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EXECUTIVE COMMITTEE CHAIR: Ken Lantz, Colorado

**NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
RESOLUTION IN SUPPORT OF AMENDING THE NAIC UNIFORM
ACCIDENT AND SICKNESS POLICY PROVISION LAW**

*Adopted by the NCOIL Health Insurance and Executive Committees on March 2, 2001.
Amended by the NCOIL Health Insurance and Executive Committees on February 21,
2003. To be reviewed by the NCOIL Health Insurance Committee on July 10, 2003.*

WHEREAS, the National Association of Insurance Commissioners (NAIC) Uniform Accident and Sickness Policy Provision Law prior to June 10, 2001 stated that, "The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician;" and

WHEREAS, the NAIC has adopted amended language that states that provision "...may not be used with respect to a medical expense policy," and which further defines "medical expense policy" as "...an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage;" and

WHEREAS, more than 30 states and the District of Columbia currently have the original provision in their insurance codes, and four states have provisional restrictions on the coverage of alcohol or drug-related injuries; and

WHEREAS, this law was promulgated by the NAIC five decades ago, when effective treatment for alcohol problems was generally not available, and predates the development of regional trauma centers; and

WHEREAS, studies demonstrate that 35-50 percent of injured patients treated in emergency departments and trauma centers are alcohol and/or drug intoxicated; and

WHEREAS, this law provides physicians and hospital administrators with a strong financial disincentive to screen patients for substance abuse problems, resulting in less than 5% of trauma patients screened for alcoholism and provided with the necessary counseling; and

WHEREAS, insurers are already currently paying for the treatment of alcohol-related injuries because they cannot identify which patients are intoxicated, since emergency departments and trauma centers generally do not screen for intoxicants; and



PRESIDENT: Bill Coughlin, NY
VICE PRESIDENT: Bill Coughlin, NY
SECRETARY: Bill Coughlin, NY
TREASURER: Bill Coughlin, NY
EXECUTIVE COMMITTEE CHAIR: Bill Coughlin, NY

WHEREAS, actuarial analysis demonstrates that routine implementation of alcohol screening and intervention in trauma centers will result in an estimated five year net national savings of \$327,250,000 in direct medical costs; and

WHEREAS, having been written fifty years ago, the Uniform Accident and Sickness Policy Provision is anachronistic because it fails to take into account research gathered in subsequent decades that has led to a redefinition of alcohol abuse and dependency as a chronic illness that is responsive to treatment; and

WHEREAS, the law also fails to take into account the current existence of regional trauma centers; and

WHEREAS, in order to respond to the aforementioned concerns, the NAIC amended the Uniform Accident and Sickness Policy Provision Law; and

NOW, THEREFORE, BE IT RESOLVED THAT NCOIL supports the amendment with respect to medical expense policies; and

BE IT FURTHER RESOLVED THAT NCOIL supports the repeal of such exclusion and restriction provisions with respect to medical expense policies in the jurisdictions that have them.

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Supporting Repeal of the Uniform Accident and Sickness Policy Provision Law.

At its 2003 Interim Meeting, the American Medical Association (AMA) adopted Resolution 912, which called for AMA to support state and specialty medical societies and the public health associations in their efforts to repeal state laws modeled after the Uniform Accident and Sickness Policy Provision Law (UPPL). This document has been developed to provide the requested assistance to those organizations seeking repeal.

I. The Origin of the UPPL.

In 1947, the National Association of Insurance Commissioners (NAIC) adopted the UPPL as a model law. The law states, in part, that health insurers

shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Thus, under the UPPL, if a patient presents in an emergency department and is found, by hospital staff or the emergency room physician, to be either intoxicated or under the influence of a narcotic, the patient's health insurer can lawfully refuse to pay for that patient's for alcohol or drug-related injuries, no matter how serious. **Of course, emergency room physicians test for blood alcohol content whenever such testing is appropriate, when injuries require surgery or the administration of medication. But the UPPL deters physicians and hospitals from performing further measures beyond testing that have a proven track record, e.g., alcohol screening, counseling, and referral.** Unfortunately, after the NAIC's adoption, most states also adopted the UPPL, but this was at a time when public intoxication was viewed as criminal activity, when addiction treatment and trauma centers were not nearly as widespread as they are today, and when knowledge and treatment of alcohol and drug problems were not nearly as advanced as they are currently. Although obsolete, many states still retain versions of the UPPL.

The AMA continues to work with organizations like NAIC and the National Conference of Insurance Legislators to effect repeal of state laws based on the obsolete UPPL.

II. States with UPPLs.

The following states currently have UPPLs (citation included)¹

Alabama 27-19-26
Alaska 21.51.260
Arizona 20-1368
Arkansas 23-85-126
California 10369.12
Delaware 18-3325
Washington, DC 35-517
Florida 627.629
Georgia 33-29-4
Hawaii 431:10A-106
Idaho 41-2127
Illinois 5/357.25
Indiana 27-8-5-3
Kansas 40-2203
Kentucky 304.17.290
Louisiana 22:213
Maine 24-A2829
Minnesota (applies to narcotics only) 62A.04(11)
Mississippi 83-9-5
Missouri 376.777
Montana 33-22-231
Nebraska 44-701.04(11)
Nevada 689A.280
New Jersey 17B:26-27
New York 3216(d)(2)(K)
North Dakota 26.1-36-04(2)(h)
Ohio 3923.05(J)
Oklahoma (narcotics only) 36-4405(10)
Oregon 743.480
Pennsylvania 1141-527
Rhode Island 27-18-4(11)
South Carolina 38-71-370(9)
South Dakota (applies only if a felony is committed) 58-17-30.8
Tennessee 56-26-108(11)
Texas 3.70-3(B)(9)
Virginia 38.2(3504)(11)
West Virginia 33-15-5
Wyoming 26-18-126

¹ Most of this information is derived from a status report generated by NCOIL staff and presented to the public on July 16, 2004. ARC staff have updated this information to make it current to August 4, 2004.

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III. Summary of Recent State Repeal Activity.²

Arizona saw the introduction of S.B. 1005. Although this was passed by the Senate in February 2002, it was never heard by a House committee.

The **California** legislature recently passed S.B. 1157, which would have repealed California's UPPL. Unfortunately, the California Governor vetoed the bill on July 8, 2004.

The **Iowa** legislature passed S.F. 2279 on April 2, 2002, and was signed by the Governor into law that same month.

Maryland repealed its UPPL in April 2001, by enacting S.B. 132.

New York has seen several efforts to repeal its UPPL over the years. In 2001, the legislature passed S.B. 5685, but that bill was vetoed by the Governor. S.B. 5570 and 981 were introduced in 2003, and carried over and introduced in 2004. They have been in the Insurance Committee since January 2004. A. 8322 was also introduced this year, and has been in the Insurance Committee since 2004.

North Carolina repealed its UPPL in 2001 with the enactment of H.B.360.

Texas saw the introduction of H.B. 2782 in 2003, which was pending in Committee when the legislature adjourned in 2003. Introduction of a new bill is planned for 2005.

H.B. 1196 was introduced in **Virginia** and has been continued to the 2005 session.

Vermont repealed its UPPL in 2002 with Act 121.

Washington's repeal was passed by its legislature and signed into law in March 2004.

Washington, D.C. is currently considering a repeal of its UPPL the form of B15-0543.

III. Bullet Points Supporting Repeal of the UPPL.

- Although the NAIC may have enacted its UPPL model law in 1947, in 2001 the NAIC, as well as the National Conference of Insurance Legislators (NCOIL) have adopted resolutions calling for the repeal of the UPPL. These organizations revised their positions because of the advances in drug and alcohol treatment made since 1947, and because of the societal costs imposed by alcohol and drug misuse.

² Most of this information is derived from a status report generated by NCOIL staff and presented to the public on July 16, 2004. ARC staff have updated this information to make it current to August 4, 2004.

- When NCOIL adopted its resolution calling for the repeal of the UPPL one of its justifications for doing so was that that alcohol screening and intervention in the emergency room could save up to \$327 million in medical costs over five years.
- While the UPPL may have originally been intended to reduce insurance costs, they actually had the opposite effect. Because UPPLs drastically limit the number of patients who are screened and subsequently treated for alcohol and substance abuse problems, UPPLs actually increase health costs incurred to treat alcohol-related injuries, which now approximate \$19 billion. Because they don't receive the needed intervention, patients continue high risk drinking resulting in increased emergency room visits and secondhand health effects to others. Insurance companies, and public payment programs like Medicaid, Social Security, etc., must therefore cover readmissions to the hospital/emergency room related to alcohol. These companies and payment programs also end up having to pay for alcohol related medical conditions such as cirrhosis, heart disease, and some types of cancer—payment which might have been unnecessary had needed intervention taken place in the emergency department.
- A cost-benefit analysis conducted at the University of Washington demonstrates that ER screening and intervention will result in an estimated three year net national savings of \$1.82 billion in direct medical costs (which, by themselves, are estimated to comprise only 15% of total costs, with the balance attributable to property damage, etc.), with \$4 saved for every dollar invested in ER screening for alcohol problems.
- The disincentive that the UPPL presents is not speculative.
 - (1) Physicians and hospital staff want to provide meaningful and effective alcohol and drug prevention, which can be particularly effective in the emergency room/hospital setting subsequent to an injury. Physicians and hospitals, particularly large trauma centers, simply cannot afford to perform alcohol/drug related screenings and counseling and write off millions of dollars every year in costs.
 - (2) Data from the federal Centers for Disease Control and Prevention indicate that emergency room physicians are significantly less likely to screen patients for an alcohol problem in states where the UPPL is embodied in state
- Injuries are the leading cause of death in individuals less than forty-four years of age, the third leading cause of overall mortality, and the number one cause of ER visits, with alcohol use being the leading contributing factor to injuries.
- More than 40% of patients seen in emergency rooms are under the influence of either alcohol or a drug (some studies suggest the number is as high as 70%). This puts physicians and other emergency department staff in a unique position to

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initiate alcohol and drug treatment—intervention can be particularly effective just after a traumatic event resulting in admission to the hospital or an emergency room. Unfortunately, the UPPL is a formidable deterrent to screening and subsequent counseling. Currently, only 15% of emergency room patients are screened or assessed for treatment.

- The fact that only 15% of patients are screened and receive treatment/counseling is particularly unfortunate because studies have shown that screening and intervention in the emergency room can be very effective in altering behavior.

In 1999, the Annals of Surgery published a three-year study of 760 trauma patients which demonstrated the positive benefits of alcohol screening and counseling. The patients were divided into two groups, those that received thirty minutes of post-screening counseling, and those that did not. The study made the following findings:

The group of trauma patients that received the counseling had a 48% reduction in readmission to the hospital;

The group of trauma patients that received the counseling also had a 50% reduction in returns to the emergency department.

Those receiving the counseling reported reducing their alcohol consumption by an average of 28 drinks per person per week.

Those trauma patients that received no treatment did not experience any reduction in their alcohol consumption.

- The 1999 study in the Annals of Surgery is just one study among many that demonstrate the effectiveness of intervention in the health care system. There are over 40 studies evaluating the use of brief alcohol interventions in health care settings, including ERs and trauma centers, which document effectiveness in reducing subsequent alcohol intake, DUIs, alcohol-related traffic infractions, alcohol-related arrests, and injury-related hospital readmissions.
- Thanks in large part to the advances in emergency room equipment and the quality of physicians and staff manning emergency rooms, the ability of most emergency departments to prevent death has reached nearly optimum levels with respect to injuries resulting from alcohol and drug misuse. The only way to make significant gains in preventing these types of injuries is to foster prevention for drug and alcohol usage through emergency department and other physician screening, counseling, and referral. But this is not happening like it should because of the UPPL.
- In some cases, the UPPL creates serious injustices for a particular patient. For example, UPPLs have been used to deny medical coverage *even when the*

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emergency room patient was not drunk, and whose alcohol usage did not cause the injury.

- UPPLs create an absurd situation where emergency room physicians and staff are required to treat the alcohol and/or drug related injury but are strongly discouraged to treat the real issue—the underlying alcohol or drug problem.
- A number of surveys have shown that most trauma physicians believe that it is important to discuss also their patient's alcohol or drug problem with emergency room patients. **And emergency room physicians test blood alcohol content any time patient treatment calls for such testing. But the UPPL creates a strong disincentives for further, proven and effective means, e.g., screening, counseling, and referral, that physicians and hospitals could use to treat the alcohol and drug misuse that lies at the heart of the problem.**
- It isn't just organizations like the AMA and the American College of Emergency Physicians that are calling for repeal of state UPPLs. The Centers for Disease Control and the National Highway Traffic Safety Administration advocate broader screening of emergency room patients for alcohol use.

Repeal of Uniform Individual Accident and Sickness Policy Provision Law (UUPPL)

Studies indicate that 40% of injured patients have a positive blood alcohol concentration (BAC) at the time of trauma center admission.ⁱ This makes alcohol use disorders an obvious target for injury prevention programs.

Alcohol screening and intervention for injured patients has been shown to reduce subsequent alcohol use, hospital readmissions, and related consequences,^{ii,iii,iv,v} Cost-benefit analysis demonstrates that screening and intervention for alcohol problems in trauma patients saves \$4 in medical costs for every dollar invested. A nationwide survey of alcohol screening practices reported that 83% of trauma surgeons believe that a trauma center is an appropriate place to provide alcohol interventions.^{vi}

However, many trauma surgeons are reluctant to measure BAC because it may prompt the patient's insurer to deny payment if the result is positive. The Uniform Accident and Sickness Policy Provision Law (UPPL) is a legal statute that allows insurance carriers to exclude coverage for alcohol and drug related injuries.^{vii}

The UPPL includes the language, "Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."

The UPPL was drafted as a model law by the National Association of Insurance Commissioners (NAIC) in 1947. Shortly thereafter it was adopted by 38 states, and four additional states adopted it with some modification.

Trauma surgeons are less likely to screen patients for an alcohol problem in states where the UPPL exists and is enforced. In this context, a BAC provides the insurance company with information that can be used to deny payment to the doctor and to the trauma center. Out of concern for the adverse financial impact on their patients and their trauma center, many trauma surgeons have decided not to screen patients for the presence of alcohol or other intoxicants.^{viii}

A variety of federal, expert, and public policy groups recommend routine screening and intervention in trauma centers, and therefore urge statutory repeal of the UPPL because it is a significant barrier to implementation of screening protocols in trauma centers.^{ix,x,xi} A variety of traffic safety organizations also urge repeal of the UPPL because it has caused many trauma centers to forego BAC testing, thus allowing drunk drivers transported to a trauma center to routinely escape detection after a crash that causes property damage or personal injury.^{xiii}

Repeal of the UPPL will not increase insurance costs because where it is enforced trauma surgeons have already stopped screening for alcohol problems in order to prevent denial of payment.

Therefore, Physicians and Lawyers for National Drug Policy (PLNDP) supports legislation to repeal laws and state insurance codes which allow denial of insurance payments for the treatment of injuries sustained while under the influence of alcohol or narcotics.

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- vii. NAIC Model Laws Regulations And Guidelines. National Association of Insurance Commissioners: Model Regulation Service. Kansas City, MO: Uniform Individual Accident and Sickness Policy Provisions Law. 2004;II-180-1.
- viii. Rivara FP, Tollefson S, Tesh E, and Gentilello LM: "Screening Trauma Patients for Alcohol Problems: Are Insurance Companies Barriers?" *Journal of Trauma* 48(1):115-118, 2000.
- ix. Hungerford DW, Pollock DA, editors. Alcohol Problems Among Emergency Department Patients: Proceedings of a Research Conference on Identification and Intervention. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2002.
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- xi. Developing Best Practices of Emergency Care for the Alcohol-Impaired Patient: Recommendations from the National Conference. NHTSA, 2000. National Technical Information Service, Springfield, Virginia 22160.
- xii. Rating The States 2002 - Report Card. Mothers Against Drunk Driving. Appendix D. Accessed at <http://www.madd.org/stats/0,1056,5546,00.html>

Challenging a Hidden Obstacle to Alcohol Treatment

Little-known Insurance Laws Thwart Screening in Emergency Rooms

The food was delicious and the champagne mellow when a 50-year-old woman and her husband celebrated their anniversary at an acclaimed Seattle restaurant. But it was raining as they left and the woman – wearing a pair of high-heeled shoes – slipped on a wet curb and badly broke her ankle.

If the mishap and its painful consequences weren't enough, the woman soon learned – to her shock and horror – that her insurance company would not pay the approximately \$22,000 in medical bills for her treatment, which included two surgeries to repair her ankle.

This celebrant, whose name is being withheld due to privacy concerns, was the victim of little known state laws that not only allow insurance companies to cite alcohol use as a reason to avoid paying for care, but also help contribute to a cycle of inadequate treatment for people with alcohol problems.

Many emergency room physicians, aware that hospitals collectively could face billions in financial losses if insurance claims are denied, do not routinely screen their injured patients for alcohol. They worry that a Uniform Accident and Sickness Provision Law (UPPL) in their states will allow insurance companies to deny health coverage for emergency treatment to people who have been drinking.

The physicians' logic: if a patient's drinking does not appear in the medical records, insurers cannot use the law to deny coverage. By using this tactic to circumvent the measure, emergency room physicians believe they can protect both their patients and their hospitals from serious medical debt.

But as Eric Goplerud, director of Ensuring Solutions to Alcohol Problems (ESAP), points out this logic also discourages wider use of alcohol screening as a diagnostic procedure among emergency room patients, a group at high risk for serious alcohol problems. "Patients who could be helped by alcohol treatment will remain unidentified and won't receive the help they need," observes Goplerud. "Without treatment, they are more

likely to drink and hurt themselves again or eventually develop serious alcohol-related medical conditions." Ensuring Solutions, based at George Washington University Medical School, works with policymakers, employers and concerned citizens to increase access to treatment for individuals with alcohol problems.

UPPLs Have Not Reduced Insurance Costs

The little known UPPLs, Goplerud says, are just one of many hidden barriers to effective treatment for people who drink in ways that are harmful to themselves or others. Paradoxically, the laws have not reduced insurance costs, their original intent. By limiting the number of patients who are screened and treated for alcohol problems, they indirectly contribute the \$19 billion the nation pays in alcohol-related health care costs (by contrast, the nation spends only \$5 billion to treat alcohol problems).

The Seattle woman's experience illustrates the dramatic and costly effect that UPPLs can have even on Americans when they have been drinking in moderation. Under the UPPLs, some insurers have denied coverage for injuries in cases where the patient wasn't legally drunk and drinking was not the cause of the injury. Moreover, few Americans even know that these laws exist – or how easily they can affect their own lives.

"If you're drinking beer while watching the Super Bowl at home in your own living room, and then trip – and require emergency medical treatment – you run the risk of not having the treatment for your injuries covered," warns Larry Gentilello, MD, a leading UPPL opponent.

UPPLs are based on a model state law drafted in 1947 by the National Association of Insurance Commissioners (NAIC), the organization of state insurance regulators, and adopted by 42 states. Some states have since repealed it; yet today it remains on the books in 38 states and the District of Columbia. The District, Virginia, California and Washington are now considering removing the law.¹ Only two states, North Carolina and South Dakota, have statutes that expressly forbid insurance companies from excluding coverage for injuries incurred while intoxicated.

"Many trauma centers are currently forced to treat the patient's injuries, while ignoring the underlying alcohol problem," says Gentilello, a trauma surgeon. "Doctors want to do what is right for their patients, but trauma centers that admit hundreds of intoxicated patients every year cannot afford to write off these costs," says Gentilello, who conducted a study of the problem while at Seattle Harborview Medical Center. "Surveys have shown that the vast majority of trauma surgeons believe that it is important to talk to their patients about alcohol use, and believe that a trauma center is an appropriate place to begin to address alcohol problems. However, UPPLs have prevented them from putting these potentially life-saving protocols into practice."

"Patients who could be helped by alcohol treatment will remain unidentified and won't receive the help they need [because of UPPLs]. Without treatment, they are more likely to drink and hurt themselves again or eventually develop serious alcohol-related medical conditions."

Eric Goplerud, PhD
Ensuring Solutions to Alcohol Problems

Brief Alcohol Counseling Can Reduce Emergency Room Visits

Gentilello, now chairman of the University of Texas Southwestern Medical School's surgery department division of burns, trauma and critical care, led a 3-year federally funded study published in 1999 in the *Annals of Surgery*

that examined the impact of alcohol screening followed by brief counseling on trauma patients. The study followed 760 trauma patients between 1995 and 1998, comparing two groups. Members of one group received 30 minutes of alcohol counseling, while those in the second group did not.

The treatment group experienced a 48 percent reduction in hospital re-admissions and a 50 percent decrease in emergency room visits, compared to the controls. Also, control group patients did not reduce their drinking levels. Patients in the intervention group, on the other hand, reported drinking an average of 28 fewer drinks per person each week.²

According to the Centers for Disease Control and Prevention (CDC), 20-30 percent of emergency room patients have alcohol problems.³ However, Gentilello stresses that only a small fraction of these are alcohol dependent and require extended treatment. A life-threatening injury resulting from an accident after drinking can motivate people with less severe alcohol problems to change their behavior. These patients could benefit greatly from a counseling session delivered in the emergency room setting taking a half-hour or less.

In recognition of advances in alcohol treatment research, the NAIC, which developed the model UPPL nearly 60 years ago, revised its model law in 2001 to permit coverage for treatment of alcohol-related injuries. But since so few states have replaced the old laws, UPPLs still continue to interfere with the recent recommendations of the federal government and medical associations. The Centers for Disease Control and Prevention, the National Highway Traffic Safety Administration and the American College of Emergency Physicians all support wider screening for alcohol problems in emergency rooms.

The Health Insurance Association of America (HIAA), however, has said that evidence proving the benefit of emergency room-based screening and brief intervention is inconclusive and "strongly opposed" amending the UPPL to permit reimbursement for alcohol-related medical problems. A 2000⁴ memo declaring this opposition stated:

"Insurance contracts have always had (and likely always will have) exclusions and limitations that serve many functions, including limiting the cost of insurance. No third-party reimbursement system can pay for every service that health care providers can provide. Regardless of uncertainty about third-party reimbursement, health care providers will always have to rely on their medical judgment in treating patients. The threat of 'maybe no coverage means absolutely no treatment' is not only insufficient justification for restricting the use of a legitimate policy exclusion, it is a shocking abdication of responsibility."

This reasoning may be lost on the Bishop family of Guilford, Conn., whose members have been fighting a losing legal battle against their insurance company for more than five years. Upholding the kind of alcohol exclusion permitted under the old UPPL, a federal appeals court ruled in 2003 that National Health Insurance Co. does not have to pay \$242,235 in medical bills incurred by 19 year-old Oliver Bishop IV for the injuries he sustained when he crashed his car into a tree while driving under the influence of alcohol.

"It's an important decision because the ruling reinforces Connecticut public policy against drunken driving," William H. Clendenen Jr., attorney for the Texas-based insurance company in the case, said of the court action.

"Surveys have shown that the vast majority of trauma surgeons believe that it is important to talk to their patients about alcohol use, and believe that a trauma center is an appropriate place to begin to address alcohol problems. However, UPPLs have prevented them from putting these potentially life-saving protocols into practice."

Larry Gentilello, MD
University of Texas Southwestern Medical School

Individuals, Hospitals and Society Pay More Because of UPPLs

But while many citizens would agree that the state has a responsibility to vigorously prosecute impaired driving, the ruling in the Bishop case could have profound ramifications for individuals with a variety of alcohol-related illnesses and injuries, the health care providers who treat them, the quality of health care for persons with alcoholism and public budgets.

The hospital where Bishop was treated, for example, may have no choice but to challenge the family for payment, since none of his extensive injuries was covered by insurance. Ultimately, liability may rest with the son, regardless of whether he has an income. Moreover, if the son's injuries result in permanent disability, the costs also could be considerable for the state and federal government if he requires Medicaid and other support, such as Social Security disability payments.

Gentilelo, as head of a trauma department, is well positioned to see how the old UPPL law contributes to the \$19 billion the nation pays in alcohol-related health care costs. By reducing the number of patients who receive alcohol screening and treatment, it indirectly increases insurance costs if patients continue to drink, become re-injured or develop costly alcohol-related medical problems such as cirrhosis of the liver, heart disease and some forms of cancer.

"The insurance companies are already paying because the doctors are not screening," he says. "The law has not reduced insurance costs at all."

"We've learned so much more in recent years about how to effectively treat alcohol dependence and other alcohol problems," ESAP's Goplerud adds. "Increasingly, decision makers in the public and private sectors are working to make these treatments more accessible. UPPLs remain one of the many barriers to achieving improved access to treatment."

- 1 A study published in the *Journal of Trauma, Injury, Infection and Critical Care* undertook a survey of all 50 states and the District of Columbia to determine the prevalence of state statutes that explicitly permit insurance companies to place exclusions in coverage for injuries that the beneficiary incurs as a result of ingesting drugs or alcohol. See Frederick P. Rivara, et. al, Screening Trauma Patients for Alcohol Problems: Are Insurance Companies Barriers?, *48 J. Trauma, Injury, Infection and Critical Care* 115 (2000). The study concluded that 38 states and the District of Columbia had provisions in their insurance codes permitting a drug and alcohol exclusion, and that the exclusion was based on the Uniform Accident and Sickness Policy Provision Law, a model statute promulgated by the National Association of Insurance Commissioners. Furthermore, the study found that four states, Minnesota, New York, Oklahoma and South Dakota, had statutes that permitted an exclusion for injuries incurred as a result of ingesting narcotics or committing a felony, and that eight states, Utah, Colorado, Connecticut, Massachusetts, Michigan, New Hampshire, New Mexico and Wisconsin, had no exclusionary provision in their insurance code.
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- 3 Centers for Disease Control and Prevention. 2002. Injury Fact Book. Available on the World Wide Web at http://www.cdc.gov/ncipc/fact_book/09_Alcohol_%20Injuries_%20ED.htm.
- 4 Theisen, R.M. December 4, 2000, memo to Regulatory Framework (B) Task Force: UPPL Permissible Exclusion for Losses Related to Alcohol or Drug Abuse. Health Insurance Association of America.

Marlene Cimonis March 2004

2021 K St. NW
Suite 800
Washington, DC 20006
Phone: 202.296.6922
Fax: 202.296.0025
info@ensuringsolutions.org
www.ensuringsolutions.org



Ensuring Solutions to Alcohol Problems (Ensuring Solutions) at The George Washington University Medical Center in Washington, DC, seeks to increase access to treatment for individuals with alcohol problems. Working with policymakers, employers and concerned citizens, Ensuring Solutions provides research-based information and tools to help curb the avoidable health care and other costs associated with alcohol use and improve access to treatment for Americans who need it. The project is supported by a grant from The Pew Charitable Trusts. For more information, please visit the Ensuring Solutions Website at www.ensuringsolutions.org.



JOIN TOGETHER

to advance effective drug and alcohol policy, prevention, and treatment

February 22, 2005

Assemblywoman Barbara Buckley, Chair
Assembly Commerce and Labor Committee
Nevada Legislature
401 Carson St
Carson City, NV 89701-4747

Dear Assemblywoman Buckley:

In 2003, Join Together, a national resource to advance effective alcohol and drug policy, prevention, and treatment, convened a national policy panel to identify recommendations to end discrimination against people with alcohol and drug problems.

Among its 10 recommendations, the panel, comprised of a diverse set of individuals including lawyers, judges, and doctors, unanimously called for the repeal of the Uniform Accident and Sickness Policy Provision Law (UPPL) because:

- Approximately 50% of trauma patients have alcohol in their blood at the time of an injury.
- Trauma professionals are reluctant to screen or test for alcohol because they know that denial of a patient's claim could result in financial loss to the hospital, staff, the patient, and his or her family. As a result fewer than 5% of trauma centers formally assess patients for a substance use disorder.
- Re-admissions for unrelated traumatic injuries go down when trauma patients are screened and, if needed, briefly counseled about their alcohol or drug use. In one study, unrelated injuries were reduced by 48%

The National Association of Insurance Commissioners recommended amending the UPPL in June, 2001 to stop insurance companies from denying claims, and the National Council on Insurance Legislators resolution called for the repeal of the UPPL, citing national savings of \$327 million in direct medical costs over five years (3/2001).

If a policy is not an effective deterrent to substance use, but does interfere with getting treatment, housing, an education, or a job, it should be changed. The UPPL is one such policy.

Sincerely,

David Rosenbloom
Director

26 February 2005

Assemblywoman Barbara Buckley, Chair
Assembly Committee on Commerce and Labor
Nevada Legislature Building
401 South Carson Street
Carson City, NV 89701-4747

RE: Supporting repeal of the Uniform Accident and Sickness Policy Provision Law

Dear Assemblywoman Buckley,

I am writing to you to urge you to support the repeal of the Uniform Accident and Sickness Policy Provision Law (UPPL) in the state of Nevada. Your efforts on this matter are critical in facilitating physicians and hospitals to effectively screen, counsel and refer patients who suffer from addiction.

As a medical doctor specializing in Internal, Addiction, and Preventive Medicine, I have spent my career treating patients and populations affected by the disease of alcoholism and drug dependence. If undetected and subsequently untreated, substance dependence is responsible for costly medical consequences including liver disease, cancer, infections, and unintended injuries such as those frequently seen in emergency departments. If we do not effectively identify persons with such a life threatening and progressive condition, the indirect economic burden such as lost work productivity and disability will also continue to soar.

Lastly, if this outdated law is not repealed and clinicians are not able to effectively provide screening, counseling and referral of patients with substance-related problems, families and children will continue to suffer the generational toll imparted by untreated substance abuse and dependence.

The American Medical Association, National Association of Insurance Commissioners, and National Conference of Insurance Legislators support repeal of the obsolete UPPL. I urge you to lead your fellow legislators in effecting this change for the citizens of Nevada to help make our communities healthy.

If you would like to discuss this further, please contact me at the Reno Sparks Tribal Health Center at 775-329-5162.

Yours very truly,

Amy J. Khan, MD, MPH
2190 Dant Boulevard
Reno, NV 89509

B-16

Denise

From: "Eric William Lamberts" <ewl@unr.edu>
To: <bbuckley@asm.state.nv.us>
Cc: <banderson@asm.state.nv.us>; <marberry@asm.state.nv.us>; <mconklin@asm.state.nv.us>; <kmclain@asm.state.nv.us>; <cgiunchiani@asm.state.nv.us>; <dparks@asm.state.nv.us>; <rperkins@asm.state.nv.us>; <fallen@asm.state.nv.us>; <lhettrick@asm.state.nv.us>; <bseal@asm.state.nv.us>; <rsherer@asm.state.nv.us>; <everett_d@sbcglobal.net>; <hgansert@asm.state.nv.us>; "Eric William Lamberts" <ewl@unr.edu>
Sent: Monday, February 28, 2005 10:56 AM
Subject: Repealing UPPL - AB 63 (fwd)

I support AB 63 which repeals UPPL, which allows insurance companies to deny coverage to anyone under the influence of intoxicating substances, no matter what their presenting diagnosis.

What's next? Denying gall bladder surgery because someone is over weight, or care for heart attacks in diabetics who present with high blood sugars?

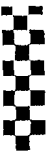
Please support this bill.

Sincerely

Eric Lamberts MD
Certified American Society of Addiction Medicine
Fellow American Academy of Family Practice
Chief of Staff, West Hill Hospital, Reno.

2/28/2005

B-17



February 28, 2005

Denise Everett
Join Together Northern Nevada
1325 Airmotive Way Suite 205
Reno, NV 89502

Dear Ms. Everett:

The Emergency Nurses Association (ENA) strongly supports the passage of Assembly Bill 63, which will effectively repeal The Uniform Accident and Sickness Policy Provision Law (UPPL) in Nevada. UPPL was promulgated as a Model Law in 1947, when treatment for alcohol problems was generally not available, and regional trauma centers did not exist.

Today, injuries are the leading cause of death in individuals less than forty-four years of age, the third leading cause of overall mortality, and the number one cause of emergency department (ED) visits. Alcohol use is the leading contributing factor to injuries and over 40% of injured patients treated in EDs nationwide are under the influence of alcohol or other intoxicants. There are over 40 studies evaluating the use of brief alcohol interventions in health care settings, including ED's and trauma centers, which document effectiveness in **reducing** subsequent alcohol intake, DUI's, alcohol-related traffic infractions, alcohol-related arrests, and injury-related hospital readmissions. According to the National Highway Traffic Safety Administration (NHTSA) in 2003, 50% of Nevada's traffic fatalities were alcohol related, 10% above the national average.

In recent years a variety of federal, expert, and consensus panels have recommended routine screening and intervention in injured patients. However, despite the interest and opportunity, data from the federal Center for Disease Control and Prevention (CDC) indicates that emergency physicians and trauma surgeons are significantly less likely to screen patients for alcohol problems in states where the UPPL is embodied in state code and most did not provide this service at their center. Of those who did not, 41 percent cited the threatened impact of screening on reimbursement as a key factor.

ENA believes that emergency nurses have an obligation to individual patients to treat not only the injury or illness, but also provide screening and brief intervention for underlying alcohol disease associated with the patient's health condition, and an obligation to protect the public - whose health and safety is placed in jeopardy every time an individual drives while impaired - by providing access to alcohol prevention and treatment services.

The National Association of Insurance Commissioners (NAIC) repealed the UPPL provision in 2001, but many States have not yet eliminated it from their laws or insurance codes. Nevada ENA applauds the efforts of our state legislature with regards to AB 63 and believes it is a forward step in establishing intervention and referral strategies for patients impaired by the use of alcohol and narcotics.

Sincerely,

Stacey R. Ingram, RN
President, Nevada ENA
1141 Sageberry Ct
Reno, NV 89509-2259

B-18

Repealing the Uniform Accident and Sickness Policy Provision Law

- The UPPL allows insurance companies to deny payment of health insurance claims if the patient is documented as under the influence of alcohol or a non-prescription drug at the time of treatment. This provision most often applies to trauma center visits.
- AB63 proposes to repeal the UPPL in Nevada, prohibiting health insurance coverage from being denied or cancelled because alcohol or drugs were a factor. ***AB63 does not propose a mandate of any kind on either trauma centers or insurance companies.***
- Wrongdoing is not a concern under the UPPL in Nevada. Alcohol need not be the cause of the injury for an insurance company to deny a claim. A person who slips and falls at home and goes to the emergency room with a broken wrist, could see the claim denied if the presence of alcohol is noted in their patient record.
- More than 40 percent of patients seen in emergency rooms across the country are under the influence of either alcohol or drugs, yet only 15 percent are screened. ***Studies indicate that doctors are less likely to screen in states with a UPPL, however, ER screenings could reduce the risk of reinjury by 50 percent.***
- A University of Washington study found that drug and alcohol screening in emergency rooms would result in a three-year net national savings of \$1.82 billion in direct medical costs.
- The UPPL was adopted in the 1950s by many states in an attempt to reduce insurance costs. There is no demonstrated evidence that the UPPL has reduced insurance costs.
- Efforts to repeal the UPPL are supported by the National Council of Insurance Legislators, National Association of Insurance Commissioners, Centers for Disease Control, American Medical Association, National Highway Transportation Safety Administration, and National Association of Addiction Medicine.
- Since 2001, Iowa, Maryland, North Carolina, Vermont and Washington state have all repealed UPPL provisions. Measures also have been introduced in Arizona, California, New York, Texas, Virginia and Washington D.C.

Screening and Brief Intervention

Impaired driving is often a symptom of a larger problem: alcohol misuse. There is compelling evidence, detailed in scientific and medical literature, that screening and brief intervention is effective in reducing drinking and impaired driving behaviors among problem drinkers.

More than 100 million people seek care in emergency departments (EDs) every year. Substantial numbers of patients who visit EDs with injuries have alcohol use problems; almost one in six traffic crash victims treated in EDs are alcohol positive and one third or more of crash victims admitted to trauma centers — those with the most serious injuries — test positive for alcohol. These patients pose not only a public health problem but also an opportunity for intervention.

NHTSA will work with physicians and other health care providers to increase routine screening of adults and adolescent patients for alcohol abuse problems, and facilitate brief counseling and referral of patients for treatment of alcohol dependency, as appropriate. To help achieve this goal, the agency will seek endorsements and enlist the support of leaders in the medical and health care community. NHTSA will simultaneously work with medical and health care professionals, develop reference materials, and provide technical assistance and promote universal adoption of the practice.

NHTSA's objective is to achieve endorsement and active promotion of screening and brief intervention from strategic national health and medical associations. The agency will work closely with each of these associations, providing materials and technical assistance as needed, to establish screening and brief intervention as standard medical practice.