug abuse than for the cost of treating another condition or illness;

(2) require prenotification of treatment, require a second opinion, or limit coverage by provisions of the insurance contract that are not applicable to other major illnesses or conditions;

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

(4) 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

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

(d) 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) "co-payment" means the portion of the cost to be paid by the insured or subscriber;

(4) "cost" means the lesser of the following:

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

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

(5) "major medical" means a disability insurance contract or subscriber contract that provides benefits for hospital and medical care with often lifetime maximum benefits per insured of at least $10,00

(6) "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) <u>AS 21.42.345 - 21.42.365</u> [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 to hospital or medical service subscriber contracts entered into or renewed on or after the effective date of this Act.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CSHB 403 (L&C)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST: _____

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

Agency Affected: Health & Social Services
BRU: Alcohol & Drug Abuse Services
_____
Components: _____
_____

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						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

The enactment of HB 403 would have no direct fiscal impact on the Department of Health and Social Services.

Prepared by: Matthew Felix _____ Phone: 596-6201
Division: Alcoholism and Drug Abouse Date: _____

Approved by Commissioner: Myra M. Munson Date: 2-24-88
Agency: _____

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

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H L+C	2-9-88	1:30 p.m.
H L+C	2-23-88	1:30 p.m
H HESS	3-9-88	8:30 a.m.
H HESS	3-15-88	8:30 a.m.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION : CSHB 403 (L&C)
PUBLISH DATE : _____

FISCAL NOTE

REQUEST:

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

Agency Affected : Health & Social Services
BRU : Alcohol & Drug Abouse Services
_____
Components : _____
_____

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						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

The enactment of HB 403 would have no direct fiscal impact on the Department of Health and Social Services.

Prepared by : Matthew Felix Phone : 586-6201
Division : Alcoholism and Drug Abouse Date : _____

Approved by Commissioner : Myra M. Munson Date : 2-24-88
Agency : _____

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

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

FOR

HOUSE BILL NO. 403

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

Passage of HB 403 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 prenotification 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 HB 403 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 HB 403 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 aparent 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 HB 403, 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. HB 403 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 HB 403.

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 2/8/88

Myra M. Munson Date

Matthew C. Felix 2/5/88

Matthew C. Felix Date

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version : House Bill No. 403

REQUEST: _____

Publish Date : _____

Revision Date: _____

Agency Affected : Health & Social Services

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

BRU : Alcohol & Drug Abuse Services

Sponsor : Boyer

Components : _____

Requestor : _____

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 HB 403 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

Approved by Commissioner : Myra M. Munson

Date : 2/8/88

Agency : _____

Distribution (by preparer) :

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)
Senate Secretary

1988 LEGISLATIVE SESSION

BILL VERSION: CSHB 403(HES)

PUBLISH DATE: HOUSE 2/26/88

FISCAL NOTE

REQUEST: No. 1

Revision Date: _____

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

Sponsor: Boyer

Requestor: _____

Agency Affected: Health & Social Services

BRU: Alcohol & Drug Abuse Services

Components: _____

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						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

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Prepared by: Matthew Felix Phone: 586-6201

Division: Alcoholism and Drug Abouse Date: _____

Approved by Commissioner: Mojra M. Munson Date: 2-24-88

Agency: _____

Distribution (by preparer):

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

(7)

HOUSE COMMITTEE REPORT

Date referred: 1/27/88 FURTHER REFERRALS: HESS
Finance

DATE: 2/23/88

The Labor & Commerce Committee has considered HB 403

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

RECOMMENDS:

[X] replace with CS HB403 (L+C) [ ] the same title
[ ] a new title

[ ] attached amendment(s)

[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
[X] zero fiscal note
[ ] zero with analysis
[ ] same as previous fiscal note published _____
[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

Chairman

SIGNING OTHER RECOMMENDATIONS:

NO REC.

Chairman's signature

DEPARTMENT OF ADMINISTRATION
DIVISION OF RETIREMENT & BENEFITS
PLEASE REPLY TO:

☐ *P.O.BOX CR*
JUNEAU, ALASKA 99811-0203
PHONE: (907)465-4460

☐ *2600 DENALI ST. SUITE 401*
ANCHORAGE, ALASKA 99503-2740
PHONE: (907) 277-7504

Public Employees Retirement System
Teachers Retirement System
Judicial Retirement System
Elected Public Officers Retirement System
National Guard Retirement System
Territorial Retirement System
Retirees Voluntary Dental-Vision-Audio Plan
Supplemental Benefits System
Group Health/Life Insurance Benefits
Deferred Compensation Plan
Public Employers Social Security Contributions

STEVE COWPER, GOVERNOR

February 12, 1988

The Honorable Dave Donley
Chairman
House Labor and Commerce Committee
P.O. Box V
Juneau, AK 99811

RECEIVED
FEB 18 1987

Dear Representative Donley:

Re: House Bill 403

This letter is in response to a question raised by Representative Boucher during my testimony on HB 403 on February 9, 1988. Representative Boucher wanted the cost of the alcoholism/drug abuse coverage component in the current State of Alaska group plan for state employees. He also requested what it would cost to implement the minimum level of coverage outlined in HB 403 in the State group plan if it had no coverage for alcoholism.

The State's carrier, Aetna, has stated that our current level of coverage for alcoholism/drug abuse is costed at $3.50 per month per employee. This equates to an estimated annual cost to the State of $504,000 or approximately 1.2% of the current premium. If our current plan had no coverage for alcoholism and implemented the coverage level outlined in HB 403, the monthly employee premium would increase by $1.75 or approximately .6% of the current premium. This level of coverage equates to an estimated annual cost to the State of $252,000.

Representative Boucher also inquired about the claims volume of alcoholism claims under the State's policy. We have requested the State's benefit consultant, Mercer-Meidinger, Inc. to provide the dollar amount of alcoholism claims over the past two years. The retrieval of these figures requires special programming on their part since such statistics are not normally retained for each component of the health plan. These figures should be available in approximately three weeks.

Please contact me should you require any further information regarding this bill.

Sincerely,

Robert F. Stalnaker

Robert F. Stalnaker
Acting Director

RFS/MBC/cam/III
cc: The Honorable H.A. Boucher
Representative
Alaska State Legislature

Note: Please Include Your Social Security Number In All Correspondence & Requests Concerning Your Benefits.

To: Rep. H. A. "Red" Boucher
Rep. Walt Furnace

From: Linda Stewart
Roger Jenkins

Subj: HB 403 - " An Act Relating to Insurance Coverage for Treatment of Alcoholism and Drug Abuse

Date: February 19, 1988

DISCUSSION

First, it must be clearly understood that alcohol and drug abuse in Alaska is a serious problem that exists in differing degrees within the rural and urban areas of the state.

Second, we acknowledge that it costs the State of Alaska approximately $170 million a year in alcohol and drug related expenses, i.e., public assistance, foster care, institutional care for children, accidents, injuries, property damage, prosecution, enforcement, courts, corrections, etc.

Third, we acknowledge there are a wide range social, economic and various other detrimental, short and long-term side affects caused by alcohol and drug abuse.

However, these are not the issues of HB 403. The problem of abuse is the CORE, but is mandated insurance coverage the answer?

Staff research shows that Alaska employers appear to be more aware and concerned with abuse problems and are providing this type of coverage over either dental or vision care.

Staff research shows that mandating these benefits will accelerate a trend by employers towards self-insurance as a means of avoiding the impact of the mandates, since at this time, there is a legal question as to whether self-insured plans must comply with most existing legislation. Additionally, individuals and employers faced with the increased costs of health coverages because of mandated benefits may severely curtail or terminate their existing group insurance programs.

There are presently 45 programs (SOADA) approved and partially funded by the State of Alaska to treat addiction. These programs serve approximately 20,000 clients per year.

Composite results show that mandating coverage will have the following affects:

35% of the sources indicated there was no measurable premium increase in the plans they covered attributable to the inception of mandated benefits.

11% of the sources indicated that they had experienced premium increases in the 1-5% range in the plans they covered attributable to the inception of mandated benefits.

50% of the sources indicated that they had experienced premium increases in the 5-10% range in the plans they covered attributable to the inception of mandated benefits.

3% of the sources indicated that they had experienced premium increases in the 10-15% range in the plans they covered attributable to the inception of mandated benefits.

Presently, coverage is primarily for in-hospital patient care or through a licensed physician's program. These programs are generally a 28 day hospital\physician program.

The social impact on a patient having to be away from the job, family or friends for an extended time is often more embarassing than the problem itself. In addition, the social stigma of admitting to having alcohol or drug problems is often more hard to handle than the abuse itself.

Staff believes that if insurance coverage applied to a broader range of abuse programs, then those persons abusing alcohol or drugs would be more inclined to seek rehabilitation. An example of this is the Salvation Army program. Presently, insurance carriers will not pay for this program even though it is state approved and certificated.

CONCLUSION

Staff does not believe that it is in the public interest to mandate insurance coverage for alcohol and drug abuse. Why should the many absorb the additional cost for the few.

RECOMMENDATION

Based on the facts presented herein, Staff believes that HB 403 should be amended as follows:

A. Insurance companies should be required to offer alcohol and drug abuse coverage as an optional premium benefit.

B. Insurance companies should be required to allow patient coverage to include out-patient care at any facility that is state approved and certificated.

5-1683Aa
Ford

AMENDMENT

Offered in the HOUSE

By Boyer

TO: HB 403

Page 1, line 22:

After "a" insert "group"

After "for" insert "major"

Page 3, after line 12:

Insert a new paragraph to read:

"(5) "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; or"

Page 3, line 13:

Delete "(5)"

Insert "(6)"

Page 4, line 12:

After "applies to"

Insert "group"

Page 4, line 14:

After "renewed"

Insert "on or"

5-1683Ab
Ford

A M E N D M E N T

Offered in the HOUSE

By Boyer

TO: HB 403

Page 1, line 7, after "abuse":

Insert "; and providing for an effective date"

Page 2, line 14:

Delete the first comma and insert "or"

Page 2, line 15, before "limit":

Insert "or"

Page 2, lines 15 - 16:

Delete "on an inpatient or outpatient basis, or require a specific form of treatment"

Insert "by provisions of the insurance contract that are not applicable to other major illnesses or conditions"

Page 2, after line 16:

Insert a new paragraph to read:

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

Renumber remaining paragraphs accordingly.

Page 2, line 17, after "of":

Insert "medically necessary treatment, including"

Page 2, line 20, after "deny":

Delete "coverage"

Insert "reimbursement for actual services rendered"

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 alcohol 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.)

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SB 363
PUBLISH DATE: 1/22/88

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						
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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. Anthon. Smith Kathy Nowlin 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)

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Bill Version: SB 363
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An act relating to insurance coverage for alcoholism.
Sponsor: Binkley
Requestor:

Agency Affected: Department 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:	0	0	0	0	0	0
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)

Since the State already provides this form of coverage, there is no anticipated increase in the division's budget requirements or the State's health insurance premiums resulting from this bill.

Prepared By: Robert F. Stalnaker
Division: Retirement and Benefits
Phone: 465-4470
Date: February 1, 1988

Approved by Commissioner: John M. Andrews
Agency: Department of Administration
Date: 2/4/88

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Passed: Alaska State Democratic Party

February 6, 1988

WHEREAS alcoholism and its effects on families, the workplace and communities has recently been the focus of the numerous news reports in Anchorage Daily News and Newsweek magazine, among others; and

WHEREAS the Governor's Interim Commission on Children and Youth (GICCY) has issued their final report which recognizes that young children and adults are at risk of family violence and abuse; and

WHEREAS children of alcoholics and drug abusers are at risk and are also prime candidates for substance abuse themselves,;and

WHEREAS the GICCY report recognizes that there are ways to deal with substance abuse through education and treatment of the abuser as well as the members of dysfunctional families; and

WHEREAS the state of Alaska spends millions of dollars a year on the impacts of substance abuse.through such programs as, Public Assistance , Medical Assistance, Foster Care, and the State Office of Alcohol and Drug Abuse, as well as increased costs for the Department of Public Safety and the Court system; and

WHEREAS thirty-four states already provide for either mandated insurance coverage or required offering of insurance coverage for alcoholism and drug abuse treatment; and

WHEREAS the costs and effects of alcohol and drug abuse on the residents of this state are very high, and it is important to all Alaskans that there is an easy method for people currently covered by health insurance to seek treatment;

WHEREAS without insurance, treatment is often put off or never obtained;
Therefore

BE IT RESOLVED that the Alaska State Democratic Party supports the enactment of legislation requiring health insurance companies to provide coverage for the treatment of alcoholism and drug abuse, mental illness,

Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

BARBARA BROWNE
RAYMOND F. BROWNE, CLU, ChFC
SUSAN T. McLAUGHLIN, MAT, MSUP, EdD
CYNTHIA D. WAGNER, CLU

There exists within the health care sector a considerable controversy over the issue of how to meet the costs of providing care for mental illness, alcoholism, and drug dependency. A major issue in this debate is the trend towards legislative mandates to include certain minimum benefits for mental illness, alcoholism, and drug dependency in insurance plans offered by insurers and health maintenance organizations. At this writing, over twenty states mandate some form of these benefits and such legislation is under consideration in a number of other states.

There is significant reluctance on the part of many insurers and health maintenance organizations to embrace any form of mandatory benefits. The insurers and health maintenance organizations have expressed the belief that provision of such benefits should be the choice of the individual or group purchaser.

The care providers for such illnesses, and other advocates of such care, contend that the social stigma and general denial systems of these illnesses prevent a groundswell of demand for such benefits by the public. They further contend that employers who are aware of this public perception do not feel meaningful pressures to voluntarily provide or expand benefits of this nature.

Against this background, a chorus of claims and counterclaims has arisen from both camps. Central among these claims are four issues which this report attempts to explore. They are:

(1) A number of insurers and health maintenance organizations claim that mandating benefits for mental illness, alcoholism, and drug dependency will dramatically increase premium costs for health care protection and be disruptive to the health care delivery system.

(2) Some insurers and health maintenance organizations indicate that mandating these benefits will accelerate a trend by employers towards self-insurance as a means of avoiding the impact of the mandates, since at this time there is a legal question as to whether self-insured plans must comply with most existing legislation.

(3) Many insurers and health maintenance organizations also contend that individuals and employers faced with the increased costs of health coverages because of mandated benefits will severely curtail or terminate their existing group insurance programs.

(4) A number of providers of care for mental illness, alcoholism, and drug dependency claim that mandating such benefits will lead to significantly increased utilization of such benefits. While conceding that this increased usage may result in modest increases in costs for such protection, they contend that there will be an offset in savings through less general medical and hospital services utilization.

It is the purpose of this paper to explore these four issues by reviewing the actual health insurance experience in six states which have had mandated benefits in some form for a period of time. The six states reviewed in our report are Arkansas, Connecticut, Maryland, Massachusetts, Oregon, and Wisconsin. These states were selected for their many diverse characteristics to provide balance to the report. They differ in region, population, economy, and other important social measurements. Their mandated benefits were incepted at different points in time and differ widely in structure.

Methodology

The relatively short period of time since Wisconsin enacted the first mandated health insurance legislation in 1972 has made it difficult to obtain hard data on claim experience on mental health, alcohol, and drug claims in post-mandated benefit periods as contrasted to pre-mandated benefit periods. In the absence of such data, we conducted our study by contacting sources located in the six study states who had been actively involved in the pricing, administration, and marketing of large numbers of group health insurance plans during both pre-mandated and post-mandated periods. No individual coverage experience was studied.

A total of thirty-one sources were

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they had experienced premium increases in the 1–5% range in the plans they covered attributable to the inception of mandated benefits.

50% of the sources indicated that they had experienced premium increases in the 5–10% range in the plans they covered attributable to the inception of mandated benefits.

3% of the sources indicated that they had experienced premium increases in the 10–15% range in the plans they covered attributable to the inception of mandated benefits.

(2) 98% of the sources indicated there had been no change from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

2% of the sources indicated changes from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

(3) None of the sources in our study states indicated that there had been any plans terminated due to the implementation of mandated benefits.

(4) 14% of the sources indicated they had experienced measurable cost reductions in other areas since the implementation of mandated benefits in plans which previously did not offer coverage in the mandated benefit areas or offered limited coverage in those areas.

43% of the sources indicated there had been no offsetting cost reductions in other coverage areas since the inception of mandated benefits.

43% of the sources indicated that it was too early to determine if there had been savings in other coverage areas since the inception of mandated benefits.

Observations

The composite figures indicate a consistency of response throughout the six states studied despite their aforementioned differences.

Premium Increases

We found no dramatic premium increases in the states studied due to mandated mental health, alcohol, and drug benefits. Some respondents indicated that a reason for this was that although individual claims for the mandated benefits may be significant, the number of claims for these benefits as a percentage of the total claim exposure was not significant in their experience. Another reason given for the moderate premium increases is that many plans already had benefits in place for mental health, alcohol, and drug abuse which approached, equaled, or exceeded the mandated benefits. The major carrier reported premium decreases in two states after mandated benefits were enacted. We believe it fair to assume that in many cases the premium increases indicated were the result of prospective rate increases by the insurers as opposed to rate adjustments based on actual experience. The respondents, in large numbers, indicated they simply had no hard claims figures on the mandated benefits being studied. It is interesting to note that a major carrier estimated claims made for substance abuse (not including mental health) were less than one-half of one percent of total claims. Another area not dealt with in our study but of considerable interest is the effect of costs occasioned by the involvement of family members in the treatment of substance abuse patients. It has been indicated that health care providers seeking reimbursement for family services are assigning nervous or mental health diagnosis such as "adolescent adjustment disorder" or "stress" to the family members (Science Management Technology Study 1981.)

Trend to Self-insurance

The two percent of the respondents reporting plans changed solely due to mandated benefits indicated only five plans were actually changed. The respondents reported a modest trend to self-insurance in plans of over one hundred lives; however, reported that mandated benefits were a minor consideration in that trend. Cash flow, plan design flexibility, and elimination of premium taxes in states where they exist, were cited as the main reasons for the movement to self-insurance. Future legislative efforts at the federal level could impact on this area if "qualified plans" were dealt with in regard to mandated benefits as contrasted to the current state approach which deals primarily with insurers and health maintenance organizations.

Plan Terminations

Without exception the respondents indicated there had been no plan terminations due to mandated mental health, alcohol, and drug benefits.

Offset Savings

No conclusion as to whether meaningful offset savings had been experienced could be reasonably determined from the sources' responses. The respondents differed more on this question than any other. It was interesting to note that those sources reporting offset savings were associated with the administration of plans with large numbers of participants. These respondents note that outpatient costs had increased with utilization after mandates, however, inpatient costs had decreased and the total of outpatient and inpatient costs had decreased. A reason cited for this result was that many participants no longer had to enter a hospital in order to receive benefits for mental health, alcohol, or drug abuse. Another factor to be reckoned with over time is the shift in costs resulting from previous misdiagnosis of drug, alcohol, and mental health claims. It is not uncommon for the family physician to label these claims differently in order to allow the patient to avoid stigma and discrimination, and to obtain reimbursement where none is provided under drug, alcohol, or mental health.
(I/R Code No. 3250.00)J

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contacted. All of the sources responded. These sources administered 84,500 plans in the study states covering a total of 8,822,100 participants. The sources have access to very significant data from both a quantitative and qualitative standpoint. The major carrier responded in each state. The largest national private carrier responded in each state. A national actuarial consulting firm responded for all states. A large national employer with locations in five of the six states responded for those five states. The balance of the responses were from major group insurers and independent agents located in the states studied. The respondents' answers were recorded exactly as given; however, it is obvious the respondents tended to round their numerical responses.

We have utilized data on mandated legislation that is aged for several years. This was done to present a mandated benefit structure for each state that would track as closely as possible with the period studied. The period studied was from the effective date of the mandates to a point thirty-six months after the mandates became effective. There may well be differences in the mandated benefits illustrated in the study and some legislation now in place.

Certain clarifications as to terminology are important. In questioning the experience of the respondents as to cost history, the respondents were asked not only if premiums increased but if premiums would have decreased in the absence of the mandated mental health, alcohol, and drug dependency benefits. This is important because respondents indicated some leveling of costs in recent years due to cost containment programs. We are also aware that it might not be desirable politically or from a marketing standpoint for an insurer to acknowledge cost increases for mandated benefits. It would not be difficult for the insurer to make internal rate adjustments to reach desirable pricing levels.

In regard to "mandated benefits," the term has a different meaning in different states. For example, in some states legislation requires inclusion of the mandated benefits in all group insurance provided in the state. In other states, the insurer or health maintenance organization must provide the benefit as an option for an employer to elect. In yet a third arrangement, an employer has the option, by written refusal, to waiver the mandated benefits.

It should be noted as a point in interest, there are many other mandated benefits that do not deal with mental illness, alcohol, or drug abuse issues which are in place in the states we studied.

It should be noted that in accessing the move from insured to self-insured health plans by employers, we measured the movements that were solely attributable to mandated benefits or where mandated benefits were the major causative factor in the respondents' view. This is important because there are two points to consider in evaluating the movement of plans from insured to self-insured status. The first point relates to the size of the group involved. The respondents indicated that a group of less than 100 participants was not generally appropriate for self-insurance. This fact has particular significance in that the number of employers with less than 100 employees generally significantly outnumbers those employers with more than 100 employees. The second point is that mandated benefits are only one of the reasons, according to respondents, that such plans change status.

Table One
Mandated Benefits in Place
During Period Studied

Arkansas

Drug—No benefits in legislation during period studied.

Alcohol—No benefits in legislation during period studied.

Mental Health—There are no minimum benefits specified for inpatient treatment. Reimbursement for services in a licensed outpatient psychiatric center on a par with those for health care services in a hospital. Minimum for both inpatient and outpatient of $4,000 per year. Employer must sign waiver to delete these benefits from coverage.

Connecticut

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group and Individual plans the benefits provide for 45 days inpatient coverage in a hospital or residential facility.

Mental Health—Inpatient benefits provide for at least 60 days full hospitalization or 120 sessions of partial hospitalization in a hospital (whether or not operated by the State) in any calendar year.

Outpatient benefits provide a deductible on a par with that for other illnesses. 50% copayment with mandated maximum benefit of up to $1,000 in any calendar year. Availability of additional benefits, up to a maximum of $1,000 at option of group policyholder with deductible or copayment provisions on a par with those for other illnesses.

Maryland

Drug—Inpatient benefits cover 21 days; there is a $1,000 outpatient benefit with 80% copayment.

Alcohol—For Group plans only, the benefits provide 7 days detoxification; 30 days residential; 30 outpatient visits for at least $1,000 with a lifetime limit of 120 inpatient days and outpatient visits combined.

Mental Health—Inpatient benefits provide at least 30 days full hospitalization in any calendar year or benefit period. Mandates optional availability for partial hospitalization. Where a patient lives at home part of the time and spends some time in a treatment program.

Outpatient benefits provide copayment of up to 50% of the benefits provided for other types of illness.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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GAAP accounting also usually accompanies return on equity calculations. Thus, stock insurers that have used GAAP primarily for external reporting purposes are having to extend and modify their systems for internal reporting and many mutual companies are being introduced to GAAP for the first time. By necessity, the financial officer has been heavily involved in the implementation of these extensions of GAAP.

Conclusion

These are but a few examples of how demands on the life insurance financial officer have greatly expanded in recent years as concerns regarding profitability and solvency have increased. These demands will continue to expand, at least over the short term, as the industry continues to adjust to the new environment.
(I/R Code No. 4400.00/4000.00)J

Stephen W. Forbes is senior vice president of LOMA's Financial Planning and Control Division. He has published over 20 articles on insurance and has won numerous research awards. He holds a PhD in Business and Applied Economics from the University of Pennsylvania where he was a Huebner Fellow.

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Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

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Susan T. McLaughlin received her BA at the University of Toronto, MAT at Reed College, MSUP at Columbia University, and EdD at Harvard. Dr. McLaughlin is a healthcare consultant in Washington, DC.

Cynthia D. Wagner received her BA in Economics from Chatham College in 1975. Ms. Wagner is Vice-President for Comprehensive Benefits Service Co., Inc. Prior to this affiliation she was Vice-President, Sales in the group division of United States Life Insurance Co.

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1. Sales through Dealers and Carriers, Street Vendors and counter sales	None	None
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D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	248	205
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2. Returns from News Agents	None	None
G. Total *(Sum of E, F1 and 2—should equal net press run shown in A)*	42,265	42,582

I certify that statements made by me above are correct and complete.
F. Robert Titus, Mgr. Support Svcs.

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In regard to "mandated benefits," the term has a different meaning in different states. For example, in some states legislation requires inclusion of the mandated benefits in all group insurance provided in the state. In other states, the insurer or health maintenance organization must provide the benefit as an option for an employer to elect. In yet a third arrangement, an employer has the option, by written refusal, to waiver the mandated benefits.

It should be noted as a point in interest, there are many other mandated benefits that do not deal with mental illness, alcohol, or drug abuse issues which are in place in the states we studied.

It should be noted that in accessing the move from insured to self-insured health plans by employers, we measured the movements that were solely attributable to mandated benefits or where mandated benefits were the major causative factor in the respondents' view. This is important because there are two points to consider in evaluating the movement of plans from insured to self-insured status. The first point relates to the size of the group involved. The respondents indicated that a group of less than 100 participants was not generally appropriate for self-insurance. This fact has particular significance in that the number of employers with less than 100 employees generally significantly outnumbers those employers with more than 100 employees. The second point is that mandated benefits are only one of the reasons, according to respondents, that such plans change status.

Table One
Mandated Benefits in Place
During Period Studied

Arkansas

Drug—No benefits in legislation during period studied.

Alcohol—No benefits in legislation during period studied.

Mental Health—There are no minimum benefits specified for inpatient treatment. Reimbursement for services in a licensed outpatient psychiatric center on a par with those for health care services in a hospital. Minimum for both inpatient and outpatient of $4,000 per year. Employer must sign waiver to delete these benefits from coverage.

Connecticut

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group and Individual plans the benefits provide for 45 days inpatient coverage in a hospital or residential facility.

Mental Health—Inpatient benefits provide for at least 60 days full hospitalization or 120 sessions of partial hospitalization in a hospital (whether or not operated by the State) in any calendar year.

Outpatient benefits provide a deductible on a par with that for other illnesses. 50% copayment with mandated maximum benefit of up to $1,000 in any calendar year. Availability of additional benefits, up to a maximum of $1,000 at option of group policyholder with deductible or copayment provisions on a par with those for other illnesses.

Maryland

Drug—Inpatient benefits cover 21 days; there is a $1,000 outpatient benefit with 80% copayment.

Alcohol—For Group plans only, the benefits provide 7 days detoxification; 30 days residential; 30 outpatient visits for at least $1,000 with a lifetime limit of 120 inpatient days and outpatient visits combined.

Mental Health—Inpatient benefits provide at least 30 days full hospitalization in any calendar year or benefit period. Mandates optional availability for partial hospitalization. Where a patient lives at home part of the time and spends some time in a treatment program.

Outpatient benefits provide copayment of up to 50% of the benefits provided for other types of illness.

Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

Massachusetts

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group and Individual plans and Health Maintenance Organizations the benefits provide for 30 days inpatient and $500 outpatient coverage.

Mental Health—Inpatient benefits provide at least 60 days full hospitalization in a licensed/accredited public/private mental hospital in any calendar year. Benefits and limitations on a par with those for other illnesses.

Outpatient benefits provide up to $500 per year for services furnished by a comprehensive health service organization, a licensed/accredited hospital, an approved mental health center, and other mental clinics or day care centers with furnished mental health services or services provided by a licensed psychotherapist, psychologist, or clinical social worker.

Oregon

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group plans only, the benefits provide for $6,000 per 24-month treatment period with mix of inpatient, residential, and outpatient and with usual copayments and deductibles.

Mental Health—General: Maximum overall benefit of up to $9,000 in any 24-consecutive month period (unless payments are for both chemical dependency, including alcoholism, in which case an overall benefit cap of $6,000 may be applied.) Deductibles and copayments on a par with those for other illnesses.

Except as noted above, inpatient benefits provide for not less than $7,500 in any 24 consecutive month period for full hospital or other health facility within the dollar limit for inpatient.

Except as noted above, outpatient benefits provide not less than $2,000 in any 24 consecutive month period.

Wisconsin

Drug—For Group plans only, the benefits provide 30 days inpatient coverage and the first $500 of outpatient treatment.

Alcohol—For Group plans only, the benefits provide 30 days of inpatient coverage; and the first $500 of outpatient coverage.

Mental Health—Inpatient benefits provide at least 30 days full hospitalization in any calendar year in approved public or private hospitals. Benefits on a par with those for other illnesses. Partial hospitalization included under outpatient coverage.

Outpatient coverage provides not less than $500 in any calendar year, including partial hospitalization. (State may adjust the dollar limit every two years.) Benefits on a par with those for other illnesses.

Table Two

Study Results—By Individual States

States and Plans Surveyed	Increase in Premium	Insured-Self-Insured	Plans Terminating	Offsetting Cost Reductions
Arkansas	None - 0	None	None	None - 33%
Groups—6,420	1-5% - 0			Significant - 0
Participants	5-10% - 100%			Too early
619,700	10-15% - 0			to determine - 67%
Connecticut	None - 75%	None	None	None - 40%
Groups—16,400	1-5% - 25%			Significant - 20%
Participants	5-10% - 0			Too early
1,565,000	10-15% - 0			to determine - 40%
Maryland	None - 42%	None	None	None - 29%
Groups—13,750	1-5% - 0			Significant - 0
Participants	5-10% - 58%			Too early
1,295,600	10-15% - 0			to determine - 71%
Massachu-	None - 40%	None	None	None - 75%
Grou-	1-5% - 40%			Significant - 0
Parti-	5-10% - 0			Too early
	10-15% - 20%			to determine - 25%
	None - 33%	None	None	None - 33%
-ps—1,060	1-5% - 0			Significant - 33%
Participants	5-10% - 67%			Too early
822,400	10-15% - 0			to determine - 34%
Wisconsin	None - 25%		None	None - 50%
Groups—5,830	1-5% - 0	None-88%		Significant - 28%
Participants	5-10% - 75%	Modest-12%		Too early
755,000	10-15% - 0			to determine - 22%

Summary

Composite Results for All Sources

(1) 35% of the sources indicated there was no measurable premium increase in the plans they covered attributable to the inception of mandated benefits.[1]

11% of the sources indicated that

(1) Some 22 sources provided both statistical and background information. A number organizations had sources reporting in more than one state. One source omitted a question due to premium tracking difficulty. Further details regarding this study are available to interested readers from the authors.

Excerpts from the PHILADELPHIA BLUE CROSS 1986 report:

In contrast, age does not influence the likelihood that males will have a last admission for rehabilitation treatment for drug abuse. Females admitted for drug abuse treatment are less likely than males to receive rehabilitation treatment as their last admission.

In summary, the majority of substance abuse patients had only one treatment episode in 1986. Detoxification treatment was the most frequently used substance abuse treatment. Overall, 45.1% of all patients treated for substance abuse used detoxification treatment only. Of those patients with multiple admissions, more than 50% sought rehabilitation treatment at least once during their treatment regimen. A small group of patients, 3.4% had more than two admissions for non-rehabilitation treatment.

Drug and Alcohol Related Hospital Utilization

While the cost of treating substance abuse is high, it does not represent all the health care costs related to substance abuse. Rather, substance abusers and their families use an inordinate number of hospital days when compared to the general Blue Cross subscriber population. Overall, substance abusers use ten times more inpatient days per thousand, and their families more than 1.5 times more inpatient days per thousand, than other Blue Cross subscribers.

Individuals treated for substance abuse use 58.9 times more hospital days per thousand for mental disorders than the general subscriber population. With the exception of obstetric diagnoses, persons entering treatment for substance abuse use more days per thousand in every diagnostic category than their families or the general subscriber population. When compared to the Blue Cross subscriber group, the rate of days per thousand for substance abusers is unusually high for digestive disorders (4.9 times greater), nervous/sense disorders (9.3 times greater), accidents/poisonings (4.5 times greater), and endocrine, nutritional, and metabolic disorders (6.4 times greater).

Family members of persons treated for substance abuse use almost three times as many hospital days per thousand for mental disorders than the general subscriber population. Families of substance abusers, compared to the general subscriber population, also use more days per thousand for genitourinary disorders (1.5 times), nervous/sense disorders (1.8 times), and endocrine, nutritional, and metabolic disorders (2.5 times). These statistics tend to support the view that the difficulties of living with a substance abuser cause serious physical and emotional problems.

Non-Substance Abuse Days Per Thousand Subscribers
By Diagnosis for Three Subscriber Populations
All Blue Cross Groups
1986

Diagnosis	Subscriber Population: Group A — Subscribers Treated for Substance Abuse	Group B — Non-Substance Abusing Family Members of Subscribers Treated for Substance Abuse	Group C — All Other Blue Cross Subscribers
Obstetrics	22.3	72.6	51.8
Circulatory	90.4	53.5	64.7
Respiratory	62.2	29.3	30.9
Digestive	268.1	43.3	54.3
Genitourinary	81.7	61.5	40.4
Nervous/Sense	164.1	31.9	17.7
Accidents/Poisoning	125.1	31.3	27.7
Mental Disorders	3,574.5	169.3	60.7
Skin/Musculoskeltal	84.1	25.6	33.3
Endocrine/Nutrition/ Metabolic	76.1	29.9	11.9
Lymphatic	22.7	0.9	6.9
Other Non-substance Abuse Diseases	113.1	56.6	36.6
ALL DIAGNOSES	4,684.4	605.7	436.9

Non-Substance Abuse Admissions Per Thousand Subscribers
By Diagnosis for Three Subscriber Populations
All Blue Cross Groups
1986

Diagnosis	Subscriber Population: Group A — Subscribers Treated for Substance Abuse	Group B — Non-Substance Abusing Family Members of Subscribers Treated for Substance Abuse	Group C — All Other Blue Cross Subscribers
Obstetrics	10.1	12.2	12.9
Circulatory	17.1	8.5	8.9
Respiratory	10.0	8.5	6.0
Digestive	41.0	10.0	8.2
Genitourinary	16.7	17.1	7.8
Nervous/Sense	14.7	4.3	2.5
Accidents/Poisonings	31.9	7.7	5.1
Mental Disorders	178.5	9.7	3.2
Skin/Musculoskeletal	15.1	4.8	4.9
Endocrine/Nutrition/ Metabolic	11.6	3.4	1.7
Lymphatic	3.2	0.3	0.8
Other Non-Substance Diseases	26.7	14.5	7.3
ALL DIAGNOSES	376.6	101.0	69.3

For substance abuse patients, mental disorders rank as the primary reason for non-substance abuse admissions, accounting for over 47% of all non-substance abuse hospital admissions. In contrast, only 9.6% of the admissions for family members and 4.6% of the admissions for the general subscriber population are for mental disorders The mental disorder admission rate for substance abusers is about fi.. times higher than the rate of admissions for all other subscribers. Further, the rate of mental disorder admissions for family members of substance abusers is three times the rate for all other subscribers. Consistent with the literature, digestive disorders and accidents/poisonings also occur more often within the substance abuse population. In general, for all non-substance abuse diagnoses categories the admission rate for family members is equal to or higher than the admission rate for the general subscriber population.

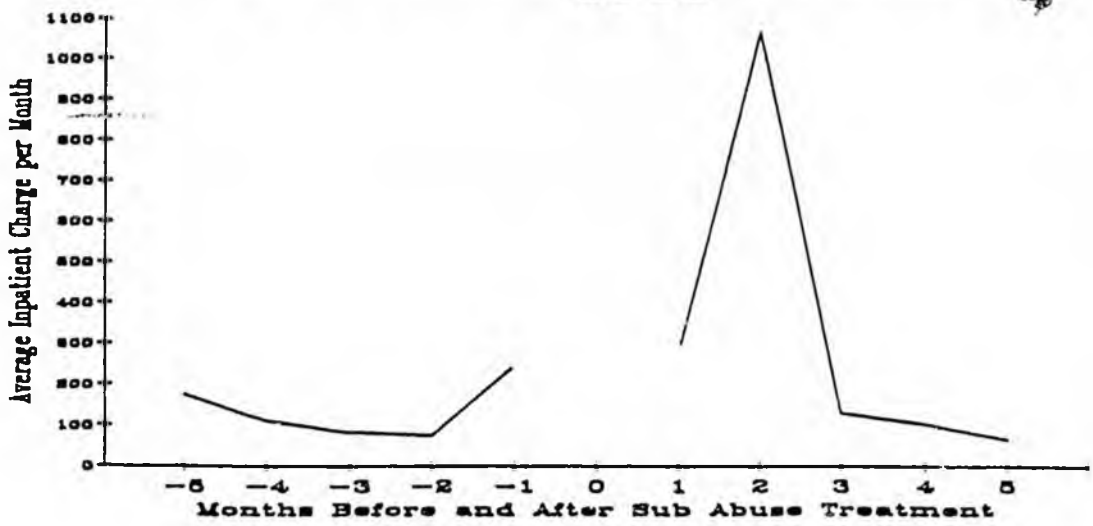
In 1986, the rates of utilization of hospital days and the percentage of admissions for accidents within the families of persons entering substance abuse treatment is lower than they were in 1985, and not significantly greater than the rate of occurrence within the larger subscriber population.

Overall, persons treated for substance abuse had 376.6 admissions and used 4,684.4 hospital days per thousand for non-substance abuse diagnoses, compared to 101.0 admissions and 605.7 hospital days per thousand for their families, and 69.3 admissions and 436.9 days per thousand for the other members of the subscriber population. This high level of hospital utilization by substance abuse patients and their families is noteable because: 1) it is dramatically higher than that of the general population; and, 2) it has occured in the same year as the treatment for substance abuse.

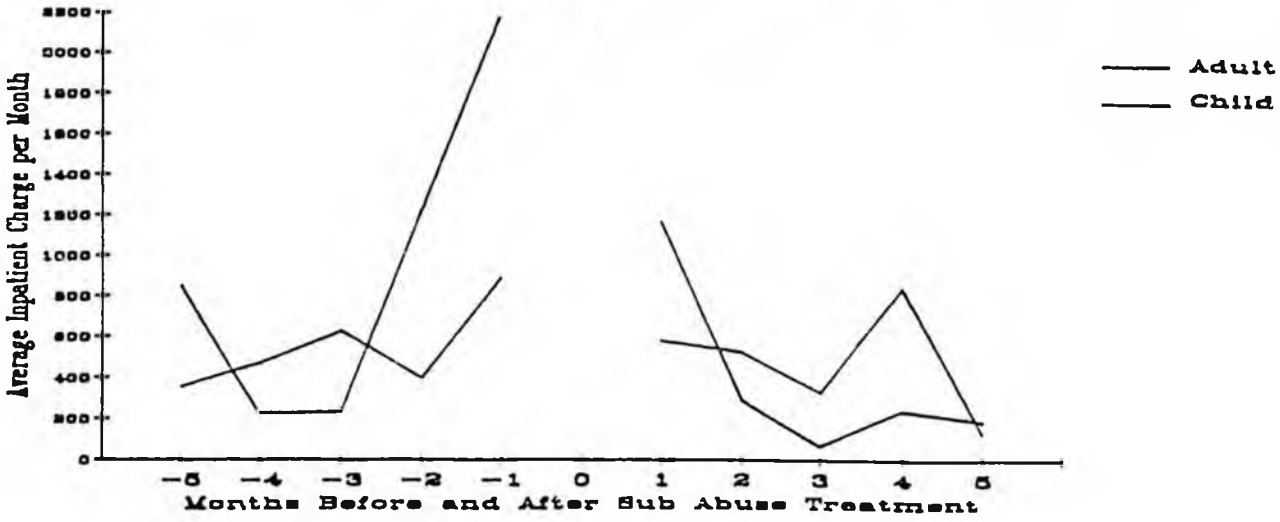
Hospital Utilization Pre And Post Substance Abuse Treatment

As has been found by several previous studies, there is a dramatic rise in hospital utilization by both substance abuse patients and their family members in the months immediately preceeding substance abuse treatment. However, the utilization of hospital services for non-substance abuse diagnoses by the substance abuse patient is even greater in the months immediately following treatment.

Non SA Hospital Utilization Before & After Treatment for Substance Abuse Substance Abuse Patients 1986



Non SA Hospital Utilization Before & After Treatment for Substance Abuse by Family Members of SA Patients 1986



(7)

HOUSE COMMITTEE REPORT

3/17

Date referred: 2/26/88

FURTHER REFERRALS: Finance

DATE: 3-16-88

The Health, Education and Social Services Committee has considered HB 403

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

RECOMMENDS:

[ ] replace with CS HB 403 (HESS)

[ ] attached amendment(s)

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the _____ Committee

[✓] the same title

[ ] a new title

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact

[ ] zero fiscal note

[ ] zero with analysis

[ ] same as previous fiscal note published _____

[✓] same as previous zero fiscal note published 2/24/88

SIGNING DO PASS:

Wilo E. Kopperman

SIGNING OTHER RECOMMENDATIONS:

Bill Hudson - should exclude small business's with 15 or fewer employees

Doug Bowles (NO REC)

Joyce Watkins - Do Not Pass

J. Ellis

Co Chairman's signature

Wilo E. Kopperman

for HB 403 from Bill Miles - Blue Cross Amendment #

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

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

(4) "cost" means the lesser of the following:

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

(B) the usual, customary, and reasonable charge for the treatment; the charge agreed to by the contract between the provider and the third party payor.

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

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

(7) "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

ISSUES
MANDATED GROUP HEALTH INSURANCE
FOR
ALCOHOLISM AND DRUG ADDICTION

THE NEED

Alcoholism and drug addiction are primary diseases that kill thousands of Alaskans each year. Addiction is, however, eminently treatable and there are 45 programs approved and partially funded by the state to treat addiction. As many as 35% of the employed patients seeking treatment in Alaska find that they have no insurance coverage or sadly inadequate coverage to pay for the costs of necessary treatment. They are left with borrowing money or returning to their addiction until they become unemployable and seek public support.

The intent of AS SB 363 is simply to recognize chemical addiction as a disease that deserves the same consideration in group health insurance policies as cancer, heart disease and other common illnesses. The bill sets minimum levels of reimbursement for treatment and mandates the same safeguards for treating alcoholics and drug addicts as the insurer provides for victims of other diseases. The long term impact on the insurance industry should be a cost savings since a) studies by insurers (i.e., Philadelphia Blue Cross, California blue Cross) have shown that untreated alcoholics and their families use as much as 10 times the amount of health care services as the norm and b) other studies (i.e., National Council on Alcoholism, U.S. Health and Human Services) reflect that 33% of general hospital beds are filled with patients being treated for illnesses directly related to addiction.

Expected Pro and Con Arguments

Con	Pro
State should not mandate insurance coverage.	State already mandates coverage for newborns as well as mandatory payment to a wide range of providers. Neither insurers or employers, due to collective denial, will add addiction coverage without mandate.
Mandate will not affect policies written out of state.	26 states already have mandates (including Washington and Oregon). In the experience of 7 other states, large numbers and self-insurers use law as guidelines in establishing a standard for their employers and subscribers.
Mandate actually shows favoritism for alcoholism and drug addiction.	Proposal would simply begin to give parity to addiction treatment in health care plans, other common illnesses carry much higher reimbursement levels than those in the bill.
Mandate costs too much.	Historically, only 1/2 of 1 percent of subscribers having coverage actually use coverage, average premium increase in 7 states is 4%, often much less (e.g., blue Cross of Washington requested 2.5% increase after enactment of Washington regulations). We already pay 170-200 million dollars a year in costs due to untreated alcoholism.
Mandate will increase costs of State employee coverage.	If bill is adjusted, the coverage for inpatient treatment could drop to 7,000 from an unlimited amount right now. There should be a cost savings if this occurs.
Mandate will increase out of state hiring.	Blatantly emotional, obstructive argument. The issue is not large enough to cause a ripple in this area.

Some Actual Cases (Fictionalized Names)

Donna K., 16 years old, brought to treatment after suicide attempt and long drug and alcohol addiction. Parents insurance contract would not reimburse for inpatient treatment despite clear need for same. Patient maintained on an outpatient basis while parents seek money for inpatient stay.

Charles T., 35 years old, arrives for treatment admitting addiction has caused him to miss 40 days of work and estrange family. Insurance plan allowed only $2,000 of coverage with 40% copayment. Discouraged, he has continued and drinking and has lost his job.

1-17-91

SOADA Information

1. Akeela House, Inc., Anchorage 561-5265
   In: $300 a month 9 months - ...
   Out: same 6 month minimum

2. Charter North Hospital, Anchorage 561-7575, 258-7777
   In: $12,000 28 days
   Out: 2,000 45 hours

3. Salvation Army - Clitherce Center 243-1121
   In: depend. on income 28 days
   Out: same 3 months

4. Yukon Kuskokwim Health Corp. 543-3321
   In: n.a
   Out: no charge 6 months - year

5. FNA - 452-1648
   In: Detox. $113 daily Few days
   Prog. $1,911 28 days
   Out: $30 a visit Cannot determine

6. City of Juneau - 586-5280
   In: depend. on income 28 days
   Out: sliding scale varies

7. Juneau Recovery Center - 586-9508
   Info. above

8. Gateway Center - 225-4154
   In: Detox. $240 3 days
   Prog. $1,960 28 days
   Out: sliding scale 1 year average

9. Kodiak Council - 486-3503
   In: sliding scale 30 days
   Out: sliding scale depends on client

10. Manilaq - 442-13311
   In: depend. on income 30-90 days
   Out: same hard to determine

11. Northern Lights Recovery Center - 243-3344
   In: depend. on income 6 weeks
   Out: same 4 months

12. Sitka Council on Alcoholism - 747-3434
In: n/a
Out: depend. on income depends on client

13. Southeast Alaska Reg. Corp. - 966-8860
In: Vet or ANHS 4 weeks
Out: n/a

14. Family Recovery Center - 262-4404
In: $10,000 4 weeks
Out: $175 daily up to 4 weeks
(aftercare is included in prog. fee)

15. Ak. Addiction Rehab. - 376-4534
In: depend. on income 6 months - 2 years
Out: n/a

16. Mat-Su Council - 376-4001
In: n/a
Out: $1,000 14 weeks
(w/aftercare $2,200)
(total for all avail care $3,400)
will accept less depend. on income

Selected Alaska Substance Abuse Facts

-- Of the 260 drug arrests in 1985 cocaine was involved in 176. 57% of those arrested were retailers followed by distributors, users, and wholesalers.

-- Alcoholics have a 30 times greater risk for suicide; 80% of successful suicides are alcohol-related. Alaska had 95 suicides in 1985.

-- In 1985 the equivalent of 4.33 gallons of absolute alcohol was sold per person over age 21 in Alaska. The U.S. average rate is 2.52 gallons per person.

-- 58 traffic fatality accidents in 1985 resulted in 69 alcohol-related fatalities. Each fatality is calculated to cost $306,000. which results in a total cost of $21,114.000.

-- In 1982 there were 1,474 liquor licenses in Alaska. In 1986 there were 1,706 liquor licenses or one license for every 178 Alaskans age 21 or over.

-- During the period of July 1985 through June 1986, 61% of the persons receiving alcoholism and drug abuse treatment services were referred by the Criminal Justice System.

-- During 1985 youth aged 0-20 accounted for 14% of alcohol-related driving fatalities. This same age group only have 7.1% of the drivers licenses.

-- 55% of all crime in Alaska is estimated to be alcohol-related. 16% of 1985 felony court filings were for drug-related charges.

-- The estimated value of drugs seized in 1985 by drug enforcement officers was $9,012,409.

-- In up to 90% of child abuse cases alcohol is a significant factor. There were over 9,500 reports of child abuse in Alaska in FY86.

-- Alcohol impaired persons accounted for 49.5% of 79 pedestrian fatalities between 1980-1984. Additionally, 30% of the drivers were using alcohol at the time of these crashes.

SELECTED COMPUTATIONS ON ALCOHOL/DRUG RELATED COSTS

Tables			
1,2,3	PUBLIC ASSISTANCE PAYMENTS:		5,828,210
4	MEDICAL ASSISTANCE PAYMENTS:		5,650,892
6	SOCIAL SERVICES:	Foster Care, Institutional care for children, Daycare, Protective Services, Homemakers *(Some drug costs included)	3,713,111
8	MOTOR VEHICLE:	Accidents, Fatalities, Injuries, Property Damage	31,903,460
13,14	CRIMINAL JUSTICE SYSTEM:	Prosecution, Enforcement, Courts, Corrections	78,644,355
	SOADA:		15,109,700
15,16, 17,18,19	COSTS OF LOST PRODUCTION:		19,870,000
20	ESTIMATED INSTITUTIONAL EXCESS COSTS, HEALTH AND MEDICAL CARE:		19,569,000
21	COUNCIL ON DOMESTIC VIOLENCE:		3,510,360
		TOTAL COSTS	188,804,421
12	Net Revenue to State from Licensure Fees and Taxation		
		TOTAL REVENUE	14,368,433
10,11,12	Estimated Loss of Income to Alaska Families		54,900,000
		Cost	185,294,041
		Revenue	(14,368,433)
		NET COST	170,925,608

The State Spends $12.69 on Services for Each $1 of Revenue Collected for Alcohol Products.

***Supporting calculations on following pages.

TABLE 4

MEDICAID PAYMENTS RELATED
TO ALCOHOL, FY 84

Medicaid Cost for AD's Per Year	Estimated Percent Alcohol-Related AD Cases	Medicaid Alcohol-Related Costs for AD's Per Year	Medicaid Cost for AFDC & Under 21 Per Year	Estimated Percent Alcohol-Related AFDC & Under 21	Medicaid Alcohol-Related Costs for AFDC & Under 21 Cases Year	Total Medicaid Costs for Alcohol-Related AFDC, 21 AD Cases Per Year
16,117,431	20%	$3,233,486	16,182,708	15%	2,427,406	$5,660,892

Source: Division of Medical Assistance, Dept. of Health and Social Services

TABLE 5

MEDICAL AND PUBLIC ASSISTANCE AGGREGATED DIRECT COSTS ATTRIBUTABLE
TO ALCOHOLISM AND ALCOHOL ABUSE, FY 84

Category	Cost of All Alcohol-Related Cases Per Year
AFDC	$2,331,914
AD	1,249,814
Adult Programs	1,644,912
Medicaid	5,660,892
Total Alcohol-Related Assistance Costs	10,877,532

Total of Tables 1, 2, 3, 4,

TABLE 8

ECONOMIC COSTS OF EXCESS MOTOR VEHICLE ACCIDENTS
ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE
ALASKA, FY 84

Accident Type	1 Number	2 Unit Cost (dollars)	3 Total Cost (dollars)	4 EAA	5 Excess Cost (dollars)
Fatalities	137	$306,000	$44,662,000	51.1%	$22,822,282
Injuries	6,840	5,000	34,200,000	15.5%	5,301,000
Property Damage	14,499	Actual Reported Damages	40,210,258	9.4%	3,779,764
Total Excess Cost Attributable to Alcohol Abuse					$31,903,046

Source:

Column 1. Provided by Alaska Department of Public Safety and the Department of Highways.

Column 2. Unit Costs for Alaska provided by Mr. Mike Lewis, Alaska Highway Safety Planning Agency

Column 3. Product of Columns 1 and 2. Total Cost for Property damage accidents provided by actual reported damages.

Column 4. Excess proportion due to alcohol abuse.
Column 5. Product of Columns 3 and 4.

TABLE 11

LOST PRODUCTION COSTS AMONG FAMILIES WITH ALCOHOL ABUSING MALE HEADS BY AGE GROUPS AND TOTAL POPULATION

Age Income Group	1 Decrease in Median Income Due to Alcohol Abuse of Male Head of Household	2 Estimated Number of Families With Alcohol-Abusing Male Head	3 Estimate of Total Lost Income (millions)
20-29	$2,446	4,040	9.8
30-39	5,580	3,291	18.4
40-49	8,903	2,138	19.1
50-59	6,362	1,202	7.6
Total		10,671	$54.9

Column 1. From Table 1, Column 3.

Column 2. From Table 2, Column 4.

Column 3. Product of Column 1 multiplied by column 2.

TABLE 13

EXPENDITURES OF THE CRIMINAL JUSTICE SYSTEM BY COMPONENT ALASKA, FY 84

COMPONENT	AMOUNT
Enforcement	
State Troopers	$ 33,786,300
Municipal Police	54,354,701
Prosecution	9,288,700
Judicial	35,932,700
Corrections	56,617,100
TOTAL	189,980,001

Source: Budget expenditures obtained from Division of Budget and Management reports. Municipal expenditures obtained from Department of Public Safety.

Table 14

ESTIMATED EXPENDITURES OF CRIMINAL JUSTICE SYSTEM ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE AS A PROPORTION OF EACH AND ALL SYSTEM COMPONENTS, FY 84

Component	Total Component Expenditure	Alcohol Related Expenditures	Percent of Expenditure for each*	Percent of Total Expenditures
Enforcement	88,141,500	40,016,241	45.4%	23.6%
Courts	35,932,700	5,569,568	15.5%	3.2%
Corrections	56,617,100	33,058,346	28.5%	13.4%

*Percent expenditures determined from survey of various agencies.

TABLE 16

PERSON YEARS LOST DUE TO EXCESS DEATHS DUE TO ALCOHOLISM AND ALCOHOL ABUSE

	AGE GROUP WHEN YEARS LOST				
Age Group of Death	20-24	25-34	35-44	45-54	55-64
20-24	49.84	196.96	191.36	179.04	153.28
25-34		102.34	200.56	187.38	160.18
35-44			222.12	421.56	360.00
45-54				112.42	189.35
55-64					93.12

Source: Economic Cost of Alcohol Abuse and Alcoholism, 1971, Hms 42-73-114 NIAAA

TABLE 17

MEDIAN TOTAL INCOME BY AGE FOR 1980

AGE GROUP	MEDIAN TOTAL INCOME
20-24	10,601
25-34	14,662
35-44	18,252
45-54	17,029
55-64	13,743

Source: Department of Labor, 1980 Census report.

TABLE 20

ESTIMATED INSTITUTIONAL COSTS OF HEALTH AND MEDICAL CARE ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE*

	Low Estimate	High Estimate	Average [illegible]
Hospitals - Acute Care			
Non-Native-Private	2,364,553	3,715,307	3,041
Public Health	1,411,715	2,270,228	1,840
Military	437,939	700,131	569
API	828,599	882,599	383
SUB-TOTAL	5,096,806	7,568,765	6,333
Physician's Services			
Non-Native and Military	5,341,125	15,435,000	10,388
Public Health Service	116,600	856,069	487
SUB-TOTAL	5,457,725	16,291,069	10,875
Drug and Drug Sundries	546,840	614,960	581
Nursing Services	1,782,198	1,782,198	1,782
TOTAL	12,883,573	26,256,494	19,569

*Update of previous estimate completed by Dennis Kelso, Ph.D., the Economic Impact of Alcoholism and Alcohol Abuse in Alaska, 1982, Volume I, pp. 83-89.

TABLE 21

ESTIMATED COST OF DOMESTIC VIOLENCE SERVICES ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE

FY86 Budget Council Domestic Violence	% of Caseload Alcohol Related	Costs Due Costs Due to Alcohol Abuse
$ 4,375,500	72%	$ 3,510,360

EQUITABLE
VARIABLE LIFE INSURANCE COMPANY
NEW YORK, N.Y.
EVLICO

EQUITABLE VARIABLE LIFE INSURANCE COMPANY
3301 C. St., Suite 500
Anchorage, Alaska 99503
(907) 561-5355
(907) 333-7667

KEITH MORTENSEN
Professional Life Underwriter
Equity Qualified Agent

March 27, 1985

Reese, Rice & Volland, P.C.
ATTN: Karen Hammerlund
211 H Street
Anchorage, AK 99501

Dear Karen:

The following is a break down of eighteen group health insurance companys and the ways each treats alcoholism.

Please use the following to help understand my abbreviations and columns.

Column 1 - Shows the yearly and lifetime maximum benefits.

Column 2 - Shows if the company will cover treatment on an inpatient or outpatient basis. All of the companys require inpatient treatment to be performed in a state approved facility.

Column 3 - Reflects the coinsurance level paid by the company.

Column 4 - Shows if the company will cover counseling treatment on inpatient or outpatient basis.

Please note that "V" stands for visits and "D" stands for days.

Sincerely,

L. KEITH MORTENSEN
Agent

MEMBER MILLION DOLLAR ROUND TABLE

COMPANY	1	2	3	4
TRAVELERS	$1,000.00 Yr $3,000.00 Life	In	80%	In-Out Out-No
WESTERN/ST PAUL	In-73 days yr Out-130 hrs	In/Out	80%	In-Yes Out-Yes
W.P.E.T.	Yr-$10,000 Life-$10,000	In	80%	In-Yes Out-No
AETNA patient benefit	May be written with coverage to cover in or out treatment and with or without yearly or lifetime at 80%.			
V.E.T.	Life-$10,000 Yr-$10,000	In	80%	In-Yes Out-No
M.O.N.Y.	Life-$20,000 Yr-$20,000	In/Out	Out-80% In-50%-$30	In-Yes Out-Yes
NEW YORK LIFE	No Limit	In-30 Days Out-15 Visits	In-80% Out $20V	In-Yes Out-Yes
PRUDENTIAL	Life-$20,000 Yr-$20,000	In/Out	In-80% Out-50%	In-Yes Out-Yes
NORTHWESTERN NAT.	——————————No coverage provided————			
NEW ENGLAND LIFE	No Limit	In/Out	80%	In-Yes Out-Yes
MUTUAL OF OMAHA	No Limit	In/Out	80%	In-Yes Out-Yes
Reflects the best coverage available for this company.				
MUTUAL BENEFIT LIFE	No Limit	In	In-80%	In-Yes
LINCOLN NATIONAL	Life-$50,000	In/Out	80%	In-Yes Out-Yes
ALLIED GRP TRUST	Life-$15,000	In-30D $10,000 Out-$60V, 50 Yr	In-80% Out-50%	In-Yes Out-Yes
UNION MUTUAL	Yr-1,000 Life-None	In-30D, yr Out-$1,000 yr	In-80% Out-50%	In-Yes Out-Yes
AMERICAN CHOICE	Life-$10,000 Yr-$10,000	In	80%	In-Yes Out-Yes
UNITED OMAHA	Life-$50,000 Yr-$1,000	In	In-80% Out-50%	In-Yes Out-Yes
GREATWEST LIFE	In-Life-$25,000 In-Yr-$10,000 Out-Life-None Out-Yr-$500.00	In/Out	In-80% Out-50%	In-Yes Out-Yes ($20V)

Eastside Alcohol Center

A nonprofit Corporation

EASTSIDE A. C., INC.
PARK 120 ; SUITE 204
606 120TH AVE NORTHEAST
BELLEVUE , WASHINGTON 98005 • (206) 454-1505

INSURANCE COMPANIES THAT COVER ACTION TO DATE

AETNA LIFE & CASUALTY
Most group policies offer 80% coverage. Individual polices vary greatly.
(Boeing, Toshiba America, Inc., First Farwest)

AMERICAN STATES LIFE INSURANCE COMPANY
80% usual and customary charges.

AUTOMOTIVE MACHINISTS HEALTH & WELFATE FUND
80% or 90%

THE BANKERS LIFE
50% (Seattle Times, Hyster Co.)

BLUE CROSS OF OREGON
Coverage $3,000.00 per every 24 months. Paid at 80%

BLUE CROSS OF WASHINGTON AND ALASKA
Policies 80 % usual and customary charges. (Evergreen General Hospital)

CARPENTERS HEALTH & SECURITY TRUST FUND
Treatment only, including all of ACTION, 80% (Baugh Construction)

CONNECTICUT GENERAL LIFE INSURANCE
Most policies pay at 80%. (United Airlines)

ELDEC CORPORATION
50%

EQUITABLE LIFE ASSURANCE SOCIETY
Must be physician referred

FIRST FARWEST INSURANCE COMPANY
80%

GROUP HEALTH COOPERATIVE
Client MUST be referred by group health (ADAP) program prior to treatment
outside services referral authorization will state what kind of services
they will pay for and dollar limit. Policies usually have either a $500.00,
$1,000.00, $1,500.00, or $3,000.00. (Also covers "SPRING" Program.)

GREAT-WEST LIFE ASSURANCE COMPANY
Must be physician referred. 80%

HEWLETT-PACKARD CO. EMPLOYEE BENEFITS
Self-insured, group policy, covers outpatient treatment.

HOSPITAL EMPLOYEE BENEFIT PLAN & TRUST
50% to 80% (Ballard Community Hospital)

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY
80% (Digital Electronics)

HEALTH MAINTENANCE PROGRAM OF SNOHOMISH COUNTY
Must be referred by Snohomish County Physician Plan M.D. - 100%

ILWU-PMA BENEFITS PLANS (Two types)
Republic Insurance is the carrier. Check your own benefit book for details.

INSURANCE COMPANY OF NORTH AMERICA
(INA)

EARLE M. JORGENSEN COMPANY
Shop Employees Health & Welfare Plan. 80%-to 90%

KING COUNTY MEDICAL BLUE SHIELD
Boeing employees ONLY-80% (Rainier National Bank)

KEMPER INSURANCE COMPANY
50%

LOCKHEED MEDICAL BENEFIT PLAN
Services must be provided by M.D. covered under mental health treatment-outpatient.

LINCOLN NATIONAL LIFE INSURANCE COMPANY
80% - policies vary

MASSACHUSETTS MUTUAL
Pays 80%

MASTERS, MATES AND PILOTS HEALTH & BENEFIT PLAN
80% up to $500.00 per year.

METROPOLITAN LIFE INSURANCE COMPANY
Frederick & Nelson - $1,000.00 basic lifetime (Doctor referral also).

NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION
Administered by: First Fairwest Insurance Company.

NATIONAL [illegible] ASSOCIATION
Western Washington Laborers Employers Health & [illegible] Trust
[illegible] Coverage

NEW ENGLAND LIFE:
Pays 80%

NEW YORK LIFE INSURANCE COMPANY
Services rendered by licensed physician - pay at 50%.

NORTHWEST ADMINISTRATORS, Inc.
Administered for: Washington Teamsters Welfare Trust [illegible], Tangendorf Banking Company, A.B.C. Seafood Company - 80% coverage.

NORTHWEST METAL CRAFTS TRUST FUND
Covers Lockheed Shipbuilding Union Local 79 - 801 (Blue Cross - administrator).

PACIFIC MUTUAL INSURANCE
Must be physician referred - coverage at 80%.

PACIFIC NORTHWEST BELL
Travelers

PAN AMERICAN WORLD AIRWAYS
Blue Cross - Coverage at 50%

PAY-N-SAVE CORPORATION
Administered by Bankers Life Insurance Company. Needs a physician referral.

PRUDENTIAL INSURANCE COMPANY OF AMERICA
Group claims 80% usual and customary charges (PACCAE). Individual policies vary greatly.

PUGET SOUND & INLAND EMPIRE WELFARE TRUST
80%

REPUBLIC NATIONAL LIFE INSURANCE
Handles many national and international unions - administrator.

RETAIL CLERKS WELFARE TRUST
Safeway, etc. - 80%

SEARS ROEBUCK AND COMPANY
80%

SEATTLE AREA PLUMBING AND PIPEFITTING LOCAS #32
Administered by Lincoln National Life - coverage is at 100

SEATTLE TIMES EMPLOYEE BENEFIT PLAN
Administered by Bankers Life Comoany - coverage at 50%

SUNDSTRAND DATA CONTROL
Group Benefit Program - $500.00 per year outpatient alcoholism benefits

TRAVELER INSURANCE
General Telephone new contract effective January . . . .
per year

[illegible] INSURANCE [illegible]
[illegible] doctor referral [illegible]

UNITED ADMINISTRATORS
Handle many local unions, welfare trust and general businesses. Coverage ranges from 80% to 90%.

UNITED BENEFIT LIFE INSURANCE
Affiliate of United of Omaha, handle many local unions, welfare trust and general business policies. $1,000.00 per year alconolism treatment, for Western Washington Laborer's.

UNITED HEALTHCARE CORPORATION
Five day outpatient coverage per year.

UNITED OF OMAHA
Outpatient coverage, varies on group policies - Washington Employer's Trust.

UNITED PACIFIC LIFE INSURANCE COMPANY
Van DeCamps Bakery, for example - outpatient coverage is $250.00 per year.

WASHINGTON STATE AUTO DEALERS INSURANCE
Administered by Prudential Life Insurance - 90% to 100%.

WASHINGTON TEAMSTERS WELFARE TRUST
Local Union #117.

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

Harold D. Holder, Ph.D.

and

Jerome B. Hallan, Dr.P.H.

H-2, Inc.
211 N. Columbia St., Suite B
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.

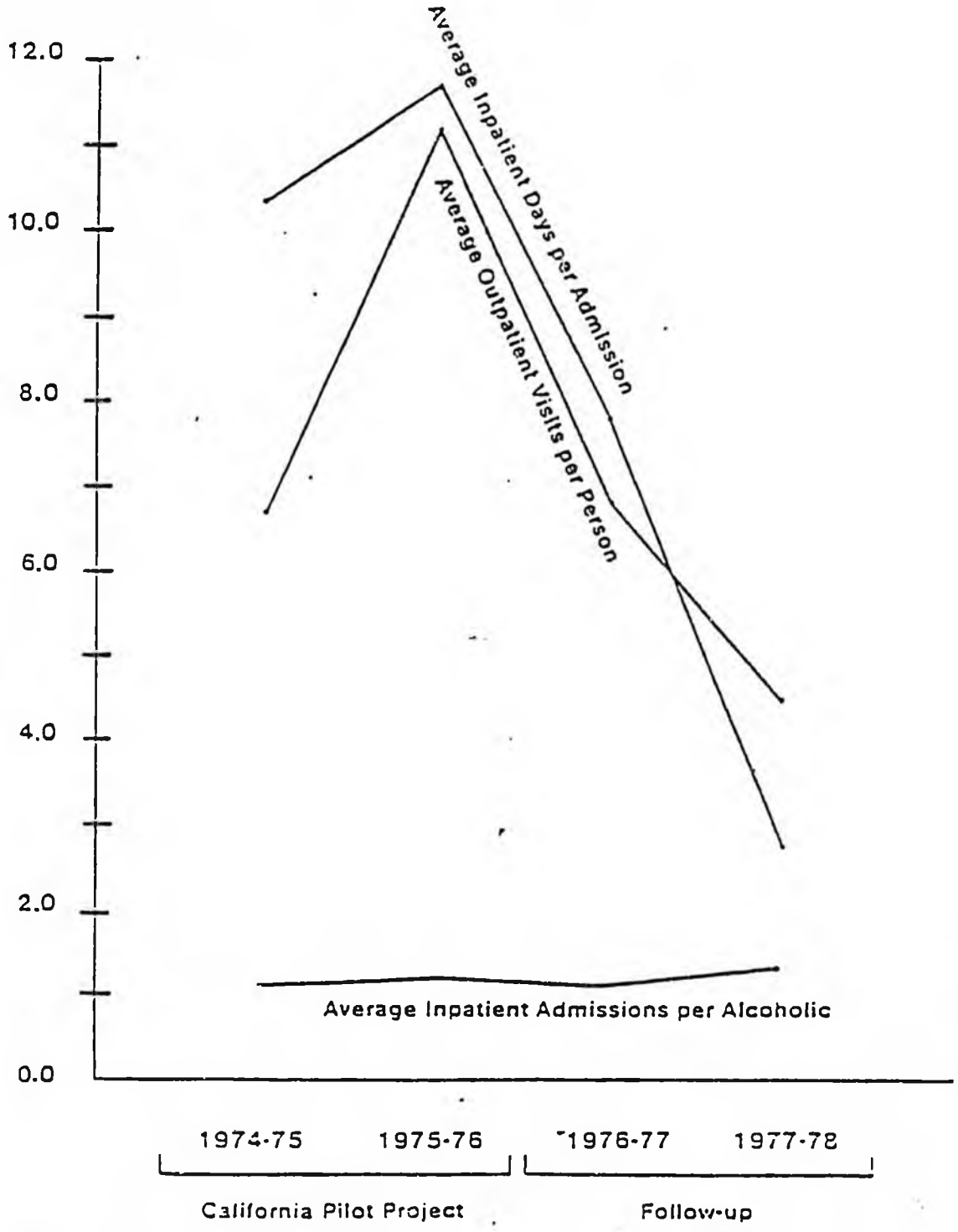
- o Outpatient care will also decrease in frequency and will represent a higher percentage of the family health care costs.

- 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



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HIGH COURT HEARS ALCOHOLISM 'WILLFUL MISCONDUCT' VA CASES

In a case with the potential for a landmark ruling on the disease concept of alcoholism, the Supreme Court was urged to invalidate a Veterans Administration (VA) regulation under which primary alcoholism is held to be "willful misconduct" in terms of certain veterans' benefits.

Lawyers for two recovered alcoholic veterans argued before the high court Dec. 7 that the VA ruling was a violation of their rights as handicapped persons protected against discrimination by Section 504 of the Rehabilitation Act of 1973.

The VA defended the regulation as reflecting Congressional intent and raised the bugaboo of alcoholic veterans across the nation applying for full disability payments for their condition. But under persistent questioning from Justice Thurgood Marshall, Jerrold J. Ganzfried, the Justice Department attorney representing the VA, conceded that alcoholism is seen by the VA as an "illness" in some contexts, namely its nationwide alcoholism treatment system.

The Supreme Court held an hour of arguments on the consolidated cases of Eugene Traynor and James McKelvey, recovered alcoholic veterans who were denied extensions of time to apply for educational benefits under a 1977 law that allowed veterans to pursue benefits beyond a 10-year eligibility period if they had been unable to do so because of a mental or physical disability not the result of "willful misconduct." A VA regulation considers primary alcoholism -- not the result of a psychiatric disorder -- to be a condition due to willful misconduct.

Since the cases were appealed from adverse lower court decisions earlier this year, they have taken on the colorations of a *cause celebre* with widespread field and media interest centering on the question of alcoholism as a disease. The National Council on Alcoholism (NCA) and the National Association of Addiction Treatment Providers (NAATP) filed "friend of the court" briefs arguing against the VA position (*AR*, June 8). Representatives of major field groups and NIAAA were on hand to hear the arguments.

The Traynor and McKelvey appeals mark the first case raising the disease issue in a substantial way to receive a Supreme Court hearing since the historic but inconclusive Powell vs. Texas decision in 1968. In that case, Powell's conviction for public drunkenness was upheld on grounds that the record failed to show that he was unable to avoid being intoxicated in public.

"The regulation comes from the era of prohibition," declared Keith A. Teel, of the Washington law firm of Covington and Burling, who argued the consolidated case for the two veterans. Teel told the high court that the VA's ruling that alcoholism was the result of "willful misconduct" has never been "reconsidered in light of current medical and scientific knowledge," and reflected an "archaic" attitude. He argued further that the VA "knows about the problem of alcoholism" since it is the "government's largest alcoholism treatment provider."

"The primary issue is not the medical question of whether alcoholism is a disease," he said. "That has been decided by Congress, by the National Council on Alcoholism and the American Medical Association."

"The question is whether the Veterans Administration can enforce a regulation that alcoholism is willful misconduct," and thereby exclude alcoholic veterans from the anti-discrimination protection of the Rehabilitation Act, Teel said. The Rehabilitation Act was extended in 1978 to include alcoholics under the definition of handicapped.

ALSO THIS ISSUE

Ganzfried was questioned closely by several justices about his contention that consumption of excessive amounts of alcohol can be seen as "conduct" or a "compulsion short of an illness," and does not constitute a "physical disability" in itself, although there are "physical consequences."

Chief Justice William Rehnquist wanted to know whether being "dead drunk" or "unconscious" constituted a physical disability preventing a veteran from pursuing his benefits.

Ganzfried said that the VA considered "primary alcoholism" as "willful misconduct," but not alcoholism that is "secondary" to a mental disorder. In a series of questions, Justice Marshall pressed the government attorney to say whether the VA regarded primary alcoholism as an illness under the regulation. At one point, the justice said, "the regulations are indefinite, but not too indefinite to take away someone's livelihood."

Ganzfried finally agreed that the VA regards alcoholism as an illness in terms of treatment and rehabilitation, for which the agency spends about $100 million annually in its medical care system. Marshall then responded, "It is an illness. It took a while, but I made it."

Justice Sandra Day O'Connor raised the question of how the court's disposition of the case might affect the issue of claims for service-connected disability compensation for alcoholic veterans -- which have never been allowed for primary alcoholism. Teel, the veterans' attorney, said if the court's decision appears to create a problem in that area, "Congress can deal with it."

Ganzfried said that if alcoholism or drug addiction were held to be conditions warranting VA disability payments, an alcoholic or addict might be given up to $1,350 a month "to continue drinking or taking drugs for life."

The Government attorney said the VA is bound by the legislative history of the 1977 law extending the period of eligibility for education and training entitlements. In its report on the bill, the Senate Veterans' Affairs Committee referenced VA regulations under which alcoholism and drug addiction are considered to be "willful misconduct" in determining service-connected disability.

On Dec. 4, three days before the Supreme Court hearing, the Senate passed legislation introduced by Veterans Affairs' Committee Chairman Alan Cranston (D-CA) early this year allowing an extension of eligibility for GI Bill benefits to veterans unable to apply on time because of their alcoholism or drug addiction (*AR*, Jan. 21). In four previous Congresses, similar Senate-approved provisions have been blocked by the House. (See following story.)

In addition to the willful misconduct issue, the case involves the question of whether the VA rulings in the Traynor and McKelvey cases are subject to judicial review, a technical issue which was also aired at the Supreme Court hearing. Ganzfried argued that Congress intended to preclude judicial review of VA decisions on benefits in order to close a "floodgate" of appeals from veterans. For the veterans, Teel contended Congressional intent was not clear, and that court review of appeals based on such statutes as the Rehabilitation Act should not be barred.

The Supreme Court's decision in the case will be handed down before the end of its current session next June. Legal experts cautioned that the panel could duck the broad question of alcoholism as a disease by ruling on more limited issues, including that of judicial review. Seven Justices heard the case. Justice Antonin Scalia, who was on the Court of Appeals panel which ruled on the McKelvey case in 1986 (*AR*, July 17, '86), did not participate. There is one vacancy on the nine-member bench.

In addition to Covington and Burling, the New York-based Legal Action Center and the law firm of Bryan, Cave, McPheeters and McRoberts represented the veterans in the cases.

SENATE PASSES BILL EXTENDING ELIGIBILITY TO ADDICTED VETERANS

The Senate passed on Dec. 4 the Omnibus Veterans' Benefits Act of 1987 (HR-2616) which incorporates provisions by Sen. Alan Cranston (D-Ca.) which would extend the eligibility period to apply for GI Bill and other educational benefits to veterans prevented from participating because of alcohol or drug dependence or abuse disabilities. Denial of such eligibility in the case of two recovered alcoholic veterans is at issue in a consolidated case argued before the Supreme Court Dec. 7. (Story above.)

The bill now goes to a conference with the House whose version of the legislation does not contain the provision for alcoholic and drug dependent veterans. On four previous occasions, House opposition has blocked Congressional enactment of similar legislation authored by Cranston, chairman of the Senate Veterans' Affairs Committee. The provision is designed to get around the Veterans Administration's ruling denying extension of eligibility to alcoholic or drug addicted veterans on grounds their conditions were the result of "willful misconduct."

The Senate Committee's report on the bill declared that "the opportunity to use GI Bill and VA rehabilitation program benefits can be extremely important to the readjustment and rehabilitation of the Vietnam-era and service-connected disabled veterans involved and that the delimiting-period

extensions for those who were, but are no longer, prevented by alcohol or drug disabilities from using those benefits would be fully consistent with the readjustment and rehabilitation goals of both programs."

The report noted that in passing the Anti-Drug Abuse Act last year, "Congress recognized the importance of providing individuals who have, or have recovered from drug or alcohol conditions with every reasonable opportunity to participate in programs that can help them return to full, productive lives."

The Committee cited concerns raised by the VA about the implications of the provision for disability payments -- an issue raised in the Supreme Court arguments. It said the legislation has been shaped to reflect the Committee's "intention not to undercut in any manner" administrative and legislative provisions related to other benefits "to the effect that alcohol or drug abuse or dependence are the result of willful misconduct."

"Hence, the Committee bill would make clear that, for the purposes of determining eligibility for an extension of the applicable delimiting period, an alcohol or drug dependence or abuse condition would not be considered a 'disability;' it would simply be considered as a 'condition' that could have prevented a veteran or eligible person from pursuing a program of education or participating in a program of vocational rehabilitation."

Although the Committee said it saw no purpose to be served by denying veterans an extension when they are prevented from pursuing GI Bill assistance during the regular 10-year delimiting period, "some undesirable circumstances might flow from a similar rule being applied for other VA benefit programs such as service-connected compensation." It explained:

"If an individual were to be granted disability compensation for alcoholism or drug addiction, there would be a strong financial incentive established -- in the form of a higher rate of compensation or the continuation of receipt of compensation -- toward the worsening or prolongation of the disability. Either of these factors are to some extent within the control of the veterans because they depend upon the amount, frequency, and duration of his or her consumption of alcoholic beverages or drugs."

The report took note of the pending Supreme Court cases, which raise the question of whether the VA regulation on "willful misconduct" violates Section 504 of the Rehabilitation Act, and said, "The Committee has never addressed the issue of the validity of the willful misconduct regulation under Section 504 with respect to alcoholism and drug addiction."

SEN. THURMOND ASSAILS ANHEUSER-BUSCH FOR 'SPUDS MACKENZIE'

Lashing out at Anheuser-Busch's promotion of the "Spuds MacKenzie" toy as "against the public interest," Sen. Strom Thurmond (R-SC) warned that Congress should look at "major policy changes" if "this is the kind of responsibility which we can expect from the alcoholic beverage industry in the future."

In the most outspoken attack on the alcoholic beverage industry delivered on the Senate floor in recent years, Thurmond labeled as "ridiculous" a claim by the Distilled Spirits Council of the U.S. (DISCUS) that the industry's voluntary public education efforts "totally alleviates the need for health warning labels."

"There has been no responsibility demonstrated on behalf of the alcoholic beverage industry to educate the youth of our nation as to the hazards of alcoholism," Thurmond declared in his Nov. 13 speech. "To the contrary, advertisements glamorize the use of alcohol. Recent campaigns target youthful drinkers, many of whom are under the legal age."

Brandishing a "Spuds MacKenzie" toy dog, Thurmond noted that the National Council on Alcoholism and other field organizations have called on Anheuser-Busch to discontinue the promotion on grounds it is encouraging youth to drink (*AR*, Oct. 13). The Senator said:

"We think to have these toys advertising beer on them for little children to be sold in the stores is absolutely unnecessary, inadvisable, and against the public interest."

Thurmond noted that an Anheuser-Busch official said the Spuds MacKenzie toy was created to promote Bud Light beer "only for those old enough to drink." He continued:

"The stuffed animals, children's toys and T-shirts small enough to fit 12-year-olds indicate the real purpose of the campaign is to entice young people to drink.

"Is this the kind of responsibility which we can expect from the alcohol beverage industry in the future? If so, I think we in Congress should get to work on some major policy changes. I am fully cognizant of the free speech rights of the alcoholic beverage industry. However, what is the cost to society of this freedom to advocate unlawful teenage drinking?"

Thurmond also cited wine coolers for what he called "additional evidence demonstrating the alcoholic beverage industry's lack of responsibility to youth." Advertising, he said, "gives the impression that wine coolers are a soft drink," not-

ing that the beverage contains more alcohol than beer.

As chairman of the Senate Judiciary Committee last year, Thurmond helped shape major portions of the Anti-Drug Abuse Act. "I was proud of our work on that legislation," he said, adding:

"However, we all know that drug smugglers and drug dealers are easy political targets. There is no one in Congress who seeks to protect their interests.

"I have said this on several occasions and I repeat it today: There is no stronger lobby in this nation than the alcoholic beverage lobby. However, today alcohol is the No. 1 drug of abuse in our country."

Thurmond, ranking Republican on the Senate Subcommittee on Children, Families, Drugs and Alcoholism, has introduced legislation over the years to require health warning labels on alcoholic beverages. In his Senate speech, Thurmond made welcoming remarks to participants at the National Conference on Alcohol Abuse and Alcoholism who viewed a video tape of the Senator's address a few hours after it was made.

BETTER HEALTH FOR AMERICANS HINGES ON LOWER ALCOHOL USE

"America will one day have to choose between alcohol and health," declared Surgeon General C. Everett Koop, M.D., ScD. "Because we can't have both."

"We cannot continue to have high levels of traffic in any drugs -- including tobacco and alcohol -- and still hope to raise the health status of the American people up there onto the higher plateau where it ought to be," Koop said in an address to the National Conference on Alcohol Abuse and Alcoholism in Washington, DC, Nov. 13.

Koop described the U.S. Public Health Service's national objectives for health promotion and disease prevention, which involves some 16 goals to be achieved by 1990 and 2000, including lower rates for infant mortality, highway fatalities, heart disease and other areas. "The presence of alcohol subverts every single one of them," the Surgeon General said.

Koop cited as examples the efforts to reduce teenage pregnancy. "We can open clinics and run in-school sex education courses and enlist the help of churches and so on. But if we don't recognize the influence of alcohol, then we're wasting a lot of time and money."

The Public Health Service is also focusing on occupational health and safety as an area where significant gains can be achieved by 1990 and 2000, the Surgeon General said, adding:

"A whole industry has been developed which now produces protective clothing and face masks and ear protectors and goggles and a thousand other items for worker health and safety But none of these items will protect the worker, if his or her judgment is altered by alcohol. Such workers might as well leave their protective items in their lockers, if all they do is take them out on the job site and use them incorrectly under the influence of alcohol.

"The fundamental, safety-oriented behavior that provides basic protection for the American worker is rendered useless, if that worker drinks.

"Contrary to all the TV ads, drinking a lot of beer out on the job is not a manly thing to do. It's stupid, dangerous behavior.

"So I maintain that you won't get very far improving on-the-job safety, if you dance around the issue of alcohol."

Koop called the National Conference the "opening salvo" in a new campaign against alcohol abuse and alcoholism. "We must deal with alcohol, if we want to achieve any substantive progress in American health status across the board," he concluded.

ALCOHOL PROBLEMS PERVASIVE, GALLUP TELLS CONFERENCE

"A substantial majority of Americans have suffered at least to some extent from their own or someone else's drinking," George Gallup, Jr., told the National Conference on Alcohol Abuse and Alcoholism Nov. 13.

As many as 4 out of 10 Americans say they have suffered physical, psychological or social harm during their lifetimes as a result of another person's drinking, Gallup said. The recent Gallup survey also showed that about 17 percent admit to suffering because of his or her own drinking, the pollster said.

"America does not have a crime problem," Gallup said. "America does not have a problem of job absenteeism and low productivity. America does not have a teenage pregnancy problem. America does not have a problem of broken homes and marriages. America has an alcohol and drug problem."

Gallup said there is some good news, however, noting survey findings that the number of people who have sought professional help for drinking problems has doubled in just three years, and that public knowledge about alcoholism has increased in the last five years. He also cited de-

clines in cirrhosis mortality, and the growth of AA.

Despite a new awareness of alcohol problems, and willingness to seek help, Gallup said, "the overwhelming majority continue to reject a return to prohibition."

"In fact, the proportion favoring a law that would forbid the sale of all beer, wine, and liquor throughout the nation is at the lowest level recorded in 51 years," Gallup said, citing survey findings that only 17 percent favor a return to prohibition, the same percentage as in a 1984 poll. In 1936, 38 percent favored prohibition, he said.

While a return to prohibition is rejected, Gallup said heavy public support is found for such measures as warning labels, higher alcohol taxes, and "equal time" requirements for broadcasters airing alcohol commercials. A recent Gallup survey found 79 percent favoring health and safety warning labels on alcoholic beverage containers; 75 percent backing legislation to require radio and TV stations running beer and wine commercials to provide the same amount of time to health and safety warning messages about drinking; and 66 percent approving a doubling of the federal alcohol excise taxes to raise funds to combat alcohol and drug abuse.

NIAAA ADVISORY COUNCIL URGES MAINTAINING ADAMHA STRUCTURE

NIAAA Advisory Council members have adopted a resolution which urges maintenance of the present ADAMHA structure for research on alcohol, drug and mental (ADM) disorders and advises against any "dilution" of its role in research.

The resolution was described as being framed in response to concerns about proposals to overhaul ADAMHA or move components to the National Institutes of Health, subject of current studies (*AR*, Sept. 29).

Developed by Advisory Council members Tom Crowley, Bernie Boswell, Roger Meyer and Robert Straus, the resolution on the ADAMHA reorganization study is being sent to HHS Secretary Otis Bowen, ADAMHA Administrator Donald Ian Macdonald, and Assistant Secretary for Health Robert Windom. It was distributed by NIAAA in a Nov. 25 memorandum.

The resolution reads: "Whereas alcohol use causes problems for an estimated 18 million American adults, this Council advises that it is essential for the federal government to maintain and gradually expand its role as key patron of biomedical and behavioral research into the causes and treatments of alcoholism.

"Whereas recent studies show that many alcoholic persons also suffer from other diagnosable mental disorders or from the abuse of additional drugs, this Council advises that it is essential for alcoholic Americans that the federal government maintain and gradually expand its role as key patron of mental health and drug-abuse research.

"Whereas direct prevention and treatment efforts for ADM disorders are at least partly supported through other public and private efforts, and whereas such efforts contribute only modestly to biomedical and behavioral reach on ADM disorders, this Council advises that the federal government must avoid diversion from, or dilution of, its major role as ADM research patron.

"Whereas this Council finds that the ADAMHA structure for research on ADM disorders has provided stunning advances in these fields, the Council recommends maintenance of that structure. The Council fears that changes in that structure could result in unforeseen and ultimately harmful reorganizations, in fragmentation of the naturally parallel courses of ADM research, and in a harmful change in the balance of biomedical versus psychosocial research in ADM disorders.

"Whereas the three ADAMHA Institutes have become the major international centers for research in ADM disorders, and whereas the ADAMHA administration has provided needed administrative support for these research Institutes, and whereas that administrative support has been compromised by the assumption of certain ADM program activities within ADAMHA but outside of the Institutes, this Council advises that those ADM program activities be centered in the appropriate Institutes.

"Whereas some well-intended persons want one or more of the ADAMHA Institutes to be administered by NIH, and whereas the Council finds that it is essential to maintain the parallel and coordinate courses of research in the ADM disorders, the Council recommends against piecemeal moving of one or two of the ADAMHA Institutes to NIH."

In the Field

JCAH TEAMS SURVEYING ALCOHOL/DRUG PROGRAMS TO INCLUDE SPECIALIST

An alcohol and drug dependence specialist will be included in all Joint Commission on Accreditation of Hospitals (JCAH) teams surveying hospitals that offer programs for treating alcohol and drug abuse, effective Jan. 1. JCAH said the move affects only those programs that have "social rehabilitation as a basic element of their mission." It follows an earlier JCAH decision to use identical standards when surveying both freestanding and hospital-based alcohol and drug abuse programs.

"The approach will support Joint Commission ef-