SB

227

COMMITTEE REPORT

SENATE

2/15/79

FURTHER: Judiciary

Date: 3/9/79

Mr. President:

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had SB 227 CSSS insurance for alcoholism and drug dependence

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for _____ [X] same title [ ] new title

and recommends INDIVIDUAL

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

Tom Lee Waldrop

Mike Collette

MEMBERS HAVING
OTHER RECOMMENDATIONS:

Glenn Hadsell
CHAIRMAN

DO PASS

S 60 (Rev. 12/78)

SB 227 "An Act relating to S. HESS 11-30
[illegible]

Introduced: 2-13-79
Logged 2-16-79
Referral Judiciary
Comm. Meeting - 3-9-79 - CS SS - taken Senate Secy @ 11:30 A.M.
" action

Notify Patty Mecklin (of Sen. Collatta's office)
PH: 3719
HESS
Revenue

HCSCSSSSB 227 (Fin)	CSSSSB 227
Relating to the health of residents of the state	Relating to ins. for Alcoholism & Drug Abuse
Sec. 39.30.092 Grp.Ins. required by 39.30.090 (1)	Sec.21.42.347 Grp.health insurance policies

Title & except

Pg.7 Lines 3-29 (identical)

Pg. 8 Line 5(b) new add.
remainder of bill identical

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to provide coverage for employees of the state and may apply to contracts for the benefit of employees of other participating governmental units only if the governing body of the governmental unit elects to have the provisions apply.

Health Care Legislation

HCS CS SS SB 227

HCS CS SS SB 227 "An Act relating to the health of residents of the state" is an omnibus health bill extending health coverage to several new groups of people and expanding the scope of coverage available.

* HIGH RISK INSURANCE POOL

People who have high risk medical conditions often are considered "uninsurable" and cannot purchase comprehensive health insurance. Section one of the bill establishes a high risk insurance pool to be administered by the largest carrier in the state. Premiums would be limited to reasonable levels and the carrier would be allowed to pass excess claims losses from this coverage on to the state through the tax system.

* ALCOHOLISM COVERAGE FOR STATE EMPLOYEES

Model benefits for coverage of alcoholism, including inpatient detoxification, inpatient treatment and outpatient treatment are added to the state employees health insurance plan. While the original bill mandated these benefits for all health insurance policies, the HESS Committee substitute bill would field test these new benefits on state employees.

* MEDICAID BY INSURANCE POLICIES OR HEALTH SERVICE CONTRACTS

Section eight of the bill directs the commissioner of Health and Social Services to provide Medicaid coverage through the purchase of private health insurance policies or health service contracts on behalf of Medicaid recipients, when this is found to be cost effective.

* RELIEF FOR MEDICAID PROVIDERS

The bill requires that the state pay interest at the rate of one percent per month to Medicaid providers on bills that are more than one month overdue, and two percent per month on bills that are more than three months overdue. It also allows the state to make an interim payment to large volume Medicaid providers prior to billing and processing of the claims.

* EXPANSION OF SERVICES AND ELIGIBLE PEOPLE COVERED UNDER MEDICAID

Sections nine and ten of the bill expand the state's Medicaid program to include all groups and all services for which federal funding is available. New additions include such eligible and services as unborn children, unemployed fathers, prescription drugs, adult dental care and physical therapy.

* COVERAGE FOR THE MEDICALLY NEEDY

Section eleven of the bill creates a new program of medical assistance for medically needy people under the state's General Relief-Medical program. The income threshold for eligibility is set at 150% of the poverty guideline for Alaska. People whose income exceeds that amount can still become eligible for assistance after they spend their "excess" income on medical bills.

* FISCAL IMPACT

The fiscal note for all these programs includes approximately $8 million from the General fund, $23 thousand from other state funds and $8 million in federal funds for FY81.

5/29/80
Bradley

Original sponsors: Colletta, Stimson and Hohman

IN THE SENATE BY THE FINANCE COMMITTEE

HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the health of residents of the state; and providing for an effective date."

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 50. COMPREHENSIVE HEALTH CARE PLANS.

Sec. 21.50.010. RESIDUAL MARKET HEALTH INSURANCE POOL. (a) The carrier which writes the largest premium volume of health insurance in the state as determined by the director shall, as a condition of transacting health insurance, establish and operate a residual market health insurance pool. Individual, group, and Medicare supplemental comprehensive health care plans as described in AS 21.50.020 shall be available through the residual market health insurance pool to every eligible individual or employer resident in the state. Applicants shall have a choice of the low option, the middle option, or the high option deductible established under AS 21.50.020.

(b) The administering carrier shall submit to the director for approval a plan of operation for the residual market health insurance pool which assures the fair, reasonable, and equitable operation of the pool. The plan shall establish procedures for administration, accounting, record keeping, and reporting for the pool, amendment of the plan, and advertising of the coverage provided. If the carrier fails to submit a plan within six months after the effective date of regulations implementing this Act, the director may adopt a plan to carry out the provisions of this section.

(c) Rates for comprehensive health coverage issued through the residual market health insurance pool may not be excessive, inadequate, or unfairly discriminatory. The rate for a given classification or group in the pool may not be more than 125 percent of the rate for a classification or group of at least 25 persons with similar characteristics at standard risk, for equivalent coverage not written through the pool. All policy forms and rates shall be filed with the director and may be disapproved within 30 days from the filing.

(d) Following the close of a fiscal year, the administering carrier shall determine the net premiums, administrative expenses, and incurred losses for the year from the operation of the residual market health insurance pool. Net gains, if any, shall be held at interest to offset future pool losses or allocated to reduce future pool premiums. Net losses may be credited against the carrier's income tax payable under AS 43.20 or its premium tax payable under this title. If the administering carrier's total assessment exceeds its tax liability for the year, the commissioner of revenue shall directly reimburse the carrier in the amount of the excess.

Sec. 21.50.020. COMPREHENSIVE HEALTH CARE PLANS. (a) Each of the three types of comprehensive health care plans (individual, group, and Medicare supplemental) shall provide minimum standard major medical benefits required by regulation.

(b) A comprehensive health care plan shall provide for a choice of deductibles. The low option deductible is $100 per person, the middle option deductible is $500 per person, and the high option deductible is $1,000 per person. The $100 maximum, the $500 maximum and the $1,000 maximum established under this subsection shall be adjusted periodically ~~yearly~~ by the director by regulation to correspond with the change in the medical care component of the consumer price index. The base year for the

computation is the first full year of operation of the plan.

(c) The sum of the deductible and copayments required in a calendar year under an option may not exceed a maximum limit of $1,000 per covered individual or $2,000 per covered family. The $1,000 and $2,000 maximums shall be adjusted ~~yearly~~ periodically by the director to correspond with the change in the medical care component of the consumer price index.

(d) A comprehensive health care plan may limit lifetime benefits to a maximum of not less than $1,000,000 per insured person.

(e) Benefits payable under a comprehensive health care plan written by the residual market health insurance pool are paid net of all health care benefits provided by or under another state or federal law including Title XVIII of the Social Security Act, Medicare, but not including Medicaid.

(f) The director shall adopt regulations establishing subrogation rights and coordination of benefits.

Sec. 21.50.030. ELIGIBILITY. (a) An individual comprehensive health care plan is open to enrollment by a resident of the state who is under 65 and can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up resulting in rates higher than the comprehensive health care plan, or a preexisting conditions limitation by two carriers within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered standard risk.

(b) A group comprehensive health care plan is available to a resident employer of three or more employees whom the employer seeks to enroll in a group plan, who can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up resulting in rates higher than the comprehensive health care plan, or a preexisting conditions limitation by two carriers within six months before the application for a group comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a group considered standard risk or a group of 25 members.

(c) A Medicare supplemental comprehensive health care plan is open to enrollment by a resident of the state who is enrolled in Medicare Parts A and B and who can provide evidence, with respect to major medi-

cal coverage, of rejection, requirement of restrictive riders a rate up, or a preexisting conditions limitation by a carrier within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered a standard risk.

(d) An individual may not purchase or renew coverage under a comprehensive health care plan established under this chapter after ceasing to be a resident of the state.

Sec. 21.50.040. ADDITIONAL CRITERIA FOR ELIGIBILITY. The director may adopt by regulation supplemental or alternative eligibility criteria which reflect the inability of an applicant to obtain coverage substantially similar to that which may be obtained by an applicant who is considered a standard risk or by a group with 25 members.

Sec. 21.50.050. POWERS OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.040 and may adopt regulations under AS 21.06.090 to carry out the provisions of AS 21.50.010 - 21.50.040;

(2) adopt by regulation reasonable limits on administrative expenses of the administering carrier which may be paid from comprehensive health care plan premiums, and minimum standards for the proportion of comprehensive health care plan premiums to be paid out in claims;

(3) examine and investigate the operation of the residual market health insurance pool and shall have reasonable access to the books, records, files, papers, and documents of the administering carrier that relate to the operaton of the pool;

(4) examine directors, officers, agents, brokers, or employees of the administering carrier for the purpose of determining if coverage is being adequately and fairly provided through the pool;

(5) contract with the federal government or with another unit

of government to ensure coordination of the comprehensive health care plan with other governmental assistance programs;

(6) undertake directly or through studies or demonstration programs to develop awareness of the benefits of AS 21.50.010 - 21.50.040 so that residents of the state may avail themselves of the health care benefits provided by these sections.

Sec. 21.50.100. DEFINITIONS. In this chapter,

(1) "administering carrier" means the carrier with the largest premium volume of health insurance in the state which is obligated under AS 21.50.010 to establish and operate a residual market health insurance pool;

(2) "carrier" means an insurer, hospital service corporation, or medical service corporation;

(3) "comprehensive health care plan" means health insurance which provides the benefits required under AS 21.50.020;

(4) "director" means the director of the division of insurance in the Department of Commerce and Economic Development;

(5) "family" means the primary insured and the covered dependents of the primary insured;

(6) "health insurance"

(A) means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, and self-insured or self-funded employee health benefit plans;

(B) does not include accident only policies, disability income policies or casualty insurance coverages subject to regulation under AS 21.39;

(7) "Medicare supplement plan" means a health insurance plan which provides benefits which complement or supplement the benefits provided by Medicare;

(8) "Medicare supplemental comprehensive health care plan" means a plan which, in conjunction with Medicare Parts A and B coverage, provides the benefits required under AS 21.50.020;

(9) "resident employer"

(A) means a person, partnership, association, trust, estate, corporation, whether foreign or domestic or the legal representative, trustee in bankruptcy or receiver or trustee of one of these, or the legal representative of a deceased person, including the state and a municipality of the state which has in its employ one or more individuals during a calendar year;

(B) refers only to an employer with a majority of employees employed in the state.

* Sec. 2. AS 21.27.410(a) is amended by adding a new paragraph to read:

(10) if an agent, solicitor, or broker transacting health insurance in the state fails to refer an applicant for health insurance whom the agent, solicitor, or broker has reason to believe may be eligible for a comprehensive health plan through the residual market health insurance pool to the administering carrier of the residual market health insurance pool.

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

(17) AS 21.50.

* Sec. 4. The director of the division of insurance, Department of Commerce and Economic Development, shall adopt regulations implementing sec. 1 of this Act by January 1, 1981.

* Sec. 5. AS 39.30.090(1) is amended to read:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audio-visual insurance, alcoholism and drug dependency insurance, or other medical

care insurance.

* Sec. 6. AS 39.30 is amended by adding a new section to read:

Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) The group insurance policy required by AS 39.30.090(1)

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and professional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 percent of the usual, customary and reasonable charge for a medical procedure, treatment or service in the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to provide coverage for employees of the state and may apply to contracts for the benefit of employees of other participating governmental units only if the governing body of the governmental unit elects to have the provisions apply.

(c) In (a) of this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 7. AS 39.30.100 is amended to read:

Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.30.090]

(1) "eligible employee" means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee, and

(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office;

(2) "governmental unit" means the state, a borough, municipal corporation, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts.

* Sec. 8. The provisions of secs. 5 - 7 of this Act apply to group policies or contracts which provide coverage under AS 39.30.090 - 39.30.100 and which are delivered, issued for delivery, or renewed in this state after the effective date of this Act. A policy or contract providing coverage for eligible employees in this state delivered, issued for delivery, or renewed after the effective date of this Act provides the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 9. AS 47.05 is amended by adding new sections to read:

Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall use available medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health maintenance organization service contracts or medical or hospital service contracts that provide one or more of the medical services available under state medical assistance programs.

(b) The policy of insurance or the contract must by its terms guarantee

(1) to provide the medical services allowed under state law;

(2) to provide medical services under policies of insurance or contracts in compliance with applicable laws and regulations;

(3) to provide the statistical data, records, and reports

relating to the provision, administration, and costs of providing medical services as required by the commissioner.

Sec. 47.05.080. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND SERVICE. (a) The commissioner may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance for services rendered and supplies furnished by them.

(b) A contract under this section shall

(1) oblige the contractor to make payments under the contract promptly and not later than 30 days after receipt of the proper evidence of the claim; and

(2) provide data, records, and reports required by the commissioner.

Sec. 47.05.090. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.05.070 - 47.05.090 when the commissioner determines that comparable benefits are available at equal or less cost than direct payments by the department to the providers of medical assistance.

Sec. 47.05.100. INTERIM PAYMENT. The department may make an interim payment before receipt of billing for service to providers who serve a large volume of state medical assistance clients under regulations of the department.

Sec. 47.05.110. INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the state shall pay

(1) interest at the rate of one percent per month when payment is delayed more than 30 days after presentation of the clean claim;

(2) interest at the rate of two percent per month when

payment is delayed more than 90 days after presentation of the clean claim; and

(3) a full months interest entitlement if the claim is not paid by the 15th day of a calendar month.

Sec. 47.05.120. DEFINITIONS. In AS 47.05.070 - 47.05.120

(1) "clean claim" means a claim for payment which can be processed without obtaining additional information from the provider of the service or from a third party; it includes a claim with errors originating in the department's claims processing system, but does not include claims from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity;

(2) "commissioner" means the commissioner of health and social services;

(3) "department" means the Department of Health and Social Services;

(4) "medical assistance" means Medicaid (AS 47.07), general relief medical (AS 47.25.120), catastrophic illness (AS 47.08) and crippled children's and maternal and child health programs (AS 18.05.-010).

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

* Sec. 11. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Services Act.

* Sec. 12. AS 47.25.120 is amended to read:

Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE UNDER THE CONDITIONS IN THIS STATE,] to

(1) a needy person who is eligible under the regulations of the department; and

(2) a medically needy person whose income is less than the medically needy income standard or who has incurred medical expenses which equal or exceed the difference between the person's monthly income and the medically needy income standard; the medically needy income standard is 150 percent of the current Federal Community Services Administration poverty income guidelines for Alaska (45 C.F.R., sec. 1060.2).

* Sec. 13. AS 47.07.020(d) is repealed.

* Sec. 14. Sections 2 - 8 and 10 - 13 of this Act take effect January 1, 1981.

* Sec. 15. Sections 1, 9, 14, and 15 of this Act take effect July 1, 1980.

Original sponsors: Colletta, Stimson and Hohman

Offered: 3/13/79
Referred: Judiciary

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to insurance for alcoholism and drug dependence; and providing for an effective date."

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

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.347. REQUIRED PROVISION OF COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) Group health insurance policies providing coverage on an expense-incurred basis and group service or indemnity type contracts issued by a nonprofit corporation

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and professional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a

licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 per cent of the usual, customary and reasonable charge for a medical procedure, treatment or service in the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) In this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 2. AS 21.87.340 is amended by adding a new paragraph to read:

(17) AS 21.42.347.

CSec 1]

* Sec. 3. The provisions of this Act apply to all group policies or contracts delivered, issued for delivery, or renewed in this state after the

effective date of this Act. A policy or contract providing coverage for persons in this state delivered, issued for delivery, or renewed after the effective date of this Act shall be considered to provide the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 4. This Act takes effect November 1, 1979.

Senator Hackney

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M March 29, 1979

SUBJECT: CSSB 227, relating to alcoholism and drug dependence insurance

TO: Senator Mike Colletta

FROM: John B. Chenoweth, Legislative Counsel

I do not want to belabor the explanation you requested of this bill. The one-page summary provided by the insurance division seems more than adequate. I did question Don Koch concerning the distinctions among the several types of policies mentioned or referenced in lines 11-13 of page 1 of the bill, and thought I would share that informaton with you.

The subsection mentioned speaks to

(1) "group insurance policies providing coverage on an expense-incurred basis"; and

(2) "group service or indemnity type contracts issued by a non-profit corporation."

(1) identifies the contracts normally issued by private insurance contracts. Private corporation contracts are typically indemnification contracts, by the terms of which the insurance company agrees to reimburse the insured for covered expenses. These contracts are usually one of three types: the "specified sickness" policy, the "flat rate" policy (paying so much per day for hospitalization for whatever the reason), and the "expense-incurred" policy (reimbursing for certain expenses designated in the policy). This bill addresses only the "expense-incurred" policy, the insurance division spokesman says, for this is the type of policy usually written by companies for the benefit of employees, and is more nearly related to the kind of coverage for hospitalization and outpatient services than other kinds of company-written policies. By the term of the bill, only group policies must now provide for the coverage.

(2) above -- the service or indemnity-type policy -- is typically the kind of coverage written by carriers providing direct subscription coverage. In a service contract, payment is made by the carrier to the hospital or health facility (and in some states to physicians) for medical services provided to persons covered. In Alaska, Blue Cross of Washington/Alaska is the principal carrier of service contracts for health care coverage. My understanding of the explanation is that only nonprofit corporations are able to enter into service contract relationships directly with hospitals and health facilities. The reference to "indemnity-type" contracts in this line extends the mandatory coverage for alcoholism and drug dependence to nonprofits who indemnify insureds as well as to those whose business follows the service approach.

I trust this helps to explain the differences in the types of coverage. From the explanation, it appears certain that the intended alcoholism and drug dependence coverage does reach all providing coverage on an expense-incurred basis, including, of course, "profit-seeking" insurance corporations writing this type of coverage.

JBC:nem

3/9/79

SB 227

Sen. Colletta. This is the result of some extensive public hearings in two plus years of work trying to address a problem that conceptually everyone is in accord with. During the interim last year, we approached the problem in a different manner. The Budget and Audit Committee was generous enough to authorize $15,000 expenditure to try to accomplish the task of writing a third-party alcoholism insurance bill. Rather than using the normal routes of hiring consultants or experts in the field, what we did was go to experts in the work ethic field of the problem and the result that is before us today is their product.

It has virtually universal support, the major insurance companies participated to a great degree in a candid manner and did providers and in some cases, a couple of users. I would hope that the committee and the Senate as a whole would look upon it very favorably because I believe you are going to hear some testimony that shows the application of many minds can usually afford at least a workable style solution to accomplish any task that is put before them.

Mr. Moore. Director of Insurance for the State of Alaska. We prepared a position paper. We appear here not as opposed to the bill. We also did bring questions up in our position papers, these questions are of costs, we aren't totally sure that the cost factor is yet determinable. The other is an unequal distribution of premiums versus benefits. Thirdly, we raise the question of whether it is appropriate or not to mandate a parallel coverage. We take no standing on any one of these questions and there may be other experts here who would like to address them. We do not oppose the bill.

My associate, Mr. Don Koch, may wish to address some particular points.

Don Koch. Chief of market surveillance with the Division of Insurance. On two occasions I was acting chairman for Senator Colletta's panel to study third-party insurance coverages. It was a pleasure to me to work with a group like that that really got down to brass tacks and came up with something we believe is a workable bill.

2515

The original SB 227 was an initial workdraft of the committee. It came out of their second meeting. There was a subsequent meeting at which point in time we came up with additional amendments and I have here a copy of a marked up version of SB 227 with the two additional pages listing the specific changes.

The committee recognized early on that employed persons in a disproportionate share of hours spent on alcoholism problems in the State of Alaska and felt that this ought to be addressed. We had some statistics before us provided by Blue Cross in an article that they have in their magazine called Perspective, their 78 version of it. Basically it indicated of employed problem

problem drinkers represent about 5% of the employed population. That may or may not be true of Alaska, there have been some suspician that it probably higher. That 5% represents roughly 15% of the expenditures of the available health care dollars, so they are using three times the amount of health care dollars that their employed counterparts (non-drinking) are utilizing. One of the first concepts that the committee dealt with was the idea that to the degree that an alcoholism benefit was utilized, it would tend to reduce the utilization of other benefits. The article that I mentioned did discuss problems that problem drinkers do have. There is an increased incidence of cancer, for instance, that surprised me. That was supported by the doctor that was on the panel. There are increased problems with some liver conditions and gastrointestinal problems. Blue Cross did some studies that did show in the use of control groups what some of these relationships were, at least as to the groups they used for their studies. They were pretty convincing.

One of the concepts or considerations that the committee dealt with was the fact that after last year there were substantial quality controls placed in the Division of Alcoholism. They are now able to establish standards in the treatment of alcoholism, they are able to deal with quality controls on the personnel that will deal with this treatment. They have a number of things that they are now able to do that lend themselves to providing some kind of insurance benefit for alcoholism because there is some reasonable and meaning limitations on those persons who can deliver those kinds of benefits.

The committee recognized that there would have to be some kind of reasonable limitation just to make the bill workable. But determined that rather than use a dollar limitation they would use a time period limitation which would tend to be responsive to inflation as time goes on. One of the concepts they deal with was that that alcoholism should be treated as any other illness rather then setting up a specific degree or kind of care limitation on care. One of the primary flaws with the bill that was before the legislature last year, SB 545, is it didn't deal with some of the things that would tend to wipe out the coverage such as pre-existing conditions exclusions. Most health care policies have a condition in the policy that says if this condition existed before coverage began, you don't have any coverage. Well, alcoholism generally is something that is a long term thing or its been accumulated over a period of time so you could well end up with a situation where you provide a benefit but no body can collect on the benefit because its a pre-existing condition from the time that coverage began. That has been dealt with by saying that you cannot have a pre-existing condition exclusion for the kinds of things that we are providing a benefit for under this bill.

The panel determined that this package should be considered a minimum package and that the package should be a reasonable package, something that could work to provide rehabilitation for persons who would be collecting the benefit. The thought being that to the degree that a bargaining unit or employer/employee

group wished to have expended coverages those would be something subject to the negotiation of the collective bargaining process.

The committee determined that they would address not only alcoholism but drug dependence, so that the benefits that are listed in the bill are somewhat of a compromise which will probably be fairly liberal in some cases for alcoholism and will pretty tight in some cases for drug dependence. It also determined that it would not deal with two areas of drug dependence mainly nicotine and caffine. They figure those are issues whose time has not come.

Another concept that the committee dealth with was that this would provide for an added source of funding for some facilities who are now hard pressed to get funds. It would also provide an incentive for those facilities or programs to come up to a standard established by the state. So to that degree we'll probably have an increase in the quality of the treatment and care for alcoholism within the state.

You'll notice that within the definition of state within the bill, there is a reference to the fact a state means all 50 states or the District of Columbia. The reasoning there was that the committee felt that this coverage should be provided wherever it can be provided by facilities that meet controls that the Division of Alcoholism has indicated, or those levels of quality and that it shouldn't be confined necessarily to Alaska since perhaps in many areas we don't have the facilities. We may have somebody who originally came up from another area or has family in another area and therefore that person might best respond to treatment and rehabilitation in that area. However, the committee determined that it wouldn't be proper to provide transportation funds for that kind of situation.

The end result of that feature is that it may well provide for a less expensive treatment since it is likely that treatment in another area is going to be less expensive than it would be here in Alaska.

Basically those were the concepts and considerations the panel dealt with. They did also look to where the opposition might be coming from on a bill of this kind. They considered a number of these issues, they dealt with a number of them, positively in some cases, in other cases they just determined that that is going to be a matter for somebody to determine policy. Cost of course is a concern. We had testimony from members on the panel that the cost would likely run somewhere between 2 and 5%. However, that is going to be controlled greatly by the utilization of the benefits to the degree that utilization of the benefit increases, that cost diminishes. I think there are others here who can speak better to that than I can.

There was a cuestions brought up about how you distinguish between the drunk and the alcoholic. The committee felt that the

benefit package was developed in such a way that the person who is just drunk and is not necessarily an alcoholic isn't necessarily going to be the guy who is collecting the benefit under this policy anyway. The bill calls for several areas of coverage, one of those is a detox or drying-out coverage these are people that generally are into an emergency medical situation anyway. We are told that quite often policies are presently paying for this but they are identifying it as something else, liver problem or dehydration, any number of things.

The idea is that this would tend to cause an outright identification of alcoholism problems. The Divsion of Insurance takes the position that we wish to be involved in some kind of a statistical approach to this thing so that we can work in conjunction with the carriers and the division of alcoholism to develop some meaningful insurance statistics for a bill of this type. That we think is an intrical part of the operation of legislation like this. There were some arguments that were presented as opposing views -- the primary one is the mandate versus option feature. As the director indicated, we don't have a position that. I do know that there are others who are looking to this and there are employers that would be concerned with it, the Health Insurance Association of America will also probably address that particular issue.

The committee did recognize that there are going to be employers and employees who will fall through the cracks. These generally fall into two categories one is those where this question of jurisdiction such as federal employees. The state law doesn't have a way to reach those. The other would be the self insured employers. The committee determined that it didn't wish to address that issue either, since that would involve something that would be very difficult as a matter of practicality to effect, it would be a difficult kind of legislation to approach. So, they felt comfortable with the bill as far as they went.

It's our opinion that what you have before you aside from the considerations the director has mentioned is a highly workable bill, it does respond to the problems that previous directors saw and addressed with Sen. Colletta last year.

Sen. Hackney. Where did you come up with that description of alcoholism?

Don Koch: The initial definition of alcoholism that you see in the first version of SB 227, when the committee saw that they felt that it was negative. I don't pretend to understand why they felt that way, but they addressed that as one of the primary concerns with the bill. They sat down and came up with another one and frankly, I don't know what the source of the other definition was but everyone seemed pretty happy with it. There was even some talk about not having a definition at all and that thought was prevelent for a while until the thought came to mind, well, if you don't define alcoholism the insurer will in his policy. They didn't want to lose to the insurer

what was meant by alcoholism.

Sen. Colletta. I concur with the proposed amendments and was made aware of them.

Don Koch. This bill does one other thing tht is perhaps a little unusual from a state standpoint, That is, it addresses contracts that are not initiated in the state. This would be the employer who is domiciled in other locations and has employees in the state, but all his negotiations take place in another location. What the comments in sec. 3 of the current bill, not of the revision, what it basically says is that if you have a contract that is issued in another location and ends up covering employees in this state that contract will be deemed to provide at least a minimum benefits that we are requiring of other insurers in the state. Even thought that language may not specifically appear in their contract.

Sen. Hackney. Would that not cover federal employees?

Don Kock. No. You can't superimpose a state law on a federal This would speak to a policy that is written under another state law, Washington, Oregon, They have reason to send employees into our state and those employees are here on a permanent basis. Those people who are here and living in this state would be entitled to the level of benefit that any other employee would from his employer.

Sen. Fahrenkamp. I was wondering what the cost will be fo the state for its employees.

Paul Arnoldt. Director for the Divsion of Retirement. I apologize that we don't have a formal fiscal note in front of you, but I have just talked to John Hopkins of Blue Cross and he advised me that the rate would run about $2.64 month per employee based upon a cover group of the state of around 8,000, I think that comes to around $250,000 plus per year. We could probably anticipate that rate going up about 20%, I think around 12 to 16% would be the rate increase then there would be some growth in the actual number of employees covered, so we figure about a 20% increase in this area.

John Hopkins. Representing Blue Cross of Washington and Alaska. I served n the panel that helped to develop the legislation.

I would like to speak to the area of cost of the bill. As we were going through the deliberations, many of the panel members came to me and said ' what is this whole thing going to cost'. I used the broad range of 3 to 5% over existing premiums. As Mr. Arnoldt has pointed out, we have now developed a firm premium or rate for the state. I think it is interesting that the $2.64 which projects out to a quarter of a million dollars a year is rally only 3% of the premium. What must be considered is the fact that on the long range the mandating of an alcoholism benefit will probably be cost effective which means you will get a higher return than what you are paying in. Earlier Mr. Koch referred to some articles prepared in a Blue Cross publication and the evidence is really conclusive that the treating of alcoholism lowers the cost to other health insurance benefits. Therefore ultimately

ultimately offsetting the cost of the alcoholism benefit. I think it is fair and necessary for me to point out that from a carriers point of view we are taking risk and you are not going to see that benefit until out there two or three years. So, we do have to go in with an initial charge. Ultimately there will be a return on that. I support the way the bill is constructed, the levels of care I think are appropriate. The committee tryed to design the legislation so that it would get two appropriate types of treatment and yet not be subject to abuse.

You take your first year and you have a quarter of a million dollars of premium coming in. For example, on state employees we are going to pay out approximately that much in claims for the treatment of alcoholism. If that corrects the alcoholism problem in 100 people, the theory is that those 100 people are going to have less of the general medical type of claims in successive years. The evidence is conclusive.

I have to say in all honesty is it going to be extremely difficult to pinpoint because you've got several curves on your graft. You've got the cost of the alcoholism benefit, medical inflation puts it up, the decrease on other medical services puts it down a little bit, and it will be tough. But conclusive evidence came from these companies that established control groups. the cold hard facts are there that it reduces the cost of medical care.

Sen. Fahrenkamp. Could you address mendated service and pre-existing . . .

John Hopkins. On pre-existing, that was put into the legislation that than an insurance carrier in writing a policy could not avoid paying for the treatment of alcoholism because of a pre-existing condition.

The question of mandating has been discussed by the panel, we tryed to say that that is not what we are here for, the panel is here to construct legislation that is workable. My own feeling is a mixed opinion on what are you trying to mandate. The Blue Cross supports this bill which does in effect mandate.

Sen. Hackney. The 8,000 is just state employees? (Yes) What wuld it do to coverage if you covered municipal employees also.

Paul Arnoldt There are currently about 2,500 employees covered under the municipalities of the state who participate in the state's in the plan that the state sponsors. Other municipalities have their own plan. The $253,440 figure that translates to is only the cost to the state. (The municipality 2,500 figure is not included in the 8,000)

John Hopkins. I recognize the state as being very cautions fiscally. One of the things that is happening right now is the general cost of medical care as reflected in insurance premiums

is not going up nearly as rapidly as it has in past years. Right now, in the last year and again in 1979 we are looking at in some cases no rate increase and in some cases very small rate increase. So I guess I would say if there was ever a time to mandate a benefit where it may have a 3% effect on premiums, now is probably a pretty good time.

Sen. Hackney. What you are really saying is among other things, hospital costs containment has perhaps been more effective in Alaska . . .

John Hopkins. Moreso than the rest of the country. Its a combination of cost containment and people going to the hospital less frequently, staying shorter, etc.

Bob Cole. Supportive of measure. It shouldn't be difficult to measure certain critical variables that should show up after this benefit if it is enacted among the state employee work force t the extent that this benefit is utilized, you should see a downturn over time of sick leave utilization, productiviy problems, death and disability payments, etc.

Out to accept SS. and then out of committee with/ indiv. recs.

SB 227 - SECTIONAL BREAKDOWN

SECTION 1 - Incorporates alcohol/drug treatments into insurance package with the following coverage:

1(A) - inpatient detox benefits for NLT 14 days of each calendar year in a state approved facility/hospital; benefits shall be equal and payable as any other covered condition.

(B) - inpatient treatment coverage benefits for NLT 30 days of each calendar year in state approved treatment program; payment of institutional & professional benefits shall be at the same level as any other covered condition.

(C) - outpatient treatment benefits NLT 30 visits each calendar year if treatment provided by a licensed physician or state approved program; payments at NLT 75% of usual charge for medical procedure, treatment or service in geographic area.

(2) - may not exclude dependents otherwise covered

(3) - may not apply preexisting or named conditions to deny coverage

(4) - may require physician's certification of necessity.

(b) Definition section.

SECTION 2 & 3 - Provisions will be applicable to all group policies and minimum coverage will be required even if language of policy/ contracts does not so specifically provide.

SECTION 4 - Effective Date.

must pay at least 80%.

SECTION ANALYSIS SS for SB 227

Sec 1 AS 21.42

Requires that all group health insurance policies issued by insurance companies and all service or indemnity type contracts issued by non-profit corporations such as Blue Cross, provide as a minimum, specified coverages related to alcoholism and drug dependence.

COVERAGES are:

A. not less than 14 days detoxification benefit at a rate equal to other benefits provided in the policy.
B. not less than 30 days inpatient treatment benefit
C. not less than 30 visits to specified outpatient treatment facilities.

Alcoholism and drug dependence coverage is to be provided for all persons covered under the group policy without regard to age, sex, state of illness, or pre-existing condition.

Section 1 also provides key definitions of alcoholism and drug dependence.

Section 2 Amends AS 21.87.347 to provide that Hospital Medical Service Corporations ie. Blue Cross, are also subject to the provisions of AS 21.42 as created by this bill.

Section 3 Specifies that coverage for alcoholism and drug dependence shall automatically apply to all persons covered by a group policy issued for delivery, delivered or renewed in this state after the effective date of the act; whether the policy wording specifically provides coverage or not.

Section 4 Provides for an effective date of November 1, 1979 in order for insurance companies to amend policies and adjust rates prior to the effective date.

POSITION PAPER SB 227

"An Act relating to insurance for alcoholism and drug dependence."

The State Office of Alcoholism and Drug Abuse is very supportive of this bill for the following reasons:

There are a great number of basically middle-class employed professional administrative and technical people in Alaska, in need of Alcoholism and Prescription Drug Abuse Treatment Services, who by and large are not showing up in State funded treatment program at the present time unless they are convicted OMVI offendors. There is every reason to think that the majority of these prople are either not availing themselves of treatment services, or are going to outside treatment programs, such as Schick-Shadel, for treatment.

There is reason to believe that a major share of all costs for acute medical care in Alaska (and elsewhere) are created by injuries and illnesses brought on by the abuse of beverage alcohol (See: excerpts from recent Blue Cross publication for an example.)

Because of the work done by SOADA and local programs over the past few years, in getting local programs brought up to Nationally recognized standards, some of them now appear to be in a position to begin to offer services that could and would be reimbursed by private insurance companies. Most notable among this group would be the outpatient programs in Anchorage, Fairbanks, Juneau, Ketchikan and Seward.

There is a new, private medically supervised Substance Abuse treatment program being opened at the Alaska Medical Center in Anchorage, this Spring.

Additionally, a new, medically supervised facility is scheduled for construction in Juneau this Summer.

Both these programs should be able to provide inpatient treatment services that will be reimbursable through the coverage proposed in this bill.

Evidence from public and private organizations around the country (Kennecott Copper, Kemper Insurance, State of California, as examples) indicates that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Provision of these benefits is an encouragement for people to avail themselves of the services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments, and hospitalization for accidental injury and related diseases should diminish. This would particularly be true if companies and/or units of government have also adopted Employees Assistance provisions in their personnel policies. (See Attachment 2)

Provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structual Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnoses of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing

inappropriate euphemistic diagnoses for claiming benefits, as they now admittedly do in apparently somewhat massive numbers. The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

Lastly, this bill was written mostly by the Insurance companies who serve Alaska, with the assistance of the Division of Insurance and some input from this Office. It appears therefore to address most of the concerns they had with the earlier version, while providing appropriate levels of coverage for Alcoholism/Drug Addiction Treatment.

The Office will be pleased to provide additional information on this bill as requested.

Recommended by:

Robert L. Cole 2/28/79

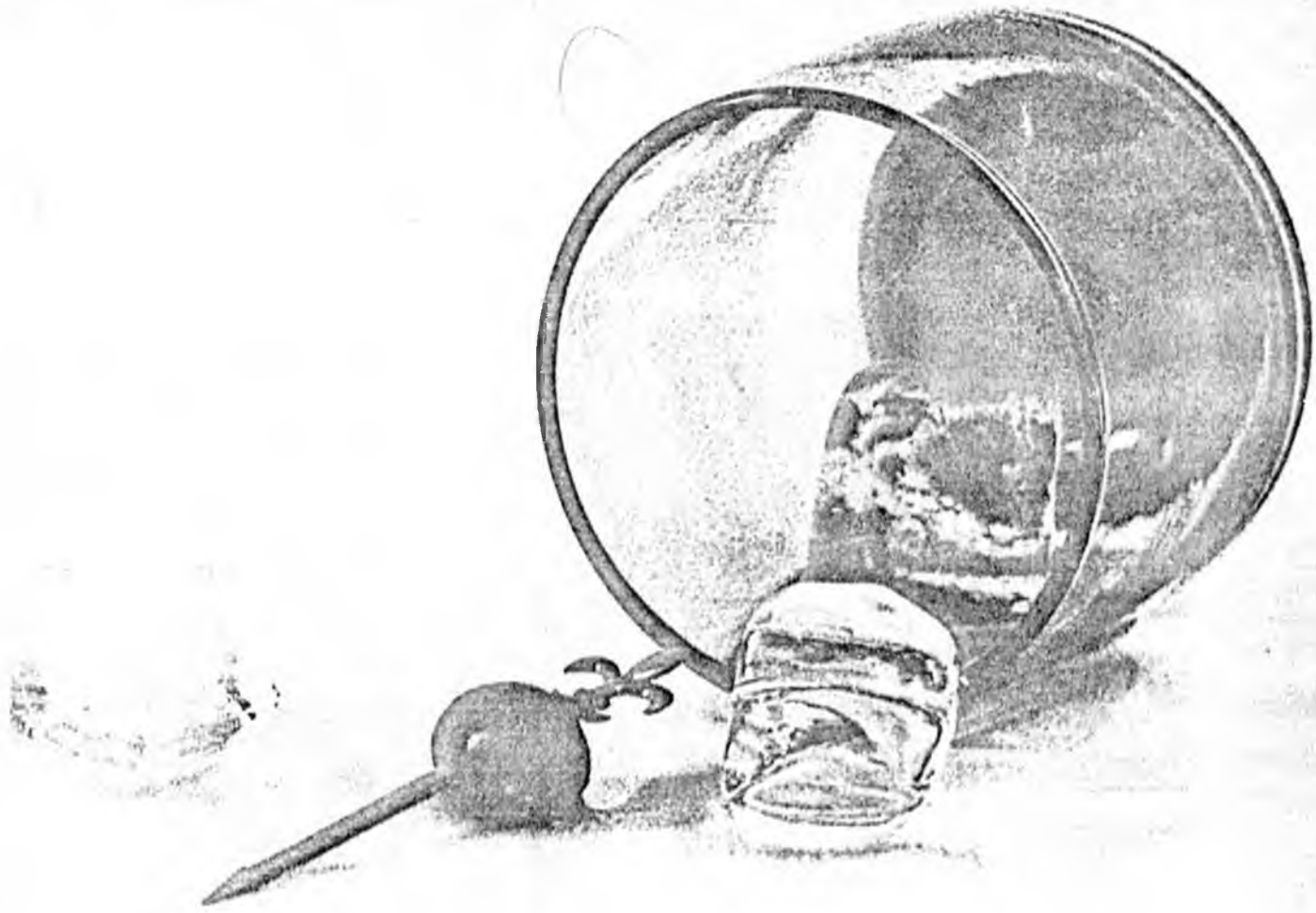
Robert L. Cole, Coordinator Date
Office of Alcoholism & Drug Abuse

Approved by:

Helen D. Beirne 3/9/79

Helen D. Beirne, Commissioner Date
Department of Health & Social Services

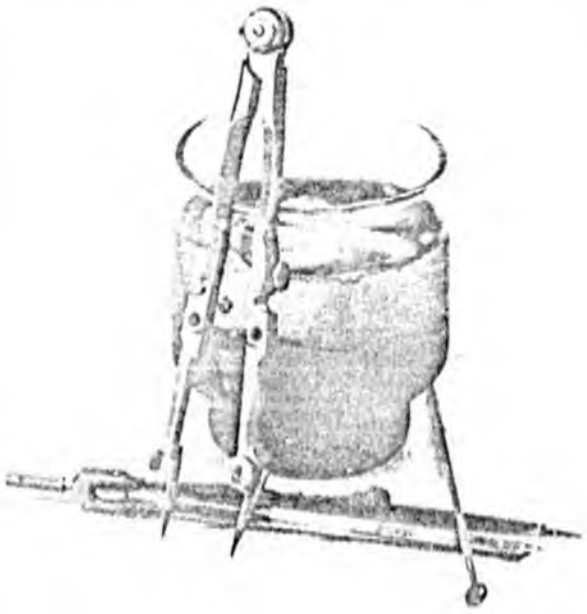
PROBLEM-DRINKING EMPLOYEES



70% Can Be Rehabilitated
(And Millions Of Dollars Saved In The Process?)

Here's a quiz on "drinking and working" . . . and the answers:

Questions	Answers
• What percentage of an employee population are problem drinkers?	5%
• How many more company dollars in health benefits does a problem-drinking employee use than the average employee uses?	3 to 1
• What share of employee health claims are by problem drinkers?	15%
• What can be done about problem-drinking employees?	Rehabilitation
• What percentage of problem-drinkers can an employer expect to rehabilitate successfully?	70%
• At what cost to the employer?	None?



Large employers such as Scovill, Economics Laboratory, Illinois Bell, the Philadelphia Fire Department and Kennecott Copper have an edge on most readers. They knew the answers even before PERSPECTIVE provided them. That's because these five employers helped contribute the data.

But Kenneth Sarvis, insurance consultant to the Florida Department of Health & Rehabilitative Services, brought the facts into focus.

His report, INSURANCE COST SAVINGS DUE TO AN ADEQUATE ALCOHOLISM HEALTH BENEFIT, makes four major contentions borne out by employer data:

1. "Problem drinkers utilize a disproportionately high portion of health benefits."
2. "There is a high rehabilitation rate for problem-drinking employees."
3. "There is a significant reduction in the utilization of health and sickness benefits by rehabilitated problem drinkers."
4. "An employer can expect significant health insurance cost savings by providing employees health insurance for alcoholism."

Sarvis' data to support each of these contentions are considerable.

THE TOLL . . .

The U.S. Department of Health, Education & Welfare has issued a report on alcohol abuse. It says:

- An estimated 10 million Americans are either problem drinkers or alcoholics.
- Drinking may be to blame for as many as 205,000 deaths a year.
- The economic toll from alcohol problems was about $43 billion in 1975 (lost production, medical bills, other expenses).
- Alcohol may be involved in: up to one-third of all suicides, half of all murders, half of all traffic deaths, one-fourth of all other accidental deaths.
- Alcohol is "indisputably involved" in causing cancer.

But . . .

- Programs to treat problem drinkers and alcoholics increased from 500 in 1973 to nearly 2,400 in 1977.

CONTENTION NO. 1:

"Problem drinkers utilize a disproportionately high portion of health benefits."

Sarvis says:

"Employee health is considerably affected by problem drinking."

He cites work done by Dr. Wilton Maxwell, studying a sample of employees with sickness or injury absence of eight days or more for which sickness payment was made. Each eight-day absence is called a "case" in the following tabulation:

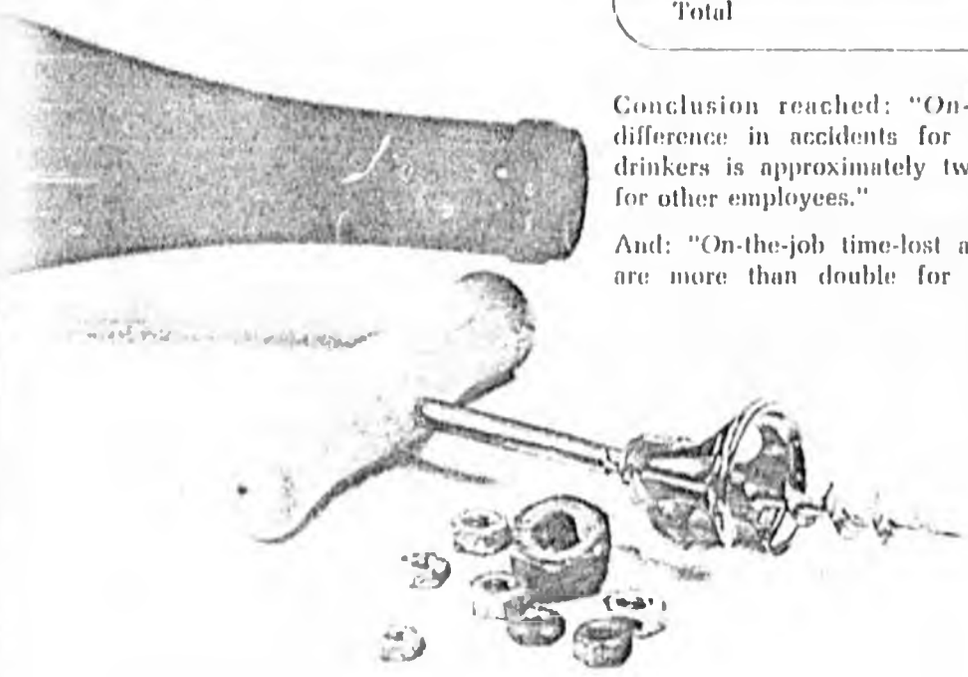
Description	Problem Group	Control Group
Number of cases	364	149
Average number of cases per employee	7.6	3.1
Total days absent	11,672	4,648
Average number of days absent per employee	243.2	96.8
Total sickness payments	$108,495	$36,862
Average sickness payment per employee	$ 2,260	$ 768

Conclusion reached: *"The average and total sickness payments indicate alcoholics cost employers three times the sickness payments of other employees."*

Moreover: "The problem group's total days absent is 2½ times that of the control group, indicating a tremendous loss in production time to the employer."

Maxwell, a PhD in sociology, also studied how frequently accidents happened to members of the two study groups:

Accident Class	Problem Group	Control Group
On job (no time lost)	29	16.0
On job (time lost)	26	11.5
Off job (eight days or more lost time)	44	0.0
Total	99	27.5



Conclusion reached: "On-the-job difference in accidents for problem drinkers is approximately twice that for other employees."

And: "On-the-job time-lost accidents are more than double for problem drinkers, indicating that the type of accident attributable to problem drinkers is more costly to the employee than other non-alcohol related accidents."

Worst of all: "*Off*-the-job accidents numbered 44 for the problem-drinking group, zero for the control group."

Overall: "The problem-drinker accident rate was 3.6 times that of other employees, a distinctive cost differential to the employer."

Maxwell explored the question of "how many hospital stays are attributable to problem drinking?" He cites the work of S. Peli and C.A. D'Alonzo in establishing frequency rates by type of illness or injury:

Selected Digestive Disorders		No. of Absences	Frequency Rate %
Gastrointestinal upsets	A	167	21.9
	C	66	7.6
Cirrhosis of liver	A	6	0.8
	C	0	0.0
Peptic ulcer	A	18	2.4
	C	13	1.5
Hernia	A	11	1.4
	C	4	0.5
Gall bladder disease	A	6	0.8
	C	7	0.8
Other digestive disorders	A	7	0.9
	C	13	1.5
Total	A	215	28.1
	C	103	11.9

A = Alcoholics C = Controls

Selected Respiratory Infections		No. of Absences	Frequency Rate %
Upper respiratory infection	A	173	22.6
	C	116	13.4
Influenza	A	71	9.3
	C	51	5.9
Bronchitis	A	35	4.6
	C	24	2.8
Pneumonia	A	15	2.0
	C	4	0.5
Total	A	294	38.5
	C	194	22.5

Selected Musculoskeletal Disorders		No. of Absences	Frequency Rate %
Arthritis	A	18	2.4
	C	5	0.6
Rheumatism	A	15	2.0
	C	7	0.8
Low back disorders, cause unspecified	A	22	2.9
	C	7	0.8
Bursitis	A	17	2.2
	C	5	0.6
Disc disorders	A	14	1.8
	C	2	0.2
Muscular strain	A	16	2.1
	C	6	0.7
Other	A	9	1.2
	C	14	1.6
Total	A	111	14.5
	C	46	5.3

Conclusion reached: *"The frequency rate of alcoholics is about three times that of other employees* for digestive and musculoskeletal disorders, and about two times that of other employees for respiratory infections," replicating other findings.

Sarvis comments: "These and similar studies indicate that problem-drinking employees are sick people who use a disproportionately high portion of employee group health insurance, contributing to high group insurance costs."

CONTENTIONS NO. 2 & 3:

"There is a high rehabilitation rate for problem-drinking employees."

"There is a significant reduction in the utilization of health & sickness benefits by rehabilitated problem drinkers."

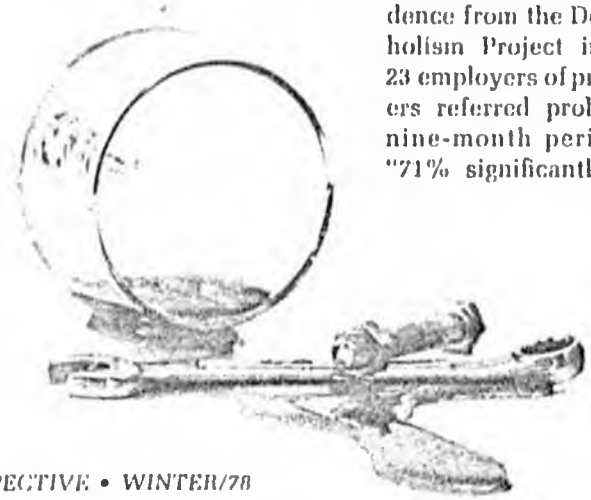
Sarvis finds "the success rate for rehabilitation of problem-drinking employees" to be "very high," indicating that "the possibility of job loss is an incentive for employees to seek rehabilitation."

He also finds that, "after problem drinkers are rehabilitated, there is a great reduction in their utilization of health and sickness benefits," thereby "significantly decreasing the cost of group health insurance."

He cites five employers who have proven track records at rehabilitating problem-drinking employees through a formal mechanism for early identification and referral:

Employer	# of Employees	"Processed"	% Rehabilitated	Savings
Scovill Mfg. Co. Waterbury, Conn.	6,500	180 in 3 years	78%	$186,550
Economics Laboratory, Inc. St. Paul, Minn.	3,500	N/I	80% for employees; 50% for dependents	Not indicated; but treatment costs were cut as much as 65% by using non-hospital facilities, such as alcoholism treatment centers.
Illinois Bell Telephone Co. Chicago, Ill.	N/I	402 in 5 years	72%	46% reduction in sickness disability and "a tremendous decrease in utilization of insurance plans."
Philadelphia Fire Department	3,410	N/I	N/I	55% decrease in sick leave for referred cases; 67% reduction in injuries; "a significant decrease in health insurance utilization."
Kennecott Copper Corp. New York City	N/I	N/I	N/I	After a year, costs for hospital, medical and surgical care were reduced 55%; alcoholics vs. other employees cost 5-to-1 for all sickness & accident activity, 3-to-1 for hospital, medical & surgical care.

N/I = not indicated



Sarvis also cites equally pointed evidence from the DePaul Industrial Alcoholism Project in Milwaukee, where 23 employers of primarily factory workers referred problem-drinking over a nine-month period. Their findings: "71% significantly improved, 46% of them reporting total abstinence and 26% 'essential' abstinence."

The consultant concludes that "*an employer can expect a high rehabilitation success rate for problem-drinking employees* — 70% is average — and a tremendous decrease in the utilization of health benefits." Savings are "maximized when an employer couples a formal mechanism for early identification and referral with appropriate health insurance coverage for alcoholism."

CONTENTION NO. 4:

"An employer can expect significant health insurance cost savings by providing employees health insurance for alcoholism."

Sarvis quotes some key numbers:

- *"5% of an employee population are problem drinkers."* (Source: National Institute on Alcohol Abuse & Alcoholism)
- *"A problem-drinking employee uses $3 in health benefits to $1 for the average employee."* (Source: Dr. Maxwell)
- "An employer can therefore estimate that *problem-drinking employees are responsible for 15% of claims paid annually*" . . . by multiplying the 5% times the 3 in the 3-to-1 ratio.
- If all problem drinkers could be rehabilitated and it could then be "assumed that alcoholism did not exist in an employee group, *the employer would pay 10% less in claims*" . . . reducing the 15% above by the difference between the numbers in the 3-to-1 ratio to arrive at the use by non-problem-drinkers.
- "It is impractical to believe that 100% of such savings could be achieved. *Some* can. If an employer provided adequate coverage for alcoholism and only 20% of problem-drinking employees were rehabilitated, *this minimal number alone could save the employer around 2% of total claims paid*" . . . multiplying the maximum 10% savings by the 20% rehabilitated.

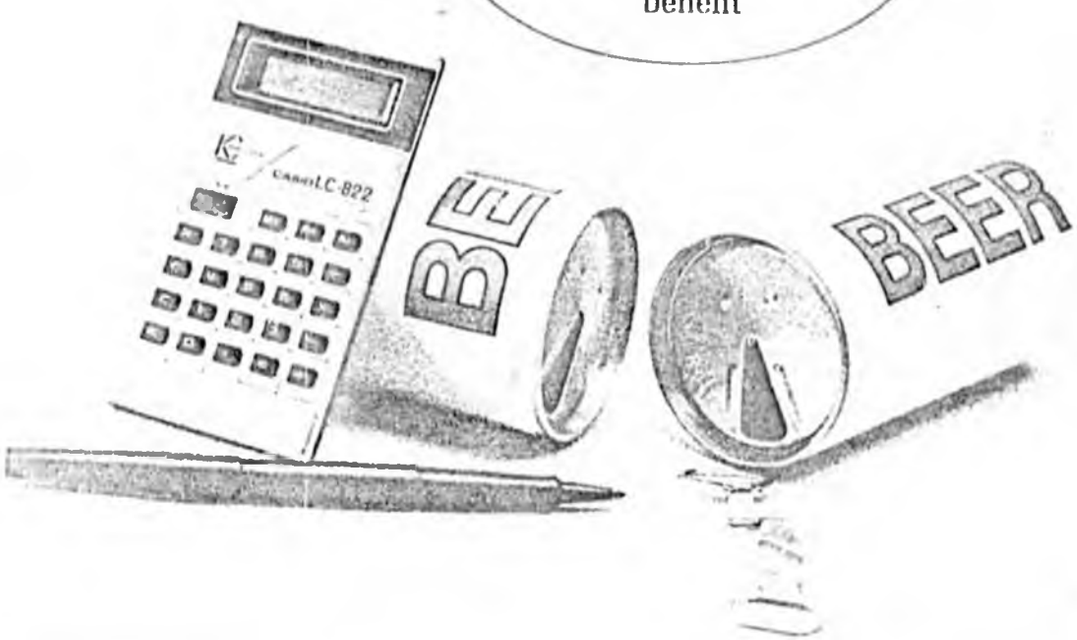
Sarvis then addresses four types of employer situations and presents evidence of savings from each.

A.
With an employee assistance program, *and* an alcoholism health benefit

B.
With an employee assistance program *but not* an alcoholism health benefit

C.
With an alcoholism health benefit, *but not* an employee assistance program

D.
With *neither* an employee assistance program *nor* an alcoholism health benefit



PROBLEM DRINKERS

Savings depend on the use of the following data:

Expected REDUCTION IN CLAIMS PAYMENTS As A Percent Of Total Claims Payments*

Problem Drinkers Referred As Percent Of Total Employee Population	Percent Increase In Total Premiums Due To Cost Of Alcoholism Benefit				
	0.5%	1.0%	1.5%	2.0%	2.5%
1.0%	1.0%	0.5%	0.1%	—	—
2.0%	2.4%	1.9%	1.4%	1.0%	0.6%
3.0%	3.7%	3.2%	2.8%	2.3%	1.9%
4.0%	5.1%	4.6%	4.2%	3.7%	3.3%
5.0%	6.5%	6.0%	5.6%	5.1%	4.7%

* Problem-drinking employees should have been rehabilitated for at least one year to achieve the expected reduction in claims payments.

Expected REDUCTION IN PREMIUMS As A Percent Of Total Premiums*

Problem Drinkers Referred As Percent Of Total Employee Population	Percent Increase In Total Premiums Due To Cost Of Alcoholism Benefit				
	0.5%	1.0%	1.5%	2.0%	2.5%
1.0%	0.8%	0.3%	—	—	—
2.0%	2.2%	1.7%	1.1%	0.6%	0.0%
3.0%	3.5%	3.0%	2.4%	1.9%	1.3%
4.0%	4.8%	4.3%	3.8%	3.3%	2.7%
5.0%	6.3%	5.8%	5.2%	4.7%	4.1%

* An actual reduction in total premiums from one year to the next could be expected only if overall insurance program costs did not increase.

Here's what the tables tell an employer with 1,000 employees whose total premium is $1,200,000 a year ($100 a month x 12 months x 1,000 employees) and whose total claims payment is $1,080,000 — a 90% claims ratio (claims as a percentage of total premium):

If PROBLEM-DRINKING EMPLOYEES were referred at the rate of:	If the ALCOHOLISM BENEFIT increased total annual insurance premiums by:	These decreases would occur in		For net savings of				
		CLAIMS PAYMENTS	PREMIUMS PAID	CLAIMS PAYMENTS		PREMIUMS PAID		TOTAL
				%	Dollars	%	Dollars	Dollars
2% a year	1%	1.9%	1.7%	.9%	$ 9,720	.7%	$ 8,400	$18,120
5% a year	2.5%	4.7%	4.1%	2.2%	$23,760	1.6%	$19,200	$42,960

The two tables also alert employees to these facts:

Employer "A"—with both referral program and benefit -- can determine the percent of problem drinkers who need to be referred vs. the cost of the alcoholism benefit to reach the cost savings he desires.

Employer "B" can determine what it will cost to add an alcoholism health benefit in order to achieve desired insurance cost savings.

Employer "C" can determine how the cost of establishing an employee assistance program in order to increase problem-drinking referrals would net out insurance cost savings.

Employer "D" can determine the cost of both referral program and benefit to produce desired insurance cost savings.

OCCUPATIONAL PROGRAMMING: A GUIDE TO HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

by

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

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

December 1976

TABLE OF CONTENTS

LIST OF TABLES

I. INTRODUCTION

Over the past decade the work environment has become an effective setting for identification of the problem drinker. The nature of the working environment which involves frequent contact with supervision and others facilitates recognition of behavioral changes and impaired performance. Because of this and recognition of the costs associated with impaired work performance there has been substantial development and growth of formal occupational programs geared to identify problem drinking employees and to motivate them to receive treatment. Certain of such programs also handle clients with behavioral, financial, and mental problems among others. Occupational programs usually involve several different functions including supervisory training, employee counseling and follow-up services.

The emphasis on and growth in occupational programming has spawned the development of several different professional work arenas. The first of these is the occupational program director who is usually company based and is charged with all facets of management and administration of the program. The second is the occupational programming consultant (OPC). OPC's were originally established by Federal government grants to the various states. Through these grants the states were able to hire two professionals whose function was to aid companies in the development and operation of occupational programs. Although the original grants establishing state-based OPC's have now expired, many of the states are continuing these positions and in fact, there is now a growing number of people in both public and private sectors who function in this work arena.

Occupational programs are not islands of activity, rather they are a part of a process which involves identification, counseling, referral, treatment and follow-up. As a client moves from initial identification and referral to the treatment phase, other important aspects of this process come into play. First, the treatment sequence itself may be variable from client to client. For some persons a period of inpatient care followed by intensive outpatient care may be necessary. For others, only outpatient care may be necessary and desirable. For still others an intermediate or transitional type of care is dictated. Second, the provision of care, whether of an inpatient, outpatient or intermediate basis, involves costs. Certain of these costs are borne by the client or possibly the provider. In many instances costs of care are borne by a third party, such as private health insurance. In this instance, the client and/or his company have made premium payments to an insurance carrier, who in turn pays all or part of the costs of care. Health insurance coverage for alcoholism is not as common as insurance coverage for physical disease and is frequently subject to limitations and exclusions. Because of the nature of his work the OPC is in a unique position to advise companies who have (or who do not have) occupational programs on the most effective forms of insurance coverage. Historically, little information on this subject has been available to OPC's or indeed other alcoholism professionals. Thus it is the purpose of this paper to provide guidance to persons in occupational programming and related areas who have an interest in the nature and extent of health insurance coverage for alcoholism for business and industry.

This guide is presented in three additional sections. Section II describes employee benefit plans and health insurance coverage for alcoholism. Section III

identifies the major factors in health insurance coverage for alcoholism. Finally, Section IV presents several alternative strategies which OPC's may wish to consider in providing guidance in the development of health insurance coverage for alcoholism.

II. EMPLOYEE HEALTH BENEFIT PLANS AND HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

A. Background

An employee health benefit plan is any type of health care plan sponsored (in whole or part) by an employer on behalf of its employees to provide benefits to meet health care expenses associated with injury or illness. Such plans may cover hospital, surgical and regular and major medical expenses. Hospital insurance covers the cost of charges for hospital room and board and associated auxillary services. Surgical and regular medical insurance provides for reimbursement of surgical fees and for the medical expense of physician services other than surgery. Major medical expense insurance is designed to pay the majority of illness costs not covered by the basic insurance package and in fact may replace the basic package.

There are three major types of companies which provide insurance in the United States. These include commercial carriers, service plans and independent plans. Commercial carriers usually involve life and casualty insurance companies who do not limit their activities only to the health area. Service plans usually imply Blue Cross/Blue Shield, which is actually a confederation of two private nonprofit organizations. Blue Cross is concerned with hospital and other related services, and Blue Shield with professional services. These organizations operate in consort with one another through independent area plans; frequently an area will cover an entire state. Independent plans are a conglomerate of employer-employee plans, community plans, private group clinics and dental service corporations. Actual payment of health care claims varies from carrier to carrier. Some reimburse the employee directly according to a fixed schedule,

and others reimburse the provider. Currently commercial carriers underwrite about 55 percent of all hospital and surgical care for the total U.S. population enrolled in a health insurance plan. Blue Cross/Blue Shield covers about 40 percent and independent plans about 5 percent. Commercial carriers account for about 70 percent of all major medical enrollees, and Blue Cross/Blue Shield accounts for about 30 percent.[1]

Over the past 25 years employee health benefit plans have increased dramatically in the United States. The number of employees with hosptial insurance rose from 24.5 million in 1950 to about 58 million in 1974. In similar fashion, surgical expense insurance went from about 18 million employees to 56 million employees during the same period of time. Perhaps even more dramatic has been the rise in major medical insurance. Though there were only some 200,000 workers covered in 1952, by 1974 coverage was being provided to about 28 million workers.[2]

Table 1 shows the percentage of all employees (public and private) covered by health insurance plans. Currently about 70 percent of the employee population has some form of hospital insurance, with nearly the same proportion of insurance having surgical and regular medical expense benefits. About one-third of the population has major medical expense benefits.

---

[1] M. Mueller and P. A. Piro, "Private Health Insurance in 1974: A Review of Coverage, Enrollment and Financial Experience," Social Security Bulletin (March 1976), pp. 3-20.

[2] Ibid.

Table 1

Percent Distribution of the U. S. Worker Population Covered by Various Forms of Health Insurance

Type of Health Benefit Plan	Percent of Total U. S. Worker Population Covered
Hospital	70
Surgical & Regular Medical Expense	67
Major Medical	34

Source: A. M. Skolnik, "Twenty Five Years of Employee Benefit Plans," Social Security Bulletin, XXXIX, No. 91 (September 1976), p. 6.

B. The Historical Development of Health Insurance Coverage for Alcoholism

While public and private activities in health insurance can be traced back to the 1930's, only in recent years has coverage for mental health in general and alcoholism in particular been included. Much of the early interest in health insurance coverage for alcoholism can be traced to 1968 when the National Center for Prevention and Control of Alcoholism initiated a study to examine beneficiary experiences and coverage provided by certain carriers.[3] Following that report the Center embarked on a series of informal meetings with carriers and other interested organizations and in 1972 (as

---

[3] N. Rosenburg, "Survey of Health Insurance for Alcoholism: Inpatient Coverage," National Center for Prevention and Control of Alcoholism, Washington, D.C., National Institute of Mental Health, 1968.

NIAAA) sponsored a state-of-the-art review of health insurance coverage for alcoholism offered by private and public insurance carriers.[4] This study found: (1) such coverage was often excluded from regular health insurance policies or available only in limited form; (2) public and private insurance carriers lagged considerably behind expressed needs for such coverage; (3) among carriers with alcoholism treatment benefits, coverage was often restricted to inpatient hospital care rather than less expensive forms of treatment; (4) the cost of alcoholism care, although poorly known at the time, was frequently used as an argument against underwriting such benefits; and (5) while the insurance industry frequently applied sanctions against claims for alcoholism treatment per se it appeared to condone the use of proxy diagnoses used as a cover for alcoholism treatment.

In 1973 a number of other studies were initiated which expanded the scope of knowledge concerning health insurance coverage for alcoholism. A report published that same year examined provider experiences in health insurance coverage for alcoholism, insurance coverage for alcoholism among a small sample of employee benefit plans provided by large United States corporations, and legislative proposals for national health insurance.[5] The survey of providers of alcoholism treatment revealed that carrier response to inpatient claims was highly variable--only in rare instances were outpatient claims reimbursed. The study also noted that the use of

---

[4] J. B. Hallan, "Health Insurance Coverage for Alcoholism," Report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1972.

[5] J. B. Hallan, "Health Insurance Coverage for Alcoholism: Proposed Benefit Provisions," Report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1973.

proxy diagnoses in the billing of insurance claims for alcoholism treatment was a common practice. The survey of 21 large corporations (employee size 2,400 to 70,000) revealed that only one corporation did not provide any type of alcoholism coverage for employees. About 40 percent of the companies provided for outpatient visits and nearly all provided coverage for inpatient care. Of those companies studied about 14 percent were self-insured, 38 percent were insured by Blue Cross/Blue Shield and the remainder by other carriers. The survey was significant inasmuch as it revealed in a preliminary sense the general existence of some form of third party payment mechanism for alcoholism treatment among employee benefit plans of major industries. Finally, a study was made of legislative proposals for national health insurance which were introduced during the period January through May in 1973. Among those proposed only one appeared to provide adequate coverage for alcoholism.

During 1972-1973 the problems associated with inadequate insurance coverage for alcoholism began to come to the attention of state legislators. By early 1974 four states had passed legislation which mandated or defined the nature of alcoholism treatment coverage which carriers must provide in policies offered within those states.[6] Since that time state legislative activities in this area have increased dramatically (see Section III).

In addition to state legislative activities during this period certain health insurance carriers began to make significant moves toward assuring health insurance coverage for alcoholism for their beneficiaries. In 1972, The Prudential Insurance Company began to honor claims for treatment in

---

[6]J. B. Hallan, "Health Insurance for Alcoholism: State Legislative and Regulatory Activities," Report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1974.

facilities other than the usually identifiable and accredited surgical, medical and diagnostic facilities. In mid-1973, Kemper Insurance Company broadened its group accident and health insurance coverage to provide for inpatient and outpatient treatment of alcoholism in hospitals and state licensed alcoholism treatment facilites. Similar coverage began to be provided by Employers of Wausau in 1974. Finally, in 1974 the Hartford Insurance Group indicated that alcoholism would be covered on the same basis as any other disease in its group policies, and that it would approve claims from alcoholism treatment facilities.[7]

In 1973, a model health insurance benefit plan for alcoholism treatment was developed for the NIAAA to reflect current treatment regimens and a need for alternatives for inpatient care.[8] These model provisions are currently undergoing study and experimentation. For example, the State of California in 1974 implemented a variation of the model benefit plan in a pilot program for State and public employees.

More recent activities concerning health insurance coverage for alcoholism have focused on (a) the development of standards for alcoholism treatment services; (b) development of standards leading toward certification of non-degreed professional treatment staff; (c) the development of several for-profit alcoholism treatment programs which are oriented to maximize third party payments; (d) training programs in third party mechanisms for NIAAA funded centers; and (e) experimental programs with

---

[7] J. B. Hallan and B. Montague, "Health Insurance Coverage for Alcoholism," Paper prepared for the 1975 Annual Meeting of the National Council on Alcoholism, 1975.

[8] J. B. Hallan, "Health Insurance Coverage for Alcoholism: Proposed Benefit Provisions," Report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1973.

selected insurance carriers and health maintenance organizations.[9]

In summary, although there appear to have been some advances in providing or assuring health insurance benefits for alcoholism treatment, such benefits continue to be highly limited and frequently unavailable. Occupational programming personnel should be aware that a number of relevant issues are yet to be resolved, including: (1) the extent to which health insurance benefits actually underwrite costs of treatment of alcoholism; (2) the impact of availability of health insurance for alcoholism on demand for treatment services; (3) the effectiveness and efficiency of alternative forms of health insurance; and (4) the potential impact of health insurance coverage for alcoholism on demands for other health services.

---

[9] J. B. Hallan and B. Montague, "Health Insurance Coverage for Alcoholism," Paper prepared for the 1975 Annual Meeting of the National Council on Alcoholism, 1975.

III. MAJOR FACTORS IN DEVELOPING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

A. Introduction

This section shall identify and describe those elements of health insurance of importance to occupational programming personnel who have responsibility for, or interest in, the development of private health insurance coverage for alcoholism. Areas to be covered include: (1) a description of the carrier industry, and (2) health insurance premiums and coverage for alcoholism.

B. The Health Insurance Industry

1. Nature and Extent of the Health Insurance Industry

All health insurance companies vendor a similar product, i.e., a mechanism (insurance) which reduces for any one individual financial risk associated with illness or injury through a pooling of the population at risk. Such insurance involves an agreement (contract, policy, certificate) for a specified period of time between the insurance company (carrier) which stipulates the parties involved, the events (sickness, injury) which may produce a loss and the monetary charge (premium) imposed by the carrier on the insured for participation in the insurance program.

The health insurance industry in the United States today is a major business enterprise. Currently some 78 percent of the civilian population (163 million) has some form of private health insurance coverage and as indicated before about three-fourths of the worker population has hospital or surgical expense insurance. In their most recent

report on the private health insurance industry, the Social Security Administration states that total revenues derived from premiums for Blue Cross/Blue Shield and commercial carriers were $12.4 billion and $13.9 billion respectively; independent plans accounted for only about $2.2 billion.[10] Currently about 58 million workers in the U.S. are covered by some form of health insurance benefits -- the most popular form of such coverage being hospitalization insurance. A list of major health insurance carriers operating in the U.S. today and their estimated group enrollments for hospitalization insurance is shown in Table 2.

Table 2

Major United States Health Insurance Carriers and Hospitalization Insurance

Insurance Company	Number of Employees Covered for Hospitalization in U.S. (in millions)
Blue Cross	25.3
Aetna	2.0
Connecticut General	1.1
Equitable Life Assurance	1.2
Metropolitan	1.7
Prudential	1.1
Travelers	3.2
Occidental Life	0.6
Provident Life	0.6

Source: 1) A.M. Skolnik, "Twenty Five Years of Employee Benefit Plans," Social Security Bulletin, XXXIX, No. 91 (Sept. 1976) pp. 3-10.
2) EBPR Research Reports: Carrier Enrollments. Chicago: Charles Spencer and Assoc., 1975 and 1976.

As can be seen, Blue Cross accounts for considerably more enrollees than do other individual carriers. Collectively, however, all non-Blue Cross companies (including many not shown in the above table) provide benefits for slightly more than half of all employees with hospitalization insurance.

---

[10] M. Mueller and P. A. Piro, "Private Health Insurance in 1974: A Review of Coverage, Enrollment and Financial Experience," Social Security Bulletin (March 1976), pp. 3-20.

2. Health Insurance Company Income

Health insurance carriers derive revenues through underwriting, rate making, marketing and sale of insurance contracts. Underwriting is a process which involves the selection, classification and rating of risks. The purpose of underwriting is to determine the probability of loss (or the level of risk to the carrier) and if the group to be insured has a similar possibility of loss as the universe of groups on which carrier charges (premiums) are based. Carriers thus aggregate their insured population into groups which have similar expectations of loss. Rate making involves the determination of premiums for the various classifications of groups.

Marketing of health insurance in many ways is similar in nature to those processes used in the vendoring of ordinary products such as hardware or liquor. First, while many insurance carriers use traditional advertising media (newspapers, television, magazines) to deseribe their "wares," other carriers conduct their sale operations by direct mail. Second, health insurance carriers frequently employ or contract with salaried representatives, agents, or brokers who sell insurance policies or contracts to individuals or groups. Commercial carriers utilize agents or brokers, while Blue Cross/Blue Shield uses salaried representatives. Third, health insurance is generally sold as a package or individualized program. The package sale involves the vendoring of an established or fixed set of benefits, while the program sale is a set of benefits specifically tailored to the needs of the client.

C. Health Insurance Premiums

A health insurance premium is the amount of money collected by a carrier in exchange for a promise to the insured that certain payments will be made to the insured or the health care provider if the insured incurs health care expenses. Premiums (usually payable annually or some division thereof) are determined in advance of the period actually covered. Thus the derivation of a premium by a carrier involves the use of historical data and expected future trends for the population group covered. Premiums usually consist of two components -- the first of which is "pure" premium, i.e., the anticipated amount of benefits to be paid to beneficiaries. Thus the pure premium can be attributed to the product of the claim frequency rate (probability of loss) and the average claim rate (average severity of claims expensed in dollars). The second component is a "loading" factor or indirect cost which covers a variety of administrative expenses, taxes, contingencies, etc. In general, actual computations (rate making) of a premium for a group such as an industry or business will depend on a variety of factors including size of the group, population make-up (age, sex), nature of work activity, etc. These factors are then compared with historical data concerning utilization and cost experience for hospital, surgical and major medical benefits. Thus the annual premiums for a given group is estimated by approximating the collective costs associated with health care utilization for similar groups.

Premiums associated with health insurance coverage for alcoholism are poorly known. Some carriers in adding alcoholism treatment benefits to an existing policy will charge an additional premium for such coverage. Other carriers will add these benefits at no additional charge. For example,

Capital Blue Cross and Blue Shield of Maryland made available benefits for care in special alcoholism treatment facilities at no additional charge. While little, however, is known about the actual mechanics employed by carriers in estimating premiums for this condition, there is a major constraint associated with this process, i.e., the lack of accurate data (for a given population) on not only the prevalence of the disease, but also the number of people who seek treatment. Interestingly, the widespread use of proxy diagnoses for treatment of alcoholism and acceptance thereof by the various carriers impedes their ability to adequately project the extent of the problem. Further, because of the continuing social stigma surrounding alcoholism, many individuals are highly reluctant to even file insurance claims.

Some indication of recent premiums for the cost of adding alcoholism treatment benefits has been documented in the Pilot Program to provide health insurance coverage for alcoholism to California state and public employees. The program, which is described in Section III-E of this report, employed a number of carriers, four of which provided coverage to over 90 percent of all the state employee subscribers. Though the Pilot Program agreed to cover costs of alcoholism treatment for this population, reimbursement by the Program to the carriers for provider costs was initially based on premium estimates derived by the carriers. These premium estimates, which are shown in Table 3, are actually additions to the premiums required for the regular policy or plan purchased by the subscriber. As can be seen, there is substantial variation between the prepaid group practice plan premium (35¢ per member) and the service and commercial plans (about 10¢-13¢ per member).

Table 3

Premiums Required By Carriers for the California Pilot Program

Carrier	Premiums (monthly)
California Western Occidental Life	$0.35 per member
Blue Cross/Blue Shield	0.35 per member
Kaiser-North	0.10 per member 0.20 per member and one dependent 0.30 per member and two or more dependent
Kaiser-South	0.13 per member 0.26 per member and one dependent 0.30 per member and two or more dependent

Source: "Alcoholism Care Utilization and Costs - California Pilot Health Insurance Coverage for Alcoholism," H-2, Inc., Raleigh, N.C., November 1975.

Analysis of two years of experimental data from the Pilot Program concerning utilization and costs revealed that the actual premiums should have been about 33¢ per month per subscriber. A rate of this magnitude should be viewed with caution, however, for (1) utilization over the two year period was low, i.e., 760 persons out of a worker population of about 141,000 and (2) alcoholism is treated under an alcoholism diagnosis as opposed to a cover or proxy diagnosis health care costs do not increase. Information is available from other carriers concerning premiums and their derivation. Note, however, that in recent years both Capital Blue Cross of Pennsylvania and Blue Cross of Maryland have introduced contracts (policies) with provisions for alcoholism care which have not involved premium increases. Finally, certain commercial carriers, such as Prudential and Hartford, who are offering insurance benefits for alcoholism allude to the possibility of premium increases for such coverage.

D. Management and Labor

Corporate management has a responsibility to provide for the design,

development and operation of employee benefit plans. As such, they are responsible for: (1) determining the nature and extent (structure) of health insurance benefits; (2) determining the insurance carrier who will provide the health insurance plan; and (3) obtaining the widest range of benefits at minimum cost. Health insurance may be provided without cost to the employee as a part of his fringe benefit package - more frequently, however, there is a monthly premium cost to the employee which represents a share of the total cost based on a scale derived by management. The nature and location of administration of the health insurance plan varies substantially from company to company. Not infrequently the plan is administered by the corporate office which oversees personnel and related activities.

In those companies which employ organized labor, unions have become an important force in determining health insurance benefits for their members. In recent years unions have become increasingly cognizant about the nature and extent of mental health problems in general and alcoholism in particular. Among the more notable efforts to date have been those of the United Auto Workers and the United Mine Workers. The United Mine Workers (which is self-insured) has for years provided for the inpatient and outpatient treatment of alcoholism. The United Auto Workers recently negotiated a comprehensive benefit package for their members which provides for treatment of substance abuse. In addition, the Teamsters Union recently indicated that alcoholism coverage would be a <u>necessary</u> bargaining item. Given that such coverage may well become a collective bargaining point over the next several years by major labor unions, occupational programming personnel are in a unique position to provide information and counsel to labor and management on this important insurance issue.

E. Benefit Structure

As indicated earlier, though the current status of health insurance coverage for alcoholism in the United States leaves much to be desired, there are encouraging trends as evidenced by actions of public agencies, state legislatures, insurance carriers and purchasers. Continued development of health insurance coverage for alcoholism must take into account the growing use of effective non-traditional forms of care, such as intermediate care facilities, recovery home care and outpatient care as opposed to the more expensive and traditional inpatient care. Accordingly, this section will focus on: health insurance benefit structures in use; a model insurance benefit plan; the impact of state legislation on benefit plans; and accreditation and licensing as they affect benefit plans.

1. Benefit Plans Used in Industry with Occupational Programs

Benefit plans for alcoholism treatment differ by virtue of their nature (inpatient, outpatient, other care, etc.) and extent (i.e., the limits of care in terms of hospital inpatient days, dollar benefits, etc.). Unfortunately, specific benefits for alcoholism treatment available to worker populations through employee benefit plans are imperfectly known. There are available several references which describe in varying detail benefit plans which can be purchased from various insurance carriers.[11, 12] These references provide a general indication of the availability of coverage for alcoholism treatment.

---

[11] Time Saver for Health Insurance, Cincinnati, Ohio: The National Underwriters Company.

[12] EBPR Research Reports, Charles Spencer and Associates, Inc., Chicago, Ill.

The Bureau of Labor Statistics* periodically publishes a digest of health and insurance plans available to employees of large corporations.[13] This source indicates the availability of psychiatric or mental health care coverage but does not mention alcoholism.

To provide more specific information of use to occupational programming personnel on existing benefit plans a survey was conducted of 31 large scale companies (average employee population = 34,000) which had ongoing occupational programs. These companies, which are scattered throughout the United States, were selected for survey in a systematic manner from the master list of programs currently on file with the Association of Labor-Management Consultants on Alcoholism (ALMACA). A composite picture of the nature of health insurance benefits for alcoholism treatment provided to the employee population by the surveyed industries is presented in Table 4. As shown, 30 of the 31 companies made specific provisions for inpatient care. About three-fourths of the companies provided special treatment center benefits (i.e., care in an alcoholism treatment center), while only one-half of the companies covered outpatient care costs. Two firms cover the cost of care in an intermediate care facility such as a halfway house. Only one company provides no benefits for alcoholism treatment of any kind.

---

[13] U.S. Bureau of Labor Statistics.

*In addition, the U. S. Department of Labor is required to keep on file details of welfare and pension plans (including health insurance) under the Welfare and Pension Plan Disclosure Act. Many of the plans on file are unfortunately out of date.

Table 4

Composite of Alcoholism Treatment Benefits Provided to Employees of 31 Large United States Companies

Type of Alcoholism Treatment	Number of Companies	Percent
Inpatient Care	30	97%
Special Treatment Center	23	74%
Outpatient Care	15	50%
Halfway House	2	7%
No Care Provided	1	3%

Source: Data from a survey of 31 employee benefit plans.

Tables 5 through 11 provide an indication of the extent of benefits available for each of the care forms usually available in insurance policies, i.e., inpatient hospital care, alcoholism treatment center care, and outpatient care. The distribution of annual inpatient days provided for alcoholism care by the companies surveyed is shown in Table 5. About 60 percent of the companies provided for about 60 annual inpatient days or less, 35 percent provided greater than 60 days; five companies provided unlimited inpatient days. One company, which does provide for inpatient care of alcoholism treatment, has a benefit structure whose exact limits are unclear.

Table 5

Distribution of Number of Annual Hospital Inpatient Days for Alcoholism Treatment Covered by Health Insurance

Days of Inpatient Care (Range)	Number of Firms	Percent
7 - 30	9	29%
31 - 60	9	29%
61 - 120	2	6%
121 - 365	4	13%
Unlimited	5	16%
Not Clear	1	3%
Not Covered	1	3%

Source: Data from a survey of 31 employee benefit plans.

Reimbursable hospital daily board and room charges for alcoholism treatment are shown in Table 6. About 40 percent of the companies will reimburse at a rate of not to exceed the prevailing semi-private room and board charges. Health insurance coverage for two companies is reimbursed at fixed daily rates of $72 and $85 respectively, while only one company provided for full coverage. Responses from ten companies which cover inpatient care were not sufficiently explicit to characterize reimbursable costs.

Table 6

Distribution of Maximum Allowable Hospital Inpatient Daily Rates for Alcoholism Treatment

Maximum Allowable Rate	No. of Benefit Plans	Percent
$72.00	1	3%
$85.00	1	3%
Prevailing Semi-Private	12	39%
Full Cost	1	3%
Covered but Not Clear	10	32%
No Response	6	19%

Source: Data from a survey of 31 employee benefit plans.

The distribution of alcoholism treatment center benefits is shown in Table 7. Eight of the companies do not provide such coverage while eighteen provide for care ranging from 7 - 120 days. About 10 percent of the companies place no annual limits on this form of care. The provisions for reimbursable daily costs for care at a treatment center differ from hospital inpatient care provisions (see Table 8). About 35 percent provide for full reimbursement of room and board charges, while only one of the companies provides for reimbursement of the prevailing semi-private room and board rate. Two companies reimburse at

daily flat rates of $72.00 and $85.00 respectively. Alcoholism treatment benefits also differ from other benefits in that about one-third of the health insurance plans surveyed required that the carrier actually approve the alcoholism treatment facility before care could be initiated.

Table 7

Distribution of Annual Number of Alcoholism Treatment Center Days

Days of Care	Number of Benefit Plans	Percent
Not Covered	8	26%
7 - 30	7	23%
31 - 60	10	32%
61 - 120	1	3%
121 - 365	2	7%
No Limit	3	10%

Source: Data from a survey of 31 employee benefit plans.

Table 8

Distribution of Maximum Allowable Alcoholism Treatment Center Daily Rates

Maximum Allowable Rate	Number of Benefit Plans	Percent
$72.00	1	3%
$85.00	1	3%
Prevailing Semi-Private	1	3%
Full Cost	11	36%
Covered but Not Clear	6	19%
Not Covered	8	26%
No Response	3	10%

Source: Data from a survey of 31 employee benefit plans.

Outpatient care benefits are shown in Table 9. Nearly one-half of the firms do not provide for outpatient care of any type. Three companies provide for a specified number of annual outpatient visits (ranging from 12 - 35 visits per year) and seven place no limits on

the number of annual outpatient visits. Note that five firms specifically covered outpatient alcoholism treatment but the extent of such care could not be ascertained from their responses.

Table 9

Distribution of Annual Outpatient Visits for Alcoholism Treatment

Number of Visits	Number of Benefit Plans	Percent
Not Covered	15	48%
12	1	3%
35	2	6%
No Limit	7	23%
Covered but Not Clear	5	16%
No Response	1	3%

Source: Data from a survey of 31 employee benefit plans.

Finally, the extent to which individual, family and group therapy are covered by the various companies is displayed in Table 10. Over one-half of the firms provide for individual or group therapy, and about one-third provide for therapy of the family. Allowable annual visits for these forms of therapy are presented in Table 11. Unlimited visitation is provided by about 30 percent of the employee benefit plans which cover individual therapy, with about 25 percent of the companies providing unlimited benefits for group and family therapy. About 10 percent specify a fixed number of visits (i.e., 35 or 40) for all types of therapy. In some instances actual benefits, though available to employees, could not be interpreted from the replies of the survey respondents.

Table 10

Distribution of Individual, Group and Family Therapy Benefits for Alcoholism Treatment

Nature of Care	Number of Firms	Percent
Individual Therapy	19	61%
Family Therapy	10	33%
Group Therapy	17	53%

Source: Data from a survey of 31 employee benefit plans.

Table 11

Distribution of Annual Maximum Allowable Visits for Individual, Group and Family Therapy

Number of Annual Visits	Individual Therapy		Group Therapy		Family Therapy	
	No.	%	No.	%	No.	%
Not Covered	12	39%	14	45%	20	64%
35	2	6%	2	6%	2	6%
40	1	3%	1	3%	1	3%
No Limit	10	32%	8	26%	7	23%
Covered but Not Clear	6	19%	6	19%	1	3%

Source: Data from a survey of 31 employee benefit plans.

To summarize the findings of the survey, it must first be pointed out that the survey sample (N=31) is quite small in comparison to the number of functioning occupational programs in the United States, which may be as high as 1,200. Second, the mere existence of a benefit structure capable of effectively covering alcoholism treatment costs in no way assures that such benefits are in fact utilized, nor does it provide an indication of the extent to which total alcohol treatment costs are being met by insurance benefit payments. The survey findings do, however, indicate that benefit plans are surprisingly liberal, i.e., adequate inpatient care and, importantly, a high

proportion of plans with coverage for less expensive forms of care. Further, the extent of benefits available in each of the care forms is favorable for treatment of alcoholism, i.e., about one-fourth of the plans place no limits on outpatient care benefits while about one-third cover the entire cost of care in an alcoholism treatment center. Importantly, the findings indicate that the health insurance industry is capable of responding to occupational program needs by providing broadly based health insurance plans.

2. The California Pilot Program Benefit Plan

Another benefit plan of interest is that employed by the State of California during their Pilot Program to determine the feasibility of providing health insurance coverage for alcoholism for state civil service workers and certain other public workers in the State of California. This two year program involved four indemnity (commercial) carriers, four prepaid group practices, two statewide service carriers and one individual practice plan. The majority of coverage, however, was provided by three organizations: Blue Cross/Blue Shield, California Western Occidental (Cal-West), and Kaiser Foundation Group Health Plan (North and South Plan).

The benefit plan employed by the State of California was similar across all carriers and included the following types of care:

a. Inpatient Care: (hospital or other medical or non-medical facility licensed by the state)

Acute: 6 days of detoxification services/year

Intermediate: 21 days of treatment/year

b. Day or Night Controlled Residential Care: (recovery home licensed by the state)

30 days of care/year

c. Outpatient Care:

up to 45 visits per year to be provided by a:

- licensed physician
- licensed counselor
- licensed clinical social worker
- licensed psychologist
- paraprofessional (working under the supervision of a licensed professional)

While utilization of benefits was low during the first year of the program, the rate of inpatient admissions and outpatient visits during the second year of operation increased dramatically. Recovery home use during the entire two year period was quite low, possibly because it was a care form unfamiliar to both carriers and practitioners. Evaluation of the plan to date indicates that the benefit structure is a feasible means of meeting the needs for third party payments for alcoholism treatment costs, and that it is capable of being implemented by different types of carriers, i.e., health maintenance organizations, non-profit service plans, and profit-making commercial carriers. Following the pilot test, the prepaid HMO (Kaiser) decided and obtained permission to continue essentially the same benefit package at only a small increase in premiums.[14]

---

[14] For further information on the California Pilot Program see (1) "Historical Development of the California Pilot Program to Provide Health Insurance Coverage for Alcoholism," H-2, Inc., Raleigh, N.C., November 1975; (2) "Alcoholism Care Utilization and Costs - California Pilot Health Insurance Program - First Twelve Months," H-2, Inc., March 1976; and (3) "Longitudinal Study of Alcoholic Patients and Their Families," H-2, Inc., Raleigh, N.C., January 1977.

3. Model Benefit Plan

Several years ago the NIAAA sponsored the development of a model benefit plan which de-emphasized the traditional and costly forms of care used in alcoholism treatment.[15] The purpose of that plan was to serve as a resource which can be utilized to develop a health insurance policy or to enhance provisions of existing policies. This plan defined and described treatment settings (inpatient, outpatient, transitional care) treatment locations (facility or service settings) and treatment attributes (form or nature of service provided, i.e., detoxification, psychotherapy, etc.). Minimum benefit provisions defined in the plan are as follows:

a. Inpatient Care: (licensed treatment facility)
   14 days in any benefit period

b. Intermediate Care: (licensed day or night hospital)
   30 days of care in any benefit period

c. Outpatient Care: (licensed treatment facility)
   45 outpatient visits during a benefit period

The benefit period specified in the Plan was 12 calendar months. It was suggested that additional care beyond the maximum specified could be sanctioned providing that a special group (called a Facility Audit Committee) reviewed the case and found the patient suitable for continued treatment.

Over time the model benefit plan has proven to be a useful resource. For example, it served as a basis for development of the

---

[15] J. B. Hallan, "Health Insurance Coverage for Alcoholism: Proposed Benefit Provisions," Report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1973.

benefit plan used in the California Pilot Program (see above) and has received wide distribution to public and private agencies, insurance regulators and insurance carriers. The model plan is not an end in itself, but can provide benchmark benefit provisions in the development of an insurance program.

4. State Legislation and Health Insurance Coverage for Alcoholism

As was mentioned earlier a number of states have taken or are considering legislative actions to either mandate or define insurance coverage for alcoholism. There has been a rapid growth in state legislative activity since 1974, with 24 states considering some form of action between January 1975 and March 1976. Cu ently, legislation has passed in 16 states and is pending in an additional 13 states. Such legislation either outright mandates the nature and extent of coverage for alcoholism or defines that such coverage is an option which must be provided by the carrier.

Table 12 provides some details of legislation which has been enacted by the states. Note that while 11 of the 16 states cover inpatient care, only 7 provide for outpatient care. There is also a considerable range of benefits specified by the legislation enacted by the states. Inpatient care limits range from a low of 10 days per benefit period (usually a year) to some 70 days. Regretably, most states which have enacted such legislation cover only group contracts. Finally, eight of the states with legislation have determined that alcoholism treatment benefits will actually be mandatory; the remaining eight states merely require that insurance carriers offer the benefits to potential purchasers.

Table 12

Summary of Health Insurance Coverage for Alcoholism Treatment in Existing State Legislation

Description		No. of States
(1)	States with enacted legislation	16
	(Colorado, Connecticut, Hawaii, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, North Dakota, Oregon, South Dakota, Tennessee, Washington, and Wisconsin)	
(2)	States which specifically cover inpatient care	11
	(Colorado, Connecticut, Hawaii, Louisiana, Massachusetts, Minnesota, Nevada, North Dakota, Oregon, South Dakota, and Wisconsin)	
(3)	States which specifically cover outpatient care	7
	(Colorado, Hawaii, Massachusetts, Minnesota, Nevada, Oregon, and Wisconsin)	
(4)	States which specifically cover other forms of care	2
	(Wisconsin and North Dakota)	
(5)	States which specify that benefits shall be the same as those for other conditions	2
	(Hawaii and Mississippi)	
(6)	Range of inpatient benefits:	
	(a) Days of care	10-70 days/benefit period
	(b) $ benefits	$500-$1000/benefit period Oregon = $2500 max/36 months
(7)	States covering:	
	(a) Group contracts	16
	(b) Individual contracts	1
(8)	States with mandatory alcoholism treatment benefits	8
(9)	States with optional alcoholism treatment benefits	7

Several aspects of this legislation should be of interest and/or concern to occupational programming personnel. First, it is apparent that legislatively mandated or defined health insurance coverage for alcoholism is becoming popular among the various states. Legislative trends to date suggest that a large majority of the states will enact or consider such legislation in the near future. Second, legislators who are interested or engaged in development of this type of legislation frequently have poor information upon which to base legislative proposals. Currently, there is no single source of information nor uniform legislation upon which to base their legislative proposals. Third, passed and pending bills may be characterized by their lack of uniformity—a situation which may complicate the operations of interstate carriers. Fourth, among those states with enacted legislation there now exists a minimum level of coverage which must be provided to beneficiaries regardless of the insurance vendor. Fifth, not all legislation mandates insurance coverage for alcoholism. Frequently, such legislation merely encourages carriers to promote the development of such coverage. Sixth, state experiences in developing and enforcing mandated health insurance coverage for alcoholism treatment may provide insights useful in the foundations of national health insurance. Finally, occupational programming personnel are in a unique position to advise legislators about deficiencies in coverage provided by carriers operating in their respective states and to provide them with information useful in the development and formulation of legislation.

5. Accreditation and Licensing

A major concern of health insurance carriers in the development of health insurance coverage for alcoholism treatment has been accreditation of treatment facilities and certification of professional personnel providing treatment. The concern stems from the traditional view held by carriers that quality and effective care cannot be assured unless provided in an accredited hospital by a physician. As a result, insurance policies frequently severely limit or outright exclude coverage of alcoholism treatment if in a facility other than a hospital and/or if provided by a non-physician. Such restrictions considerably limit possible reimbursement for the alcoholism treatment alternatives now available and, unfortunately, encourage the utilization of the more expensive (and often the least appropriate) forms of care. Federal and state governments and certain carriers have begun to seek resolutions in this issue. First, the NIAAA developed accreditation standards for alcoholism treatment facilities under a contract with the Joint Commission on Accreditation of Hospitals (JCAH). With these standards the JCAH began a program to accredit facilities; and to date some 300 facilities across the United States have been examined and duly accredited. Second, the NIAAA has encouraged a coalition of professional organizations to address the various issues involved in certification of professional personnel in the treatment of alcoholism. The intent of such a coalition would be to develop a means for the formal recognition of alcoholism treatment personnel. Third, various states through their own legislative activities (see the previous section) have specified

that insurance benefits must be applicable to care received in a treatment facility duly licensed (as opposed to accreditation) by that state. Finally, several interstate carriers have begun to specify in their policies that treatment costs will be reimbursed if the facility/service providing such care has been duly approved by the carrier.

In spite of these actions, it is not uncommon at this point in time to find insurance carriers who are lethargic in their recognition of non-traditional care forms. While the situation is not impossible, experiences of consultants and various treatment programs suggest that a lengthy program of marketing and selling to insurance carriers may be necessary before effective reimbursement is achieved.[16]

---

[16]See for example W. Williams and D. Descoteau, "Assumption, Flexibility and Perseverance," a paper presented at the Fifth Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism, San Diego, California, October 20-23, 1976.

IV. ALTERNATE STRATEGIES FOR DEVELOPING HEALTH INSURANCE COVERAGE

Several alternative strategies may be employed by occupational programming personnel in an effort to increase or develop insurance coverage for alcoholism care. Each strategy has as a goal increasing coverage or making available coverage for alcoholism care as a result of an increased awareness of decision makers representing employees, employers, legislators, or carriers themselves.

The first alternative strategy is to convince carriers to voluntarily provide such coverage, either through including alcoholism coverage specifically in the policies they offer, or removing barriers which exclude such coverage from existing policies. This strategy, while likely the most difficult, is feasible. Carriers are historically conservative in extending coverage, particularly in the case of alcoholism care for which there is little actuarial data. Furthermore, as has already been mentioned, a number of concerns exist in the health insurance industry about the alcoholic population--primarily based on the view that the typical alcoholic is a street bum or public inebriate.

While either increased awareness and sophistication of a key decision maker with one or more health insurance companies may produce the desired coverage, a major factor for voluntary coverage will be that of competition between carriers. Increased sales by a competitor who is more responsive to consumer demands for health insurance coverage for alcoholism treatment may be a motivating factor of far greater significance than corporate social responsibility. In general, the term for employing this strategy is "create competition."

The following steps are suggested for occupational programming personnel in employing this strategy:

1. Review current health insurance practices offered by insurance carriers in the state to determine if coverage for alcoholism is adequate or in need of improvement. Compare current coverage with the "model" benefit plan recommended by NIAAA or a good plan offered in another state.

2. Develop not only an understanding of what coverage is available but also what can be made available through marketplace competition. Each health insurance company should be contacted individually (either by an OPC or a group purchaser) to negotiate for an increase in coverage. Remind the company that there are other carriers who can be contacted and point out that large group purchasers may go to those carriers.

3. Prepare a plan for bringing current employee benefit policies in given industries up to at least a minimum level.

4. Encourage group purchasers to shop around and let carriers know that they are doing so.

This strategy is more likely to work when used in conjunction with some of the other strategies which follow.

A second strategy is to encourage major purchasers of health insurance demand alcoholism coverage. This strategy can be most effective because employee representatives such as labor unions and other employee groups are continuously seeking better fringe benefits. Recommended steps in this strategy include:

1. Locate the largest employee groups in the state, including both public or private employee groups, and document the nature of

alcoholism treatment insurance coverage.

2. Prepare plans for alcoholism care which are suitable additions or changes in coverage provided under current plans.

3. Contact representatives of the employee groups, review the plan, and show why the increase is both needed and is desirable for their members. If specific information is available about the extent of associated problems such as absenteeism or sickness for an employee group, this may help establish the case. However, establishing direct rapport and credibility in the presentation is the major factor. In most states, the largest employer, or certainly one of the largest, will be the state government. If the OPC is state-employed, it is possible to press the case as an enlightened member and as a professional.

4. Suggest specific action steps for the employee representatives in demanding coverage.

A third alternative strategy is to encourage the enactment of mandated health insurance coverage for alcoholism treatment by the state legislature. Currently, there are 16 states with legislation which requires that any health insurance carrier offering coverage in that state must include, or at least provide as an option, coverage of alcoholism treatment. This strategy will involve the preparation of data and testimony and most likely the development of bills in conjunction with a supportive legislator or group of legislators. Since legislators are elected officials, they are likely to be supportive of coverage if it is believed to be demanded or desired by employees and their representatives. The steps in this strategy include:

1. Contact a legislator likely to be sympathetic, based on prior legislative bills, campaign promises or expressed interests concerning

alcoholism.

2. Prepare (before the first meeting with the legislator) model legislation for review with him and his staff, which could be added to the existing statutes concerning health insurance. Be informed, understand the current statutes, be aware of activities in other states with similar interests and of similar size, and provide information about the extent of alcoholism on the employed population in that state.

3. Work out a strategy with the legislator for introducing the bill into an upcoming or current legislative session.

4. Be prepared for testimony and for organizing the testimony of others. A fact sheet and suggested write up of the testimony could be distributed to all members of the committee and to those who are likely to testify themselves for the legislation.

5. Contact employee representatives and encourage them to testify and/or to exert influence on the legislature in favor of the bill. In general, function as a staff support for the key legislator(s) who are promoting the bill. Good staff work will be very beneficial in assuring rapid passage of the bill through the legislative channels. While the initial piece of legislation proposed may be the most desired, be prepared to compromise and accept a more restricted version. Once the current laws have been altered to require alcoholism coverage of some type, it is easier in subsequent sessions to lobby for increased coverage and to break down barriers imposed by health insurance carriers.

Central Maryland Health Systems Agency, Inc.

Alan Bayer

Senior Program Consultant

501 St. Paul Place
Baltimore, Md. 21202

Phone: 301 - 752-3500

Attached is a study on health costs associated with alcohol abuse.

The intended audiences for this report are health care administrators, third party payors, legislators, and other interested citizens.