

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILES 8672

62 SCOMM 6: SENATE SPECIAL COMM. ON ALCOHOLISM 1977-78

the death of the insured employee or group member the dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of dependents' coverage.

(9) No group hospital policy covering miscellaneous hospital expenses issued or delivered in this State shall contain any exception or exclusion from coverage which would preclude the payment of expenses incurred for the processing and administration of blood and its components.

(10) No policy of group accident and health insurance, delivered in this State more than 120 days after the effective day of the section, which provides in-patient hospital coverage for sicknesses, shall exclude from such coverage the treatment of alcoholism. This subsection shall not apply to a policy which covers only specified sicknesses.

(11) No policy of group accident and health insurance, which provides benefits for hospital or medical expenses based upon the actual expenses incurred, issued or delivered in this State shall contain any specific exception to coverage which would preclude the payment of actual expenses incurred in the examination and testing of a victim of rape or attempted rape to establish that sexual contact did occur or did not occur, and to establish the presence or absence of venereal disease or infection, and examination and treatment of injuries and trauma sustained by the victim of rape or attempted rape arising out of the rape or attempted rape. This subsection shall not apply to a policy which covers hospital and medical expenses for specified illnesses and injuries only.

(12) No group hospital, medical or surgical expense policy shall contain any provision whereby benefits otherwise payable thereunder are subject to reduction solely on account of the existence of similar benefits provided under other group or group-type accident and sickness insurance policies where such reduction would operate to reduce total benefits payable under those policies below an amount equal to 100% of total allowable expenses provided under these policies. 1937, June 29, Laws 1937, p. 696, § 367; 1941, July 17, Laws 1941, vol. 1, p. 838, § 1; 1947, July 21, Laws 1947, p. 1125, § 1; 1949, Aug. 2, Laws 1949, p. 1050, § 1; 1951, June 29, Laws 1951, p.

ration within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one day period. (L. 1974, ch. 190, § 4; July 1.)

40-2,103. Same; time when provisions required in policies.

The requirements of this act (*) shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of the act (*). (L. 1974, ch. 190, § 5; July 1.)

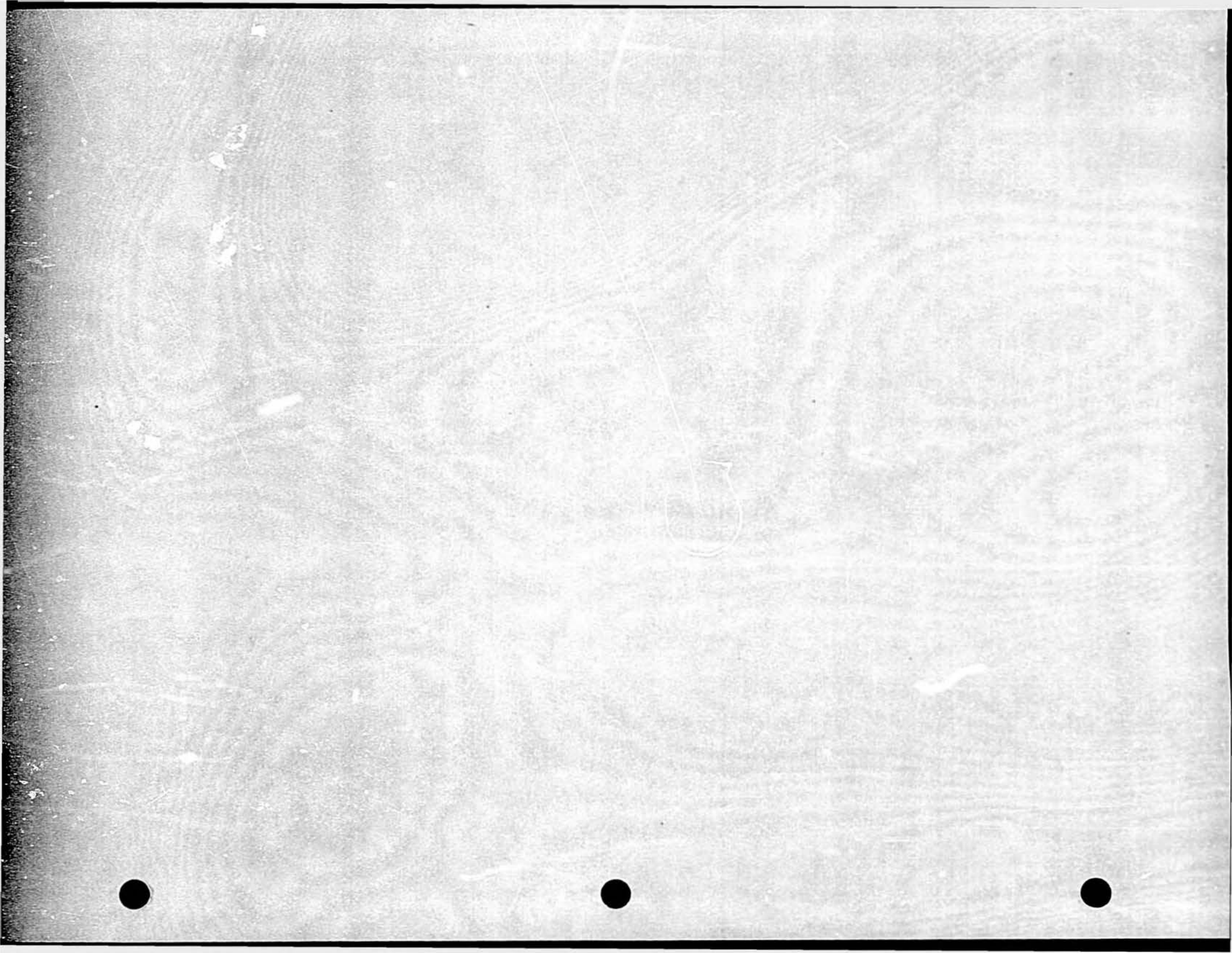
* "This act," see, also, 40-2,102, 40-1809, 40-1909, 40-19a10.

40-2,104. Insurance coverage to include reimbursement for services performed by certified psychologist.

Notwithstanding any provision of an individual or group policy or contract of health and accident insurance delivered within the state whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly certified psychologist within the state of Kansas, the insured, or any other person covered by the policy or contract shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or a duly certified psychologist. (L. 1974, ch. 189, § 1; July 1.)

40-2,105. Insurance coverage for reimbursement of services rendered in treatment of alcoholism.

Every insurer, which issues any group policy of accident and sickness, medical or hospital expense insurance which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must make available by affirmative offer and, if requested by the contract holder, provide reimbursement or indemnity under such policy which shall be limited to not less than thirty (30) days per year when such person is confined in either a licensed hospital for the treatment of alcoholism or a facility licensed under the provisions of K.S.A. 1977 Supp. 65-4014 for the treatment of alcoholism. (L. 1977, ch. 161, § 1; July 1.)



LOUISIANA

HEALTH AND ACCIDENT INS. R.S. 22:215.6

~~215.5. Group, blanket and franchise health insurance: treatment for alcoholism~~

~~Any group, blanket or franchise health insurance policy issued under R.S. 22:215 of this title after July 1, 1975, shall include as an option, to be exercised at the choice of the policyholder, as defined in R.S. 22:215, covered benefits for the treatment of alcoholism rendered or prescribed by a physician licensed pursuant to Chapter 15 of Title 37 of the Louisiana Revised Statutes, received in any licensed hospital or any other public or private facility or portion thereof duly authorized by the appropriate state authority to provide alcoholism treatment and rehabilitation services.~~

Any insurer who, on July 1, 1975, has group, blanket or franchise health insurance policies in force shall have until July 1, 1976, to convert such existing policies to conform to the provisions of this section. (Added by Acts 1974, No. 252, § 1.)

Acts 1974, No. 252 § 1 enacted the above section as R.S. 22:215.3. It has been redesignated to avoid duplication in numbering on authority of R.S. 24:253.

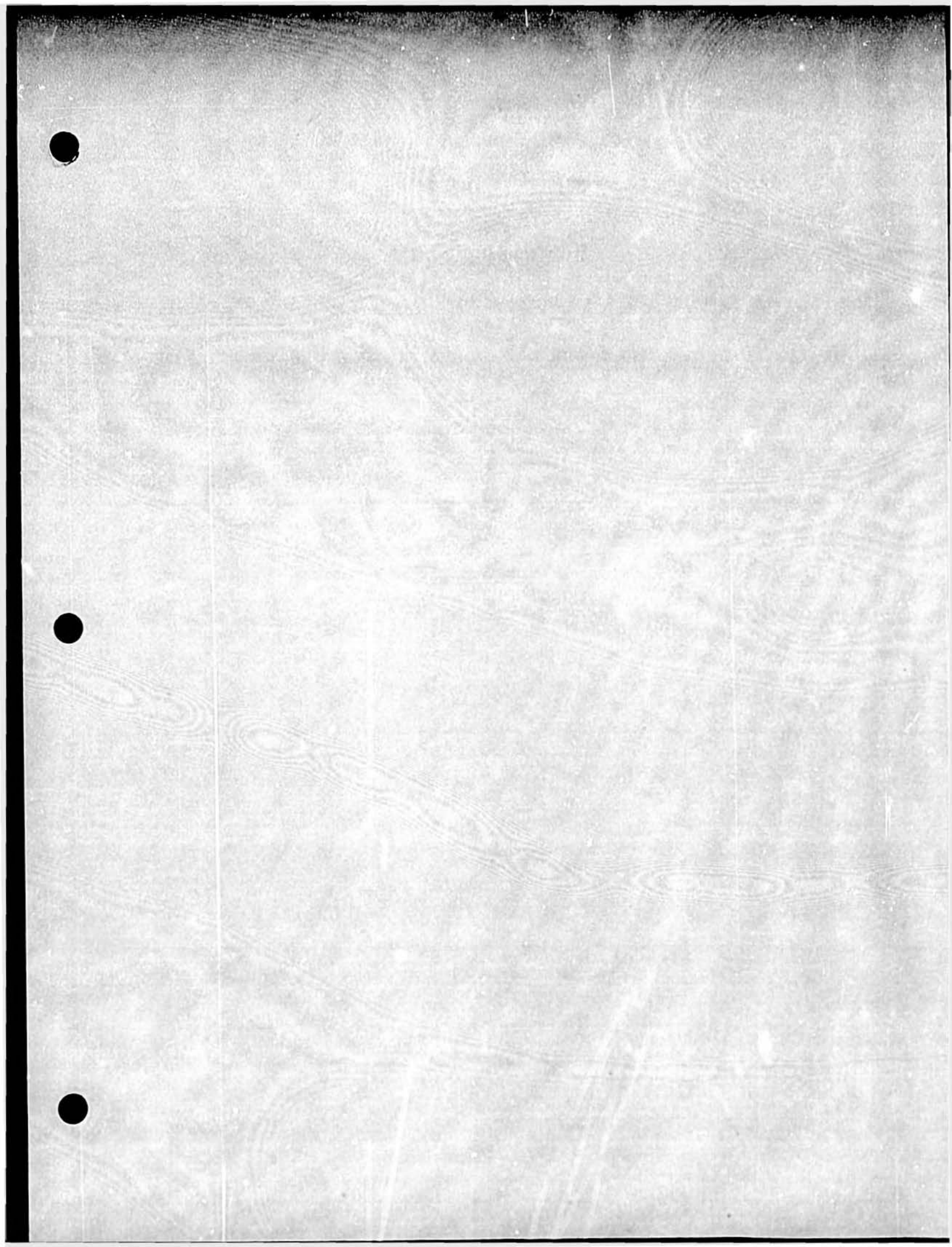
215.6. Group or blanket health and accident insurance replacement; continuance of benefits

A. Upon the replacement of one carrier by another of any group or blanket health and accident insurance policy for ten or more members issued for delivery or delivered in this state, any limitation on benefits otherwise payable because of preexisting conditions clauses, if any, in the succeeding carrier's plan shall be the lesser of:

(1) The benefits of the new plan determined without application of the preexisting conditions limitation.

(2) The benefits of the prior plan.

B. In a group of fifty or more members the succeeding carrier shall give credit for the satisfaction or partial satisfaction of any deductibles or waiting periods in its plan effected under a prior plan providing similar benefits. In the case of deductible



MARYLAND

GROUP AND BLANKET HEALTH 4SA § 447L

(b) The individual converted policies must provide benefits as required by the Commissioner. The Commissioner may establish different requirements and different levels of benefits for various types or categories of coverage and for varying types of group policies. In establishing minimum requirements, the Commissioner may establish exclusions and benefit limitations which he deems appropriate. The Commissioner may exempt certain types of group policies, and certain types of coverage under such policies, from the requirements of this section, where, in his discretion he deems such exemption appropriate. The Commissioner may establish conditions under which the conversion privilege shall not be operative. Such conditions may include, but need not be limited to, replacement of a terminated coverage by similar group coverage or by health programs sponsored by any government or by the group policyholder.

(c) The Commissioner shall establish notification requirements for the insurer to the person whose coverage is being terminated of his right of conversion, and requirements regarding the timely election of the conversion privilege. The requirements for notification shall include, but need not be limited to, a provision in any certificates furnished persons covered under group and blanket health insurance policies setting forth the conditions applicable to election of the conversion privilege.

(d) After January 1, 1978 the provisions of this section shall apply to all group policies delivered or renewed in the State, upon the effective date or renewal anniversary date, whichever is later, of the policy.

(Added 1976, ch. 274; amended 1977, ch. 526.)

§ 477L. Benefits for expenses of alcoholic rehabilitation treatment program

(a) After July 1, 1976, every insurer which proposes to issue a group hospital policy or a group major medical policy in Maryland shall offer the prospective group policyholder at an appropriate additional premium the option of providing benefits for expenses arising from any alcoholic rehabilitation

48A § 477M MARYLAND INSURANCE CODE

treatment program licensed by the Department of Health and Mental Hygiene, Division of Licensing and Enforcement or approved by the Department of Health and Mental Hygiene, Division of Alcoholism Control.

(b) Benefits shall provide the minimum requirements specified by the Department of Health and Mental Hygiene, Division of Alcoholism Control for not less than 30 days or partial days of in-patient care in any period of 12 consecutive months. For purposes of this section, two out-patient visits shall be considered as equivalent to one day's care.

(c) For purposes of this section, any proposed change in benefits provided by an existing group hospital or group major medical policy shall be considered a proposal to issue a policy under subsection (a).

(d) The provisions of this section shall apply only if an initial enrollment of at least 25 certificate holders under the new or expanded group policy can reasonably be expected.

(Added 1976, ch. 432.)

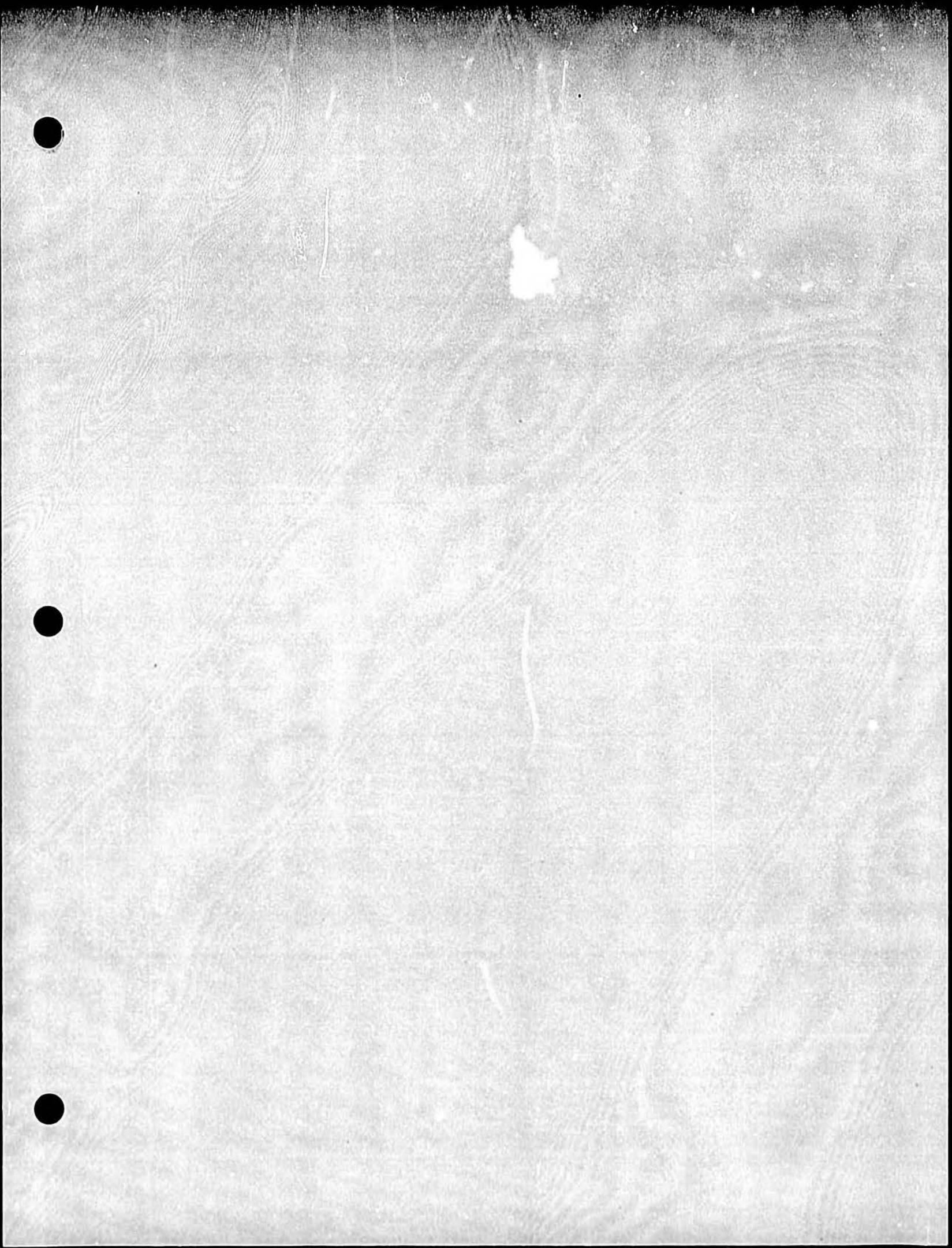
§ 477M. Benefits for costs of psychiatric care through partial hospitalization

(a) *Option to be offered prospective group policyholders.*—After January 1, 1977, every insurer which proposes to issue a group hospital policy in Maryland shall offer the prospective group policyholder at an appropriate premium adjustment, if any, the option of providing benefits for the cost of psychiatric care through partial hospitalization.

(b) *Meaning of "partial hospitalization".*—As used in this section, partial hospitalization means a psychiatric service offered in a hospital or in a psychiatric day care treatment center or in a community mental health facility providing medically directed intensive or intermediate short-term psychiatric treatment for a period of less than 24 hours but more than 4 hours in a day for any individual patient.

(c) *Minimum period.*—Benefits shall provide for psychiatric care for a minimum of 30 partial hospitalization treatment days during any period of 12 consecutive months.

(d) *Changes in existing group policy.*—For purposes of this



MICHIGAN

Ch. 36 GROUP & BLANKET DISABILITY 500.3609

(2) No such group policy may be issued or delivered in this state unless a copy of the form shall have been filed with the commissioner and approved by him.

(3) Such policies shall also be subject to section 3474 (filing of risk classifications and rates). P.A.1956, No. 218, § 3606, Eff. Jan. 1, 1957.

§ 500.3608 Same; required provisions

Sec. 3608. Every policy of group disability insurance shall contain:

(1) A provision that the policy, application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured, shall constitute the entire contract between the parties, and that all statements made by the employer, or the executive officer or trustee, or by the individual employees or members, shall, in the absence of fraud, be deemed representations and not warranties, and that the statements shall not be used in defense of a claim under the policy, unless they are contained in a written application.

(2) A provision that the insurer will issue to the employer, or to the executive officer or trustee of the association, for delivery to the employee or member, who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled to and to whom payable.

(3) A provision that to the group or class thereof originally insured shall be added from time to time all new employees of the employer, or members of the association eligible to, and applying for insurance in the group or class. P.A.1956, No. 218, § 3608, Eff. Jan. 1, 1957, as amended P.A.1974, No. 50, § 1, Eff. July 1, 1974.

~~§ 500.3609 Coverage for alcoholism and drug abuse treatment only~~

Sec. 3609. Any insurer who delivers, issues for delivery, or renews in this state a policy of group disability insurance shall offer to include in such policy a provision that the insurer will provide coverage for such inpatient and outpatient treatment of alcoholism and drug abuse as may be agreed upon between the insured employer or other insured organization

and the insurer to be provided in a facility approved by the department of public health for hospitalization or treatment of alcoholism and drug abuse. Such coverage shall be subject to the provisions of sections 3406 to 3466¹ of this act. P.A.1956, No. 218, § 3609, added by P.A.1974, No. 50, § 1, Eff. July 1, 1974.

¹ Sections 500.3406, 500.3466.

§ 500.3610 Required provisions, group disability policies

Sec. 3610. Every policy of group disability insurance shall contain the applicable provisions required in sections 3406 through 3466.¹ P.A.1956, No. 218, § 3610, added by P.A.1974, No. 225, § 1, Eff. Nov. 1, 1974.

¹ Sections 500.3406 to 500.3466.

§ 500.3611 Newly born children

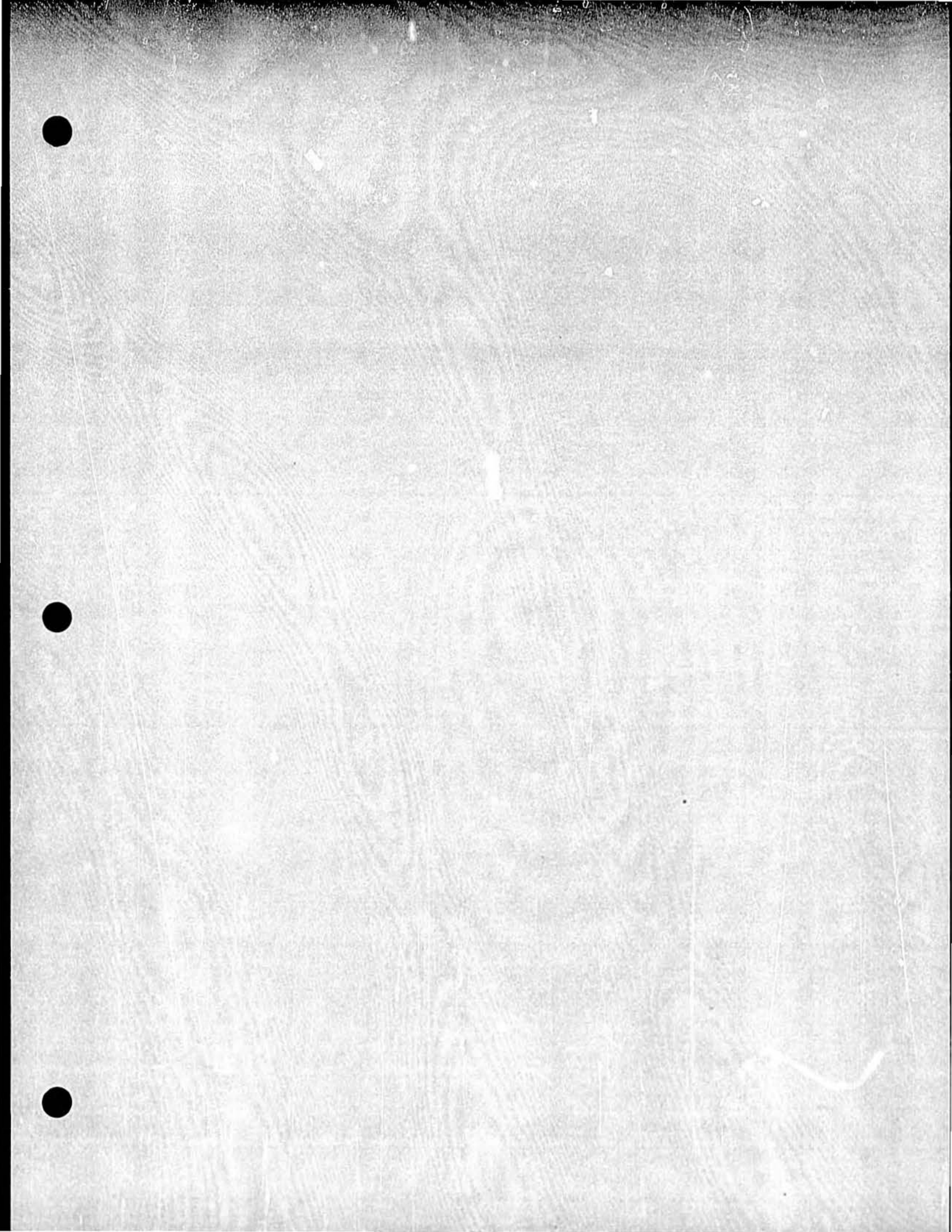
Sec. 3611. (1) All group disability insurance policies providing coverage on an expense incurred basis which provide coverage for a family member of the insured shall, as to that family member's coverage, also provide that the disability insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

(2) The coverage for children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium shall be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond the 31-day period. P.A.1956, No. 218, § 3611, added by P.A.1975, No. 20, § 1, Imd. Eff. April 3, 1975.

§ 500.3620 Family expense insurance

Sec. 3620. (1) **Definition.** Family expense insurance is that form of accident and health or hospitalization, medical, surgical and sick-care insurance which is written under 1 policy issued to the head of a family who may be either spouse, and insuring such head and 1 or more dependents, and may



MINNESOTA

ACCIDENT AND HEALTH

§ 62A.149

§ 62A.148 Group insurance; provision of benefits for disabled employees

No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. If the employee is required to pay all or any part of the premium for the extension of coverage, payment shall be made to the employer, by the employee. Added Laws 1973, c. 340, § 2.

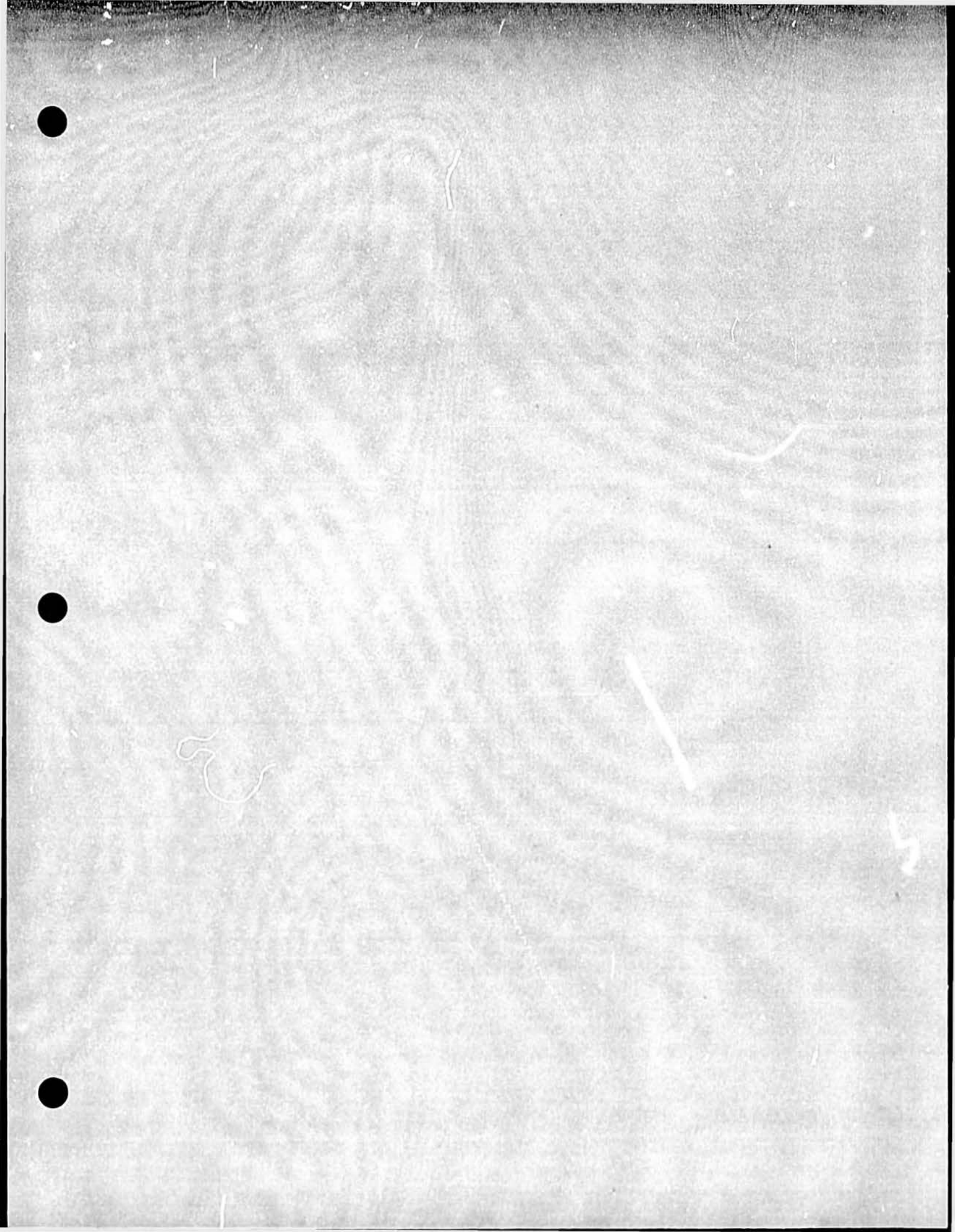
§ 62A.149 Benefits for alcoholics and drug dependents

Subdivision 1. No policy or plan of insurance regulated under chapter 62A, or subscriber contract offered by a nonprofit health service plan corporation regulated under chapter 62C shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of insurance unless the policy, plan or contract specifically includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of alcoholism, chemical dependency or drug addiction in

- (1) a licensed hospital,
- (2) a residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine,
- (3) a non-residential treatment program approved or licensed by the state of Minnesota.

Provided, however, that the restrictions and requirements of this subdivision shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy.

Subd. 2. Coverage under subdivision 1, clauses (1) and (2), shall be for at least 20 percent of the total patient days allowed by the policy and in no event shall coverage be for less than 28 days in each 12 month benefit year. Coverage under subdivision 1, clause (3), shall be for at least 130 hours of treatment in a 12 month benefit year. Laws 1973, c. 585, §§ 1, 2; amended Laws 1976, c. 262, § 1.



§ 83-9-27. Alcoholism care and treatment—coverage.

Notwithstanding any provision of any policy of accident or sickness insurance as defined by section 83-9-1, issued on or after January 1, 1975, whenever such policy provides for the reimbursement for loss resulting from sickness, or from bodily injury by accidental means, or both, said reimbursement shall include health service benefits to any insured or any person covered thereunder, on the same basis as other benefits, for care and treatment of alcoholism.

For purposes of sections 83-9-27 through 83-9-31, alcoholism is defined as the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

SOURCES: Laws, 1974, ch. 522 § 1, eff from and after January 1, 1975.

Cross references—

As to commitment of alcoholics for treatment, see §§ 41-31-1 et seq.

As to alcoholism, alcohol abuse prevention, control and treatment, see §§ 41-30-1 et seq.

ALR Annotations—

Clause in life, accident, or health policy excluding or limiting liability in case of insured's use of intoxicants or narcotics. 13 ALR2d 987.

§ 83-9-29. Alcoholism care and treatment—application of law.

The provisions of sections 83-9-27 through 83-9-31 shall apply only to group policies or group plans of health affording coverage from sickness, or bodily injury by accidental means, or both, or nonprofit health plans corporations regulated by the Mississippi Insurance Commission issued or renewed after January 1, 1975.

The provisions of sections 83-9-27 through 83-9-31 shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy.

SOURCES: Laws, 1974, ch. 522 § 2, eff from and after January 1, 1975.

§ 83-9-31. Alcoholism care and treatment—limitation of coverage.

The coverage required under section 83-9-27 shall not exceed one thousand dollars (\$1,000.00) during any calendar

NEVADA

HEALTH INSURANCE CONTRACTS 689A.030

689A.010 Short title. This chapter may be cited as the Uniform Health Policy Provision Law.
(Added to NRS by 1971, 1751)

689A.020 Scope of chapter. Nothing in this chapter applies to or affects:

1. Any policy of liability or workmen's compensation insurance with or without supplementary expense coverage therein.

2. Any group or blanket policy, except as to NRS 689A.380 (definitions of terms).

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or as to

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant become totally and permanently disabled, as defined by the contract or supplemental contract.

4. Reinsurance.

(Added to NRS by 1971, 1751)

689A.030 Scope, format of policy. No policy of health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

1. The entire money and other considerations therefor shall be expressed therein;

2. The time when the insurance takes effect and terminates shall be expressed therein;

3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, dependent children, from the time of birth as provided in NRS 689A.043, or any children under a specified age which shall not exceed 19 years except as provided in NRS 689A.045, and any other person dependent upon the policyholder;

4. The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points (the "text" shall include all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions);

5. The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in NRS 659A.050 to 659A.200, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies:

6. Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

7. The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

8. The policy shall provide benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007.

9. The policy shall provide, at the option of the applicant, benefits for expenses incurred for the treatment of alcohol and drug abuse as provided in NRS 659A.047.

(Added to NRS by 1971, 1752; A 1973, 546; 1975, 446, 1108, 1848)

659A.040 Required provisions: Captions; omissions; substitutions.

1. Except as provided in subsections 2 and 3, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in NRS 659A.050 to 659A.170, inclusive, in the words in which the same appear, except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

2. Each policy, delivered or issued for delivery in this state after November 1, 1973, shall contain a provision, if applicable, setting forth the provisions of NRS 659A.045.

3. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall

6S9B.010 Scope of chapter; short title.

1. This chapter may be cited as the Group or Blanket Health Insurance Law.

2. This chapter applies only to group health insurance contracts and to blanket health insurance contracts as provided for in this chapter.

(Added to NRS by 1971, 1767)

6S9B.020 "Group health insurance" defined; eligible groups and benefits.

1. "Group health insurance" is hereby declared to be that form of health insurance covering groups of two or more persons, formed for a purpose other than obtaining insurance.

2. Any group health policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, dental or surgical services, home health care or health supportive services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

3. The commissioner may, in his discretion, require the form of each certificate proposed to be delivered in this state under a group health policy not made under the laws of this state to be filed with him by the insurer for informational purposes only.

(Added to NRS by 1971, 1767; A 1971, 1954; 1975, 447)

6S9B.025 Uniform billing, claims forms. Every insurer under a group health insurance contract or a blanket health insurance contract and every state agency, for its records shall accept from:

1. A hospital the Uniform Billing and Claims Forms established by the American Hospital Association in lieu of its individual billing and claims forms.

2. An individual who is licensed to practice one of the health professions regulated by Title 54 of NRS such uniform health insurance claims forms as the commissioner shall prescribe, except in those cases where the commissioner has excused uniform reporting.

(Added to NRS by 1975, 897)

6S9B.030 Required provisions in group policies. Each such group health insurance policy shall contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by

the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

2. A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family unit.

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

4. A provision for benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007.

5. A provision for benefits, at the option of the applicant, payable for expenses incurred for the treatment of alcohol and drug abuse, as provided in NRS 689B.037.

(Added to NRS by 1971, 1767; A 1975, 448, 1850)

689B.032 Required provision concerning coverage relating to complications of pregnancy.

1. No group health or blanket health policy may be delivered or issued for delivery in this state if it contains any exclusion, reduction or other limitation of coverage relating to complications of pregnancy, unless the provision applies generally to all benefits payable under the policy.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires hospital confinement for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

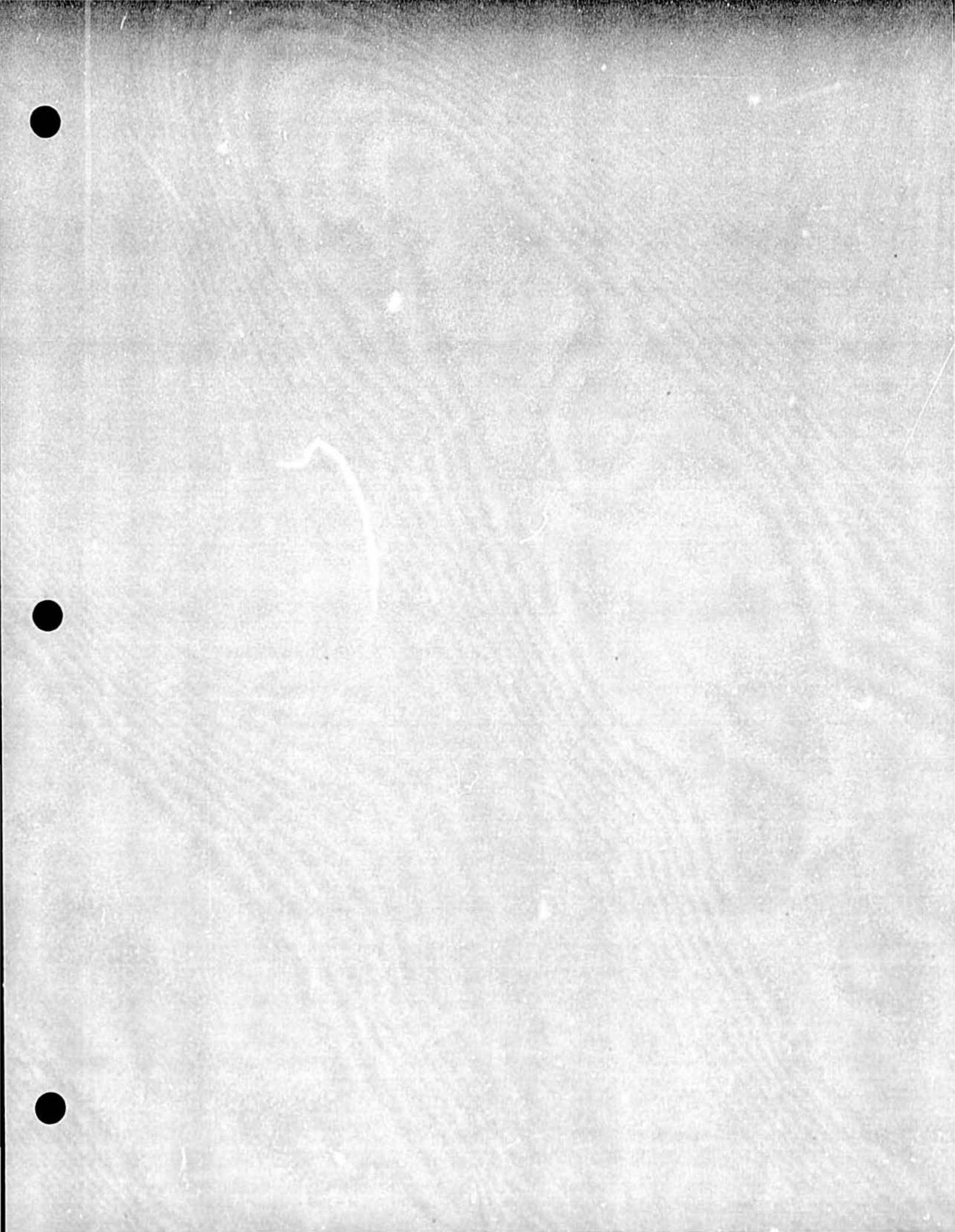
(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. A policy subject to the provisions of this chapter which is delivered or issued for delivery on or after July 1, 1977, has the legal effect of including the coverage required by this section, and any provision of the policy which is in conflict with this section is void.

(Added to NRS by 1977, 415)

689B.033 Required provision concerning coverage for newly-born children.

1. All group health insurance policies providing coverage on an expense-incurred basis and all employee welfare plans providing



Chapter 26-39

**MENTAL ILLNESS AND ADDICTION
INSURANCE COVERAGE**

Sec.

- 26-39-01 Definitions.
- 26-39-02 Insurance companies to comply with chapter.
- 26-39-03 Types of coverage required.
- 26-39-04 Types of benefits required.
- 26-39-05 Other policies.

§ 26-39-01. Definitions

As used in this chapter, unless the context or subject matter otherwise requires:

1. "Licensed treatment facility" means any hospital, as defined in subsection 29 of section 52-01-01 and the state department of health rules and regulations pursuant thereto or as licensed under section 23-17.1-01, offering treatment for the prevention or cure of mental illness, alcoholism, drug addiction, or other related illness.

2. "Partial hospitalization" means that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment.

Source: S.L. 1975, ch. 263, § 1.

§ 26-39-02. Insurance companies to comply with chapter

No insurance company, nonprofit hospital service corporation, or nonprofit medical service corporation authorized to do business within this state shall deliver, issue, execute, or renew any policy of health insurance on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by such policy and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for such coverage unless such policy shall conform to the requirements of this chapter.

Source: S.L. 1975, ch. 263, § 2.

26-39-03 NORTH DAKOTA INSURANCE CODE

§ 26-39-03. Types of coverage required

Any policy described in section 26-39-02 shall provide benefits, of the same type offered under such policy for other illnesses, for health services to any person covered under such policy, for the diagnosis, evaluation, and treatment of mental illness, alcoholism, drug addiction, or other related illness, in a licensed hospital.

Source: S.L. 1975, ch. 263, § 3.

§ 26-39-04. Types of benefits required

The benefits described in section 26-39-03 may be provided for inpatient treatment and treatment by partial hospitalization:

1. In the case of benefits provided for inpatient treatment, such benefits shall be provided for a minimum of seventy days of service in any calendar year.

2. In the case of benefits provided for partial hospitalization, such benefits shall be provided for a minimum of one hundred forty days of service in any calendar year.

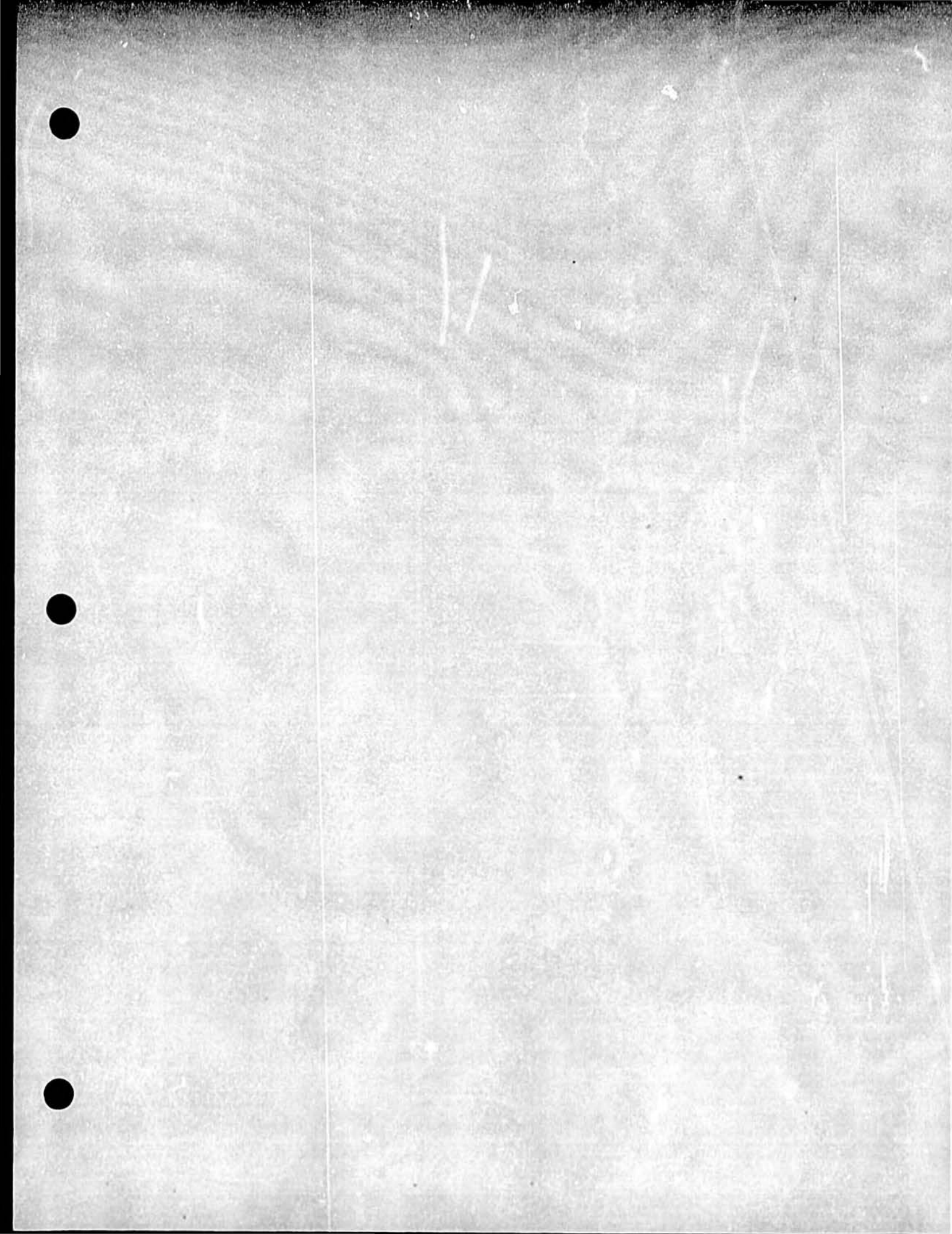
3. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits shall be payable, each day of inpatient treatment shall be equivalent to two days of treatment by partial hospitalization.

Source: S.L. 1975, ch. 263, § 4.

§ 26-39-05. Other policies

The provisions of this chapter shall not be construed to prevent any insurance company or nonprofit hospital or medical service corporation from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this chapter, where such policy or contract is not subject to such provisions.

Source: S.L. 1975, ch. 263, § 5.



option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

[1967 c.359 §428]

743.411 Entire contract; changes. A health insurance policy shall contain a provision as follows: "ENTIRE CONTRACT; CHANGES: This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

743.412 Coverage for alcoholism treatment; conditions; limits. A health insurance policy providing coverage for hospital or medical expenses not limited to expenses from accidents or specified sicknesses shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The applicant shall be informed of his option to request this coverage.

(2) The inclusion of the coverage may be made subject to the insurer's usual underwriting requirements.

(3) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(4) The policy may limit hospital expense coverage to treatment provided by:

(a) A health care facility licensed under ORS 441.015 to 441.037, 441.525 to 441.595, 441.910 to 441.920, 441.990, 442.300, 442.320, 442.330, 442.340 to 442.350 and 442.400 to 442.450 or accredited by the Joint Commission on Accreditation of Hospitals; or

(b) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health Division under ORS 430.260.

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than \$3,000 in any 24-consecutive month period.

[1977 c.632 §2]

743.414 Time limit on certain defenses; incontestability.

(1) A health insurance policy shall contain a provision as follows: "TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of that period."

(2) The policy provision set forth in subsection (1) of this section shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, or to limit the application of ORS 743.450 to 743.462 in the event of misstatement with respect to age or occupation or other insurance.

(3) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the provision set forth in subsection (1) of this section the following provision, from which the clause in parentheses may be omitted at the insurer's option: "INCONTESTABLE: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

(4) The policy shall contain a provision as follows, which shall be a separate paragraph under the same caption as, and

ORSON

743.549

OREGON INSURANCE CODE

743.549 Restriction on reduction of benefits provisions in group and blanket health policies. No group or blanket health insurance policy providing hospital, medical or surgical expense benefits, and which contains a provision for the reduction of benefits otherwise payable thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to 100 percent of total allowable expenses.

[1973 c.143 s.2]

743.552 Guidelines for application of ORS 743.549. The commissioner shall by rule establish guidelines for the application of ORS 743.549, including:

(1) The procedures by which persons insured under such policies are to be made aware of the existence of such a provision;

(2) The benefits which may be subject to such a provision;

(3) The effect of such a provision on the benefits provided;

(4) Establishment of the order of benefit determination; and

(5) Reasonable claim administration procedures to expedite claim payments under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision.

[1973 c.143 s.3]

743.555 Application of ORS 743.549 and 743.552. ORS 743.549 and 743.552 shall apply to any group or blanket health insurance policy containing a provision described in ORS 743.549 which is issued more than 90 days after June 26, 1973. Policies which are in existence 90 days after June 26, 1973, shall be brought into compliance on the next anniversary date of the applicable collectively bargained contract, if any, whichever date is latest.

[1973 c.143 s.4]

743.557 Group health insurance coverage for alcoholism treatment. A group health insurance policy providing cover-

age for hospital or medical expenses shall provide coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(2) The policy may limit hospital expense coverage to treatment provided by:

(a) A health care facility licensed under ORS 441.015 to 441.087, 441.525 to 441.595, 441.810 to 441.820, 441.990, 442.300, 442.320, 442.330, 442.340 to 442.350 and 442.400 to 442.450 or accredited by the Joint Commission on Accreditation of Hospitals; or

(b) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health Division under ORS 430.260.

(3) Except as permitted by subsection (1) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than \$3,000 in any 24-consecutive month period.

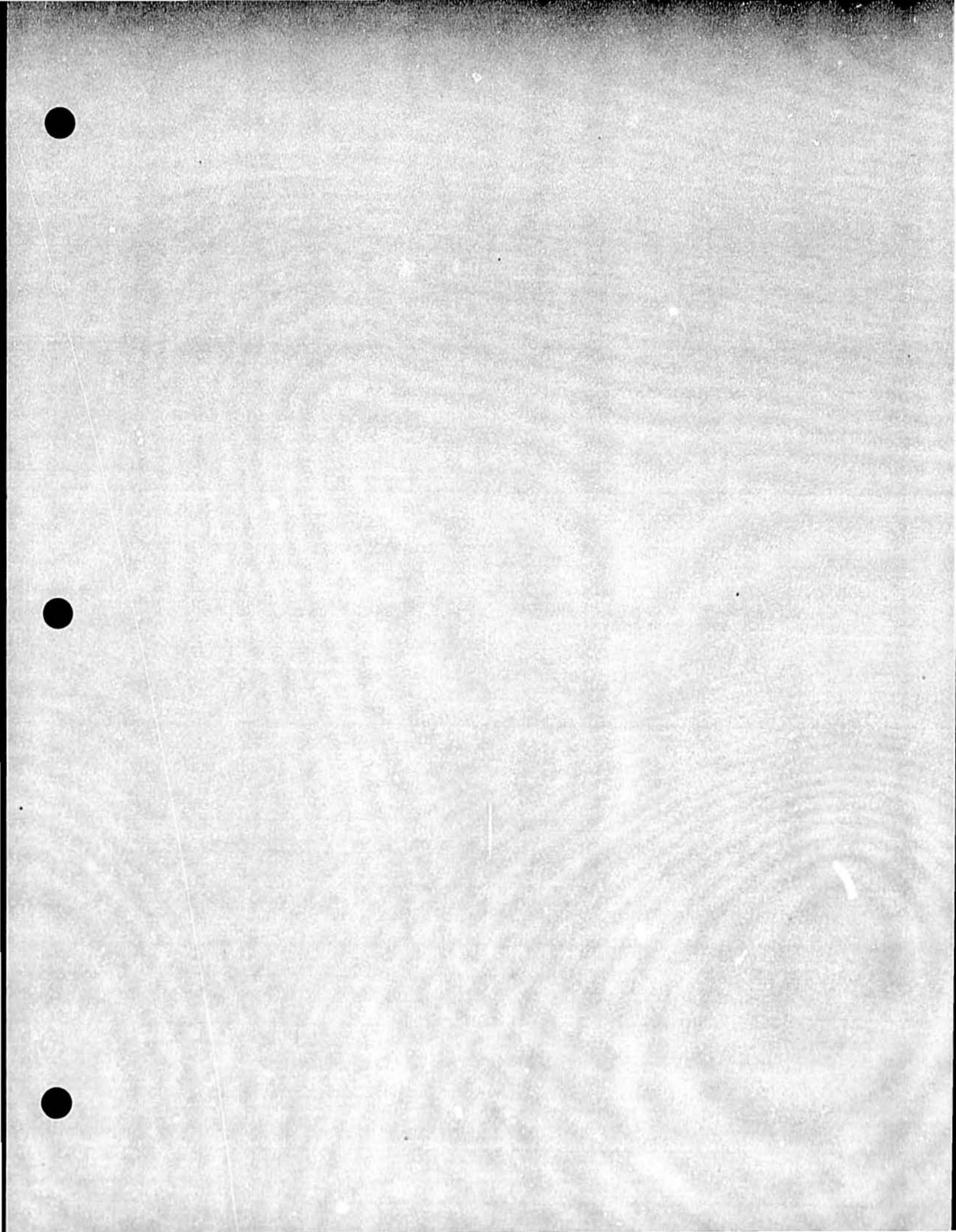
[1975 c.689 §2; 1977 c.632 §3]

743.558 Group health insurance coverage for mental or nervous conditions. Every insurer offering group health insurance benefits shall offer benefits for expense arising from mental or nervous conditions that meet the following requirements:

(1) In the case of benefits based upon confinement as an inpatient in a hospital, the period of confinement for which benefits are payable shall be at least 30 days in any calendar year.

(2) In the case of major medical expense coverage, benefits, after the applicable deductible, shall be at a 50 percent rate for covered expenses incurred by the insured while other than an inpatient in a hospital, and benefits shall be available for such expenses during any calendar year up to a maximum of \$500.

[1973 c.613 §2]



SOUTH DAKOTA

GROUP AND BLANKET HEALTH POLICIES 58-18-7.3

payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

Source: SL 1966, ch. 111, ch. 26, § 1(6).

§ 58-18-7.1. Coverage for inpatient treatment of alcoholism to be offered in group policies

Any insurer which delivers or issues for delivery in this state group accident and sickness insurance policies which provide coverage on an expense incurred basis shall offer, in writing, to include in such group policies or contracts issued or renewed on or after July 1, 1977, coverage for the inpatient treatment of alcoholism in a licensed hospitals or residential primary treatment facilities approved by the state of South Dakota which are carrying out an approved program pursuant to diagnosis and recommendation of a doctor of medicine.

Source: SL 1975, ch. 314, § 1; 1976, ch. 314, § 1; 1977, ch. 411, § 1.

§ 58-18-7.2. Benefits provided under alcoholism coverage— Maximum treatment periods permitted

The alcoholism coverage to be offered in writing shall provide benefits on the same basis as benefits provided for the treatment of other sicknesses covered under the group policy; provided, however, that the coverage by the insurance carrier need not exceed thirty days' care in any six-month period, and further provided that the total days' care per recipient need not exceed ninety days during the life of the contract.

Source: SL 1975, ch. 314, § 2; 1977, ch. 411, § 2.

§ 58-18-7.3. Policies not within alcoholism coverage requirement

Sections 58-18-7.1. and 58-18-7.2 shall not apply to group

58-18-8 SOUTH DAKOTA INSURANCE LAWS

major-medical insurance policies or accident only, or limited or specified disease policies.

Source: SL 1975, ch. 314, § 3.

§ 58-18-8. Statements by applicant—Representations not warranties—Requirements as to writing in order to avoid insurance or reduce benefits

Each such group health insurance policy shall contain in substance a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

Source: SL 1966, ch. 111, ch. 26, § 2(1).

§ 58-18-9. Summary statement of coverage for delivery to member of insured group

Each such group health insurance policy shall contain in substance a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group, a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family unit.

Source: SL 1966, ch. 111, ch. 26, § 2(2).

§ 58-18-10. Additions to group originally insured

Each such group health insurance policy shall contain in substance a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

Source: SL 1966, ch. 111, ch. 26, § 2(3).



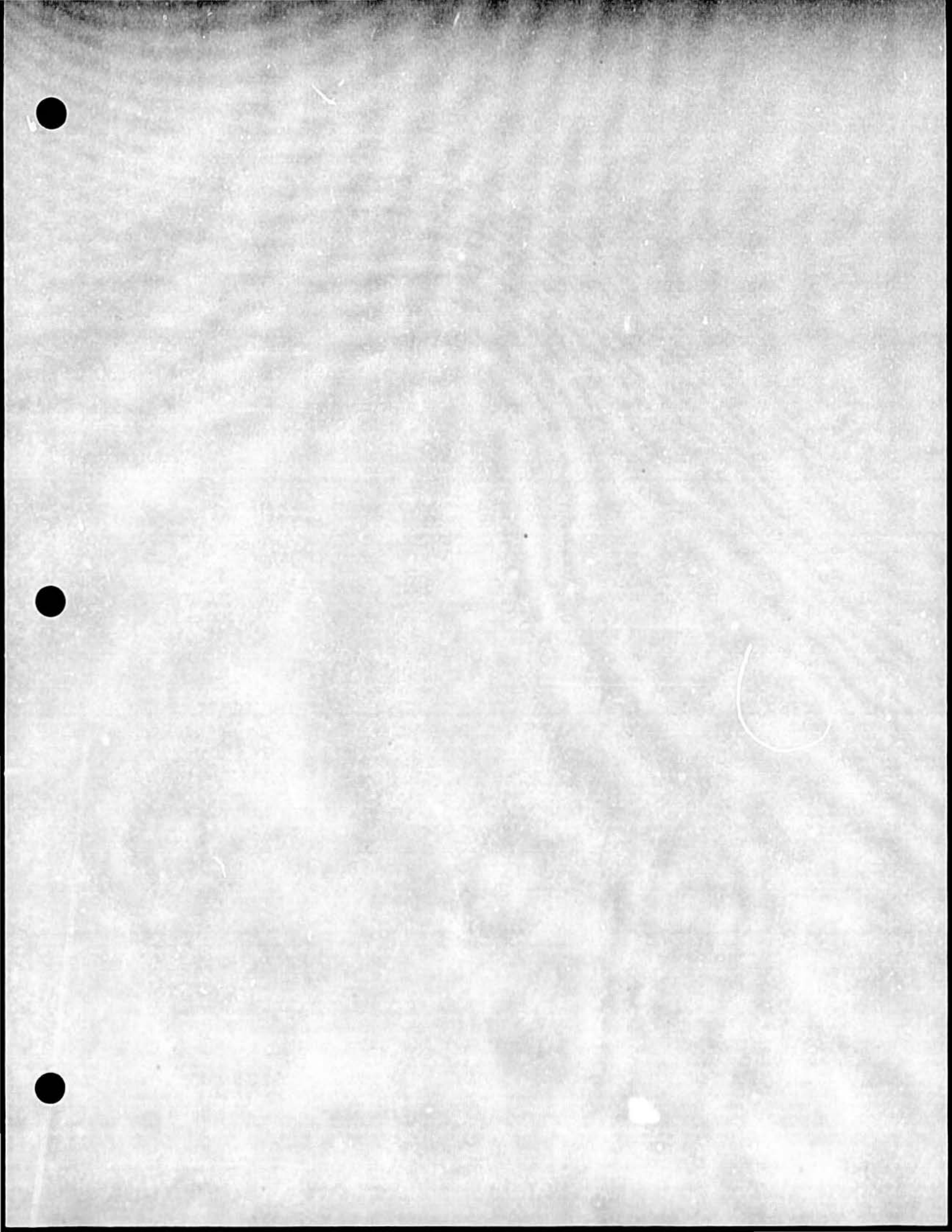
The provisions of this section shall apply to all such policies, plans and contracts issued, renewed or reinstated on and after July 1, 1974, and to all other policies, plans and contracts otherwise in existence on July 1, 1974, whenever there be a premium or rate change thereunder. [Acts 1974 (Adj. S.), ch. 151, §§ 1, 2.]

56-1167. Health insurance—Coverage of mental illness.

All other provisions of the laws of the state of Tennessee notwithstanding, any individual, franchise, blanket or group policy of insurance issued pursuant to title 56, which provides hospital expense and surgical expense insurance and which is entered into, delivered, issued for delivery, or renewed (excepting individual insurance policy renewal) by agreement or otherwise, commencing on July 1, 1974, shall provide benefits for expense of residents of the state of Tennessee covered under any such policy or plan, arising from psychiatric disorders, mental or nervous conditions (as described and defined in the Diagnostic Standard Manual of the American Psychiatric Association), alcoholism, drug dependence (both defined as mental illness in § 33-302 (f)), or the medical complication of mental illness or mental retardation, unless the policy or plan of insurance specifically excludes or reduces the above benefits. [Acts 1974 (Adj. S.), ch. 482, § 1.]

56-1168. Accident and sickness—Denial of coverage for mental illness for lack of surgical facilities prohibited.

Any provision of the law to the contrary notwithstanding, no policy of accident and sickness insurance may be entered into or renewed on or after July 1, 1974, if such policy by way of exclusion, definition, or otherwise denies coverage to an insured undergoing care and treatment in a facility for the care and treatment of mentally ill or mentally retarded persons, based upon the fact that the facility does not have organized facilities for operative surgery, if, in fact, the facility in question has, at the time a claim arises, a bona fide arrangement, by contract or otherwise, with an accredited hospital to perform such surgical procedures as may be required by the facility for mentally ill or retarded persons. [Acts 1974 (Adj. S.), ch. 625, § 1.]



THE INSURANCE CONTRACT § 38.1-348.7

services shall be construed to include a dentist performing such services within the scope of his professional license. (1968, c. 292.)

§ 38.1-348.6. Coverage of newborn children required

All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, as to such family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one day period. The requirements of this section shall apply to all insurance policies and subscriber contracts delivered and issued for delivery, reissued, renewed or extended in this State on and after November one, nineteen hundred seventy-six. An insurance policy written before November one, nineteen hundred seventy-six shall be deemed to be reissued or renewed if the provisions of that policy or contract allow the insurer to change the terms of the policy or contract or adjust the premiums charged, and if a change or adjustment is made on or after November one, nineteen hundred seventy-six. (1975, c. 281; 1976, c. 342.)

§ 38.1-348.7. Coverages for mental, emotional or nervous disorders

A. All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and

§ 38.1-348.7 VIRGINIA INSURANCE CODE

individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient in a mental hospital or a general hospital, provide coverage for mental, emotional or nervous disorders, with limits that are not more restrictive than for any other illness except that such benefits may be limited to thirty days of active treatment in any policy year. The requirements of this section shall apply to all insurance policies and subscriber contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment is made.

B. Every insurer which proposes to issue a group hospital policy or a group major medical policy in this State and every nonprofit hospital and medical service plan corporation which proposes to issue hospital, medical or major medical service plan contracts which provide coverage for the insured or the subscriber shall, in the case of outpatient benefits, make available additional benefits as specified herein for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for such policy or contract to select any alternative level of benefits as may be offered by the insurer or service plan corporation. Outpatient benefits shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that the coinsurance factor need not exceed fifty per centum of the coinsurance factor applicable for physical illness generally, whichever is greater, and the maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to not less than one thousand dollars.

This subsection B shall apply to policies or contracts delivered or issued for delivery in this State on or after November one, nineteen hundred seventy-seven; but shall not apply to blanket, short-term travel, accident only, limited or specified disease,

THE INSURANCE CONTRACT § 38.1-348.7

individual conversion policies, or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under State or federal governmental plans.

As used in this section, the following terms shall have the meanings indicated below.

(1) "*Outpatient benefits*" means only those payable for (i) charges made by a hospital for the necessary care and treatment of mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, (ii) charges for services rendered or prescribed by a physician or a psychologist duly licensed to practice in Virginia for the necessary care and treatment for mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, or (iii) charges made by a mental health treatment center, as defined herein, for the necessary care and treatment of a covered person provided in such treatment center.

(2) "*Mental health treatment center*" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician or a psychologist duly licensed to practice in Virginia and which facility is also: (i) licensed by the State, or (ii) funded or eligible for funding under federal or State law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

C. "*Mental, emotional or nervous disorders*" as used in this section, shall include physiological and psychological dependence upon alcohol and drugs; provided, however, that in instances where the optional coverage made available pursuant to § 38.1-348.8 B is accepted by or on behalf of the insured or subscriber and included in a policy or contract "mental, emotional or nervous disorders" shall not include coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs. (1976, c. 355; 1977, cc. 603, 606; 1978, c. 349.)

§ 38.1-248.8 VIRGINIA INSURANCE CODE

§ 38.1-348.8. Coverages for alcohol and drug dependence

A. As used in this section:

1. "*Treatment*" includes diagnostic evaluation, medical, psychiatric and psychological care, counseling and rehabilitation for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs which is determined to be necessary by and is provided by a certified alcoholism counselor, certified drug counselor, professional counselor, psychologist, or social worker licensed or certified pursuant to chapter 28 (§ 54-923 et seq.) of Title 54, or by a licensed physician.

2. "*Alcoholism or drug addiction facility*" means a facility in which is provided a State-approved program for the treatment of alcoholism or drug addiction and which is (i) a facility licensed by the State Board of Health pursuant to chapter 16 of Title 32 (§ 32-297 et seq.) or by the State Mental Health and Mental Retardation Board pursuant to chapter 8 (§ 37.1-179 et seq.) or chapter 11 (§ 37.1-203 et seq.) of Title 37.1; (ii) an office or clinic of a licensed physician or clinical psychologist; (iii) a State agency or institution or (iv) a facility accredited by the Joint Commission on Accreditation of Hospitals.

3. "*Intermediate care facility*" means a duly licensed, residential public or private alcoholism or drug addiction facility which is not a hospital and which is operated primarily for the purpose of providing a continuous, structured twenty-four-hour-a-day State-approved program of inpatient treatment and care for inpatient alcoholics or drug addicts.

B. No group accident and sickness insurance policy providing coverage on an expense incurred basis and no group service or indemnity type contract issued by a nonprofit corporation which provides coverage of a family member of the insured or the subscriber, shall be delivered or issued for delivery in this State on or after July one, nineteen hundred seventy-eight, unless coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs as hereinafter provided was made available as an option. Such coverage made available as

48.21.155 Washington Insurance Code

quently than annually after the two year period following the child's attainment of the limiting age. (1977 1st ex.s. c 80 § 32; 1969 ex.s. c 128 § 4.)

48.21.155 Coverage of dependent children to include newborn infants and congenital anomalies from moment of birth. Any group disability insurance contract except blanket disability insurance contract, providing hospital and medical expenses and health care services, renewed, delivered or issued for delivery in this state more than one hundred twenty days after February 16, 1974, which provides coverage for the dependent children of persons in the insured group, shall provide coverage for newborn infant children of persons in the insured group from and after the moment of birth. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth. (1974 1st ex.s. c 139 § 2.)

48.21.160 Alcoholism treatment benefits—Legislative declaration. The legislature recognizes that alcoholism is a disease and, as such, warrants the same attention from the health care industry as other similarly serious diseases warrant; the legislature further recognizes that only very infrequently do health insurance contracts and contracts for health care services include provisions providing benefits for the treatment of alcoholism. In order to assist the many citizens of this state who suffer from the disease of alcoholism, and who are presently effectively precluded from obtaining any medical assistance under the terms of their health insurance contract or health care service contract, the legislature hereby declares that provisions providing benefits for the treatment of alcoholism shall be included in new contracts and that "this 1974 act is necessary for the protection of the public health and safety. (1974 1st ex.s. c 119 § 1.)

*Reviser's note: "this 1974 act" (1974 1st ex.s. c 119) consists of RCW 48.21.160, 48.21.170, 48.21.180, 48.21.190 and 48.44.240.

48.21.170 Alcoholism treatment benefits—Provisions of contracts issued or renewed July 1, 1974-January 1, 1975. Each group disability insurance contract which is issued, or renewed, on or after July 1, 1974 and before January 1, 1975.

and which insures for hospital or medical care shall contain provisions providing benefits for the treatment of alcoholism rendered to the insured by alcoholism treatment facilities approved under RCW 70.96.092 and for the treatment of alcoholism rendered to the insured by an alcoholic treatment facility which is an "approved treatment facility" under RCW 70.96A.020(2). (1974 1st ex.s. c 119 § 2.)

48.21.180 Alcoholism treatment benefits—Provisions of contracts issued or renewed after January 1, 1975. Each group disability insurance contract which is issued, or renewed, on or after January 1, 1975 and which insures for hospital or medical care shall contain provisions providing benefits for the treatment of alcoholism rendered to the insured by an alcoholic treatment facility which is an "approved treatment facility" under RCW 70.96A.020(2). (1974 1st ex.s. c 119 § 3.)

48.21.190 Alcoholism treatment benefits—RCW 48.21.160—48.21.190, 48.44.240 inapplicable, when. RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to the renewal of a contract in force prior to the pertinent date provided for such contract under RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended where there exists a right of renewal on the part of the insured or subscriber without any change in any provision of the contract: *Provided further,* That RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to contracts which provide only accident coverage, nor to any contract written as supplemental coverage to any federal or state programs of health care including, but not limited to, Title XVIII health insurance for the aged (commonly referred to as Medicare, Parts A and B), and amendments thereto. (1975 1st ex.s. c 266 § 10; 1974 ex.s. c 119 § 5.)

48.21.200 Reduction or refusal of benefits on basis of other existing coverages. (1) No group disability insurance policy which provides benefits for hospital, medical, or surgical expenses shall be delivered or issued for delivery in this state after September 8, 1975 which contains any provision whereby



State of Wisconsin \ DEPARTMENT OF HEALTH & SOCIAL SERVICES

DIVISION OF COMMUNITY SERVICES
1 WEST WILSON STREET
MADISON, WISCONSIN 53703

October 6, 1977

TO: Directors, State Alcohol Authorities
Directors, Single State Drug Abuse Agencies

FROM: Larry W. Monson, ACSW, Director
Bureau of Alcohol and Other Drug Abuse

Re: INFORMATIONAL BULLETIN ON WISCONSIN INSURANCE COVERAGE FOR ALCOHOL AND
OTHER DRUG ABUSE

Attached is an informational bulletin prepared by our Insurance Commissioner's Office for distribution to health care providers in our State, regarding insurance coverage for alcohol and other drug abuse. We also have attached referenced sections of our State Statutes as noted on the last page of this brochure.

I though you might be interested in our insurance coverage for alcohol and other drug abuse, especially with the increased emphasis on collections via all sources of Third Party payments to generate program revenue.

If you have any questions or desire further information, please contact our Acting Chief of Program Operations and Management as follows:

Mr. Clifford Bertagnoli
Acting Chief, Program Operation and Management
Bureau of Alcohol and Other Drug Abuse
Room 523, 1 West Wilson Street
Madison, WI 53702
(608) 266-0907.

LW:brs

cc Carl Akins, Executive Director, NASDAPC
Riley Regan, Chairperson, CSTAA
Gus Hewlett, ADPA
William Butynski, Chairperson, ADPA
Joel Egertson, NIAAA
Louise Meister, NIDA

RECEIVED
OCT 21 1977

Office of Alcoholism & Drug Abuse

TITLE XLI.

Insurance Code.

CHAPTER 600

GENERAL PROVISIONS

600.01 Scope of application of code.
600.02 Interpretive rules.
600.03 Definitions, usages and synonyms.

600.12 Construction.
600.13 Orders relaxing restrictions.

600.01 Scope of application of code. (1) **GENERAL.** (a) The insurance code restricts otherwise legitimate business activity and what the code does not prohibit is authorized unless contrary to other provisions of the law of this state.

(b) Unless otherwise expressly provided, this code does not apply to:

1. Reinsurance.

2. Death and disability benefits provided by an organization the principal purpose of which is not to provide such benefits but charitable, educational, social or religious objectives not related thereto, if the organization does not incur a legal obligation to pay a specified amount.

3. Group or blanket insurance covering risks in this state if:

a. The policyholder exists primarily for purposes other than to procure insurance;

b. The policyholder is not a Wisconsin corporation or other resident and does not have its principal office in Wisconsin;

c. No more than 25% of the certificate holders or insureds are resident in this state;

d. On request of the commissioner, the insurer files with the commissioner a copy of the policy and a copy of each form of certificate; and

e. The insurer agrees to pay taxes on the Wisconsin portion of the business on the same basis it would do if authorized to do business in this state, and provides the commissioner with such security as the commissioner deems necessary for the payment of such taxes.

4. Group or blanket insurance covering risks mainly outside this state if:

a. The policyholder exists primarily for purposes other than to procure insurance;

b. The policyholder is not a Wisconsin corporation or other resident and does not have its principal office in Wisconsin; and

c. Any Wisconsin residents insured under the policy are covered because their principal place of employment is outside the state.

5. Other business specified in rules promulgated by the commissioner if the transaction of such business in this state does not require regulation for the protection of the interests of Wisconsin insureds or public or for which it would be impracticable to require compliance with this code, when necessary expenses and efforts are compared with the possible benefits.

6. Transactions independently procured through negotiations under s. 618.42, except as they are subject to taxation under s. 618.43.

(2) **EXCEPTIONS.** After a hearing, the commissioner may order an insurer to transfer the Wisconsin portion of the business under sub. (1) (b) 3 or 4 to an authorized insurer if it is written by an unauthorized one, or may subject any insurance under sub. (1) (b) to this code, if he finds that the foregoing conditions are not satisfied or that any circumstances require that the insurer be authorized to do business in this state or that the transactions be subject to this code in order to provide adequate protection to Wisconsin insureds and public. Coverage of a resident of this state is the doing of an insurance

(2) **PROOF OF INCAPACITY.** The insurer may require that proof of the incapacity and dependency be furnished by the person insured under the policy within 31 days of the date the child attains the limiting age, and at any time thereafter except that the insurer may not require proof more frequently than annually after the 2-year period immediately following attainment of the limiting age by the child.

History: 1975 c. 375.

632.89 Required coverage of alcoholism and other diseases. (1) **DEFINITIONS.** In this section:

(a) "Outpatient treatment facility" means a facility licensed or approved by the department of health and social services whose outpatient services meet the standards established in s. 51.42 (12) and which provides those services, except inpatient services, enumerated in s. 51.42 (5) (b) to (d) for the prevention and amelioration of mental disabilities, including but not limited to mental and nervous disorders, alcoholism and drug abuse.

(b) "Hospital" is a facility described in s. 140.24 (1) (a) and (c) which is licensed under s. 140.26 or is an approved public or private treatment facility for the treatment of alcoholics as defined in s. 51.45 (2) (b) and (c).

(c) "Physician" has the meaning designated in s. 990.01 (28).

(d) "Outpatient services" means services, medications, equipment and supplies performed or furnished by or under the supervision of or on referral from a physician at a hospital or outpatient treatment facility to a patient who is not a bed patient of the hospital or outpatient treatment facility.

(2) **REQUIRED COVERAGE FOR ALL INSURERS UNDER CHAPTERS 611 AND 613.** (a) **Scope.** Each group disability policy, joint contract or contract providing hospital treatment coverage shall include coverage for:

1. Inpatient hospital treatment of mental and nervous disorders, alcoholism and drug abuse.

(b) **Exclusions in coverage.** Except as provided in par. (c), coverages under pars. (a) and (d) may not be subject to exclusions or limitations which are not generally applicable to other conditions covered under the policy or contract.

(c) **Minimum confinement.** Coverages under par. (a) 1 may not provide less than 30 days' confinement in any calendar year.

(d) **Outpatient treatment.** Every contract or joint contract issued by an insurer subject to this section providing coverage for outpatient treatment shall provide coverage for outpatient services for mental and nervous disorders, alcoholism and drug abuse including but not

limited to partial hospitalization services, prescribed drugs and collateral interviews with patients' families, relating to diagnosed alcoholism, drug abuse, or mental and nervous disorders of the patient, in an amount not less than the first \$500 in any calendar year for any alcoholism or drug abuse services, or for outpatient services provided by or under contract for a board established under s. 51.42, and \$500 for any other outpatient services for mental and nervous disorders. No contract or joint contract written in combination with major medical coverage shall be required to provide coverage under this paragraph for more than \$500 for any combination of disabilities required to be covered under this paragraph. The department of health and social services may by rule promulgated under ch. 227 adjust this amount at 2-year intervals to reflect changes in the cost of medical care.

(3) **ADDITIONAL REQUIRED COVERAGE FOR CORPORATIONS SUBJECT TO CH. 613.** Any corporation subject to ch. 613 is subject to sub. (2) and in addition its group disability policies, joint contracts or contracts which provide for hospital treatment or outpatient treatment shall provide:

(a) Outpatient hospital treatment of alcoholism;

(b) Outpatient and home dialysis treatment for kidney disease and kidney transplantation expenses; and

(c) Protection for both recipient and donor of any transplant organs, as provided in s. 49.48 (3) (b).

(4) **AMOUNT OF PROTECTION FOR ORGANIZATIONS SUBJECT TO SUB. (3).** Coverage under sub. (3) (b) and (c), combined with coverage under s. 632.78 (2), shall not be less than \$30,000 annually.

(5) **MEDICARE EXCLUSION.** No insurer or other organization subject to this section is required to duplicate coverage available under the federal medicare program.

(6) **RULES.** The department of health and social services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under this section and s. 632.78 (2), which shall not be inconsistent with or less stringent than applicable federal standards.

History: 1975 c. 223, 224, 375.

632.90 Tuberculosis coverage. (1) No policy of disability insurance, whether under subch. II of ch. 40 or otherwise, may include hospital or medical expense coverage unless it contains a provision for a minimum 90 days' continuous coverage of costs for tuberculosis charges, fees or maintenance under ch. 50, including both inpatient care and outpatient dispensary charges or fees. This section applies

Original sponsor: Rules Committee
by Request

Offered: 4/18/78
Referred: Finance

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2

CS FOR SENATE BILL NO. 545

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

TENTH LEGISLATURE - SECOND SESSION

5

A BILL

6

For an Act entitled: "An Act relating to health insurance."

7

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

8

* Section 1. AS 21.89 is amended by adding a new section to read:

9

Sec. 21.89.050. ALCOHOLISM UNDER HEALTH INSURANCE. All policies,

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contracts or prepaid plans for individual or group health insurance with

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the exception of Medicare Supplement issued or delivered in the state on

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or after the effective date of this Act shall contain provisions pro-

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viding benefits for the treatment of alcoholism. This coverage may be

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waived in writing by a group policyholder on or before the effective

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date of the policy.

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BILL ANALYSIS

ASSIGNMENT DATE _____

UNASSIGNED _____

DEPARTMENT Commerce & Economic Development	SPONSOR (PRINCIPAL)	BILL NO. SB 545
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DEPARTMENT POSITION
Not opposed in principal, provided significant amendments are made.

DIVISION DIRECTOR Insurance	DATE 4/3/78	COMMISSIONER H. Phillip Hubbard	DATE
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GOVERNOR'S OFFICE USE

POSITION NOTED POSITION APPROVED POSITION DISAPPROVED

BY: _____ DATE: _____

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)
A whole series of bills concerning alcoholism.

(2) a. ORGANIZATIONAL SUPPORT FOR BILL Uncertain	(2) b. ORGANIZATIONAL OPPOSITION TO BILL Uncertain
---	---

(3) PROGRAM EFFECTS OF BILL
None

(4) FISCAL IMPACT: NONE FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:
See Attached.

(6) COMMENTS:
See Attached.

The thrust of the bill is to require that insurance companies providing indemnity against medical expense and health care contractors, such as Blue Cross or HMO's and other prepaid health programs, provide coverage for medical treatment of alcoholism to the same extent it would provide medical treatment for any other disease.

The Division of Insurance does not basically oppose the concept, but, as drafted, SB 545 presents substantial problems of interpretation when approving policies.

A primary concern would be the coverage for pre-existing conditions. Currently, under the terms of most insurance policies, medical coverage is either limited or not provided for pre-existing medical conditions. Particularly in group policies, which are renewed annually, it is unlikely that anyone would become an alcoholic within the short period of time of an annual policy. Therefore, alcoholism will almost always be a pre-existing condition, and, thus, not covered under the current health insurance coverages. Yet, this is not the result which, I am sure, is intended by the drafters of the section.

Secondly, there is a wide variety of treatment for alcoholism ranging from simply "drying out" the alcoholic so that he is removed from his state of inebriation, but not really cured of his alcoholism, to carefully pre-planned programs of medical and psychological treatment to cure the alcoholic of his desire for drink.

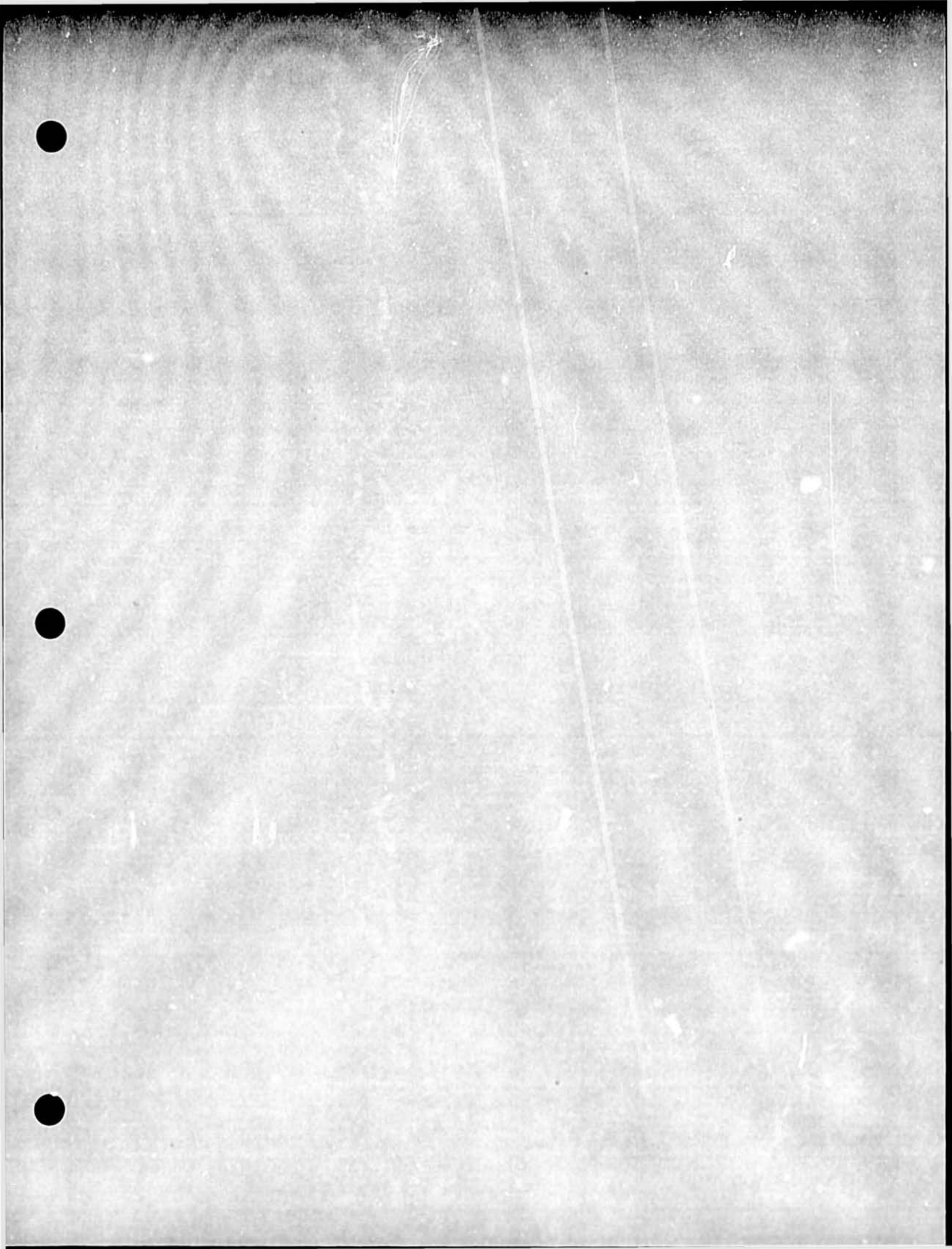
The latter, of course, is what is intended by the drafters to be covered under the health insurance policies, but it is not clear whether it is intended that "drying out" should also be covered. The Division of Insurance could not sanction any insurance policy covering the "drying out" process, since it does not tend toward rehabilitation, but only making "first aid" changes in the individual without making any effort to address the underlying problem.

Finally, the question of cost has to be considered. With respect to group programs it may be the intent of the Legislature to establish, as a matter of public policy, that group sponsors incur the cost of providing additional coverage for alcoholic rehabilitation, but to the extent that there is contribution to the cost of medical insurance by the employee or member of the group, it is imposing this burden on a large segment of society for the benefit of the few who would have the opportunity to take advantage of the coverage. The division would not particularly oppose this aspect of the bill so long as it is clearly understood by the Legislature that it would have this impact.

If it is desired that the legislation have such an economic impact, then it must consider whether it is going to permit, or prohibit, waivers of alcoholic coverage by individual members of the group.

The division believes that the bill will need substantial redrafting before it would accomplish the desired results, but having some understanding of the results that are anticipated, the Division of Insurance believes that the fundamental objective of the bill is worthy of support.

RLB/mh/2/4



HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO · NEW YORK · WASHINGTON

LESLIE P. HENRY, *President*

LEGAL DEPARTMENT

John P. Hanna, *Senior Vice President and General Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604

(312) 939-0801

March 29, 1976

The Honorable Richard L. Block
Director of Insurance
State of Alaska
Pouch "D"
Juneau, Alaska 99811

RECEIVED
DIV. OF INS. & LIC. REG.
APR 14 2 55 PM '76
ALASKA DEPT. OF
COMMERCE & ECONOMIC
DEVELOPMENT

Re: Alaska H. B. 190 - Alcoholism and Drug Addiction Coverage

Dear Director Block:

I appreciate very much receiving your letter of March 5, 1976 concerning H. B. 792.

There is another bill now in the Alaska legislature that I am very much concerned about. H. B. 190 would require all group and blanket disability insurance policies that provide benefits for hospital expenses due to an illness or injury also to include coverage for the treatment of alcoholism or drug addiction as an illness, would further require that coverage be furnished for treatment in certain facilities other than general hospitals.

To begin with I would like to say that we generally oppose legislation mandating particular health insurance coverages. We don't think that a legislature should decide for insurers and their policyholders what insurance coverage should be included in health insurance policies, for a number of reasons including the following:

1. Health insurance laws have not historically mandated particular coverages. Once they begin to do so, there is no logical place to stop, until absolutely every health care cost must be covered. Most people cannot afford to pay for coverage for all such costs.
2. The mandated coverages are not the ones most needed by most people. People should first have adequate coverage for hospital, medical, and surgical expenses for injuries and sicknesses in general, before they should think of buying coverages for particular conditions or for particular types of services. Since budgets of individuals and employers are limited, only a certain amount of money is reasonably available for health insurance.

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March 29, 1976

(2)

To the extent the legislature mandates coverages for particular conditions or services, it forces the policyholder to reduce the amount of money available for more needed general coverages. The legislature cannot possibly know what coverages a particular individual's or employer's money should be spent for.

3. Most bills that would mandate particular coverages seek to require a coverage that is already available from insurers. If people have not chosen to buy an available coverage, there must be some good reason that they have not. In such cases, the legislature would, in effect, be saying: even though policyholders choose not to buy the particular coverage, the legislature knows better what is good for them and will force them to do what they choose not to do themselves. Where coverage is not available, it is normally because the risk is not an insurable one or is not insurable at a reasonable price.

4. Mandating particular coverages in employer-employee group policies interferes with the collective bargaining process.

5. Bills that would mandate a particular coverage are often drafted in a way that ignores necessary fundamentals of insurance and prevents an insurer from designing the coverage properly. Different coverages may very well need to be designed differently if they are to operate properly and avoid costly abuses.

All of the above comments apply to H. B. 190.

Group insurance coverage is already available to provide benefits for the treatment of alcoholism and drug addiction. Those group policyholders which want such coverage, and can afford it, can secure it from a substantial number of insurance companies. H. B. 190 could be interpreted as requiring the same coverage for these two conditions as is provided for other illnesses. That would be wrong, because these conditions require different treatment from illnesses in general, and coverage specifically for alcoholism or drug addiction must be designed differently to meet special requirements.

Alcoholism is a peculiar thing. No one knows what causes it. There is no cure for it. There is no known medical treatment that is very successful. The only known treatment with any consistent success is what is done by Alcoholics Anonymous, and what Alcoholics Anonymous does is not coverable under a health insurance policy. The only known way to prevent the symptoms of alcoholism from recurring is for the individual to develop enough willpower so that he never takes another drink.

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(3)

All medical and psychological treatment for alcoholism should at the current status of our medical knowledge, be considered as experimental. Likewise insurance coverages for any such treatment must be regarded as experimental. Insurers should be left free by the legislature to do the necessary experimenting.

Much of what I have just said about the treatment of alcoholism also applies to the treatment of drug addiction. The only known cure is for the individual to develop enough willpower to stop taking drugs. Treatment should be regarded as experimental. Insurance companies should likewise be left free to experiment with coverages for the treatment of drug addiction.

The cost of coverage for the treatment of alcoholism and drug addiction can be substantial. In connection with an almost identical Alaska bill (S. B. 35 of the 1973 session) which would only have mandated coverage for the treatment of alcoholism, Aetna Life and Casualty Company, in its letter of March 21, 1973 to Director O'Shea, estimated that for a typical group of 150 members, the mandated alcoholism coverage would increase the premium rate on the order of 9 to 14%. Adding drug addiction coverage would of course make that figure larger. H. B. 190 contains a number of defects. I will list the more important ones that occur to me.

1. It should not apply to blanket insurance. Blanket insurance is usually accident only coverage. It would seem unwise for the legislators to turn accident only policies into policies which have to cover two types of sicknesses. Those blanket insurance policies which provide coverage for both injuries and sicknesses are mostly policies issued to schools to cover school children or university students. They are generally tailor made for the particular type of institution and the medical facilities that that institution has. Those policies should not be altered by a legislative requirement that is general in nature and is not tailored to the particular institution and its facilities.
2. The bill would also apply to group accident only policies or to group policies that are designed to cover only a specified disease or a few specified diseases (e. g. a cancer policy or a dread disease policy). Such policies should not by legislation be turned into something they were never designed to be.
3. The reference to any "other licensed treatment facility" is most troublesome. Before we can provide coverage for care or treatment in a given facility we have to know what that facility is and what it does. We should not be asked to extend coverages to any facility just because it is licensed. Some states do not have standards for licensing of alcoholism or drug addiction treatment facilities, so that the reference in the bill to state would not

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(4)

give us the controls needed in trying to provide coverage for treatment in such institutions.

4. The bill does not appear to give us the freedom we need to design benefits specifically tailored to the available types of treatment for alcoholism and drug addiction and to the facilities in which that treatment is given.

5. The bill could be interpreted as applying to previously issued policies, which may be unconstitutional as impairing the obligation of contract, and which would interfere with existing collective bargaining agreements.

6. The bill does not allow sufficient lead time to prepare and secure approval of the necessary policy forms.

The employer-employee programs dealing with alcoholism, that have experienced some degree of success, are programs that involve much more than just health insurance coverage. Generally they consist of an employee education program, a medical staff that becomes involved in early detection and in following up after formal treatment ends, an arrangement with a hospital or other facility which has a specific program for the treatment of alcoholism, and an arrangement to work with Alcoholics Anonymous. Only larger employers can afford such a costly program. The legislature should not force smaller and medium sized employers to pay for an elaborate program, nor for just the insurance portion of a program which, to be successful, requires much more.

We hope that you will join us in trying to convince the legislature that it should not adopt H. B. 190.

Sincerely,

Charles D. Kuhnen/RT

Charles D. Kuhnen
Counsel

CDK:rt



HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO NEW YORK WASHINGTON

LEGAL DEPARTMENT
Charles D. Kuhnen, Counsel

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

April 11, 1978

RECEIVED
DIV. OF INSURANCE
APR 14 2 51 PM '78
ALASKA DEPT. OF
COMMERCE & ECONOMIC
DEVELOPMENT

Honorable Richard L. Block
Director of Insurance
State of Alaska
Pouch "D"
Juneau, Alaska 99811

Re: Alaska S. B. 545 - Alcoholism Coverage (Hearing Scheduled for
April 17, 1978)

Dear Director Block:

We hope that your legislature will this year as it has in the past, resist efforts to pass a law which would mandate the inclusion of alcoholism coverage in disability (health) insurance policies.

Senate Bill 545 would require group and individual "health" insurance policies to provide that alcoholism is an illness, and to include benefits for the treatment of alcoholism that are not less than those "for any other illness". In the case of an individual health insurance policy, the alcoholism coverage could be "waived" in writing by the policyholder on or before the effective date of the policy.

My letter to you of March 29, 1976 on H. B. 190 (a copy is attached to this letter) indicates why we oppose mandating particular health insurance coverages, why alcoholism coverage in particular should not be mandated, and what the additional cost to policyholders for alcoholism coverage has been estimated to be (9% to 14% increase in premiums for group insurance).

If the State really wants to do something to help alcoholics, tampering with insurance company experiments to provide effective alcoholism coverage is not the route to take. What the State should do is appropriate some money to: (1) encourage alcoholics and their families to use Alcoholics Anonymous and Alanon, and (2) inform employers of the advantages of having a well-designed program for early detection, treatment, and follow-up as to

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(2)

employees and family members who are, or are becoming alcoholics. If the latter included assistance for small employers in the form of money or services, so much the better.

Glowing reports of highly successful medical treatment of alcoholism for the employees of an employer are also highly suspect if the employer does not have a well-rounded program of early detection, etc., and if Alcoholics Anonymous is not involved. Those that I have checked do not have credible statistics. Likewise, reports of extremely low costs for insurance coverage probably indicate a program that is used so little that it should be classified as having little effect, e.g. the California program of two years ago for State employees and their dependents.

The following additional comments apply to S.B. 545.

- (1) Insurance benefits for the treatment of alcoholism should not be the same as for physical sicknesses. They should be different because the kinds of treatment are different. They should be small enough to encourage the patient to try to help himself. Some of the experts in alcoholism treatment have warned us not to make the insurance benefits too high.
- (2) To require insurance policies to contain a provision that says alcoholism is an illness would be a waste of words and money. I have never seen a policy which says this, so companies would have to revise their policy forms - even those which already cover alcoholism. We agree that alcoholism is a type of sickness. To say so in the policy won't change anything. Almost all policies do not cover some sicknesses and some injuries.
- (3) In Alaska the correct statutory term for health insurance is "disability insurance", which includes all types of health insurance, e.g. accidental death, loss of time, hospital expense, dental expense, specified disease (such as policies covering only cancer expense), etc. See AS 21.12.050 (disability insurance defined), AS 21.51 (disability insurance policies). "Health" insurance is not distinguished from accident insurance either in your laws or in industry usage. Therefore, S.B. 545 as written either has no proper statutory meaning or it includes types of policies which should not provide alcoholism expense coverage, e.g. accident only policies, loss of time policies, cancer policies, dental policies, etc.

- (4) The bill appears to try to apply to Blue Cross-Blue Shield ("prepaid plans"), but cannot do so without using the proper statutory language (see AS 21.87) and without amending AS 21.87 (see AS 21.87.030). The bill should apply to the competitors of health insurers if it is to apply to health insurers.
- (5) The words "issued or delivered" on line 11 are incorrect. The correct wording would be "delivered or issued for delivery". See, e.g. AS 21.51.020.
- (6) The idea of coverage being "waived" is awkward. An applicant for a policy indicates what coverage he wants on an application form. Would there have to be a separate document called a "waiver", or would all application forms have to be redrafted to contain "waiver" language? Why is the individual given the right to "waive" coverage at any time "on or before the effective date of the policy"?
- (7) The bill does not allow any lead time for insurers to prepare and secure approval of policy forms, or to change their procedures in regard to the coverages affected by the bill.

Some 18 states have some kind of law concerning health insurance coverage for alcoholism. Most affect only group insurance. Some don't specify any particular benefits, but those that do normally have a rather limited benefit. These laws differ from one another, which is wasteful in cost and provides more than enough experimentation. Enclosed is a list of states with such laws, which list the Alaska legislative staff asked for and received from us.

Properly designed alcoholism coverage is readily available in group health insurance from a large number of companies. There is no need to require the companies that don't know how to write this coverage to do so anyway. And it is undesirable to require all groups to purchase this coverage whether they want it or not.

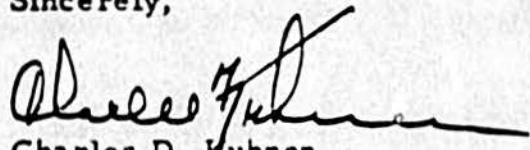
As to individual health insurance policies, I do not have an HIAA survey on what companies are writing in the way of alcoholism coverage. From talking to some companies, I have the impression that most companies cover alcoholism treatment in a general hospital. A few companies are experimenting with out-of-hospital alcoholism treatment coverage under individual policies. I think

Honorable Richard L. Block
April 11, 1978

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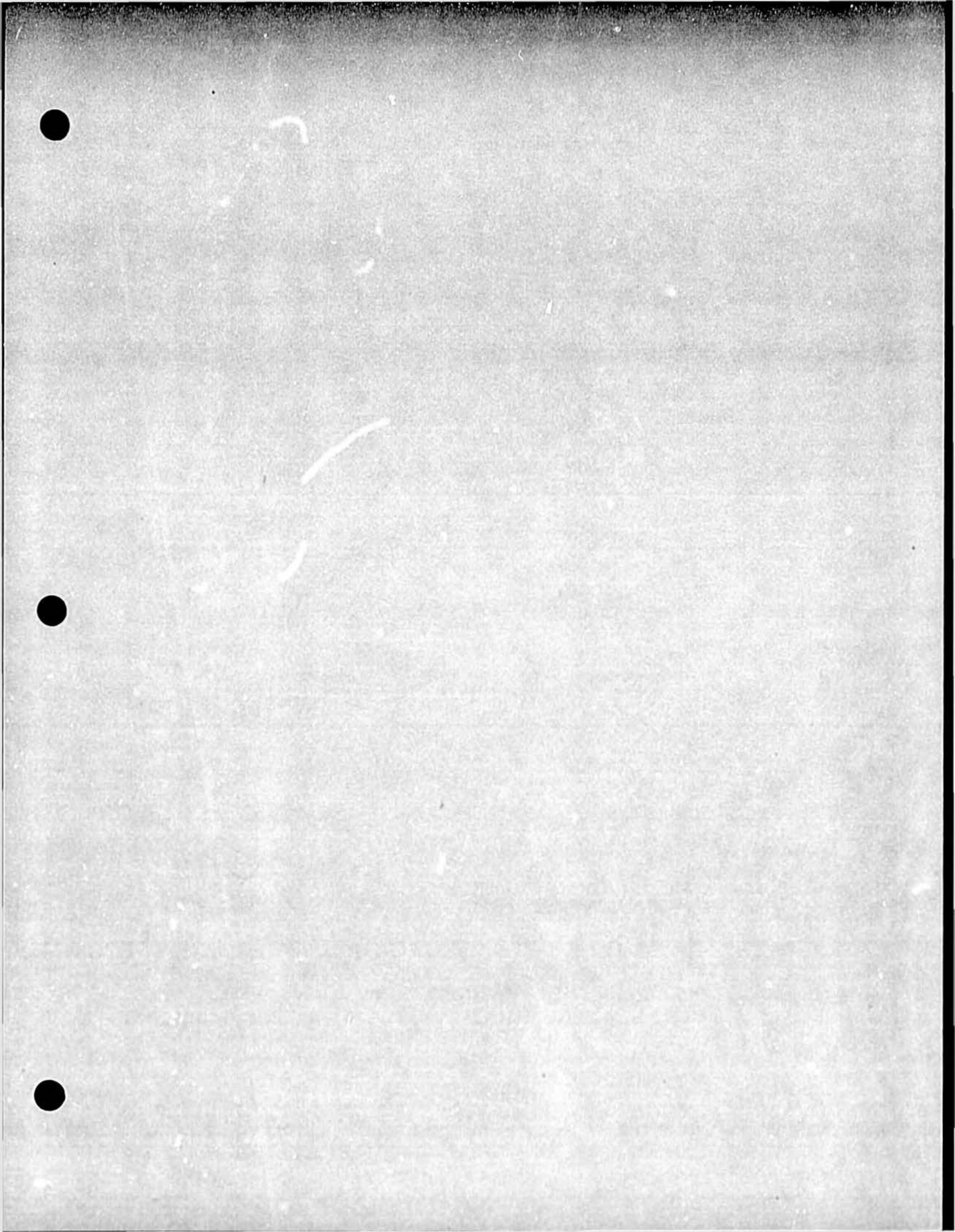
it would be unwise to require any company to cover what it is not now willing, ready, and able to cover. Companies may be so wary of the risks involved that the requirement becomes counterproductive.

Sincerely,



Charles D. Kuhn
Counsel

CDK:rt
Enclosure





15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361 3000

April 17, 1978

Senator Glenn Hackney, Chairman
Senate Health, Education & Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

I would like to take this opportunity to commend the actions of the committee which studied the alcoholism problems in Alaska and drafted this package of legislation to answer those problems. Blue Cross of Washington and Alaska is particularly interested in one bill in that package, Senate Bill 545. Blue Cross supports the intent of this bill.

The intent, as I understand it, in this legislation is to provide the best benefits available for as many Alaskans as possible for the treatment of alcoholism. To reach that goal you need contracts which provide coverage which is affordable. Otherwise groups will not buy insurance either because it contains benefits the group does not want or the cost is too high.

Two major issues, the level of benefits provided and the cost of the coverage, are the items of negotiation between the insurer and the purchaser. To legislate away those items of negotiation will result in instances where no coverage will be afforded to some groups because the employer either will not buy the standardized coverage or cannot afford to buy it.

This is particularly true when you are dealing with alcoholism coverage. An estimate of the costs of coverage which you would mandate are not readily available because we have no experience on which to determine rates. We do not have the data which would enable us to project rates for increased coverage. We only know that alcoholism treatment is one of the most expensive components in our package. And increasing alcoholism treatment will increase cost by a percentage we cannot predict.

In Senate Bill 545, you mandate that the benefit for alcoholism may not be less than for any other illness.

At the present time, there are approximately 280 group contracts for Blue Cross coverage in Alaska. While those contracts are all similar, they do vary in individual provisions. Those contracts do not treat all illnesses in an identical fashion. To specify that alcoholism treatment "may not be less than for any other illness" is not a definitive explanation for our

Page Two
April 17, 1978

purposes, since benefits for specific illnesses may vary from contract to contract.

The therapeutic treatment of the physical effects of alcoholism is now covered in all contracts unless a purchaser specifically deletes coverage for alcoholism. And that does happen. Some purchasers represent groups characterized by membership in a church where there is a religious prohibition on the use of alcohol. Those purchasers want the right to waive that coverage. It is one of the items which is negotiated between the insurer and the purchaser.

In most contracts there is an additional benefit which pays for a limited amount of treatment in an approved alcoholism facility. Let me explain the difference. The Alaskan who is admitted for treatment at Providence Hospital or at Valley Hospital will have complete coverage. The same is true if he is referred to and treated at Shadel Hospital, Riverton Hospital or Alcenias in the State of Washington. In all of those instances the person is a patient at a contracting hospital and is receiving medical care. Other programs are offered which go beyond medical care. These are programs which provide treatment for the mental aspects of alcoholism. Blue Cross pays for this treatment in the same manner as the treatment of any other mental illness.

Blue Cross insures the subscriber for the costs of medical and dental care. The group policyholder has the ability to purchase varying benefit packages. That becomes a major factor in both employee relations and business expenses. It is a factor which must be retained.

Since it is the intent of this Legislature to provide additional opportunities for treatment of alcoholism, I urge you to seriously consider this revised language.

Section 1. AS 21.89 is amended by adding a new section to read:

Sec. 21.89.050. ALCOHOLISM UNDER HEALTH INSURANCE. All policies, contracts or prepaid plans for individual or group health insurance with the exception of Medicare Supplement issued or delivered in the state on or after the effective date of this Act shall contain provisions providing benefits for the treatment of alcoholism. This coverage may be waived in writing by a group policyholder on or before the effective date of the policy.

This language will mandate that every employer include a benefit for alcoholism treatment. It provides an option for waiver of entire groups. It does not include a waiver on individual policies, which was included in your original bill. Blue Cross has very specific business reasons for asking you to make that change. If every non-group subscriber could opt to delete alcoholism coverage, the costs of administering the program would increase. We estimate that the administrative cost would nearly equal the coverage cost for alcoholism benefits now offered. The option

Page Three
April 17, 1978

would not save the subscriber money. The option would, however, increase the likelihood of error in payment. If you want complete coverage of all contracts, then no language of waiver should be included. While this will be a factor in a few marketing instances, Blue Cross will not be opposed if, in the interests of maximum coverage, you decide to delete the waiver provisions.

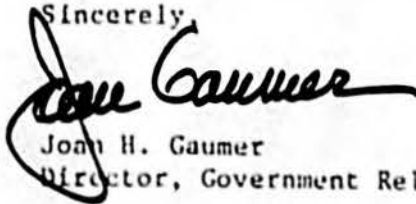
If the Alaskan statutes require the provision of benefits, there will be increased availability of treatment. And yet you will have preserved the right of the employee and employee groups to bargain for benefits. You will have preserved the right of an employer to structure benefits offered to the costs allowable in his business.

Any other course can result in costs for health care insurance which cannot be met. When that happens, more and more persons or groups "go bare", with no coverage. And the final result is that more persons become the responsibility of the state under Medicaid.

I urge your support of the Blue Cross language.

Thank you.

Sincerely,



Joan H. Gaumer
Director, Government Relations

JHG:kg

cc: Bill Sumner
Patrick Rodey
Edward C. Willis
W. E. Bradley

ROBERTSON, MONAGLE, EASTAUGH & BRADLEY

A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

200 NATIONAL BANK OF ALASKA BUILDING

PHONE (907) 586-3340

CABLE: ROMEA

TELEX: 099-45-376

P O BOX 1211

JUNEAU, ALASKA 99802

ANCHORAGE OFFICE

310 THE FINANCIAL PLAZA

P O BOX 679

ANCHORAGE, ALASKA 99510

PHONE (907) 277-6693

TELEX: 090-29-496

R. E. ROBERTSON (985-1381)

F. O. EASTAUGH

J. S. BRADLEY

W. G. HUDDY

L. B. JACOBSON

R. B. BAKER (ANCHORAGE)

M. T. THOMAS

L. J. BARKER (ANCHORAGE)

J. F. CLARA

R. M. HOFFMAN

J. R. TANGEN

L. G. BERRY (ANCHORAGE)

C. R. RICH (ANCHORAGE)

D. A. HOLBROOK

J. D. MILLER (ANCHORAGE)

T. A. SOFO

W. R. HULEN (ANCHORAGE)

D. E. CUADRA (ANCHORAGE)

OF COUNSEL

M. E. MONAGLE

April 18, 1978

RECEIVED
STATE OF ALASKA

APR 18 1978

DEPARTMENT OF COMMERCE
& ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE

The Honorable Richard L. Block
Director, Division of Insurance
Department of Commerce and
Economic Development
Pouch D
Juneau, Alaska 99811

Re: S. B. 545

Dear Director Block:

Enclosed is a draft of language which the American Council of Life Insurance plans to propose as a substitute for the present language of HB 545. We believe that it is much more accurate in form and predictable in effect than the present language, but would accomplish the intended objections of the bill. I would be glad to discuss it with you at your convenience.

Very truly yours,



M. T. Thomas

cc: Robert Cole
Office of Alcoholism
& Drug Abuse

SUBSTITUTE LANGUAGE FOR ALASKA S.B. 545

Section 1. The purpose of this Act is to encourage consumers to avail themselves, of basic levels of benefits under disability insurance policies and subscriber's contracts for the care and treatment of alcoholism, and to preserve the rights of the consumer to select such coverage according to his medical-economic needs.

Section 2. AS 21.89 is amended by adding a new section to read:

Sec. 21.89.050. AVAILABILITY OF COVERAGE FOR ALCOHOLISM.

(a) Insurers and nonprofit hospital or medical service corporations transacting disability insurance in this State shall make available under hospital and major medical expense incurred insurance policies and under hospital and medical subscriber's contracts the level of benefits specified herein for the necessary care and treatment of alcoholism, subject to the right of the applicant for the group or individual policy or contract to reject the coverage or to select any alternative level of benefits as may be offered by the insurer or service corporation.

(1) Under basic hospital policies or contracts, inpatient hospital benefits consisting of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that benefits may be limited to not less than 30 days per confinement as defined in the policy or contract.

(2) Under major medical policies or contracts, inpatient hospital benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that:

(i) Inpatient hospital benefits may be limited to not less than 30 days per confinement as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days of confinement, the durational limits, dollar limits, deductibles and coinsurance factors applicable thereto need not be the same as applicable to physical illness generally.

(ii) As to outpatient benefits, the coinsurance factor may not exceed 50% or the coinsurance factor applicable for physical illness generally, whichever is greater, and the maximum benefit for alcoholism in the aggregate during any applicable benefit period may be limited to not less than \$500.

(iii) Maximum lifetime benefit limits may be no less than an amount equal to the lesser of \$5,000 or 12-1/2% of the lifetime policy limit.

(b) For purposes of this section, the following terms shall have the meanings indicated below.

(1) "Inpatient hospital benefits" means only those payable for charges made by a hospital, as defined in the policy or contract, for the necessary care and treatment of alcoholism furnished to a covered person while confined as a hospital inpatient; and with respect to major medical policies or contracts, also includes those payable for charges made by a physician, as defined in the policy or contract, for the necessary care and treatment of alcoholism furnished to a covered person while confined as a hospital inpatient.

(2) "Outpatient benefits" means only those payable for 1) charges made by a hospital for the necessary care and treatment of alcoholism furnished to a covered person while not confined as a hospital inpatient, and 2) charges for services rendered or prescribed by a physician for the necessary care and treatment for alcoholism furnished to a covered person while not confined as a hospital inpatient.

Section 3. AS 21.87.340 is amended by adding a new paragraph to read:

(17) AS 21.89.050

Section 4. APPLICABILITY. This Act shall apply to policies or contracts delivered or issued for delivery in this State more than 180 days after the effective date of this Act; but shall not apply to blanket, short term travel, accident only, limited or specified disease, individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under State or Federal governmental plans.

A BRIEF HISTORY OF MAJOR ALCOHOLISM LEGISLATION
PROPOSED DURING THE TENTH ALASKA STATE LEGISLATURE

During the first session of the Tenth Alaska State Legislature, early in 1977, Governor Hammond developed legislation dealing with the problem of alcoholism in the State of Alaska. When portions of this proposed legislation, which later became known as the "Governor's Alcohol Package," reached the Senate side of the Legislature, several Senators felt that some questions should be answered before they took any action. The Senate Special Committee on Alcoholism and Alcohol Related Legislation was formed, and Senator Mike Colletta was appointed chairman of this committee. The other committee members were Senators Ziegler, Ray, Hackney and Ferguson. Representative Lethin was appointed as House liaison member. During the life of this special committee, 36 hearings were held in 31 communities. During the hearings four areas were consistently labeled as major problems and were discussed by the participants of the meetings. These were: Prevention and Education, Alternatives to Drinking/Treatment, Local Options and Enforcement. After the first round of hearings the committee solicited specific comments from over 2500 people. From the testimony at those hearings and the written comments the committee received, thirteen bills were developed and proposed to the Legislature during the second session. Below I have listed the bills in the Governor's package and the bills developed through the Special Committee. I have also listed what the status of each of those bills were at the end of the second session, Tenth Alaska State Legislature.

- SB76 "An act providing a method of adjusting certain tax rates."
(Died in (S) State Affairs Committee.)
- HB196 "An act relating to the excise tax on, and licence fees for, sale of intoxicating liquors." (Died in (H) Finance Committee.)
- HB232 "An act relating to Municipale Sales tax." (Died in (H) Community and Regional Affairs Committee.)
- HB240 "An act relating to Alcoholic Beverages." (Died in (H) Judiciary Committee.)
- SB167 [HCSCSSB167amH] "An act relating to the excise tax on and license fees for sale of intoxicating liquors." (Died in (H) Rules Committee.)
- HB340 "An act relating to the treatment of alcoholism and drug abuse." (Died in (H) Health, Education and Social Services Comm'ttee.)
- SB540 "An act making a special appropriation to the office of alcoholism in the Department of Health and Social Services for the prevention and treatment of alcoholism and alcohol abuse. (Died in (S) Finance Committee.)
- SB541 [SB541am] "An act relating to alcohol and drug abuse education in public schools." (Signed into law; July 22, 1978)
- SB542 [CSSB542amH] "An act adding to the powers and duties of the office of alcoholism." (Signed into law; July 22, 1978)
- SB543 [CSSB543amH] "An act relating to alcoholism grants-in-aid." (Signed into law; July 22, 1978)

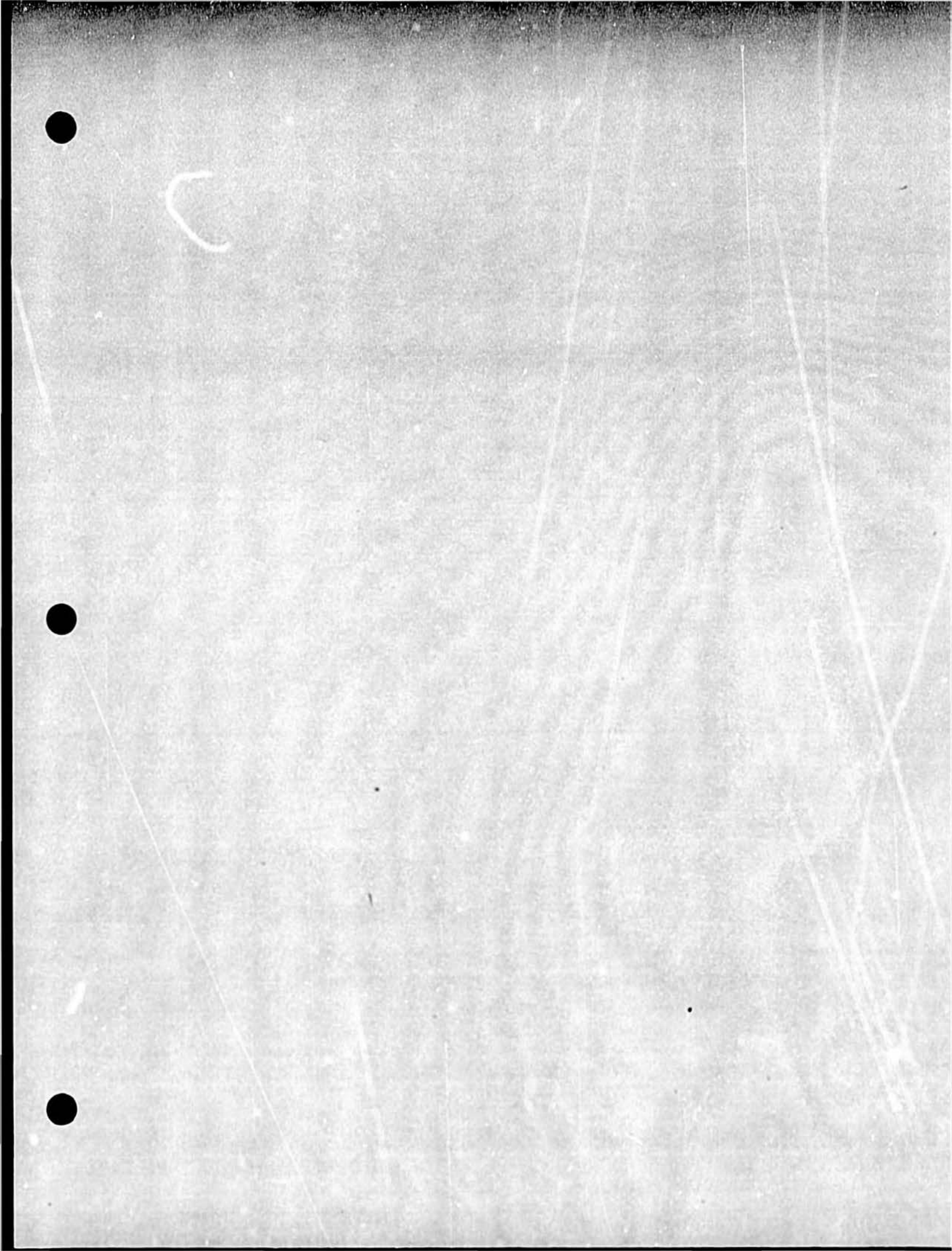
- SB544 [CSSB544am] "An act relating to standards for alcoholism treatment facilities." (Signed into law; July 22, 1978)
- SB545 "An act relating to health insurance." (Died in (S) Finance Committee.)
- SB546 [SB546amH] "An act establishing a tax credit for contributions to alcoholism programs." (Failed on the (H) floor.)
- SB547 [SB547am] "An act making a special appropriation to the Department of Revenue to increase the number of enforcement personnel employed by the ABC Board." (Signed into law, July 22, 1978 - Governor reduced appropriation by \$50,000.)
- SB548 [CSSB548am] "An act relating to waiter and waitress permits." (Failed on the (S) floor.)
- SB549 "An act relating to the serving of intoxicating liquor." (Died in (S) Health, Education and Social Services Committee.)
- SB550 "An act relating to administration and enforcement of Alcoholic Beverage Control statutes and regulations." (Died in (S) Commerce Committee.)
- SB551 "An act relating to the rehabilitation of persons who commit criminal offences as a result of alcohol problems." (Died in (S) Health, Education, and Social Services Committee.)
- SB552 [FCCSHCSSB552] "An act relating to alcohol." (Signed into law, July 22, 1978.)

Key to Bill Titles

SB	Senate Bill
HB	House Bill
CS	Committee Substitute
HCS	House Committee Substitute
SCS	Senate Committee Substitute
FCCS	Free Conference Committee Substitute
am	Amended on the floor of the House of origin
amH	Amended on the floor of the House of Representatives
amS	Amended on the floor of the Senate

Below is an example of how the bill title symbols are read.

[CSSB542amH] Committee Substitute for Senate Bill 542 as amended on the floor of the House.



Liquor

SUMMARY OF THE GOVERNOR'S

ALCOHOL BILLS

SB 76

Adjusting tax rates. ((S) State Affairs, then C&RA, then Fin.)
Status date: 1/25/77

Directs the Commissioner of Revenue to adjust the alcohol taxes to bring them in line with changes in the consumer price index for the previous year. The legislature had the right to disapprove the changes by a Resolution of the majority of each house.

CS HB 196

Excise tax and license fees on sale of Alcohol. ((H) Fin. &
HCS CS SB 167 Ret. (H) Rules)
Status date: 4/19/77 & 5/28/77

A conservative estimate is that alcohol abuse cost the state over \$17 million last year. Alcohol excise taxes generated only \$7 million. This bill attempts to make up the difference.

General Wholesale License Holders:

- * may not sell to a consumer.
- * may sell liquor in the original package and wine in bulk quantities of not less than 5 gallons to license holders.
- * Internal revenue strip stamps shall be on all liquor packages requiring them.
- * A general wholesale license shall be required for each distributing point.
- * The general wholesale license fee schedule is based upon the total amount of business transacted during any year. The minimum fee is \$500 up to \$50,000 with fee increases adjusted upward to reflect greater volume of business.

Malt beverage and wine license holders fall under the same constraints as holders of general wholesale license holders. There is a \$100 minimum fee up to the first \$10,000 of business transacted with fee escalations for greater volume of business.

Studies have said that a price rise far higher than this would be necessary to significantly reduce alcohol sales.

Retail License Holders:

- * may sell liquors in original packages and wine in bulk.
- * Internal revenue stamps strips shall be on packages of liquor requiring them.

- * Consumption of liquor on premises prohibited.
- * Sales are limited to less than 20 wine gallons to any one person in any sale.
- * The license fee is raised from \$600 to \$1,000.

For retail liquor stores whose gross sales do not exceed \$20,000 per year the fee is \$300.

HB 232

Municipal sales tax; alcohol. ((H) C&RA, then Fin.)
Status date: 2/18/77

Municipalities:

- * may regulate by ordinance barter, sale and possession of alcohol.
- * When a community votes to become "dry" they may by ordinance make sale of alcohol a misdemeanor.
- * Municipal taxes may include only property taxes on liquor inventories and sales taxes.

Boroughs:

- * may levy and collect a higher sales tax on liquor than other commodities.

This is aimed at encouraging local treatment and compensating local governments for their alcohol-caused expenses.

HB 240

Alcoholic beverages; licenses. ((H) Jud, then Fin &
SB 183 (S) C&RA, then Fin.)
Status date: 2/21/77 & 3/17/78

These two bills are identical.

The Director of the ABC Board who is appointed by the Governor is no longer subject to confirmation by the legislature.

- * Shall enforce regulations adopted by the board.
- * Although the Director is not a member of the board, he may cast a tie-breaking vote.
- * The Director shall issue all licenses under Title 4.

Voters have the option of completely restricting sale of alcohol and banning shipment of mail or telephone ordered alcohol.

Dry Communities: Should a town vote itself dry (no type of liquor store) or if a town has already voted dry, the following things will happen:

- * Communities which limit liquor sales should not have to pay the penalty of lost sales tax revenue. Communities which are presumed dry should have the benefit of more effective alcohol law enforcement. Therefore, the state will pay each voted dry community \$10 per resident.
- * In order to reduce bootlegging, no person in a dry community will be allowed to possess more than the equivalent of a case of fifths of liquor and 4.5 gallons of wine and beer.
- * Sale in violation of local option (bootlegging) will be punished as a felony with a maximum sentence of six years and a fine of \$30,000 (up from one year and \$5,000) It is thought that the present penalties are so low as to be an acceptable cost of doing business to bootleggers some of whom make up to \$100,000 a year.
- * As a further deterrent to bootleggers using automobiles, aircraft or boats, the state may seize a vehicle used in bootlegging activities. Upon conviction of the offender the court may order the conveyance transferred to the community where the offence took place, or to the state. Owners of common carriers having no knowledge of the illegal transaction and mortgage or lien holders will be protected.

HCS CS SB 167 Excise tax and license fees on sale of alcohol. (Ret. (H) Rules)
Status date: 5/28/77

This bill is the same as HB 196 but also provides that all malt beverages (1% or more by volume) wines and hard or distilled liquors are subject to the following taxes:

- 1) malt beverages - 25 cents a gallon or fraction of a gallon.
- 2) wines or other liquor of less than 14% (lowered from 21%) - the tax rate is raised 40 cents (from 60 cents to a dollar) per gallon or fraction of a gallon.

- 3) liquors of more than 21% increases \$1 (from \$4 to \$5)
- 4) wine or liquor of 14% but not more than 21% is taxed at \$1.35 a gallon or fraction of a gallon.

Beverage Dispensary License Holders:

- * may sell alcoholic beverages for consumption on the premises only.
- * The fee is raised from \$500 to \$750 for unincorporated communities, and in incorporated communities with a population up to 1,500 (as determined at the time the application is filed). In all unincorporated communities and incorporated communities with a population up to 1,500 (as determined at the time the application is filed) the fee is raised from \$1,000 to \$1,500.
- * Each applicant shall file a \$2,500 bond to assure ownership, financial responsibility and compliance to liquor laws.

Restaurant License Holders:

- * may sell beer and wine with meals furnished in good faith. The fee is raised from \$300 to \$500.

Roadhouse Licenses: - may be issued to owners which allow the sale of wine and beer for premises serving food. The alcohol may be consumed on the premises only. The roadhouse may not be located less than 18 miles from corporate city limits.

In-flight Catering Licenses: - authorize the issuance of licenses to permit sale of alcohol along with meals. Holders may not sell to a consumer and must purchase from a licensed wholesaler. The fee for this license is \$600.

Unlimited Community Liquor Licenses: - would allow communities to run their own liquor store. The advantages are that under community management, the store may limit sales, and control sale hours to minimize abuses of alcohol and binge drinking. The profits may be used by the community for any purpose including local treatment and alcohol caused costs.

Limited Community Liquor License: Issuance of these licenses preclude issuance of private liquor licenses. This license allows the community to run a liquor store which would only be allowed to sell a limited amount of alcohol (2.4 wine gallons to any one person in a given day). This alcohol must be ordered two weeks in advance.

Public Notice: When a liquor license is applied for or renewed, notice must be posted rather than advertised as was previously done, unless the ABC Board determines that advertised notices are in the public interest. Announcements of proposed issuance, renewal or transfer of licenses must be bilingual when necessary.

- * Technical provisions are included in the bill for protest of local governing bodies and areas outside municipalities.
- * Transfer of ownership of licenses is contingent on a determination by the ABC Board that debts and taxes are paid or that satisfactory security is given.

Local Option Elections: Upon petition of 35% of the voters, or action by the governing body, an election will be held which will allow the voters to choose the following alcohol options:

- 1) Going "dry" ad prohibition of bootlegging.
- 2) Community Liquor License.
- 3) Unlimited Community Liquor License.

Advertising Ban: Holders of liquor licenses may not advertise alcohol in any newspaper, magazine or on any cable or broadcast television or radio station.

Solicitation: It would become illegal for men as well as women to solicit the purchase of alcoholic beverages at licensed establishments.

Violations: Upon conviction of a licensee for a violation, notification and record of conviction shall be sent to the appropriate municipality which may suspend the license for first and second violations and on the third violation, the Board but not a council or assembly may revoke the license and declare the bond forfeited.

HB 340

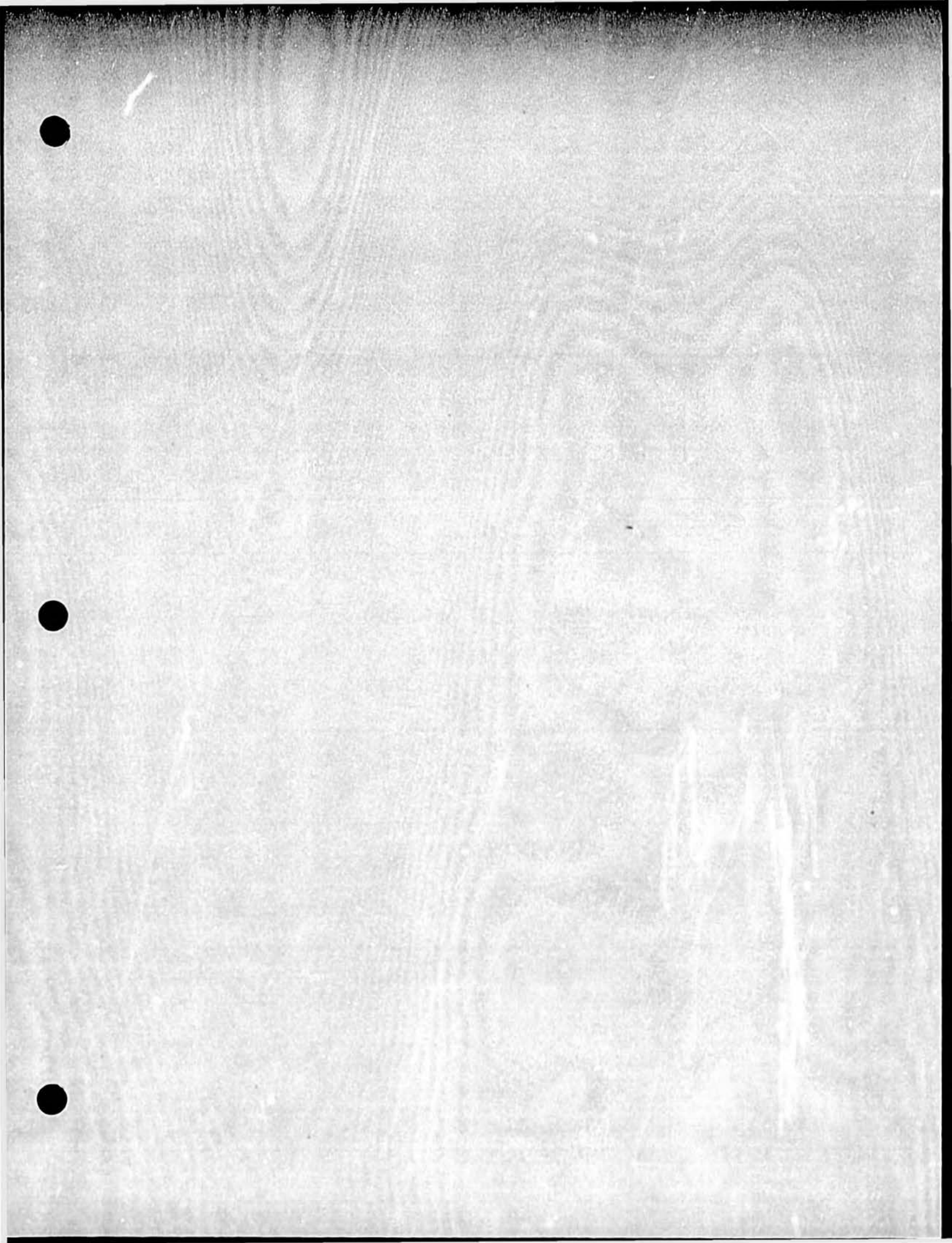
Alcohol and drug abuse treatment. ((H) HESS, then Jud &
SB 242 (S) HESS, then Fin.)
Status date: 3/11/77

These bills are identical. They combine the Alcohol and Drug Abuse offices with a combined budget. Grantees in the field will remain separate.

- * Advisory boards will be combined from current nine member

boards into a single nine member board.

- * The office of Alcoholism's current ambiguous "approval" authority over treatment facilities will be changed to a specific licensing authority.
- * Involuntary commitments to treatment facilities will be simplified by allowing the court to commit directly to a licensed facility rather than to the office of alcoholism.



SUMMARY OF BILLS INTRODUCED BY THE RULES COMMITTEE BY REQUEST OF THE SPECIAL COMMITTEE ON ALCOHOLISM AND ALCOHOL RELATED LEGISLATION:

SB 540 "An Act making a special appropriation to the office of Alcoholism in the Department of Health and Social Services for the prevention and treatment of alcohol abuse and alcoholism; and providing for an effective date." (S HESS then Fin 3/17/78)

This bill appropriates \$8,200,000 to the office of alcoholism for planning, coordinating, regulating, monitoring, and evaluating the statewide alcoholism program and to provide training and technical assistance to local programs.

SB 541 "An Act relating to health education in public schools." (S HESS then Fin 3/17/78)

Section 1 requires the inclusion of alcohol and drug abuse education in the health education programs already required in the public schools.

Section 2 is a statement of legislative intent that the public school systems implement programs of alcohol and drug abuse education.

SB 542 "An Act adding to the powers and duties of the office of Alcoholism." (S HESS then Fin 3/17/78)

Section 1 empowers the office to award grants and directs that grants and contracts awarded by the office shall be, whenever possible, for at least two years.

Section 2 requires the office to establish standards for training paraprofessional alcoholism workers.

Section 3 requires the department to identify facilities and services available through community organization for the treatment of alcoholics, including identification and utilization for detoxification of under utilized hospital beds.

Section 4 requires the office to develop and implement a training program for government employees whose duties bring them into contact with alcoholics.

Section 5 establishes within the office a revolving loan fund for temperate social activities. It also provides for the administration of the fund.