ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILES 8672

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

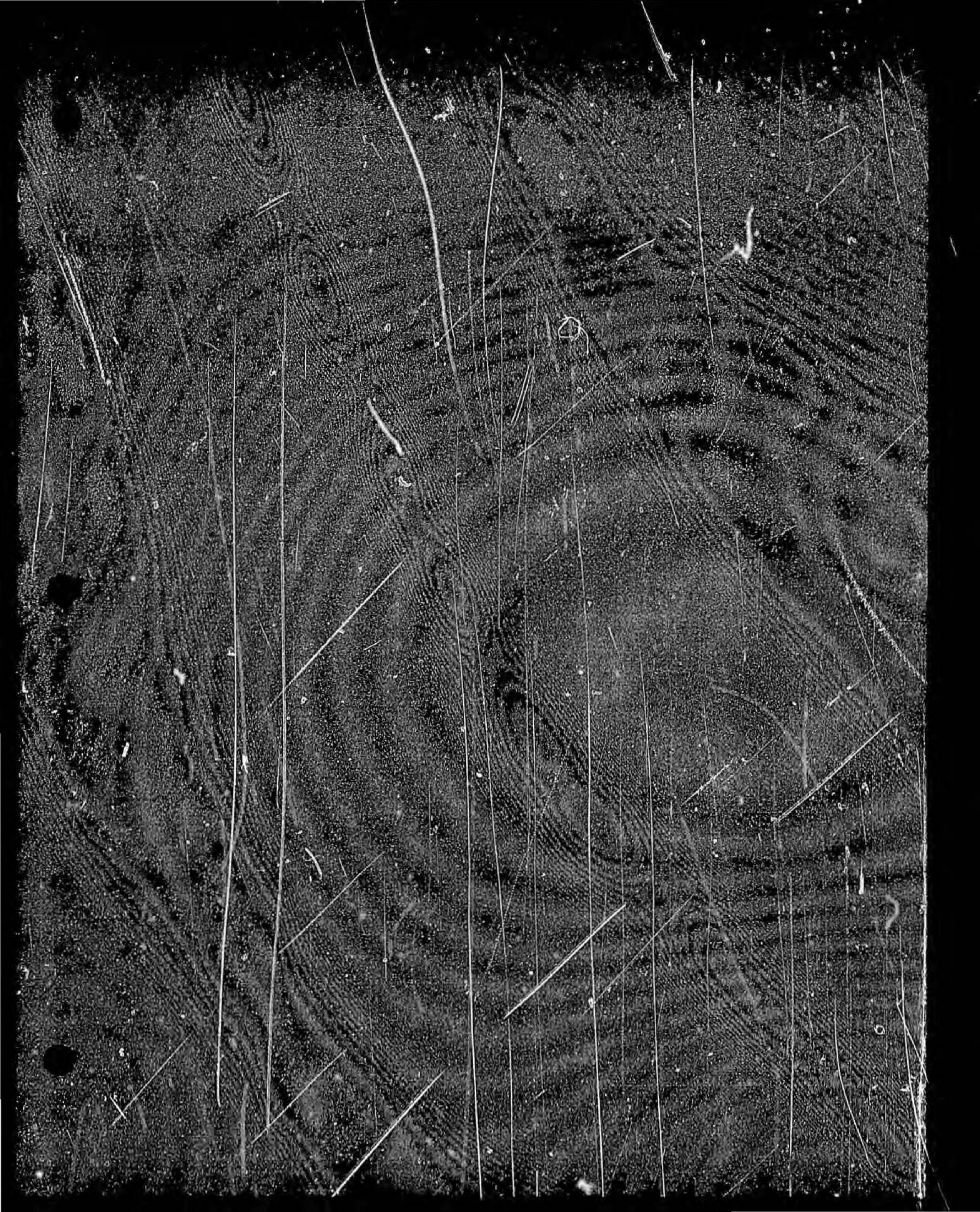
Q. What should a provider or patient do if there is a question about whether a claim for insurance benefits has been properly handled?

A. He or she should write to the Consumer Services Bureau of the Office of the Commissioner of Insurance describing the problem and including the name of the insurance company, the group policy number, and the subscriber or certificate number, if appropriate.

Consumer Services Bureau
Office of the
Commissioner of Insurance
123 West Washington Avenue
Madison, WI 53702
(608) 266-0103

Footnotes

1. 632.89 (2) (a), Wis. Stats.
2. 600.01 (1) (b) 3., Wis. Stats.
3. 632.89 (2) (a) 1., Wis. Stats.
4. 632.89 (2) (d), Wis. Stats.
5. 632.89 (3), Wis. Stats.
6. 632.89 (2) (c), Wis. Stats.
7. [illegible].89 (1) (a), Wis. Stats.
8. [illegible].89 (1) (d), Wis. Stats.



IFS No. 46
April 3, 1978

niaaa information & feature service

From the National Clearinghouse for Alcohol Information of the National Institute on Alcohol Abuse and Alcoholism

3rd Party Coverage Cuts Nonalcoholism Care Cost

A large-scale study in California has demonstrated that, when comprehensive insurance benefits for the treatment of alcoholism are provided, the cost of nonalcoholism health care may be reduced by some 25 percent per month for the alcoholic person.

In addition, figures from a 23-month pilot program for California State employees and their families showed that, when the alcoholic patient enters treatment, the frequency of inpatient care decreases and less expensive forms of care such as outpatient treatment are used more frequently.

The study project, which served about 337,000 beneficiaries and was funded by the State, also further confirmed the feasibility of providing a uniform and comprehensive model of insurance coverage for alcoholism treatment at a moderate increase in premium cost. The added cost for this coverage during the pilot program was figured at $2.05 per year or 17 cents per month.

This cost figure was based on a relatively low utilization of the alcoholism benefits, noted Drs. Harold D. Holder and Jerome B. Hallan of H-2, Inc., a research firm in Raleigh, N.C., which was commissioned by the National Institute on Alcohol Abuse and Alcoholism to study the impact of the program. Utilization was especially low in the first 12 months of the 23-month period, but increased substantially in the last 11 months, they said.

The project, which was under the supervision of the California Office of Alcoholism Program Management, provided a uniform set of alcoholism treatment benefits which included inpatient care of up to [illegible]7 days a year (including 6 days' detoxification), residential care of up to 3[illegible] days a year, and outpatient care of up to 45 visits a year.

Total benefits paid for the cost of treating the 766 patients served in the program were about $459,000. The insurance carriers' administrative costs of $94,000 brought the overall program cost to $553,000, or an average benefit cost of about $600 per patient.

The program paid for 422 inpatient admissions at an average cost of $1,392, representing about 83 percent of the total dollar benefits paid. Outpatient care services were utilized by 542 persons, with an average of 9.2 visits per patient at an average cost of $17 per visit, or 16 percent of the total benefits paid. Recovery home care was the least utilized service with 15 admissions at an average cost of $451.

General hospitals accounted for about 38 percent of the 422 admissions, alcohol treatment units in a general hospital for about 35 percent, and special alcoholism treatment hospitals for 21 percent.

The physician was the most frequent provider of outpatient care and the paraprofessional was the next most frequently used. The latter had the lowest average cost per visit—$15.

The estimate of a 25 percent drop in nonalcoholism care costs for a family after the alcoholic member began alcoholism treatment was based largely on a longitudinal study of the general health care experience of 240 families included in the pilot program coverage. Care was provided by the program to 462 alcoholic members of these families.

The cost of general health care for these 462 persons averaged $179.50 per person a month before alcoholism treatment began, but dropped to $133.22 after the start of treatment, Drs. Holder and Hallan reported. Thus, the saving was about $46 a month in nonalcohol related health care costs, or a total of about $370 per person for the time that care costs were followed.

Projecting this figure to embrace all of the 766 persons who used alcoholism benefits in the program, the researchers came up with a total cost savings of $283,297. Based on the ratio of this figure to total alcoholism care costs of $690,500 in the program, they found that for each $1 spent by the pilot program on alcoholism treatment, there was at least a 42-cent savings to the insurance carriers in the care of the alcoholic person.

The insurance coverage was provided through nine different carriers. However, more than 90 percent of the beneficiary population was covered by three carriers—Kaiser Foundation Group Plans, Blue Cross/Blue Shield, and California Western Occidental.

When the project ended in May 1976, the Kaiser Plans were the only carrier of the nine to continue providing alcoholism treatment benefits modeled after the pilot program, doing so at a small increase in the monthly premium. This carrier, which provides prepaid coverage, had the lowest per-visit charges among the nine.

For more information on the study, write: Jerome B. Hallan, Dr. P.H., H-2, Inc., 7334 Chapel Hill Rd., Raleigh, N.C. 27607.

Pamphlet Warns on Drinking in Pregnancy

The woman who is pregnant or plans to become pregnant is the target of a new pamphlet being distributed by the National Institute on Alcohol Abuse and Alcoholism.

The pamphlet, "Alcohol and Your Unborn Baby," states that drinking by the expectant mother could endanger the health of the fetus and suggests that, if she chooses to drink, she should limit her intake per day to no more than one ounce of absolute alcohol — the approximate equivalent of two mixed drinks, each containing one ounce of distilled spirits; or two five-ounce glasses of wine; or two 12-ounce cans of beer.

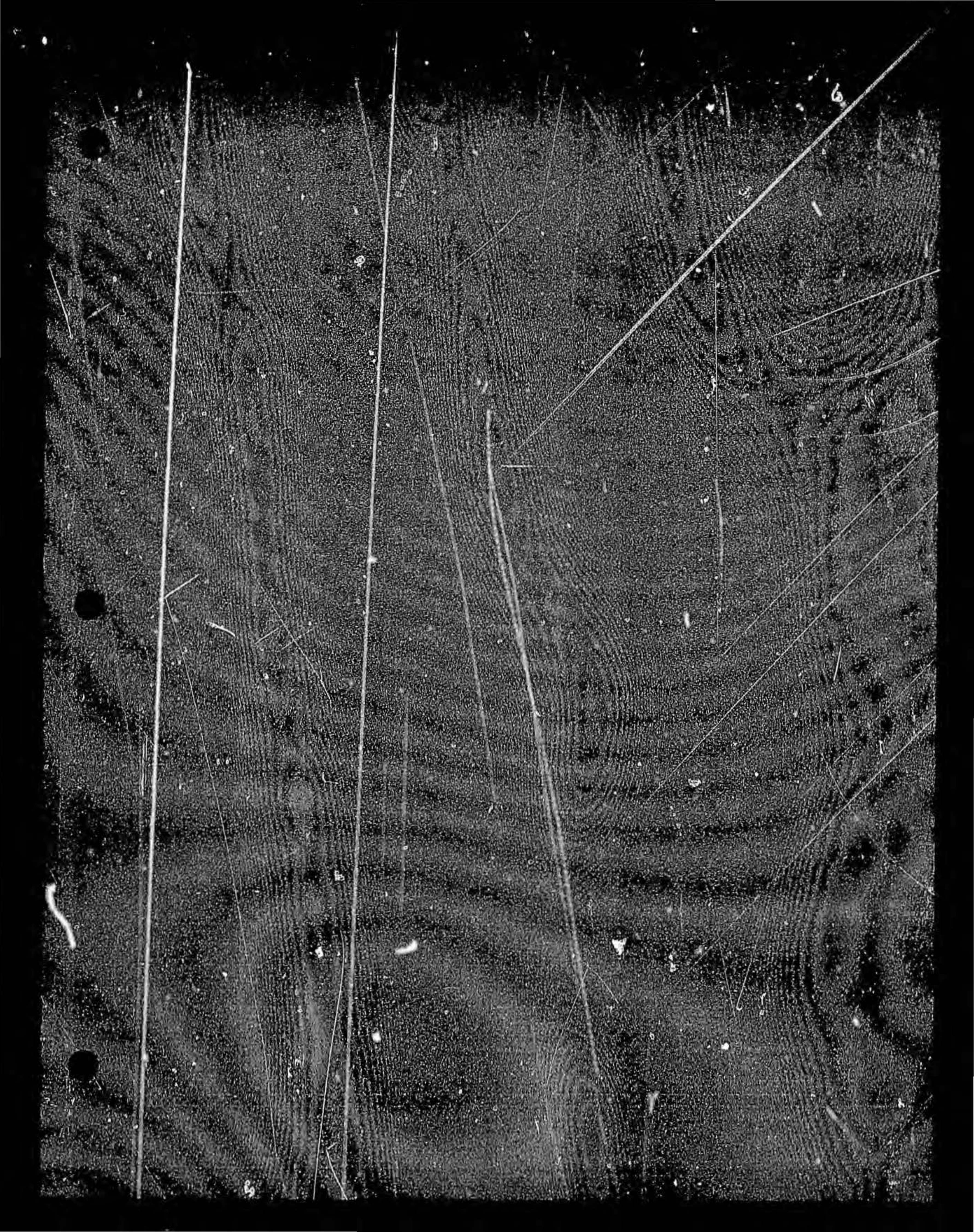
Publication of the pamphlet is part of a national effort by NIAAA to raise public awareness about the dangers posed to the fetus by drinking during pregnancy. The campaign particularly emphasizes the risk of developing the fetal alcohol syndrome (FAS)—a specific pattern of physical, mental and behavioral abnormalities that can occur in the offspring of women who drink heavily during pregnancy.

The possibility that even moderate drinking by the pregnant woman can harm the unborn baby is still being investigated, as is the effect of binge drinking, the pamphlet notes. Also being studied is the possible role of other risk factors, such as smoking and poor nutrition, in FAS.

The pamphlet tells where to get help for drinking problems and also touches on the use of other drugs during pregnancy, alternatives to drinking, and ways of coping with anxiety and depression.

"Alcohol and Your Unborn Baby" is being distributed through the National Clearinghouse for Alcohol Information to obstetrician-gynecologists' offices and for use in supermarket displays. Copies have also been sent to state alcoholism authorities, prevention coordinators, and program directors.

Single copies of the pamphlet are available by writing Dept. FAS, National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, Md. 20852.



ALCOHOL & HEALTH   H.E.W. October 1978

CHAPTER XI. FINANCING ALCOHOLISM TREATMENT SERVICES

The magnitude of the alcohol problem in this country and the economic costs to society of alcohol-related problems have been discussed in chapter I of this report. It has been noted that health care costs directly attributable to alcohol-related problems are an estimated 12.1 percent of U.S. national health expenditures. There is a significant opportunity for reducing health care expenditures if effective alcoholism treatment services are supported. Recognition of this opportunity has led to funding by Federal, State, and local governments, as well as to modifying health insurance policies to cover alcoholism services. This chapter discusses these and other funding sources that currently are being used to finance alcoholism treatment services.

GOVERNMENT SUPPORT

Since its inception in 1970, the National Institute on Alcohol Abuse and Alcoholism has been helping to establish alcoholism programs by funding service projects directly and by making Federal formula grants available to States. An added source of Federal moneys became available from NIAAA in 1974 when incentive grants to the States were authorized to encourage the adoption of the Uniform Alcoholism Treatment and Intoxication Act. In addition, Federal support from other agencies (table 1) totaled approximately $207 million in 1976.

The financial base at the local level has expanded as States and other local governments either matched Federal funds or appropriated other sources of support. Federal, State, and local administrators consequently have sought to determine what resources are available for alcoholism programs and to identify what services these moneys are buying. This information is compiled in NIAAA's State Alcoholism Profile Information System (SAPIS), developed to discover the impact of formula grants within the States. According to a 1977 SAPIS report of 43 States providing information, average financial sources were formula grants, 13 percent; other NIAAA funds, 17 percent; local sources, 17 percent; and State and other Federal funds, 53 percent. An average of $7,322,000 per State was available to the States in FY 1976.

Information about resources undoubtedly will be improved by the SAPIS program, the impact of 1976 legislation requiring an accounting of States' public and private alcoholism service facilities in formula grant applications, and a recent NIAAA initiative to compile an annual report on all Federal activities related to alcohol problems.

Whatever the precise level of public funding of treatment services may be, nonpublic support clearly is required if adequate treatment resources are to be made available. Therefore, the extent of health insurance coverage for alcoholism treatment is of great concern. To illustrate the situation, table 2 shows the amount of insurance coverage of clients of selected NIAAA programs in 1976. The proportion of individuals with health insurance at all and with alcoholism coverage in particular varies

widely with the type of program. Health insurance coverage varies from 21 to 85 percent and alcoholism coverage from 10 to 45 percent. The proportion of individuals with health insurance who also have alcoholism coverage ranges from 18 percent to 53 percent.

HEALTH INSURANCE

Health insurance has been made available specifically for alcoholism only within the last decade. In the past, alcoholism was a hidden illness, and treatment usually took place in a State-supported institution because care in the private sector was either unavailable or prohibitively expensive. Little is known about the nature or extent of insurance coverage for alcoholism before the mid-1960's. However, it is safe to assume that many alcoholics received treatment under the mental health benefits of their insurance policies.

By the late 1960's it became clear that insurance carriers and providers were applying obvious sanctions to the treatment of alcoholics. Hospitals frequently blocked the admission of alcoholics, and health insurance policies limited coverage in many ways. With the dramatic surge of health care costs in this era and the increased recognition of the extent of alcoholism and alcohol abuse, the need to establish effective private third-party payment mechanisms was clear. NIAAA worked with representatives of health agencies and insurance carriers to study the status of alcoholism insurance coverage, to identify barriers to improved coverage, and to develop model benefit provisions.

PRIVATE SECTOR PLANS

The private sector has three major components: Blue Cross-Blue Shield plans, commercial insurance companies, and independent plans. Blue Cross-Blue Shield is a confederation of two private nonprofit corporations. Commercial companies include life and casualty insurance companies as well as other companies that provide health coverage. Finally, independent plans include employer- or employee-sponsored programs, health maintenance organizations, private group clinics, and dental service corporations.

Blue Cross-Blue Shield

An estimated 84 million subscribers are covered by the approximately 70 Blue Cross and Blue Shield associations operating in the United States and Puerto Rico. In 1976, the Blue Cross Association (BCA) and NIAAA initiated a nationwide study to determine the feasibility of offering comprehensive benefits for alcoholism treatment throughout the Blue Cross health insurance system. The study has produced a series of technical assistance documents designed to address the essential components needed in comprehensive alcoholism coverage. They were (1) a marketing package, including the benefit structure, a defined target population, rates, and a subscriber education program; (2) an administrative segment covering contracts with health care providers, legal constraints, and control of benefit utilization; (3) a guideline for test-site selection; and (4) a program for evaluating test-site results.

Some individual Blue Cross plans are offering increasingly comprehensive alcoholism benefits. In 1974, for instance, Capital Blue Cross in Pennsylvania introduced an alcoholism benefit that provided rehabilitation treatment immediately following detoxification in institutions specializing in alcoholism treatment. Premiums were not increased for this benefit because the plan's administrators realized that alcoholism treatment previously had been paid for under other diagnoses. Current data indicate that the benefit will reduce the number of claims and the total costs incurred by the carrier.

Blue Cross of Maryland provides alcoholism treatment benefits through one program in residential nonhospital settings and through another in outpatient care. Substance-abuse benefits--including alcohol and other drugs--were made available to the approximately 1 million members of the United Auto Workers Union, their spouses, and dependent children by Blue Cross and Blue Shield of Michigan.

Commercial Carriers

The trend among major commercial carriers is toward offering coverage for alcoholism treatment. The percentage of policies specifying exclusions or limitations on alcoholism coverage dropped from 16.5 percent in 1972 to 13 percent in 1975, according to one survey.

Independent Plans

Health Maintenance Organizations (HMO's). HMO's provide basic and supplemental health care on a prepaid basis to their membership. To qualify for Federal subsidies, an HMO must offer medical treatment and referral services for alcohol or other drug abuse. The Group Health Association of America, a national voluntary organization of group health plans, initiated an alcoholism treatment feasibility project to test the potential of comprehensive alcoholism treatment services in prepaid group practice plans. Although the data are too limited to be conclusive, indications are that there is a reduction in total health care use when alcoholism is identified and treated appropriately.

The Harvard Community Health Plan. This plan in Cambridge, Mass., which includes both inpatient and outpatient alcoholism benefits, reported a monthly cost for alcoholism treatment of only $0.05 per member. During the first year, no client used the inpatient treatment beyond the benefits provided.

Employee Benefit Plans. The industries sponsoring occupational alcoholism programs usually have policies that cover inpatient services, according to one survey. Considerably less coverage was provided for outpatient treatment.

Unions and Health Insurance Plans. The Nation's labor unions have participated actively in encouraging health insurance coverage for treating alcoholism and other drug abuse. Unions affiliated with the AFL-CIO and major independent unions such as the United Auto Workers, the United Mine Workers, and the Teamsters are implementing and expanding alcoholism treatment benefits.

PUBLIC SECTOR PROGRAMS

Several health insurance assistance programs are provided by law under Federal or State auspices and are financed through taxes. Benefits, fixed by law, are available to those who qualify under the plan. These publicly supported programs include medicare, medicaid, CHAMPUS (Civilian Health and Medical Care Program for the Uniformed Services), the Veterans' Administration program, and State temporary workers' compensation systems.

Medicare

Primarily, medicare pays medical expenses to individuals aged 65 or older who are entitled to retirement benefits under title II of the Social Security Act or under the Railroad Retirement System. Administered by the Social Security Administration, medicare's benefits and eligibility requirements are uniform for all participants and include hospital insurance and supplementary medical insurance for the aged and disabled. Medicare categorizes alcoholism and drug abuse treatment under psychiatric or mental health services, and the coverage is less than that available for physical illness.

Medicaid

Medicaid provides medical assistance to low-income individuals. Treatment cost is shared by the States and the Federal Government. A major limitation is that persons aged 21 to 64 cannot receive care in a psychiatric hospital under medicaid. In several States, however, medicaid plans provide reimbursement for treatment of problems associated with drug or alcohol abuse. Because services for alcohol or drug abuse problems are not mentioned in the medicaid statutes, the States determine whether treatment should be excluded or included.

A 1976 telephone survey revealed a wide range of practices. Most States reimburse for inpatient treatment of organic illnesses caused by or related to alcoholism, and 85 percent of the States reimburse for outpatient care for these illnesses. The proportion of States that reimburse for direct treatment of alcoholism is substantially lower. Approximately two-thirds reimburse for treatment at a community health center; nearly one-third pay for care at an alcoholism treatment center or from an alcoholism counselor; and about one-tenth absorb treatment costs at a halfway house or similar facility.

Title XVI

Under title XVI of the 1973 Social Security Act, supplemental security income (SSI) is granted by the Federal Government to those eligible for Aid to Families with Dependent Children, to the blind, to persons who are otherwise disabled, and to needy persons over the age of 65. The present social security law requires an alcoholic SSI recipient to designate a third party to receive his or her supplementary income. Often, this procedure undermines the self-confidence of recovering alcoholics. Pending legislation would enable the attending physician of the facility where an individual is undergoing treatment to certify that direct payment of SSI benefits

to the patient would be beneficial. The costs of alcoholism treatment generally are not covered by the SSI program.

Title XX

Title XX, a 1975 amendment to the Social Security Act, currently contributes $2.7 billion annually to the States for social services. The required State comprehensive plans may include alcoholism treatment services if they are defined explicitly. A 1976 analysis of services available for treatment of alcoholism and drug abuse under State title XX plans revealed that 10 States provide services specifically concerned with treatment of alcohol abuse; 11 pay for services related to both alcohol and drug abuse, and 16 reimburse for specific mental health services.

CHAMPUS and CHAMP-VA

This insurance program for dependents of military personnel covers inpatient and outpatient care for alcoholism. However, inpatient rehabilitative care beyond detoxification is limited to a lifetime maximum of three admissions, and outpatient treatment is limited to psychiatric services. A similar program, CHAMP-VA, is available to the dependents and survivors of some disabled veterans.

Disability Insurance

Public disability programs involving workers' compensation are available in all 50 States. Compensation is limited by 27 States if alcoholism or problem drinking is the cause of injury resulting in a claim.

OTHER FEDERAL INVOLVEMENT

National Health Insurance

In view of the tremendous health, social, and economic costs related to alcoholism, benefits for alcoholism and related health problems should be considered in the development of health insurance coverage. These should include a range of service components to assure a minimum level of continuity of care for alcoholism treatment.

A recent cost-benefit study of alcoholism treatment centers reinforces the argument for including coverage for alcoholism care in any health insurance package. The study found that the national economy will realize 10 years of benefits, estimated at close to $22 million, from the operation of 41 alcoholism treatment centers during the last half of 1974. However, half of the 20 legislative proposals for national health insurance introduced in the 94th Congress did not mention alcoholism specifically.

Civil Service Plans

The Federal Government offers 55 health insurance plans to its employees. Most of these include some benefits for alcoholism, although the extent

of the coverage varies widely. Some plans have a specific alcoholism benefit, but most alcoholism treatment is part of the mental health benefits or some other benefit category.

NIAAA Activities

NIAAA has sponsored a range of studies to plan increased health insurance coverage for alcoholism treatment and has developed experimental projects to demonstrate the feasibility of this type of insurance. The agency helped to develop standards for treatment facilities that, when implemented, lead to accreditation. When a facility is accredited by the Joint Commission on Accreditation of Hospitals (JCAH), more carriers are willing to insure the care provided there. More than 200 alcoholism programs nationwide have been accredited by JCAH.

One of the agency's feasibility studies resulted in a model alcoholism treatment package designed to provide insurance companies with a basis for projecting a range of costs in various alcoholism treatment settings. The model benefit package recommends 6 days of inpatient emergency care, 14 days of inpatient care, 30 days of outpatient care, 30 days of short-term intermediate care, and 60 to 90 days of long-term intermediate care. This package was tested for 2 years in the California State Employees' Insurance Alcoholism Program.

NIAAA is concerned with State and local service programs in several administrative areas, including training, cost accounting systems, and policy procedures, and is working with others in the field to develop certification standards for alcoholism counselors.

STATE INVOLVEMENT

State Regulatory Agencies

Since State insurance departments are empowered by statute to regulate the extent and cost of insurance contracts and the conduct of insurance carriers, State legislative actions have become important in setting minimum standards for alcoholism treatment. A mid-1976 survey of State legislative activities showed that insurance coverage for alcoholism treatment had increased considerably since 1974. Unfortunately, the enacted legislation often emphasizes inpatient care and limits outpatient treatment, although recently some States have mandated more extensive outpatient benefits. By mid-1977, 20 States had enacted legislation into law, and 11 other States had introduced legislation related to health insurance coverage for alcoholism (figure 1).

California State Employees' Insurance Alcoholism Program

This 2-year pilot alcoholism program was based on the model benefit package described briefly above and more extensively in the Second Special Report on Alcohol and Health. It offered benefits for 158,000 State emloyees and more than 300,000 family members, through nine insurance carriers. The program involved no risk for the various moneys paid for both alcoholism treatment claims and carrier administrative expenses.

Figure 1. State Legislative Activities Relating to Health Insurance Coverage for Alcoholism, 1971-77

SOURCE: Data from Jerome Hallan and Becky Hayward, Health insurance coverage for alcoholism: Current status. Unpublished report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0023. Raleigh: H-2, Inc. 1977.

The alcoholism benefit package provided

- inpatient care in a hospital or other licensed facility, including up to 6 days of detoxification services and 21 days of treatment a year;

- day or night residential care in a licensed recovery home for a maximum of 30 days annually; and

- outpatient care limited to 45 visits a year to a physician or to a licensed or certified professional or paraprofessional mental health worker.

For each of the 766 persons participating in the program, the average expenditure was approximately $600. Some 422 inpatient admissions were recorded at an average cost of $1,392. An estimated 540 persons each attended an average of nine outpatient sessions at an average cost of $17 a session. Outpatient care benefits represented approximately 16 percent of the total benefits paid. Recovery-home care was the least used service.

For one evaluation, data were collected on nonalcoholism health care for 2 years before treatment began and continued during treatment. Preliminary findings indicate that average monthly nonalcoholism treatment costs were reduced by approximately 25 percent after a person began treatment for alcoholism.

If the State of California had not paid for all costs of the pilot program, the additional average premium for each family enrolled in the State and public employees' program would have been only $2.05 a year, or $0.17 per month, to cover the cost of alcoholism treatment. However, these estimates are based on a relatively low utilization rate for the available services.

SUMMARY

- Federal, State, and local government funds constitute a significant proportion of the resources for alcoholism treatment. If adequate treatment coverage is to be provided to alcoholics, a major increase in the share of this support must be provided by health insurance.

- Lack of third-party reimbursement has limited the number of service providers. Until recently, insurance carriers were reluctant to cover treatment of alcoholism, but the trend is changing. For example, in 1972 approximately 25 percent of all Blue Cross plans specifically excluded alcoholism. By 1976, only 4 of 60 plans responding to a survey excluded alcoholism treatment.

- Although some private insurance carriers still exclude or limit alcoholism treatment, increasing numbers are providing coverage.

- Increasingly comprehensive alcoholism benefits are being offered by individual Blue Cross plans. Some offer alcoholism treatment in special inpatient centers and others provide innovative outpatient

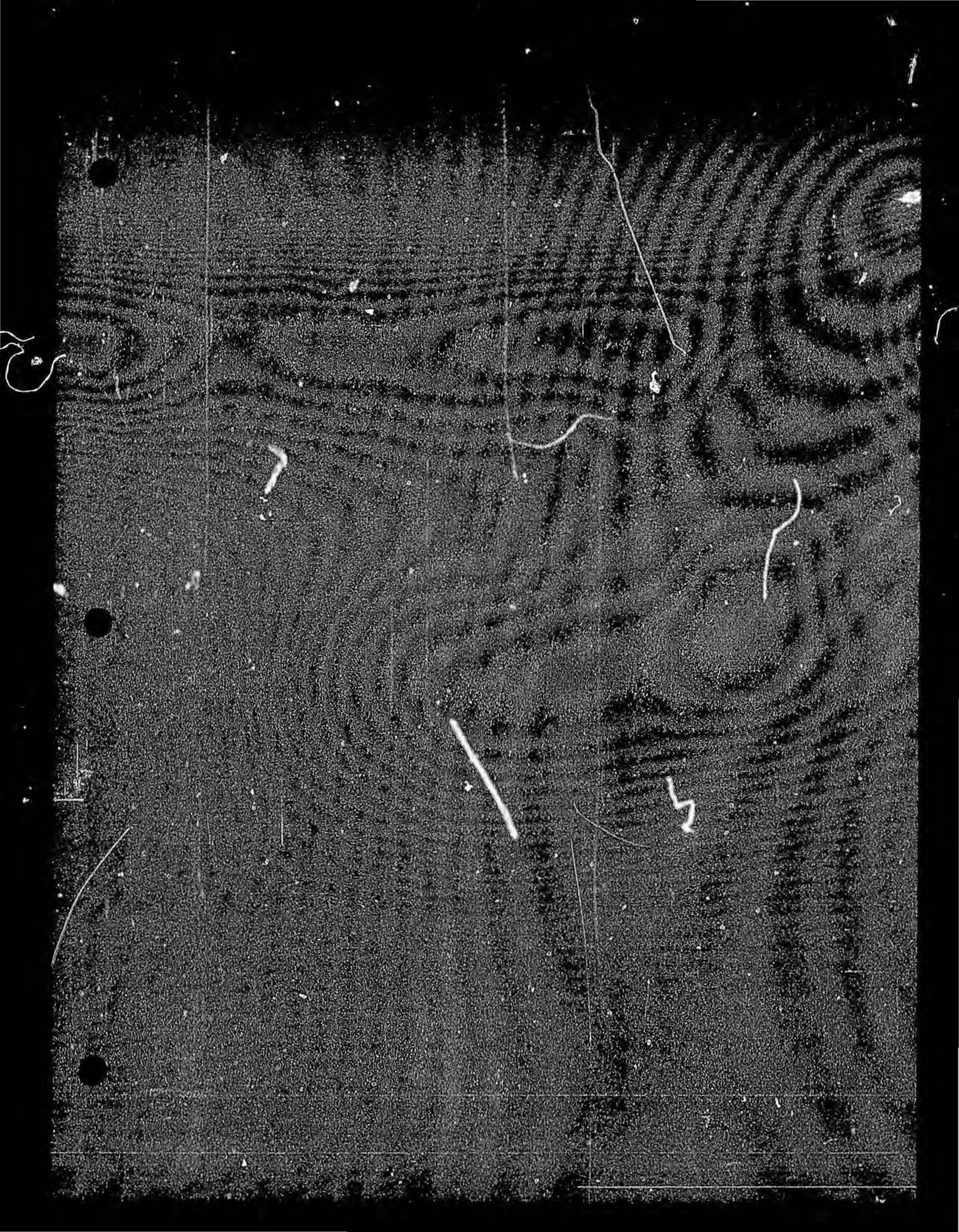
care. The United Auto Workers union Blue Cross coverage includes both residential and outpatient treatment.

- Many employee health insurance plans specifically include inpatient alcoholism treatment; far fewer cover outpatient treatment.

- State legislatures are concerned about the availability of insurance for alcoholism treatment. Twenty States have enacted legislation either mandating that alcoholism coverage be provided or requiring that it be available as an option.

- Preliminary findings from a California experimental project indicate that the average monthly nonalcoholism health care costs for both the alcoholic and the immediate family were reduced by 25 percent after the individual began treatment for alcoholism.

- Varied benefits are offered in the public sector. Current medicare provisions for alcoholism treatment to the aged and disabled are restrictive compared to benefits available for physical disease. Medicaid programs often ignore treatment for alcoholism. The Supplemental Security Income Program (title XVI of the Social Security Act) employs sanctions against the alcoholic who fails to stay in treatment. Alcoholism treatment is specifically provided for under the Social Services for Individuals and Families Program (title XX of the Social Security Act) in 10 States, and specific alcoholism services are reimbursed by 11 States.



A STUDY OF HEALTH INSURANCE COVERAGE FOR ALCOHOLISM FOR CALIFORNIA STATE EMPLOYEES

by

Harold D. Holder, Ph.D.
Jerome B. Hallan, Dr. P.H.

H-2, Inc.
7334 Chapel Hill Road
Raleigh, North Carolina 27607

December, 1976

ABSTRACT

A. INTRODUCTION

In 1974, the State of California undertook a pilot program to test the feasibility of providing model health insurance coverage for alcoholism for all the employees of the State as well as employees of certain public and county municipalities which contract with the State for employee health benefits (Ref. 1). The program was the result of specific action taken by the California Legislature which approved the Program and appropriated money from the State's general fund for its operation. About 337,000 beneficiaries (employees and family members) were covered by these benefits at the time of program initiation.

The California Office of Alcoholism Program Management was instrumental in the development of the Pilot Program and was responsible for its overall management. Another agency, the Public Employees Retirement System (PERS) was responsible for day-to-day administration.

The Program was based on provision of a uniform set of alcoholism treatment benefits, as follows:

1. Inpatient Care: (hospital or other medical or nonmedical facility licensed by the State)
   Acute: 6 days of detoxification services/year
   Intermediate: 21 days of treatment/year
2. Day or Night Controlled Residential Care: (recovery home licensed by the State)
   30 days of care/year
3. Outpatient Care: up to 45 visits per year to be provided by a:
   - licensed physician
   - licensed counselor
   - licensed clinical social worker
   - licensed psychologist
   - licensed or certified paraprofessional

The Program benefits were vendored by nine different insurance carriers, including four prepaid group practices, two service types, two indemnity type carriers, and one individual practice. Three of the carriers - Kaiser Foundation Group Plan (North and South), Blue Cross/Blue Shield, and California Western Occidental (California West) - provided coverage for more than 90 percent of the beneficiary population. The Program was established such that there was no risk involved for the various carriers; i.e., State monies paid for alcoholism treatment claims and carrier administrative expenses. The Program began in June 1974 and ended in May 1976. At that point the Kaiser Foundation Plans sought and received approval from the State to continue model insurance benefits for alcoholism treatment for their state and public employee population for a small increase in monthly premiums.

This report is the third in a series of evaluation reports concerning various aspects of the California Program. The first report was concerned with the historical development of the program and as a consequence it: (1) traced the legislative history of the program; (2) documented the efforts and activities of the several public agencies which were instrumental in establishing and operating the program; and (3) made a series of observations and conclusions regarding the program, its development and, importantly, how those experiences could be useful in other programs which emphasize health insurance coverage for alcoholism treatment.[1] The second report reported on program utilization and costs for the first 12 months of the program. Specifically it examined: utilization of the various services available under the Program; treatment deviations for the various services and average costs associated with these therewith; comparisons of service utilization and costs

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[1] J. B. Hallan, H. D. Holder, and M. J. Stucker, "Historical Development of the California Pilot Program to Provide Health Insurance Coverage for Alcoholism," Raleigh, NC: H-2, Inc., November, 1975.

among the various carriers; and projections concerning the annual premium costs necessary to underwrite the costs of treatment provided by the program.[2]

This report is presented in several chapters and appendices. The remainder of this introductory chapter summarizes important findings, while Chapter II provides a detailed description of utilization costs and carrier experiences during the lifetime of the program. Chapter III reports on certain characteristics or patterns of care received by the beneficiary population. A longitudinal study of nonalcoholic health care utilization by the alcoholic and his family is reported in Chapter IV. Finally, this report also contains several appendices including two (Appendices A and B) which present the various data collection instruments used in the utilization and cost study and in the longitudinal study respectively. Appendix C documents certain medical care indices used to adjust the variation in year to year health care costs.

B. SUMMARY OF FINDINGS

The following is a summary of findings and conclusions concerning the various studies made of health care utilization and costs derived from the California Pilot Program to provide alcoholism treatment insurance benefits to State personnel.

Summary of 23 Month Operational Data

A summary of data on inpatient, outpatient and recovery home care provided under the Pilot Program during its 23 months of operation is presented in Table I-1. The total benefits paid to claimants under the Pilot Program excluding administrative costs were about $459,000; total carrier administrative

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[2] J. B. Hallan, H. D. Holder, M. J. Stucker, "Alcoholism Care Utilization and Costs California Pilot Health Insurance Program - First Twelve Months," Raleigh, NC: H-2, Inc., March, 1976.

TABLE I-1

SUMMARY OF COSTS, BENEFIT PLANS AND CARE UTILIZATION UNDER THE CALIFORNIA PILOT PROGRAM

July 1, 1974 - May 31, 1976

	Total Persons	Total Admissions or Visits [1]	Average Charge Per Admission/Visit	Total Charges [2,3]	Total Benefits Paid [2,3]
1. Inpatient Care	339	422	$ 1,392	$587,341	$382,475
2. Outpatient Care	542	5,028	17	83,316	71,164
3. Recovery Home	15	15	461	6,920	5,478
Total	766[4]	N/A		$677,577	$459,117

N/A = Not Applicable

[1] Source: Analysis of claims submitted by carriers and prepaid programs to PERS.

[2] Source: California Public Employees Retirement System

[3] Does not include benefits paid by Cal-West under its basic plan before the Pilot Program. Inpatient care benefits paid by Cal-West were $133,484 and outpatient care benefits were $3,844.

[4] Adjusted for double counting in care utilization.

costs amount to some $94,000. Overall costs of the program amounted to about $553,000 or an average benefit cost of about $600 for each of the 766 persons who participated in the program.

The Program incurred 422 inpatient admissions at an average cost per admission of $1,392. Consequently inpatient benefits represented about 83 percent of the total dollar benefits paid. Allowing for readmissions by the same person, a total of 339 people utilized inpatient services during the Pilot Program. There were 542 persons who utilized outpatient care in the Program. Each of these incurred about 9.2 outpatient visits at an average cost per visit of $17. Outpatient care benefit payments represented about 16 percent of total benefits paid by the Program. Recovery home care was the least utilized service with 15 admissions at an average cost per admission of $451.

Details of inpatient and outpatient care provided under the Program are presented in Tables I-2 and I-3 respectively. General hospitals accounted for about 38 percent of the 422 Pilot Program admissions; a slightly smaller proportion (35 percent) of admissions was made to alcohol treatment units in a general hospital. Special alcoholism treatment hospitals accounted for only 21 percent of admissions. There was considerable variation in treatment facility charges varying from a low of about $600 per admission in a general hospital to a high of $1965 in a hospital with an alcohol treatment unit. Table I-3 reveals that the majority of persons received outpatient care from a physician. Paraprofessionals were used the next most frequently and had the least average cost per visit, $15. Psychologists and social workers were used at about the same frequency (i.e., each group incurred some 360 visits) by Pilot Program beneficiaries. Psychologists with average charge of $31 per visit were the most expensive form of outpatient providers.

TABLE I-2

SUMMARY OF INPATIENT ADMISSIONS AND CHARGES: CALIFORNIA PILOT PROGRAM

Facility Type[1]	Number of Admissions	Average Charge per Admission
General hospital	159	$ 598
Alcohol unit in a hospital	147	1965
Alcoholism hospital	87	1823
Other	29	1008
TOTAL	422	

[1] Definitions of facilities used in the California Pilot Program will be found in Chapter .

Source: California Public Employees Retirement System

TABLE I-3

SUMMARY OF OUTPATIENT UTILIZATION AND CHARGES: CALIFORNIA PILOT PROGRAM

Provider	Number of Visits		Average Charge per Visit
Physician	2,216		$25
Paraprofessional	1,972		15
Social worker	362		24
Psychologist	357		31
Counselor	121		15
TOTAL	5,028	Overall Average	$17

Examination was also made of the patterns of care incurred by the Pilot Program beneficiaries. First, it was found that a majority of persons utilizing hospital inpatient care incurred only a single visit during their course of treatment. Nearly equal proportions of all admissions incurred a stay of 20 days or more (40 percent) or less than 6 days (35 percent). Second, though the average person utilizing outpatient care incurred some 9 visits during the course of treatment, fully one third of all clients using this form of care incurred no more than 1-2 visits. Third, examination of uses of inpatient and outpatient care by a single client revealed that outpatient care is more frequently used among clients who have multiple inpatient admissions. Extreme users of inpatient care however (i.e., 4 or more admissions), tend not to use outpatient care. Finally, examination of treatment durations revealed that the majority of clients tend to complete their treatment within 3 months with only a small fraction (about 10 percent) still in treatment after one year.

While the Pilot Program benefits were available through nine different carriers, the majority (over 90 percent) of beneficiaries were covered by Cal-West (a State-wide indemnity plan), Kaiser Foundation Health Plan - North and South (a prepaid group practice Plan), and Blue Cross/Blue Shield (a non-profit service plan). Table I-4 shows selected comparative information about health care utilization, charges and benefits paid by the major carriers operating under the Program. The average cost per inpatient admission varied from $905 for Blue Cross/Blue Shield subscribers up to $1,567 for Cal-West subscribers. Together these two carriers incurred the majority (63 percent) of Pilot Program inpatient admissions. Correspondingly, Kaiser-North and Kaiser-South incurred the majority of outpatient visits with an average cost per outpatient visit of $20 for Kaiser-North and $7 for Kaiser-South. Outpatient costs reported by the other carriers were more expensive, i.e., the

TABLE I-4

UTILIZATION AND COSTS BY CARRIER - CALIFORNIA PILOT PROGRAM

July 1, 1974 - May 31, 1976

Carrier	Inpatient		Outpatient		Recovery Home	
	Admissions [1]	Average Paid Per Admission [2]	Visits [1]	Average Paid Per Visit [2]	Admission [1]	Average Paid Per Day [2]
Cal-West	139	$1,567	659	$24	7	$10
Kaiser-North	91	1,119	1,338	20	2	24
Kaiser-South	49	1,278	2,139	7	1	17
Blue Cross/Blue Shield	127	905	874	29	4	18

1 Source: Analysis of claims submitted by carriers and prepaid programs to PERS.

2 Source: California Public Employees Retirement System

Cal-West average was $24, Blue Cross/Blue Shield was the most expensive at $29. While recovery home visits were reported by all four carriers or plans, nearly one-half of all such visits were reported by Cal-West--which had the lowest average daily recovery home costs of $10. Kaiser-North recovery home costs were the most expensive at $24 per day.

The projected annual premium addition to pay for the total program was $2.05 annually or 17¢ per month additional to the average cost for a policy under the PERS system. This projection is based on full 23 months of experience for the Pilot Program which had a low utilization of provisions for alcoholism treatment during the first 12 months but substantially increased utilization the last 11 months.

Finally, projections were made of the annual premium addition which would have been necessary to cover the costs of alcoholism treatment experienced by the program. Based on the full 23 months experience, average premium increases of $2.05 annually (17¢ per month) per policy would have covered all costs of care. Note, however, that these premium beneficiary addition estimates are based on a relatively low program utilization, i.e., only a small proportion of the target population utilized available benefits.

Summary of Longitudinal Study Findings

The longitudinal study consisted of analysis of utilization and costs for the alcoholic and his family during the 12 month period prior to the first treatment contact under the Program (the "pre" period) and during the period following the first treatment contact (the post period). The study examined the health care experiences of 240 families which had at least one member participating in the Pilot Program. As such, at least one family member was diagnosed an alcoholic and received treatment under provisions of

the Program. The study examined the utilization of general health care and its cost (not including any alcoholism treatment provided under the Pilot Program).

(1) Inpatient Care

Survey data revealed that the frequency of inpatient care for the total family and its alcoholic member decreases following initial treatment of the problem drinking member for alcoholism. The average length of inpatient stay decreases for the family primarily as a result of decreased length of stay for the nonalcoholic family members. On the average the alcoholic member's stay in the hospital increased by one day and, as a result, average costs per admission are higher. While the lengths of stay and average costs per inpatient admission are higher, the overall average monthly costs for inpatient care of the alcoholic are less. Average monthly costs for the family increase as a result in increased costs for nonalcoholic family members.

Generalizing from this study, as the alcoholic family member enters treatment for alcoholism, his/her frequency of inpatient care and total costs for such care could be expected to decrease. The alcoholic will enter the hospital less often but stay longer. He will utilize hospital care less often than other family members who also use such care. This suggests that either previous inpatient treatment was increased by a result of undiagnosed and untreated alcoholism or specific treatment for alcoholism replaces previous inpatient care under secondary diagnoses.

(2) Outpatient Care

While the alcoholic member utilizes hospital care less often for general health care after entering treatment for alcoholism, outpatient care tends to increase. Costs for outpatient care were found, however, to remain

about the same or slightly higher. This increase in outpatient care, with a corresponding decrease in hospital care, suggests that the alcoholic's illnesses are less acute and can be more frequently handled on an outpatient basis. The alcoholic member's frequency of outpatient care is comparable with other members who use such care.

(3) Care Patterns for Health Insurance Carriers and Prepaid Programs

The families in the longitudinal study were grouped according to the program or health insurance company with which they were enrolled. Blue Cross/Blue Shield, which before the Pilot Program provided no coverage for treatment of alcoholism when diagnosed as sucy, of all carriers and providers experienced the most marked changes in general health utilization and costs as alcoholic family members received alcoholism treatment. Families with Blue Cross/Blue Shield had a marked drop in inpatient care frequency and costs. Costs alone decreased 50 percent. While the outpatient care of the alcoholic member decreased, other family members' utilization of outpatient care increased. In like manner, the average lengths of stay and average costs per admission decreased.

Cal-West, as a carrier which provided coverage for some alcoholism treatment before the Pilot Program, had an overall increased incidence of care (inpatient and outpatient). Cal-West experienced higher inpatient costs for alcoholic family members than for other family members; this resulted from a few exceptionally high claims during the period of the longitudinal study. While incidents of care were increasing, the length of inpatient stay decreased as a result of an average drop of almost two days per stay for the alcoholic family member.

Kaiser-South, the only prepaid program participating in the longitudinal study, experienced a marked (around 50 percent) decrease in the

monthly incidence of care (inpatient and outpatient). However, average inpatient costs per admission increased, primarily as a result of a three-fold increase in the length of inpatient admission for alcoholic family members. Outpatient care frequency decreased with costs varying only slightly.

Overall, families grouped by the carriers and the prepaid program follow the trends shown for the total population with some exceptions. The more restrictive the coverage for alcoholism treatment provided under health insurance policies or a prepaid program, the more dramatic the decreases in general health care costs and utilization will be when alcoholism treatment as such is covered or expanded.

(4) Diagnosis and Care

An examination was made of the various diagnoses used while treating the families in the survey before alcoholism treatment and following its initiation. A clear decrease was observed in the number of diagnoses which are identified as surrogate or substitute for a primary diagnosis of alcoholism following initiation of treatment. This would be expected to result when a diagnosis of alcoholism entitles a patient to a comprehensive treatment program for the condition. The diagnoses most affected were in "mental disorder" categories and the utilization rates and costs for care with these diagnoses decreased when the Pilot Program began.

(5) Cost Reduction

For the months that health care costs for the alcoholic were tracked, there was an average monthly cost of $179.50 for inpatient, outpatient and other care before beginning treatment for alcoholism and $133.22 after treatment began. This produces an estimated savings of $369.84 per person for the time that care costs were followed or a total estimated savings of

$283,297 for the 766 persons receiving care during the period of the Pilot Program. See details in Appendix D. In short, for each $1.00 spent on alcoholism treatment by the Pilot Program, there was at least a 42¢ projected savings to the insurance carriers and prepaid plans in health care costs of the alcoholic, i.e., the ratio of the total alcoholism care costs of $690,500 (Pilot Program, $553,173, plus Cal-West Basic Plan, $137,327) to the total estimated savings in health care (other than alcoholism) of $283,297.

C. CONCLUSIONS

Conclusions which may be drawn from the study include the following:

(1) The California Pilot Program experienced a relatively low utilization of health insurance benefits for alcoholism treatment relative to the accepted estimates of treatment needs in the worker population.

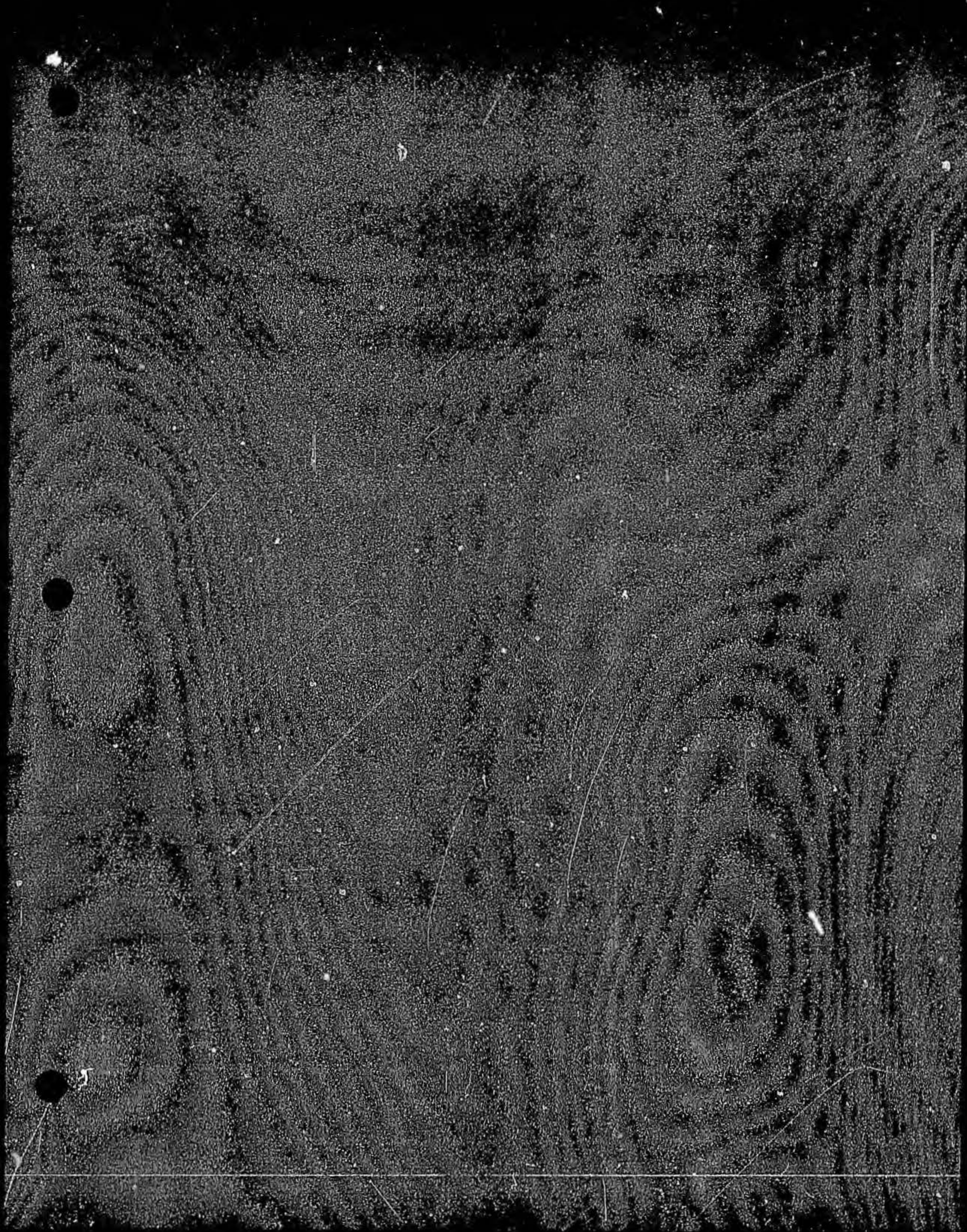
(2) The program demonstrated the feasibility of providing a uniform and comprehensive set of insurance benefits for treatment of alcoholism. Utilization was well within the limits established by the Program benefit provisions and projections of insurance premiums necessary to finance such a program indicate only moderate increases above usual insurance costs.

(3) Some variation found in utilization and costs between the types of carriers involved in the program were not significant. Part of the variation may be explained by the existence of alcoholism treatment benefits in place before the Pilot Program began.

(4) When alcoholism is treated under an explicit diagnosis, utilization and costs for health care (other than alcoholism) decrease. This decrease is a result of (a) direct treatment of alcoholism and (b) the use of a primary diagnosis of alcoholism instead of a proxy or substitute diagnosis which has historically been acceptable for claims purposes.

(5) Inpatient treatment utilization and costs decreased when the alcoholic began participation in the Pilot Program. Other less expensive forms of care such as outpatient treatment were used more frequently.

(6) The Program demonstrated that following implementation of the comprehensive benefit program other health care costs were substantially reduced for the alcoholic population. Though the data are preliminary indeed there is indication that nonalcoholism treatment costs may be reduced by some 30 percent per month upon initiation of treatment for alcoholism.



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A REPORT ON HEALTH INSURANCE COVERAGE OF ALCOHOLISM AND DRUG ABUSE TREATMENT IN ALASKA

Prepared for:

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IV. THE RESULTS OF A SELECTED SAMPLE OF THE ALASKAN HEALTH INSURANCE INDUSTRY

I. THE SURVEY

This survey of health insurance coverage of alcoholism and drug abuse treatment available in Alaska, was conducted to establish the current "state of affairs" of such coverage. In addition, a short history of health insurance coverage and a discussion of the attitudes and philosophy of "third-party" payors (both public and private) are presented and examined.

Since the health insurance "industry" is subject to state regulation, we have included pertinent aspects of law and regulation applying to the state's regulating entity, the Department of Commerce and Economic Development, Division of Insurance. The Division of Insurance also was reviewed for its general philosophy regarding health insurance regulation.

In summary, we feel that the report shows:

1. That private carriers and quasi private (e.g., Blue Cross) carriers are providing more and better coverage than ever before.

2. That "public" carriers, such as Medicaid, General Relief-Medical, etc., provide little or no coverage.

3. That alcoholism and drug abuse treatment programs can increasingly qualify for third-party payment and make the transition from grant to private funding.

4. Finally, that treatment programs need to pursue:
   a. funding by "public" carriers
   b. additional coverage and benefits from the private sector, perhaps through insurance regulation.

II. THE HEALTH INSURANCE "INDUSTRY"

A. Definitions

The Health insurance "industry" is the collection of economic entities, public and private, which offer to reduce or remove the cost of treatment for physical or mental illnesses (with important exceptions) for covered individuals.

Further definitions of "illnesses" and "covered individuals" are in order.

For practical reasons, "illnesses" are those disorders of the body or mind that are accepted by the medical community as such. Where the medical community has wavered, insurance interests have often reduced or removed coverage. Even where the medical community has defined a specific illness, insurance interests have often reduced or removed coverage to suit their experience factors or profit motives.

"Covered individuals" are those subscribers to health insurance who meet criteria set by the insurance company. Being a policy-holder is not enough. Certain illnesses may be subject to limited coverage. The coverage may be subject to conditions: treatment approval by the insuror; who treats the illness; where it's treated, the length of treatment, etc.

The "covered individuals" clause in insurance policies can dramatically affect the actual coverage available to the insured. It is also the major concern to those who feel that the generally accepted definition of health illness should include alcoholism and drug abuse treatment.

B. A Short History

Insurance against illness can take many forms, perhaps even dramatic ones. The Chinese (Circa 2,000 B.C.) are often given the credit for the first "insurance" against illness. It was perhaps the simplest of coverages. Wealthy Chinese employed physicians to keep them well. If the person paying got ill, payments stopped. If the patient died, the physician was summarily killed. Perhaps society has never gone further from that model than today, where physicians are often criticized (and sued) for doubtful treatment, patients do die, and the major process of paying for physicians' services is still controlled by the physician.

The ancient Greeks had benevolent societies, some of which provided medical coverage (such as it was) in return for regular payment to the society.

The English added limited physician and general health coverage to its marine and life insurance coverages. This occurred in

the middle of the 17th century, but the philosophy remains the same as today's coverage. Health insurance was then and is still today considered a hard to manage, unprofitable business by the private insurance companies. It is generally carried as an added inducement to attract buyers of life and casualty coverage.

C. Private Carriers

Recent years have seen a change in attitude among commercial insurance carriers. That change, toward more coverage for ambulatory care, appears closely paralleled to the rise in demand for national health insurance. While the interests of private-sector insurers have never been high in regards to health insurance, as stated previously, one can see that nationalization of the health insurance industry could lead to nationalization of the more profitable lines of coverage offered by insurance carriers. This appears to be sufficient motivation for the increasingly flexible coverage of health services, particularly alcoholism treatment. Moreover, such coverage, while available, can still be controlled by specified limits set at arbitrary levels that may, in effect, give little or no practical coverage. This is the case of private insurance coverage of alcoholism and drug abuse treatments. Part IV to this report, and Attachment A, expand on this further.

D. Quasi-Private Carriers

The most substantial insurance carriers in the quasi-private (non-profit) sector of the health insurance field are the Blue Cross/Blue Shield plans. With a nationwide subscription of approximately 85 million, Blue Cross has 50% of all institutional health care coverage.

Blue Cross is a loose confederation of individual plans of health insurance coverage which provide coverage of institutional charges for services. Several features are required of member plans to the national association. The most prominent are:

1. That each plan be a non-profit community organization with governing boards composed of both the general public and providers of service.

2. That each plan "substantially" cover hospitalization costs.

3. That each plan pay out at least 85 percent of subscribers' premiums as benefits.

4. That each plan provide for its continued financial solvency, and provide reasonable accounting and statistical records.

5. That each plan cooperate with other member plans.

In return for agreeing to the terms of the association, the following are the significant benefits of national membership:

1. National advertising

2. Use of the Blue Cross emblem, and the general franchise for the sale of Blue Cross benefits within a designated territory

3. Use of association facilities for coordinating accounts involving treatment and payment where such activity involves two or more Blue Cross plans

4. Easy provision for the transfer of subscribers

5. Use of the extensive lobbying efforts of Blue Cross in Washington, D.C.

Blue Cross plans have been subject to considerable criticism in recent years for affiliations with the various hospital associations. More pointed has been the criticism of the national Blue Cross Association's affiliation with the American Hospital Association. While private health carriers have always main-

tained a natural "arm's-length" relationship with the institutional providers of paid health care, Blue Cross (BCA) was formed by the American Hospital Association (AHA) in the 1930-40 period. Those close ties have lately made BCA and the AHA the objects of much public concern. In a period of exponentially rising health costs (and compensating rises in health insurance premiums), it is only natural that public attitudes about control of the rise in the cost of health treatment would focus on a group of organizations which both provide health care and control the payment for the same care. In response to this criticism, BCA and the AHA have moved farther apart organizationally since 1972, when they split the joint board of directors of BCA and AHA into separate directorships.

The 1940's saw the American Medical Association sponsor Blue Shield's predecessor organizations to both provide insurance coverage for physician's fees and to certify and control physicians eligible to receive payment. Blue Shield has member plans, a national association (National Association of Blue Shield Plans (NABSP)), and is subject to the same criticisms made of Blue Cross: that the provider-insuror relationship is too close to be cost-effective; that NABSP, like BCA, is too provider-dominated to play a leading role in containing the rapid escalation of health care costs; and that neither BCA nor NABSP offer any real incentive for preventive medicine.

Health Maintenance Organizations (HMO's) are an alternative to traditional third party payors. They date back to the late 1920's where they began achieving a slow but steady following on both the West Coast (Ross-Loos, Kaiser-Permanente, etc.) and East Coast (Health Insurance Plan of Greater New York, etc.). The passage of Public Law 93-222, the Health Maintenance Organization Act of 1973, has served as an impetus to the growth of HMO's by providing funding and other benefits. That impetus has been somewhat blunted by a requirement that HMO's obtaining federal development funds under P.L. 93-222 have open enrollment periods in which all applicants desiring coverage be admitted both in order of application and irrespective of previous medical conditions. Since all insurance relies on the spread of risk across a large enough base of subscribers to be cost-effective, this may prove to be a permanent hindrance to any but the largest of HMO plans.

E. Public Carriers

The only "public carrier" of health benefits are the federal/ state agencies involved with the Medicare or Medicaid programs.

Medicare is a program for people 65 and older, and certain disabled people under 65, which provides some coverage for traditional hospital treatment under Part A of Medicare and some coverage of physician treatment under Part B. of Medicare.

Medicare is provided by the federal government and administered by the Social Security Administration.

Medicaid is a program, for certain eligible people, where the federal and state governments share the cost of medical treatment. Eligibility generally means "needy," as defined by Aid to Families with Dependent Children (AFDC) requirements and other programs of a welfare nature. Each state has a considerable number of options in choosing under which programs they wish to elect coverage.

General-Relief Medical is a State of Alaska program where the State agency administering the Medicaid program also can pay for health benefits to certain persons not otherwise eligible for Medicaid coverage. This is frequently used to pay for drugs used in treatment.

F. Other Possible Coverages

Since basic charges for institutional care often have a custodial element, e.g., a portion of a daily charge for inpatient hospital care would include a "room and board" charge, it is possible to charge non-medical agencies for that portion of institutional care. Examples in Alaska include the Veteran's Administration and the Bureau of Indian Affairs.

Another potential source for health treatment coverage would be the State of Alaska's program of vocational rehabilitation. That program, administered by the Department of Education's Division of Vocational Rehabilitation, can provide reimbursement of the cost of health benefits given to clients of that division. If the disabled person can be rehabilitated from a certified disability, and other minor requirements are met, benefits are generally available. Alcoholism abuse and drug abuse, however, are administratively excluded "due to poor results." Only after a certain abuse-free period has been attained are clients accepted for rehabilitation.

III. STATE REGULATION OF HEALTH INSURANCE IN ALASKA

The State of Alaska's Department of Commerce and Economic Development is the state agency responsible for applying the State laws on the insurance industry. Within that Department, the Division of Insurance administers the State's mandates on insurance. Within the Division of Insurance, there is no sub-entity to handle health insurance separate from any other line of insurance.

A review of Alaska Statutes (A.S.) showed that Title 21 governed insurance per se. A few chapters under A.S. 21 applied to health insurance. Important chapters are:

1. Chapter 6 -- The commissioner has certain duties, powers, etc. These do not include the power to prescribe coverage, limits of coverage, or other benefits to be paid.

2. Chapter 36 -- States that certain trade practices in marketing must be followed. This chapter also protects against frauds.

3. Chapter 42 -- Prescribes that annual reports be filed and provides for the timing of such filings.

4. Chapter 51 -- Disability coverage (including health) is described. This chapter only notes the State's approval of a clause in policies to preclude coverage of health ailments in existence before the date of coverage.

5. Chapter 54 -- describes group disability coverage. No specifics on health.

There are no regulations based on the statutes. Further, discussions with officials of the division disclose a policy of not interfering with the free-enterprise process of "caveat emptor," let the buyer beware. This has its roots in the division's belief that since most coverage is via group policies, and since most group policies affecting are negotiated, those negotiations permit the buyers of group plans to protect their own interests in regard to what services are covered, limits of coverage, covered individuals, etc.

In summary, the State of Alaska's agency involved in insurance company regulation, the Division of Insurance, does not feel that it should regulate health insurance beyond basic prohibitions against fraud and some miscellaneous requirements for filing annual reports of financial condition and economic stability.

IV. THE RESULTS OF A SELECTED SAMPLE OF THE ALASKAN HEALTH INSURANCE INDUSTRY

A. Overview

The health insurance industry, as mentioned in previous sections of this report, is an assortment of diverse entities. Those entities range from private, for-profit carriers to purely "public" carriers such as Medicare and Medicaid. All are different in degrees of coverage of health benefits in general, and alcoholism and drug abuse treatments in particular. This section deals with alcoholism or drug abuse treatment benefits exclusively.

This survey of available coverage began with an added dimension. Originally, it was hoped that negotiations could be started with the major carriers to produce an agreement on methods of cost-finding and rate-setting. This proved impossible, since none had detailed requirements for cost-finding and rate-setting nor had any ever prescribed any to their health providers. This attempt was abandoned in favor of surveying the current provisions and coverages available to the majority of Alaskans.

B. The Sample

As seen on Attachment A to this report, the major carriers are listed, along with the general provisions of coverage of alcoholism and drug abuse treatments. It was felt that the sample was broad in terms of effect on alcoholism and drug abuse benefits since the estimated number of Alaskans covered (225,239) equals 53.6% of the current estimated population of 420,000. Possible reduction of the above figures for duplication of coverage (where a spouse might also be employed and therefore double-counted), is offset by the Aetna survey. Since no figures were available for Aetna, that company's total coverage isn't listed. Since Aetna has major employers, as shown on Attachment A, their coverage should neutralize any reduction for double-counting of the other carriers. Also note that no coverage for state/federal programs was counted.

In reviewing the coverage note that all information was obtained from the companies themselves and should be quite current. Excerpts of limits of coverage, the narrative of coverage and requirements for coverage, all were taken from summaries of current policies in force during 1978.

C. The Results

The results were both impressive and sobering. The impressive portion was the private insurance industry. Having often been

cast as totally non-responsive to the non-hospital model of care, the results instead show that basic coverage is offered by the private insurance carriers in non-hospital settings. This fact, along with a trend toward ambulatory care coverage, presents bright prospects for reimbursement where free-standing programs can present the following credentials:

1. Community viability (acceptance)

2. An organization composed of dedicated professionals and paraprofessionals who are results-oriented.

3. An adequate financial organization, geared to collect, assimilate, and analyze cost-finding and rate-setting data.

The sobering thoughts are two-fold:

1. While the coverage is there, treatment is generally limited in dollar amount of benefits and days of treatment allowed. In the future, with greater acceptance of viable treatment programs, health benefits for alcoholism and drug abuse programs should equal those offered hospitals for basic and major medical coverages.

2. A second sobering thought involves the rather dismal record of the federal and state governments in providing non-grant funds for alcoholism and drug abuse treatment. With federal Medicare of little consequence due to the minimal number of alcoholics/drug abusers over age 65, we see the following for other federal/state programs:

   a. Medicaid-alcoholism/drug abuse services would be covered if the state had elected coverage of "clinic services" as a Medicaid option. The State, even with federal shared funding available, has not opted for such coverage for Medicaid-eligible Alaskans.

   b. State General Relief-Medical: alcoholism/drug abuse treatments are specifically excluded by 7 AAC 47.210, under authority of AS 47.05.010 and AS 47.25.120.

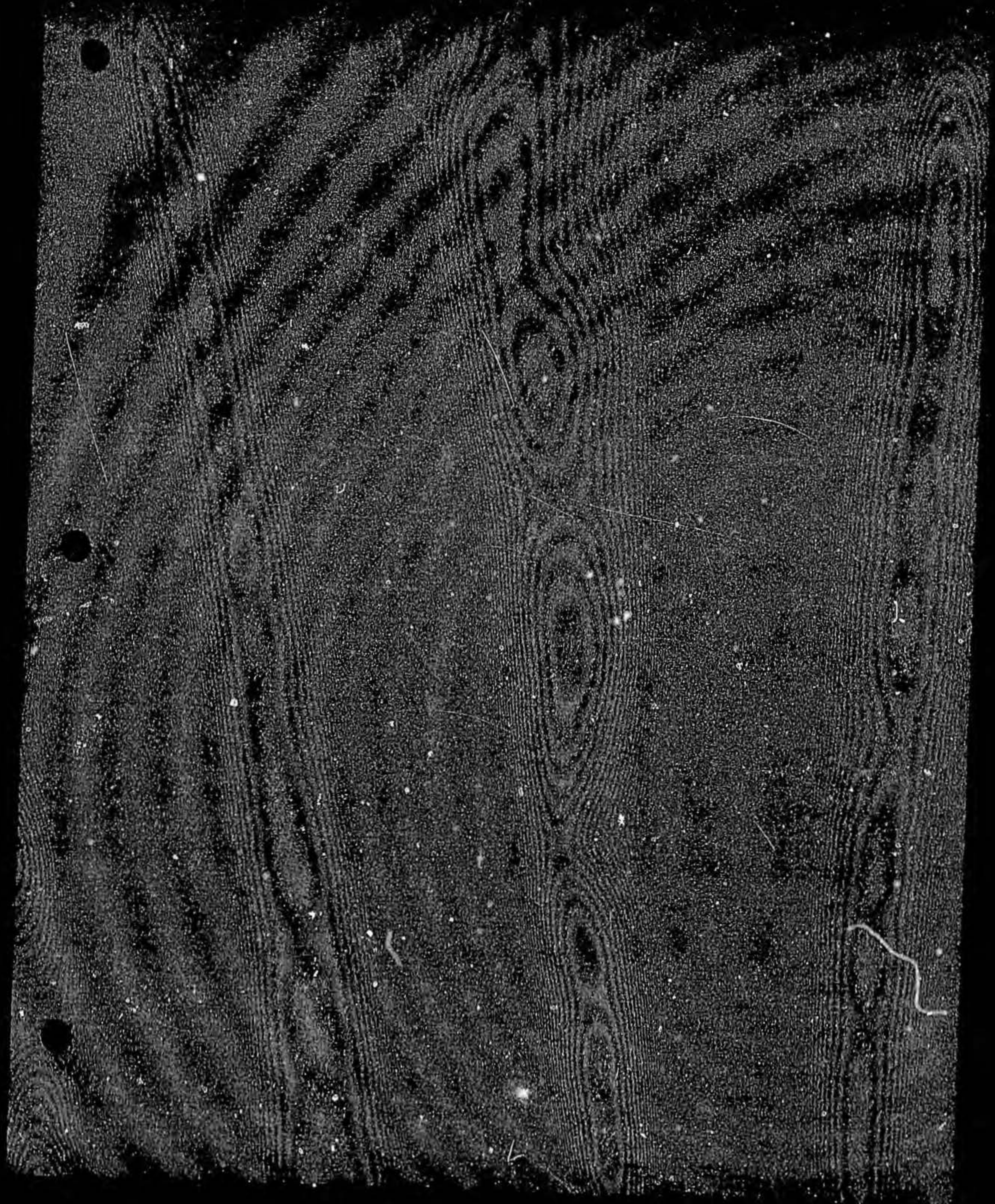
   c. Federal Social Security (excluding Medicare): as described above, the Social Security Administration can provide disability benefits for those under age 65. Those disability benefits only apply to the disabled individual, not the institution which may provide rehabilitation

through treatment. Surprisingly, Social Security regulations (Regulations No. 16, Subpart Q, Section 416.1710) require treatment as a condition of Supplemental Security Income (SSI) payments to the disabled, but provide no benefits toward payment for such treatment.

d. State Department of Education, Division of Vocational Rehabilitation (DVR), has the state authority and responsibility for evaluating, planning, and implementing rehabilitation services for those who can benefit from them. That authority includes paying for medical treatment of a rehabilitative nature for clients. By administrative directive, however, DVR will not deal with an alcoholic or drug abuser until six months after the applicant is drug or alcohol-free.

Carrier	Covered?	Brief Description of Coverage: Basic Plan	Maj. Med.	Limits: Year	Limits: Lifetime	Brief Narrative of Sample Plan	Company	Alaskans Covered: Employees	Total Covered* (Employee X 3.5 factor) (Blue Cross x 2.7 factor)
AETNA									
Alcohol Abuse	Yes	Same Coverage		45 days $500 deductible	No days limit $ Limit	M.D. Referral or diagnosis M.D. provided or M.D. "directi "Effective" Program - DETOX ALONE DISQUALIFIES. "LICENSED BY THE STATE, INPATIENT COVERA 24HR RN coverage.	Alyeska Pipeline Service Co. ARCO (Alaska) Alaska Painters Union Southern Baptist Convention	No Data	No Data
Drug Abuse	No	N/A	N/A						
BLUE CROSS									
Alcohol Abuse	Yes	Same Coverage		$1,000 80% Co-Insurance	$250,000	M.D. Supervision "State Approve Facility	Statewide Alaska	39,784	108,556
Drug Abuse	Yes	Same Coverage		$1,000 80% co-insurance	$250,000				
TEAMSTER #959									
Alcohol Abuse	Yes-if recog. by 959	Same Coverage		70 days per incident No year or lifetime per se		Not well defined, but definitel medical model. Licensed. JCAH accredited	Teamster Local 959	25,000 members	87,500
Drug Abuse	Only Emergency and emergency inpatient	N/A	N/A						
TRAVELERS INSURANCE									
Alcohol Abuse	Yes	Same Coverage		120 days per incident (inpatient) 50 visits outpatient deductible, then 80% to $2,000, then 100%.		M.D. "orders for care" and diagnosis, state license, JCAH accredited	Alaska Carpenters (all locals) Parker Drilling All others including Honeywell, Methodist Ministers, Burroughs Corp., Servomation Conf.	2,500 500 1,250	8,750 1,750 4,375
Drug Abuse	Yes	Same Coverage							
METROPOLITAN LIFE									
Alcohol Abuse	Yes	Same Coverage		120 days per year	$250,000 lifetime	"Licensed" by State, "Diagnosis or recommended by Doctor of Medicine"	University of Alaska Municipality of Anchorage (Part of)	2,376 1,712	8,316 5,992
Drug Abuse	Yes	Same Coverage		80% co-insurance to $1,000					
MEDICAID									
Alcohol Abuse	No State Coverage								
Drug Abuse	No State Coverage								
STATE GR-MEDICAL									
Alcohol Abuse	No State Coverage								
Drug Abuse	No State Coverage								
SOCIAL SECURITY									
SSI - Alc-Drug	No Coverage for Institution								
SSDI - Alc-Drug	No Coverage for Institution								
STATE VOC. REHABILITATION									
Alcohol Abuse Drug Abuse	No Coverage for Institution nor for Alcoholic or Drug Abuser until six months "sobriety"								

* Factor based on industry norms



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AN OUTLINE OF A UNIFORM ACCOUNTING AND FINANCIAL REPORTING SYSTEM FOR ALCOHOLISM AND/OR DRUG ABUSE TREATMENT PROGRAMS IN ALASKA

Prepared for:

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Department of Health and
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I. INTRODUCTION

The methods and means used to generate third-party payments are often as diverse as the institutions which use them. In this report we will outline and discuss generally accepted processes that the average program (or institution) should find adaptable to their administrative capacity, necessary for management reporting, as well as acceptable to third-party payors' reporting needs.

In undertaking to make their program flexible enough to meet the demands for information posed by third-party payors, each provider will need to assess their organization's strengths and weaknesses in respect to this definition of a health provider:

> An organization, practicing the healing arts, which recognizes the constraints of cost versus benefits in rendering the maximum service to the greatest number of people.

This definition, well recognized by the private sector, will need special attention by provider organizations which often began operations with a general statement that "help is needed...we should provide services" rather than the question "help is needed...can we provide effective services at a reasonable cost?"

With the above in mind, here is an outline of a viable provider organization; from Board of Directors and Management, on down to the cost-finding and rate-setting which support the organization.

II. OUTLINE OF THE UNIFORM ACCOUNTING AND FINANCIAL REPORTING SYSTEMS (UAFRS)

A. The Board of Directors, Management and the Budgeting Process.

In its corporate form (profit or non-profit), each provider must have a viable Board of Directors. Without going into great detail, each Board should:

1. Be representative of the community being served.

2. Provide guidance and direction to Management in:

   a. setting priorities for the delivery of new services or programs,
   b. setting the philosophy for rate-setting,
   c. setting the philosophy for bad-debt and indigent write-off policies,
   d. setting the standards for reduction of existing services, where necessary,
   e. review and approve the annual budget offered by Management.

Of the above, no item represents more time, effort, and importance to both Management and the Board than the budgeting process. "The Budget" is not only a way to make concrete the goals and objectives for the organization, but also the financial plan supporting the attainment of those goals and objectives.

Through the planning process, an organization states what it would like to achieve. Through budgeting, it states realistically what it can achieve. In effect, the budget takes the planning process and fits it to the artificial time-frame of single (fiscal) year and multiple periods (e.g., 3-year plan) that present goals and objectives reasonable for the organization to achieve within the given time. While multiple year budgets are not discussed further in this report, they can be used with an extension of the principles discussed herein.

A systematic process of budgeting should provide 1) a means to both define and quantify expected output toward meeting goals and objectives; 2) a means of recording, summarizing, and accumulating data to evaluate the results of operations; and 3) a means of controlling the expenditure of resources toward meeting the goals and objectives.

Since a budget provides a means to both state and quantify expected output toward meeting goals and objectives, what should it consist of? In general, a budget should include:

1. Statistical information that measures intake, treatment (including follow-up), discharge, and recidivism figures.

   Statistical information should begin with the client encounter, duly recorded, and a track through the treatment system. It should include:

   a. Admission data for inpatient/outpatient treatment such as (a) name and identifying number (e.g., social security number);
      (b) specific symptoms of illness stated;
      (c) day, date, and by whom admitted;
      (d) third-party insurance coverage, if any.

   b. Treatment given (including follow-up) with (a) physician named; (b) type of treatment (by incidence-coded); (c) length of treatment; (d) third-party carrier index;
      (e) self-pay index, if any; and (f) referral, if made.

c. Discharge data, to include (a) carrier billing status; (b) self-pay billing status; (c) follow-up for recidivism review.

While the above are important examples of statistical information, each provider organization should develop its own statistical base, not only to enable the billing of third-parties and others, but to provide internal reports to management on the cost/ efficiency of provider departments.

2. The budget should also consist of information expressed as a measure of the cost of operations of each discrete service category. These service categories represent cost centers. They can include and be expressed as follows:

For Alcoholism Treatment Programs:

a. Emergency care
b. Inpatient care
c. Intermediate care
d. Outpatient care
e. Outreach
f. Aftercare

g. Consultation and education

h. General administration/support services.

For Drug Abuse Programs:

a. Outpatient drug-free care

b. Residential drug-free care

c. Outpatient Methadone Treatment

d. General administration/support services.

3. The budget should also have a narrative combining statements of goals and objectives with the necessary statistical and cost information (including projections) that represent a sound plan of action for the budget period.

B. The Accounting Structure.

It should be emphasized that one of the most significant aspects of designing a successful financial reporting system (to include budgeting), is the design of the accounting classification system. This system begins with the following basic categories:

1. Assets
2. Liabilities
3. Surplus or Reserves
4. Revenues
5. Expenses

The cateogries of accounting we will be dealing with are expenses and revenues. These are where cost finding and rate setting impact the financial reporting system. Cost finding is a discipline of the expense classification system, while adequate revenues are a result of rate setting policies, including the results of cost finding.

Classification of Expenses

Since the accounting classification of expenses are of paramount importance to any program, they should be designed with special care. Most organizations can design (or already have available) a "chart of accounts" that displays the natural

classification of expenses such as "personal services," "supplies," "equipment," etc. Most programs also include a numeric designator as an "account number," e.g. "713" is "supplies" displayed as follows:

	Chart of Accounts
XXX	Telephone Expenses
XXX	Utilities Expenses
713	Supplies Expenses
XXX	Interest Expenses

With the above already in place, one can easily add sub-account numbers by cost center, e.g.:

	Chart of Accounts
713.00	Supplies Expense-Control Total
713.01	Supplies Expense-Outpatient Drug-Free
713.02	Supplies Expense-Residential Drug-Free
713.03	Supplies Expense-Outpatient Methadone Treatment
713.04	Supplies Expense-Administration/Support Services

The above will enable not only the recording, summarizing and classifying of the natural expense elements, but also the same treatment for cost centers. By breaking the natural expenses up into predetermined cost centers, according to usage or other good service measure, we can accumulate the normal categories

of expenses one step further. This treatment provides for 1) a way to accumulate direct costs on both cost centered and traditional methods of accumulation, so as to not disturb the traditional reporting of agencies, and 2) a way to maintain cost-center expenses for control purposes and as a base for rate-setting.

Having identified and recorded traditional expense categories into cost centers, the agency should maintain subsidiary ledgers of each expense category. By adding all sub-account (cost-center) transactions together, the total of the subsidiary postings should always equal the postings total of the account entitled, as in our example, "Account 713.00 Supplies Expense-Control Total." By maintaining the separate but related elements of general accounting and cost-finding, we can gather the cost-finding data as a supplement to the existing accounting system. This should ease the transition from a "general" to a "general and cost-finding" accounting structure.

C. The Cost-Finding System

The common accounting treatment, used to analyze and schedule costs of operations, is to define direct and indirect costs of operations, accumulate costs on a direct and indirect basis, and allocate such costs to the cost centers on a reasonable basis. As is well-known, the proper cost of any activity includes all goods and services utilized during a period, whether received from sources outside or from within. Cost centers, in turn, should correspond to the services rendered (e.g., "Intermediate Care Department") rather than to a physical facility (e.g., "Building A").

Total costs may be accumulated for any department. Each department will have its own total costs, parts of which have been received from other departments. As a result, the total cost of operating can be determined by listing the direct costs of each department along with some general costs, such as interest and depreciation. When all indirect costs have been allocated, and the program has completed its cost-finding procedure, the total cost of operating may be established by summing the total costs of the various departments.

Some Departments may not receive their total costs because of methods used in a cost allocation procedure. Since the method of allocation used is basically a managerial decision governed

by the economy of gathering the data, and the purposes for which it is gathered, such factors may make total allocation impractical. It is possible to make a special study to obtain the total cost of a department not receiving its total costs under the cost finding method used by the management.

It can be seen that, where possible, the total cost of operating a department should properly include costs of all assets and services used in a period. The basic chart of accounts, however, provides for the accumulation of only the direct costs of the responsibility centers. In order to arrive at the total cost, it is necessary to use a cost allocation procedure, or a special cost study which assigns indirect costs to an activity. Even in these cases, total costs would be specially defined for the cases where contractual agreement, custom, or tradition make it necessary to exclude certain costs in reports. In some cases, other cost analyses may be more appropriate.

Allocating Costs

In general cost finding, the direct costs recorded in the accounts are entered on a worksheet. The unassigned expenses (depreciation and interest, for example) then are allocated to the various departments. Then, the adjusted costs of the non-revenue producing departments are allocated to each other and to the revenue producing centers. The occurrence of the results produced depends to a great degree on the bases of allocations used and the order of their distribution.

The costs attributable to various departments are allocated to other departments and cost centers on a basis related to the amount of services rendered to each. When a department's costs are being allocated among the departments and cost centers which have received its services, the basis for apportioning costs should be determined by whether the use of that basis will effect an equitable cost allocation. The bases generally used to distribute costs are: Quantity of service and actual dollar amount of service. On Attachment A, examples of allocation bases are presented for the reader's review.

Quantity of service bases are those that make use of actual counts, or reasonably reliable estimates, of the amount of service rendered by a department or cost center. Some of these are costs that measure the main service of a department, such as patients served. Others are counts that may be used to represent a measure of the relative provision of service that may be applied when the real measure of service is difficult to define. An example is the number of administrative hours spent and the allocation of administrative staff cost to other cost centers. The possibilities of using weighting factors for the quantitative estimates should always be examined.

The actual dollar amount of service is often used where the services rendered by a department or activity involve distribution of supplies or other items for which either the purchase

price or the amount charged to clients is known or can be determined. The cost of items purchased can be kept and, as the items are drawn by departments, the costs of the supplies requisitioned can be tabulated by each cost center, or a charge basis can be used. General supplies and expenses are familiar examples. Here, certain supplies are distributed to other departments and cost centers, usually by requisitions. The cost of supplies requisitioned may be used or, as discussed later, a price schedule may be established that will permit the determination of a dollar amount for the items sent to each department or cost center served. These amounts may then be used as the basis for distributing the costs of general supplies and expenses.

Special analyses of cost or time could also be used to determine the proportions of service that a department normally renders to other cost centers. From the studies, percentages or proportions could be established to be applied to costs when a cost apportionment procedure is used. As long as the routine services to departments are fairly consistent from period to period, this method would be reasonable. If special studies are used, care should be taken to review the situation periodically, particularly when there has been a change in procedure or a relatively significant change in costs.

Outline of the Cost-Finding Procedure

An outline of the general cost-finding procedure is given below.

The setting up of the procedure, which will be designed for management purposes and needs, can be outlined as follows:

1. Select the cost centers from which and to which costs will be distributed.
2. Determine the basis for distributing the costs.
3. Establish the mechanics for obtaining the necessary periodic accounting and statistical data.
4. Select the method to be used in the cost apportionment.

Mechanics of the Procedure

1. Collect the necessary accounting and statistical data from the general ledger and statistical reports, and put them in appropriate columns of schedules and worksheets, by cost center.

2. Adjust and reclassify the accounting data for certain direct costs that were not treated as departmental costs in the routine process of accounting.

3. Allocate the costs according to the bases established. (This will require computations on separate worksheets and allocations on a master schedule. In addition, deductions often must be made for cost recovery items.)

4. Report the data by cost centers and/or departments.

The first step in cost finding is to collect the necessary accounting and statistical data from departmental statistical reports, and put them in the appropriate columns of schedules and worksheets. The cost-finding procedure begins with the placement of the summarized statistical data for the period in the Statistical Data column of a schedule supporting the lead schedule (see Attachment D). In addition, cost and other data taken from the accounts in the general ledger are listed in the same schedule.

The second step in general cost finding is to make preliminary reclassifications and adjustments, if necessary, to direct expenses (this is a "fail-safe" review to catch those direct costs which may have slipped through the original procedure described above).

Step three in the cost finding procedure is to allocate general service cost centers to revenue producing centers (see

Attachment E). In cost finding, the principle is to first allocate the accumulated costs of those departments or cost centers that render the most service to others and receive the least service in return (Attachments B & C). Where this determination cannot be made, first allocate the indirect costs to the department having the greatest amount of accumulated costs.

Step four, it is now necessary to summarize the cost data in a formal report for use by management. The form of such a report will vary depending on the type and amount of information desired. It is this report that combines the non-cost statistics with the aforementioned costs. The combination should produce unit costing. Such unit costs then become the basis for rate setting, discussed in the next section of this report.

Unit Costing

Generally, cost centers record only one type of service, e.g., counseling. Where the program determines that cost centers include several separate sub-cost components (or services), then unit costing becomes refined to:

1. Unit cost per direct labor hour
2. Unit cost per other direct costs
3. Unit cost per ancillary and other indirect costs.

Where such refinement is needed, the worksheets merely separate direct labor (time rendered directly to or on behalf of a patient) from indirect labor (the remainder of patient time) and direct non-labor costs from ancillary and other indirect costs.

This analysis (displayed at Attachment F) can be valuable in measuring efficiency and effectiveness of services delivered and is recommended for inclusion in the Uniform System. The time sheet displayed at Attachment G provides for the accumulation of time by:

1. Day and date of treatment/service
2. The person rendering treatment/service
3. The type of treatment/service rendered
4. Whether the service was direct or indirect, to the patient.

The final feature of cost finding is the summarizing of patient encounter data into the cost-finding system. The application of cost-finding with the patient encounter figures will produce unit costs showing:

1. Total units of service by cost center
2. Unit costs of such units of service

See Attachment H for a sample unit cost report.

The utility of unit cost analysis, one should remember, serves as 1) an efficiency and effectiveness evaluation; 2) a means to measure budgeted units of service vs. planned; and 3) other management uses such as cost control, as well as the basis for rate-setting.

A final series of uses for unit costing involve:

1. Permitting management a review of the allocation bases used in the cost-finding technique
2. Permitting management to analyze the need for special cost studies, where needed.

Questions on Allocation Bases

Since cost finding utilizes statistics in making the distribution of indirect costs to revenue producing departments, the quality of the allocations and, in fact, the entire cost finding process is dependent on the quality of the statistics. In considering the allocation bases suggested in the cost finding procedures, it is important that the statistics used are appropriate for each individual situation. If they are not, more appropriate bases should be used. The basis chosen in each situation should be the one that most accurately measures the proportionate amount of benefits received by departments to which allocations are to be made.

After having made decisions as to the propriety of the various allocation bases, there are several questions that must be considered in connection with the gathering of statistics:

1. Is the effort expended in gathering the statistics commensurate with the magnitude of the cost to be distributed?
2. Is there some way to simplify the process of accumulating statistics, such as by testing, sampling, or estimating?
3. How frequently must the data be accumulated?

Special Costs Studies

A special cost study may be defined as a cost analysis supplemental to the routine accounting process and to the general cost-finding procedure. Its purpose is to provide information for specific managerial uses.

The most important application of the results of such studies is in the solution of financial management problems; however, studies may also be used for public relations purposes.

The major use of special cost studies, however, is in providing information that will aid management in making decisions and in establishing policies concerning certain phases of the department's operations. Studies of particular activities are valuable

because they may provide detailed information ordinarily not reported, yet necessary for full analysis of an administrative problem. It is possible to obtain cost and statistical figures for almost any purpose desired by management. The administrator should consider the need for studies of cost and statistics, as well as studies of other relevant factors, when seeking a solution to a management problem.

Another general use to be made of the data from a special cost study is the presentation of information to the public. The results of a general cost finding procedure can be used for the same purposes, but frequently there is a need for presenting total costs information on general service activities, information not provided by the cost finding procedure.

Some of the areas of administrative action in which these studies would be most appropriate are:

1. Judging the operational efficiency of an activity in terms of total cost,
2. Determining the cost of adopting new technical procedures,
3. Determining whether equipment should be replaced,
4. Evaluating the cost of alternative choices in: purchasing equipment, utilizing technical or non-technical personnel, utilizing equipment or personnel,

conducting an activity or contracting with outsiders for the service, and utilizing equipment centrally or in departments.

5. Determining costs for allocation purposes, and
6. Determining costs of specific activities within a department.

Special studies may be prepared whenever management desires information for specific situations.

D. The Rate Setting System

The discussions in this report are based on a rate philosophy of equity among patients. Equity dictates that rates should reflect the cost of the specific services rendered to each individual patient, plus an appropriate provision for such additional amounts as are needed for capital purposes, contingencies, and so on.

Despite the objective of relating rates to cost, rates do not usually reflect all of the differences in cost that can apply to each service the patient receives. A practical alternative is to evaluate the average cost of specific medical services and calculate rates based on such averages. This is what has been outlined in the previous sections of this report.

Basic Policy Decisions

Before specific rates can be calculated, there are certain broad policy decisions which each provider must make. These policy decisions relate to the level of income the provider requires in order to meet its financial needs.

The first of these considerations deals with the problems of inflation and technological improvements. Because of inflation, the purchasing power of today's dollar received from a patient is not the equivalent of the purchasing power of a dollar spent

twenty years, or even two years ago. Because depreciation provisions today are computed on the basis of the original cost, an institution that includes only amounts equivalent to depreciation provisions in its rate structure is permitting the purchasing power of its capital to be eroded. Depreciation provisions (and, consequently, rates) which are based on historical cost are almost certain to be inadequate when the institution faces the problem of replacement of obsolete or worn-out facilities at a later date. In addition, the factors of innovative and technological change can influence the amount of working capital needed to finance current operations. Therefore, consideration must be given to these factors in setting the rates of the institution.

Another significant rate consideration, which must be dealt with at the policy level, is the cost of free services, including charity service and bad debts. One of the considerations that clouds all discussion of the rate implications of free care is the question of whether it is a cost or merely a reduction of income. From a bookkeeping standpoint, it is generally recommended that free care be shown as a reduction of income. However, from a rate-making standpoint, and in order to cover the subsequent or concurrent reduction of income, the cost of free care must either be included in rates charged to paying patients or be recovered in some other way. For example, if

bad debts and charity represent 10% of amounts billed to patients, then rates must be set at about 111% of cost in order to collect 100% of cost.

The policy consideration with respect to free care relates to the question of how free care should be financed. For example, should the charity element of free care be paid for by philanthropy, by government (using government as a broad term to indicate all kinds of government agencies), by the paying patients, or by some combination of these sources? This issue is extremely complex and will not be discussed in detail. However, certain of the factors pertinent to a policy resolution of these questions are:

1. Is the free service a result of a legal (and moral) responsibility of the institution, such as emergency admittances?

2. Is the free service attributable to the community service responsibilities voluntarily assumed by the institution?

3. Are acceptable alternative facilities available for the medically indigent? What is considered acceptable?

Policy decisions with respect to other types of free service are less complex. Bad debts, for example, pose no complex problems, and there is almost universal acceptance of the inclusion of the cost of bad debts in the rates charged to paying patients.

Policy consideration also must be given to the necessity for the retirement of loans and reserve funds. Certainly loans must be retired, and funds must be made available for this purpose. Also, it is nearly impossible to operate at an exact, break-even level, and it would appear prudent to provide some margin over and above debt and other requirements to ensure that operations will continue on a sound financial basis.

To summarize, in addition to regular operating expenses, rates must be set to cover:

1. Replacement of facilities, taking into account inflation and other change factors,
2. Working capital requirements,
3. All service and other costs (e.g., free care) not otherwise reimbursed,
4. Debt requirements,
5. As much excess as necessary to provide for sound financial operations, and
6. New or expanded plant facilities.