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Publication Date

2007-04-19



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Analysis of Assembly Bill 1461: Alcohol and Drug Abuse Exclusion

A Report to the 2007-2008 California Legislature
April 19, 2007

CHBRP 07-05



The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and proposed repeals of health insurance benefit mandates. CHBRP was established in 2002 to implement the provisions of Assembly Bill 1996 (*California Health and Safety Code*, Section 127660, *et seq.*) and was reauthorized by Senate Bill 1704 in 2006 (Chapter 684, Statutes of 2006). The statute defines a health insurance benefit mandate as a requirement that a health insurer or managed care health plan (1) permit covered individuals to obtain health care treatment or services from a particular type of health care provider; (2) offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or (3) offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

A small analytic staff in the University of California's Office of the President supports a task force of faculty from several campuses of the University of California, as well as Loma Linda University, the University of Southern California, and Stanford University, to complete each analysis within a 60-day period, usually before the Legislature begins formal consideration of a mandate bill. A certified, independent actuary helps estimate the financial impacts, and a strict conflict-of-interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, drawn from experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit mandates, reviews draft studies to ensure their quality before they are transmitted to the Legislature. Each report summarizes scientific evidence relevant to the proposed mandate, or proposed mandate repeal, but does not make recommendations, deferring policy decision making to the Legislature. The State funds this work through a small annual assessment of health plans and insurers in California. All CHBRP reports and information about current requests from the California Legislature are available at the CHBRP Web site, www.chbrp.org.

A Report to the 2007-2008 California State Legislature

Analysis of Assembly Bill 1461: Alcohol and Drug Abuse Exclusion

April 19, 2007

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Suggested Citation:

California Health Benefits Review Program (CHBRP). (2007). *Analysis of Assembly Bill 1491: Alcohol and Drug Abuse Exclusion*. Report to California State Legislature. Oakland, CA: CHBRP. CHBRP 07-05.

PREFACE

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 1461, specifically the proposal to amend Section 10369.12 of the California Insurance Code. Under the proposed legislation, health insurers would no longer be permitted to write health insurance policies that exclude coverage of losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician. Other types of disability insurance would continue to be able to use the exclusion. CHBRP's analysis focuses on these provisions of AB 1461 and not the provisions related to the substance abuse intervention, counseling, and treatment pilot program. In response to a request from the California Assembly Committee on Health on February 28, 2007, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq., of the California Health and Safety Code. CHBRP submitted analyses to the State Legislature of two bills with similar provisions: SB 1157 (2004) on April 27, 2004, and SB 573 on April 7, 2005.

Wade Aubry, MD, Patricia Franks, BA, Janet Coffman, MPP, PhD, and Edward Yelin, PhD, all of the University of California, San Francisco, prepared the medical effectiveness analysis. Min-Lin Fang, MLIS, of the University of California, San Francisco, conducted the literature search. Sara McMenamain, MPH, PhD, Helen Halpin, MSPH, PhD, and Zoë Harris, MPH, all of the University of California, Berkeley, prepared the public health impact analysis. Nadereh Pourat, PhD, and Gerald Kominski, PhD, of the University of California, Los Angeles, prepared the analysis of the cost impacts. Jay Ripps, FSA, MAAA, of Milliman, provided actuarial analysis. Susan Philip, MPP, and Joshua Dunsby, PhD, of CHBRP staff prepared the background section and integrated the individual sections into a single report. Sarah Ordódy, BA, provided editing services. In addition, a subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Wayne Dysinger, MD, MPH, of Loma Linda Medical Center reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 1461

Assembly Bill 1461 proposes to amend Section 10369.12 of the California Insurance Code. Under the proposed legislation, health insurers would no longer be permitted to write health insurance policies that exclude coverage of losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician. Other types of disability insurance would continue to be able to use the exclusion.

In response to a request from the California Assembly Committee on Health on February 28, 2007, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq., of the California Health and Safety Code. CHBRP's analysis focuses on the provision of AB 1461 pertaining to the amendment of the Insurance Code and not those provisions related to the substance abuse intervention, counseling, and treatment pilot program. CHBRP submitted two separate analyses to the State Legislature of two previous bills with identical provisions: SB 1157 (2004) on April 27, 2004, and SB 573 (2005) on April 7, 2005.¹

Because the provision relevant to the previous bills are identical to AB 1461, CHBRP updates the previous analysis by reviewing the literature for new and relevant studies, and soliciting information from interested parties, health insurers, the California Department of Insurance, and the Department of Managed Health Care. In addition, CHBRP conducted structured interviews with 12 emergency medicine physicians and trauma surgeons practicing in 8 California hospitals to learn about their knowledge of the Uniform Accident and Sickness Policy Provision Law (UPPL) exclusion and AB 1461, as well as their standards of practice with regard to diagnosis, counseling, and treatment of patients who are intoxicated or under the influence of a controlled substance. CHBRP's analysis focuses on evidence of the effects of the UPPL exclusion on emergency-related services because available literature and information from stakeholders suggests that the exclusion is most likely to affect these services. CHBRP did not analyze the medical effectiveness of screening and counseling in emergency departments (EDs) or trauma centers as an intervention to prevent alcohol or substance abuse, because AB 1461 does not propose mandating such screening and counseling.

Medical Effectiveness

AB 1461 differs from most legislation that CHBRP addresses, because it would prevent insurers from *excluding coverage* for illnesses or injuries sustained when an enrollee is intoxicated or under the influence of a controlled substance not prescribed by a physician. Most bills that CHBRP analyzes are proposals that would *mandate coverage* for services or treatment of a disease or condition.

- Few articles about the UPPL have been published in peer-reviewed scientific journals.

¹ The CHBRP analyses of SB 1157 (2004) and SB 573 (2005) may be found at www.chbrp.org/analyses.html.

- Several articles described cases in states other than California in which insurers denied coverage for injuries sustained by persons while intoxicated or under the influence of a controlled substance.
- One article documents that 24% of hospitals with Level I or Level II trauma centers have had one or more claims denied due to the UPPL exclusion, but does not indicate whether health professionals who practice in these hospitals are less likely to provide screening and counseling for alcohol and substance abuse.
- Interviews with emergency medicine physicians and trauma surgeons in California suggest that decisions about screening and treatment for alcohol and substance abuse are driven not by physicians' knowledge of the UPPL exclusion or of patients' insurance status, but by the nature and severity of patients' illnesses and injuries, the need for information to make clinical decisions about diagnosis and treatment, ethical concerns, and the federal Emergency Medical Treatment and Active Labor Act (EMTALA). Under EMTALA, hospitals must provide certain services to stabilize patients before asking for insurance information or ability to pay.
- Most emergency medicine and trauma physicians interviewed, even those who head EDs and trauma centers, said that they were not aware of the existence of the UPPL statute in California or in other states.
- AB 1461 would not necessarily increase the number of Californians who receive screening and counseling for alcohol and substance abuse, because it would not mandate coverage for screening or counseling and would not remove other barriers to the provision of these services, such as:
 - The availability of resources to provide screening and counseling;
 - Physicians' beliefs regarding the benefits screening and counseling;
 - Lack of emphasis on the benefits of screening and counseling for alcohol and substance abuse during medical school and residency;
 - Lack of training in the provision of screening and counseling during medical school and residency; and
 - Concern about patients' privacy, confidentiality, and receptivity to screening and counseling.

Utilization, Cost, and Coverage Impacts

- Coverage
 - AB 1461 would apply to Californians with private health insurance coverage through policies regulated by the California Department of Insurance (CDI), but not through plans regulated by the Department of Managed Health Care (DMHC). Enrollees in CDI-regulated plans account for approximately 9% of the total privately-insured population.

- Based on information gathered from CHBRP's survey of plans and insurers, approximately 96.3% of those insured by CDI-regulated plans and affected by AB 1461 are insured by health policies that are already in compliance with AB 1461. Therefore, only about 3.7% of all enrollees in CDI-regulated plans (approximately 68,000) have policies that contain the UPPL exclusion.
- Utilization
 - An estimated 281 claims for 110 individuals were denied in 2006 due to the UPPL exclusion. These claims were primarily for outpatient services, and approximately 19% of all denied claims were for ER services.
 - If AB 1461 were to pass into law, such denials would be prohibited and the number of denials should drop to zero.
- Costs
 - The average unit cost of each denied claim is estimated to be \$1,260.
 - AB 1461 is not estimated to impact the overall expenditures. However, the uncovered costs of previously denied claims would be distributed to the entire population of insured in the individual CDI-regulated market in the form of premiums and copayments. These uncovered costs were previously borne either by the provider (e.g., hospital, physician) or the individual whose claim was denied. Averaged over all CDI-regulated policies, insured premiums are estimated to increase by 0.005% and member copayments are estimated to increase by 0.002% in the overall market. However, the increase in per member per month (PMPM) premiums in the individual CDI-regulated market is estimated to be 0.018%.

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 1461

	Before Mandate	After Mandate	Increase/ Decrease	% Change After Mandate
Coverage				
Number of individuals subject to the mandate	20,694,000	20,694,000	0	0.000%
Percentage of individuals with coverage (policies without UPPL exclusion)	99.7%	100.0%	0.3%	0.330%
Percentage of individuals in CDI-regulated plans with coverage (policies without UPPL exclusion)	96.3%	100.0%	3.7%	3.704%
Number of individuals with coverage (policies without UPPL exclusion)	20,626,000	20,694,000	68,000	0.330%
Utilization				
Total number of claims denied using UPPL exclusion	281	0	-281	-100.000%
Average cost of claim denied	\$1,260.00	\$1,260.00	0	0.000%
Expenditures				
Premium expenditures by private employers for group insurance	43,944,936,000	43,944,936,000	0	0.000%
Premium expenditures for individually purchased insurance	5,515,940,000	5,516,199,000	259,000	0.005%
CalPERS employer expenditures	2,631,085,000	2,631,085,000	0	0.000%
Medi-Cal state expenditures	4,015,964,000	4,015,964,000	0	0.000%
Healthy Families state expenditures	627,766,000	627,766,000	0	0.000%
Premium expenditures by employees with group insurance or CalPERS, and by individuals with Healthy Families	11,515,939,000	11,515,939,000	0	0.000%
Member copayments	5,153,127,000	5,153,222,000	95,000	0.002%
Expenditures for noncovered services	354,000	0	-354,000	-100.000%
Total annual expenditures	73,405,111,000	73,405,111,000	0	0.000%

Source: California Health Benefits Review Program, 2007.

Notes: The population includes individuals and dependents covered by employer sponsored insurance (including CalPERS), individually purchased insurance, or public health insurance provided by a health plan subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975. All population figures include enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment sponsored insurance. Member contributions to premiums include employee contributions to employer sponsored health insurance and member contributions to public health insurance. Expenditures for adults insured through the Managed Risk Medical Insurance Board are included in Medi-Cal premiums.

Key: CalPERS = California Public Employees' Retirement System.

Public Health Impacts

- It is estimated that across the United States, 7.9% of all ED visits are alcohol-related while 1.3% of ED visits are due to drug abuse or misuse.
- Of drug-related ED visits, 31% were associated with cocaine use, 17% were associated with marijuana use, 11% were associated with heroin use, and 10% were associated with the use of stimulants such as amphetamines or methamphetamines.
- Gender and racial differences in the rates of substance abuse related–ED visits have been found with higher rates of alcohol-related ED visits among men and blacks and higher rates of methamphetamine-related ED visits among men and whites.
- CHBRP found no compelling evidence that AB 1461 would change physician practice patterns in terms of screening and counseling for alcohol and substance abuse or treatment for illness and injuries sustained in conjunction with alcohol or substance abuse. Therefore, we conclude that this mandate would have no impact on overall public health outcomes, the reduction of gender or ethnic disparities in regards to substance abuse, the reduction of premature death, or the reduction of economic loss associated with disease.

INTRODUCTION

Assembly Bill 1461 proposes to amend Section 10369.12 of the California Insurance Code, by prohibiting health insurers from having the ability to use a specific exclusion in insurance policies.

The exclusion in Section 10369.12 allows that:

A disability policy may contain a provision in the form set forth herein.

Intoxicants and controlled substances: 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 controlled substance unless administered on the advice of a physician.

The exclusion in Section 10369.12 is contained in a model law developed by the National Association of Insurance Commissioners (NAIC). This law is commonly referred to as the Uniform Accident and Sickness Policy Provision Law (UPPL). (The exclusion in the UPPL quoted above will be referred to as the, "UPPL exclusion.")

Under the proposed legislation, health insurers would not be able to include this exclusion in their policies and thus could not deny claims for any losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance. Other types of disability insurance would continue to be able to use the exclusion.

CHBRP's analysis focuses on those provisions of AB 1461 pertaining to amendment of the Insurance Code and not those provisions related to the substance abuse intervention, counseling, and treatment pilot program. CHBRP submitted separate analyses to the State Legislature of two previous bills with identical provisions: SB 1157 (2004) on April 27, 2004, and SB 573 (2005) on April 7, 2005. Both bills passed out of the State Legislature and were vetoed by the Governor.²

SB 1157, SB 573, and AB 1461, are unlike most proposed legislation reviewed by CHBRP. These bills do not mandate coverage of a specific service, procedure, or device, but rather restrict an insurer's ability under specific conditions to deny payment for a wide range of services. These services could include those rendered in the emergency department (ED), surgery, or subsequent follow-up care in physicians' offices.³ AB 1461 would not be a benefit mandate requiring plans

² The CHBRP analyses of SB 1157 (2004) and SB 573 (2005) may be found at www.chbrp.org/analyses.html. The Governor's veto message may be found at www.governor.ca.gov/govsite/pdf/press_release/SB_1157_Veto.pdf and www.leginfo.ca.gov/pub/05-06/bill/sen/sb_0551-0600/sb_573_vt_20050711.html.

³ Carriers would need a toxicology report to verify that the claim is a result of alcohol or substance use in order to deny it. According to CDI and a review of a sample of EOC language using the UPPL exclusion, it is generally used to deny services rendered for injuries sustained while intoxicated or under the influence, not medical care needs resulting from alcoholism or prolonged use of substances.

or insurers cover the treatment alcoholism or substance abuse.⁴ Hence, CHBRP did not analyze the medical effectiveness or public health impacts of screening and counseling in EDs or trauma centers as an intervention to prevent alcohol or substance abuse, because AB 1461 does not propose mandating such screening and counseling.

The analysis that follows describes the background of the model law—the UPPL—that contains the exclusion, and background on EDs and trauma centers in California. The report then presents an analysis of the potential impacts of prohibiting use of the exclusion provision on the delivery of care, coverage, costs, and public health impacts. CHBRP’s analysis focuses on evidence of the effects of the UPPL exclusion on emergency-related services because available literature and information from stakeholders suggests that the exclusion is most likely to affect these services. In the *Utilization, Cost, and Coverage* section of this report, some denied claims were not directly for ED services. CHBRP did not have sufficient data to ascertain whether these claims were follow-up services to an original ED claim, though this possibility clearly exists.

CHBRP updates the previous analyses by reviewing the literature for new and relevant studies, soliciting information from interested parties, health insurers, the California Department of Insurance (CDI), and the Department of Managed Health Care (DMHC).

In addition, CHBRP conducted structured interviews with 12 emergency medicine physicians and trauma surgeons in 8 public, university-affiliated, and private hospitals in several regions of California. Physicians were asked: (1) if they are familiar with current law in California that permits health insurers to use the UPPL exclusion; (2) if they are familiar with AB 1461, which would prohibit use of this exclusion; (3) if they are aware of whether patients coming to the hospital’s ED or trauma center have health insurance, the type of insurance, or whether their insurance policies exclude coverage for alcohol or drug related injuries or illnesses; (4) what their standard practice was in terms of ordering toxicology screens to determine whether patients have used alcohol or a controlled substance; (5) what their standard practice was regarding substance abuse counseling; (6) whether knowledge that a patient’s health plan excluded coverage for injuries and illnesses caused by alcohol and controlled substance use would affect their decisions regarding diagnostic tests and treatment.

Model UPPL

The original model UPPL, which includes many required and optional provisions, was created and approved in 1947 by the NAIC. An organization of insurance regulators from the 50 states, the District of Columbia, and four U.S. territories, the NAIC coordinates regulation of multi-state insurers by developing model laws and regulations that states can adopt. The original provision of the UPPL that was the model for Section 10369.12 of the California Insurance Code read as follows:

⁴ In contrast. AB 423 (2007)—another bill under analysis by CHBRP—would require both health insurers regulated by CDI and health plans regulated by DMHC to provide the same amount of coverage for substance abuse and non-severe mental illnesses as they provide for medical care and severe mental illnesses.

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.

Thus, insurers using this exclusion were allowed to deny payment for alcohol- or narcotic-related claims. Forty-two states, including California, and the District of Columbia adopted the original or a modified version of the model UPPL exclusion (Ensuring Solutions, 2004).

In the late 1990s, a national advocacy effort began to press for modification or repeal of the UPPL provision addressing denial of payment for intoxication-related claims. Advocates were concerned that if ED physicians believed that insurers would deny payment for such claims, these physicians would avoid screening for alcohol intoxication or use of controlled substances and thus miss opportunities for counseling. In June 2001, the National Conference of Insurance Legislators (NCOIL) adopted a resolution in support of an amendment to the model UPPL provision. Subsequently, the NAIC voted unanimously to repeal the provision of the UPPL relating to intoxicants and narcotics and to adopt a new model law that bars health insurers from denying payment on the basis of intoxication or use of narcotics. The revised model legislation reads as follows:

- (10) (a) A provision as follows:
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.
- (b) **This provision may not be used with respect to a medical expense policy.** [emphasis added]
- (c) For purposes of this provision, “medical expense policy” means an accident and sickness insurance policy that provides hospital, medical, and surgical expense coverage.

Although the NAIC adopted the new model law, individual states must enact their own laws in order for this provision to be in effect. Since 2001, 10 states and the District of Columbia have passed laws that effectively prohibit health insurers from denying claims based on the insured's being intoxicated or under the influence of a narcotic, including Colorado, Connecticut, Delaware, Indiana, Iowa, Maryland, North Carolina, South Dakota, Vermont, and Washington. Three other states (Illinois, Tennessee, and Texas) currently have proposed legislation working its way through their legislatures (Ensuring Solutions, 2007).

Emergency Departments and Trauma Centers in California

The intent of AB 1461 is to create an atmosphere where practitioners who provide care in EDs and trauma centers are not dissuaded from screening and providing intervention services for individuals with alcohol or drug abuse problems.

An ED is a 24-hour location in a licensed hospital, serving an unscheduled patient population with anticipated needs for emergency medical care (CMS, 2007). Trauma centers are licensed hospitals, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and designated as a trauma center by the local Emergency Medical Services Agency. Trauma centers

are generally required to provide a program medical director, a nurse coordinator, a basic emergency department, a multidisciplinary trauma team and other specified service capabilities. There are 64 trauma centers in California with varying levels of designation (e.g., Level I, II, III, IV, pediatric and/or adult) depending on the specialties and resources available on site (EMSA 2007). EDs and trauma centers are the major frontline providers of care and treatment for people who are intoxicated with alcohol or under the influence of controlled substances and who sustain injuries or illnesses consequent to alcohol or other drug use.

MEDICAL EFFECTIVENESS

AB 1461 differs from most legislation that CHBRP analyzes. Most bills CHBRP analyzes would *mandate coverage* for specific services or diseases or conditions. Instead, AB 1461 would prevent insurers from *excluding coverage* in certain circumstances. Ascertaining the effectiveness of legislation that would prohibit coverage exclusions is difficult, because most research in health care focuses on evaluating the impact of preventive, diagnostic, or therapeutic interventions.

Several forms of evidence are necessary to assess the impact of prohibiting use of the UPPL exclusion. First, researchers need evidence that health insurers are issuing policies that contain the UPPL exclusion. As discussed in further detail in the Utilization, Cost, and Coverage section, a few carriers in California sell policies with such exclusions and have denied claims based upon them, but the number of persons affected is relatively small.

Second, researchers need to determine the potential consequences of prohibiting these exclusions. Advocates for prohibiting the use of the UPPL exclusion maintain that prohibiting its use would facilitate screening and counseling of ED and trauma center patients regarding alcohol and substance abuse (Gentilello et al., 2005a; Rivara et al., 2000). To ascertain whether this is the case, researchers would then need to document that health professionals are aware of the UPPL exclusion and that it influences their decisions regarding the provision of screening and counseling for alcohol and substance abuse in EDs and trauma centers.

Finally, if researchers find evidence that the UPPL exclusion affects clinicians' decisions, they would then need to evaluate whether prohibiting use of the UPPL exclusion is associated with increases in screening and counseling. To answer this question, researchers would have to identify states that have prohibited use of the UPPL exclusion, obtain data on screening and counseling before and after repeal, compare trends in these states to trends in states that have not prohibited use of the exclusion, and control for other factors that might influence the provision of screening and counseling. To date, no researchers have published this sort of comparative analysis.

Literature Review Methods

Studies of the effects of the UPPL exclusion were identified through searches of PubMed and other databases. The search was limited to abstracts of peer-reviewed research studies that were published in English. Thirty-two articles were identified: 19 were retrieved, and 14 were included in the review. CHBRP did not search for articles on the medical effectiveness of screening and counseling in EDs or trauma centers, because AB 1461 does not propose mandating such services. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B: Literature Review Methods.

Study Findings

Only nine articles on the UPPL exclusion were found. Two articles reported the results of surveys conducted to determine the number of states that permit UPPL exclusion provisions

(Fornili and Goplerud, 2006; Rivara et al., 2000). Another was a research study on alcohol abuse screening and counseling that cited the UPPL exclusion as a barrier to increasing the number of persons screened and counseled in EDs and trauma centers (Gentilello et al., 2005b).

Only four articles presented specific examples of health insurers that denied reimbursement for treatment of illness or injury based on the UPPL exclusion. One article described a Federal Appeals Court decision that upheld a health insurance carrier's right to include an alcohol and substance abuse exclusion in its policies (Teitelbaum et al., 2004).⁵ In this case, the Second Circuit Court of Appeals upheld National Health Insurance Company's use of the UPPL exclusion provision to deny payment for care provided to an enrollee in Connecticut who had a major car crash while driving under the influence of alcohol. The second article cited the Connecticut case as well as a case in Florida in which a health insurer denied a claim for treatment of injuries sustained by an intoxicated enrollee who was hit by a motor vehicle (Gentilello et al., 2005a). A federal appeals court ultimately ruled in favor of the enrollee in the Florida case. A third article presented an example from Washington State in which a woman was denied coverage for two surgeries to treat an ankle that she fractured while exiting a restaurant after an anniversary celebration at which she had drunk alcohol in moderation (Fornili and Goplerud, 2006). The fourth article was a summary of proceedings from a conference on hospitalized trauma patients who have alcohol problems. One participant stated that Empire Blue Cross, a large insurer based in New York State, wrote policies that included the UPPL exclusion provision (Gentilello, 2005).

Three studies analyzed information about clinicians' perceptions of the effects of the UPPL exclusion on screening and counseling for alcohol and substance abuse (Fornili and Haack, 2005; Gentilello et al., 2005a; Schermer et al., 2003). These studies suggest that concerns about reimbursement affect some clinicians' and managers' decisions about screening for alcohol and substance abuse in EDs and trauma centers. One study reported the results of a national survey of trauma surgeons regarding barriers to alcohol and substance abuse screening. Twenty-seven percent of respondents reported that they believed screening would jeopardize reimbursement for treatment of patients' illnesses or injuries (Schermer et al., 2003). However, the survey question did not specifically address the role that UPPL exclusion plays in decisions to screen for alcohol or substance abuse.

The other two studies in this grouping obtained more specific information about the impact of the UPPL exclusion. The first reported the results of a series of focus groups conducted with nurses at a university-affiliated hospital in Virginia. Nurses who worked in the hospital's ED and trauma center reported that the UPPL exclusion leads hospital managers and physicians to resist screening and counseling for substance abuse and referring patients for substance abuse treatment (Fornili and Haack, 2005). The generalizability of findings from this study to EDs and trauma centers in California is limited, because all participants worked at a single hospital in another state.

The second assessed trauma surgeons' awareness of the UPPL exclusion and their experiences with denials of claims due to patients' use of alcohol or a controlled substance (Gentilello et al., 2005a). The authors found that most respondents did not know whether they practiced in a state

⁵ Connecticut subsequently prohibited UPPL-type exclusions.

that permitted UPPL exclusions. Only 13% reported that they practiced in a state in which the UPPL exclusion was in effect, whereas 70% of them actually practiced in such a state. Despite lack of knowledge of the UPPL, 24% reported that their hospitals had one or more claims denied during the past six months because a patient had been intoxicated or under the influence of a controlled substance at the time an illness or injury occurred. The authors assert that concerns about denial of claims influence screening practices, but performed no statistical tests to assess whether trauma surgeons who practiced in hospitals in which claims were denied reported lower rates of screening and counseling than trauma surgeons who practiced in hospitals that had not experienced denials. The study also does not indicate whether any of the denials occurred in California.

Summary of Key Informant Interviews

Interviews with emergency medicine physicians and trauma surgeons in California found no evidence that the UPPL exclusion provision affects clinicians' decisions regarding screening and counseling for alcohol and substance abuse. The interviewees stated that decisions about screening for alcohol or substance abuse are based on the nature and severity of patients' illnesses and injuries, the need for information to make clinical decisions about diagnosis and treatment, ethical imperatives, and the federal EMTALA legal requirements. Under EMTALA, hospitals must provide certain services to stabilize patients before asking for insurance information or ability to pay.

The interviewees also reported that physicians and surgeons who practice in EDs and trauma centers usually do not know whether patients have health insurance or if patients' policies contain the UPPL exclusion provision when they began evaluation and treatment.. Most emergency medicine and trauma physicians interviewed, even those who head EDs and trauma centers, said that they were not aware of the existence of the UPPL exclusion as a statute in California or in other states.

In addition, the interviews revealed that there is no standard practice in terms of screening for alcohol and drugs or providing counseling in EDs and trauma centers. In many cases, patients provide this information voluntarily. Some emergency physicians told us that they do provide counseling when there is an opportunity to do so during an ED encounter. Trauma centers were more likely than EDs to routinely screen for alcohol and drugs. This routine practice was linked to protocols that state and local emergency medical services authorities require Level I and II trauma centers to follow.

AB 1461 does not mandate that health insurers provide coverage for alcohol and substance abuse screening and counseling. If AB 1461 were enacted, health insurers would have to reimburse providers for treatment of illnesses or injuries regardless of whether a person was intoxicated or under the influence of a controlled substance not prescribed by a physician at the time that the illness or injury occurred. However, they would not be required to reimburse providers for screening and counseling. The provision of alcohol and substance abuse screening and counseling may not increase if providers were reluctant to do so unless they would be reimbursed for these services.

Even if coverage for alcohol and substance abuse screening and counseling were mandated, the provision of these services still may not increase. Insurance coverage does not address other barriers to screening and counseling that experts have noted. These barriers include clinicians' perceptions of the benefits of screening and treatment for substance abuse, their responsibility to provide screening and counseling, their ability to screen and counsel patients effectively, and patients' attitudes toward screening (Danielsson et al., 1999; Gentilello et al., 1995). Other barriers include concerns about availability of resources for screening and counseling, patient privacy and confidentiality, lack of training in screening and counseling, and lack of collaboration between specialists in addiction medicine and emergency physicians and trauma surgeons (Danielsson et al., 1999; Gentilello, 2005).

In summary, the review of the literature, queries of health insurers in California, and interviews with emergency medicine physicians and trauma surgeons suggests that only a small number of Californians are affected by the UPPL exclusion provision in current law. These sources of information further suggest that enactment of AB 1461 would not affect the number of persons receiving treatment for illnesses and injuries sustained while they were intoxicated or under the influence of a controlled substance not prescribed by a physician. AB 1461 also would not necessarily result in a substantial increase in screening and counseling for alcohol and substance abuse.

UTILIZATION, COST, AND COVERAGE IMPACTS

Under California's existing insurance code, health insurers are allowed to exclude coverage of losses sustained or contracted as a consequence of the insured's being intoxicated or under the influence of any controlled substance, unless administered on the advice of a physician. AB 1461 would prohibit health insurers from writing health insurance policies with the above exclusion. Other types of disability insurance would continue to be able to use this exclusion.

AB 1461 would only apply to the portion of the California population that has health insurance coverage through policies regulated by the CDI—approximately 9% of the total privately insured population. The remaining privately-insured population obtains coverage through Knox-Keene licensed plans regulated under the California Health and Safety Code by the DMHC and are therefore not subject to this mandate.

AB 1461 would not apply to California Public Employees' Retirement System (CalPERS) or publicly funded programs including Medi-Cal, Healthy Families, Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP).

Present Coverage and Utilization Levels

Current Coverage of the Mandated Benefit

CHBRP examined various sources to determine whether there are CDI-regulated policies in California that currently allow insurers to deny all claims based on whether the enrollee was found to be intoxicated or under the influence of a controlled substance ("UPPL exclusion").

- CHBRP surveyed the eight largest health insurance carriers in the state, which insure approximately 90% of the CDI-regulated market.
- CHBRP queried CDI regarding whether any health policies approved for sale in California contained the UPPL exclusion.
- CHBRP queried DMHC and the CDI to determine whether they had received any complaints from consumers regarding denials of claims related to the UPPL exclusion.
- CHBRP reviewed the gray literature to determine whether any evidence exists regarding the use of the UPPL exclusion in health policies in California.

Seven health insurance companies responded to CHBRP's carrier survey, and most indicated that they do not use the UPPL exclusion in their health insurance policies. Of insured individuals enrolled in CDI-regulated plans, approximately 96.3% of enrollees are in health policies that currently do not contain the UPPL exclusion prohibited by AB 1461. Therefore, only about 3.7% of all enrollees in CDI-regulated plans (approximately 68,000) have policies that contain the UPPL exclusion.

CHBRP has attributed those insured by these CDI-regulated policies to the individual market for the purpose of these analyses. Further investigation of the policies with UPPL exclusion revealed these enrollees to have policies as members of association health plans (AHPs) however, they

were individual policies with no contribution by the AHP towards premiums.⁶ CDI does not have a searchable database of approved health policies to determine systematically what proportion of carriers may sell health insurance policies containing the UPPL exclusion. Senior Counsel in the Policy Approval Bureau of the CDI stated to CHBRP that there was one blanket policy that was approved in 2007, to their knowledge. However, that policy had not yet been sold in California and the use of UPPL exclusion in health policies in California is rare in general. Use of the exclusion policy in other types of insurance policies (such as travel) and accident-only is more typical, but AB 1461 does not apply to those types of policies.

Review of the gray literature uncovered research conducted by Ensuring Solutions to Alcohol Problems, an advocacy organization housed at the George Washington University Medical School. Researchers conducted a review of health insurance policies in various states and found that four small insurance policy carriers in California use the exclusion (Ensuring Solutions, 2007). CDI confirmed that three of those four policies (information on the fourth was not available) use a version of the UPPL exclusion.⁷ These four carriers together represent less than 1% of the CDI-regulated market, and the total enrollment in policies using the UPPL exclusion is not known.

Current Utilization Levels and Costs of the Mandated Benefit

Current utilization levels

The current number of claims denied due to the UPPL exclusion is obtained from the health insurance companies that reported including such a provision in their existing policies. Using administrative data, estimation methods, and information provided through CHBRP survey of health plans and insurers, an estimated total of 281 such claims for an estimated 110 individuals were denied in calendar year 2006 due to the UPPL exclusion.

Further investigations by CHBRP on complaint data from the DMHC showed no complaints about cases where coverage was denied because the insured was intoxicated or under the influence of a controlled substance for the timeframe January 1, 2005, to March 13, 2007. CDI's databases do not track details of complaints made related to benefits. CDI representatives are not aware of consumer complaints regarding intoxication-related claims denials or problems with coverage for related services.

Unit price

AB 1461 prohibits "denial of any loss." Subsequently, a denied claim may include services delivered in the ambulatory care, ED and outpatient, or an inpatient hospital setting. Data provided in response to CHBRP survey of health plans regarding the application of the UPPL exclusion indicated that 3% of the estimated 281 denied claims were for inpatient services,

⁶ While these enrollees have a number of advantages available to the large group market, including lower premiums and more negotiating power, they are similar to non-group policies since the individual can be the policy holder, is generally responsible for the entire amount of the premium, and may be subject to medical underwriting (Kofman et al., 2006). The attribution of these enrollees to the individual market is also consistent with the baseline population model using CHIS 2005, where respondents reporting paying for their privately purchased individual policies through professional associations are considered as part of the individual market.

⁷ Personal communication with Policy Approval Bureau, CDI, March 27, 2007

followed by 14% for outpatient visits and 64% for physician services that were not directly ED related. It is possible that these claims were made as follow-up visits related to an ED visit or if they were an urgent care visit related to an injury, however data confirming this was unavailable. About 19% of claims were for ED care broken down into 9% for outpatient ED and 10% physician services in the ED. ED services accounted for 10% of total costs. The average cost associated with all denied claim types was \$1,260.

The Extent to Which Costs Resulting from Lack of Coverage Are Shifted to Other Payers, Including Both Public and Private Entities

Denial of claims due to the UPPL exclusion will leave the burden of payment for the health care services received on the insured individual. Of the total individuals insured in the CDI individual market, 30% earn less than 300% of the federal poverty level and are unlikely to afford paying for high cost claims. These individuals may arrange for a payment plan to pay for all or part of the costs of denied services. The cost of denied claims not recovered from patients will most likely be borne by the providers, including physicians and hospitals, as uncompensated care.

Public Demand for Coverage

As discussed in the Introduction, organizations such as the NCOIL and the NAIC are in favor of repealing the provision of the UPPL exclusion relating to intoxicants, or effectively prohibiting insurers from denying coverage for health insurance claims based on intoxication or being under the influence of a controlled substance. In addition, several California-based organizations, such as the California Society of Addiction Medicine, are in favor of the bill and show there is certain level of public interest in AB 1461. CHBRP is to report on the extent to which collective bargaining entities negotiate for and the extent to which self-insured plans currently have coverage for the benefits specified under the proposed legislation, following the criteria for analysis specified under SB 1704 (2006). Currently, the largest public self-insured plan—CalPERS preferred provider organization (PPO) plan—does not use the UPPL exclusion in their contracts. Based on conversations with the largest collective bargaining agents in California, no evidence exists that unions are negotiating the details of the UPPL exclusion contained in their health insurance policies.⁸ In general, unions tend to negotiate for broader contract provisions such as coverage for dependents, premiums, deductibles, and coinsurance levels. In order to determine whether any local unions engage in negotiations in such detail, they would need to be surveyed individually.

Impacts of Mandated Coverage

How Will Changes in Coverage Related to the Mandate Affect the Benefit of the Newly Covered Service and the Per-Unit Cost?

Impact on per-unit cost

Given the very small magnitude (0.3%) of the insured California population who are subject to this mandate, AB 1461 is not expected to have an impact on the unit cost of claims that will not be denied after its passage.

⁸ Personal communication with the California Labor Federation and member organizations on January 29, 2007.

Postmandate coverage

Post AB 1461, individuals who would have been previously denied under the UPPL exclusion would be covered. This mandate will prohibit denials and require coverage for approximately 68,000 individuals currently subject to this UPPL exclusion.

Changes in coverage as a result of premium increases

The overall expenditures are expected to remain unchanged post AB 1461 as described later in this section. However, AB 1461 is expected to shift the cost of denied claims from those individuals with such claims to the overall population insured in the individual CDI market in the form of increased premiums (0.005%) and member copayments (0.002%). The estimated increase in premiums is not expected to lead to loss of coverage for the insured population in the individual CDI market, or a change in the number of uninsured in California.⁹

How Will Utilization Change as a Result of the Mandate?

AB 1461 is expected to eliminate denials as a consequence of the UPPL exclusion in insurance policies. This number is expected to be approximately 281 claims in the year following the mandate. Based on the discussion of physician practices in delivery of care in EDs and trauma centers in the Medical Effectiveness section, it is possible but highly unlikely that the scope of services are negatively affected by the UPPL exclusion. In other words, some providers currently may not provide services in anticipation of denial of services and with the knowledge that the patient is subject to the UPPL exclusion. However, CHBRP assumes that no life-saving services are denied to patients at the time care is sought because the Emergency Medical Treatment and Active Labor Act forbids denial of such services. There is no evidence available that indicates that any other services would not be provided in anticipation of a denial of claims.

To What Extent Does the Mandate Affect Administrative and Other Expenses?

All health insurers include a component for administration and profit in their premiums. CHBRP assumes that the administrative cost proportion of premiums remains unchanged as the result of AB 1461.

Impact of the Mandate on Total Health Care Costs

CHBRP estimates that if AB 1461 is implemented, the total claims currently denied due to the UPPL exclusion in the CDI individual market will no longer be denied. Prior to the mandate, individuals with denied claims would be responsible for paying such claims as they would other uncovered services. After the passage of AB 1461, the costs of previously denied claims would be distributed to the entire population insured in the individual CDI market in the form of premiums and copayments (Tables 3 and 4). This shift in cost translated to an estimated increase of 0.018% in PMPM insured premiums in this market.

⁹ Further information on CHBRP methodology on estimating impact of mandates on coverage is available at http://www.chbrp.org/documents/uninsured_020707.pdf

Costs or Savings for Each Category of Insurer Resulting from the Benefit Mandate

AB 1461 is expected to shift the cost of denied claims due to UPPL exclusion from those subject to this exclusion to the entire population insured in the CDI individual market. This shift means a reduction of an estimated \$354,000 in expenditures for “noncovered services” borne by those with denied claims to \$259,000 (\$0.03 PMPM) in total premiums and \$95,000 (\$0.01 PMPM) in member copayments paid by those insured in this market segment.

Impact on Access and Health Service Availability

AB 1461 is not expected to impact the availability of health services due to the small proportion of the population subject to the mandate. The impact of AB 1461 on access to services is also expected to be minimal. Life-saving services are provided in emergency settings regardless of insurance status, and physicians provide those based on clinical necessity. For services that are not life saving, there is no evidence that providers deliver fewer or no services in anticipation of denial of reimbursement by the insurance company.

Table 2. Baseline (Premandate) Per Member Per Month Premium and Expenditures, by Insurance Plan Type, California, 2007.

	Large Group		Small Group		Individual		CalPERS	MediCal Managed Care		Healthy Families	Total Annual
	DMHC-Regulated	CDI-Regulated	DMHC-Regulated	CDI-Regulated	DMHC-Regulated	CDI-Regulated	HMO	65 and Over	Under 65	Managed Care	
Population subject to the mandate	10,354,000	363,000	3,086,000	679,000	1,268,000	794,000	791,000	165,000	2,513,000	681,000	20,694,000
Average portion of premium paid by employer	\$249.51	\$323.69	\$249.52	\$281.52	\$0.00	\$0.00	\$277.19	\$181.00	\$120.43	\$76.82	\$51,194,004,000
Average portion of premium paid by employee	\$53.66	\$74.60	\$94.73	\$61.82	\$269.42	\$148.66	\$48.92	\$0.00	\$0.85	\$5.78	\$17,057,625,000
Total premium	\$303.17	\$398.28	\$344.26	\$343.34	\$269.42	\$148.66	\$326.11	\$181.00	\$121.29	\$82.60	\$68,251,629,000
Member expenses for covered benefits (deductibles, copays, etc)	\$16.35	\$46.30	\$25.58	\$90.75	\$45.45	\$36.35	\$16.82	\$0.00	\$0.56	\$2.25	\$5,153,127,000
Member expenses for benefits not covered	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.04	\$0.00	\$0.00	\$0.00	\$0.00	\$354,000
Total expenditures	\$319.52	\$444.58	\$369.84	\$434.09	\$314.86	\$185.05	\$342.92	\$181.00	\$121.85	\$84.85	\$73,405,110,000

Source: California Health Benefits Review Program, 2007.

Note: The population includes individuals and dependents in California who have private insurance (group and individual) or public insurance (e.g., CalPERS, Medi-Cal, Healthy Families, Access for Infants and Mothers [AIM], Major Risk Medical Insurance Program [MRMIP]) under health plans or policies regulated by DMHC or CDI. All population figures include enrollees aged 0–64 years and enrollees 65 years or older covered by employment-based coverage.

Key: CalPERS = California Public Employees' Retirement System; CDI, California Department of Insurance; DMHC = Department of Managed Health Care; HMO = health maintenance organization and point of service plans.

Table 3. Postmandate Impacts on PMPM and Total Expenditures by Insurance Plan Type, California, 2007

	Large Group		Small Group		Individual		CalPERS	Medi-Cal Managed Care		Healthy Families	Total Annual
	DMHC-Regulated	CDI-Regulated	DMHC-Regulated	CDI-Regulated	DMHC-Regulated	CDI-Regulated	HMO	65 and Over	Under 65	Managed Care	
Population subject to the Mandate	10,354,000	363,000	3,086,000	679,000	1,268,000	794,000	791,000	165,000	2,513,000	681,000	20,694,000
Average portion of premium paid by employer	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0
Average portion of premium paid by employee	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.03	\$0.00	\$0.00	\$0.00	\$0.00	\$259,000
Total premium	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.03	\$0.00	\$0.00	\$0.00	\$0.00	\$259,000
Member expenses for covered benefits (Deductibles, copays, etc)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$95,000
Member expenses for benefits not covered	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-\$0.04	\$0.00	\$0.00	\$0.00	\$0.00	-\$354,000
Total member expenditures	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0
Percentage impact of mandate											
Insured premiums	0.000%	0.000%	0.000%	0.000%	0.000%	0.018%	0.000%	0.000%	0.000%	0.000%	0.000%
Total expenditures	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%

Source: California Health Benefits Review Program, 2007.

Note: MediCal DMHC-Regulated Under 65 includes the Major Risk Medical Insurance Program (MRMIP) and Access for Infants and Mothers (AIM) programs.

Key: CalPERS = California Public Employees' Retirement System; CDI, California Department of Insurance; DMHC = Department of Managed Health Care; HMO = health maintenance organization and point of service plans.

PUBLIC HEALTH IMPACTS

Present Baseline

Chronic inebriates and drug users often use emergency services, including the ED. Due to their substance abuse and the nature of their complicated medical needs—which are often exacerbated by acute intoxication, being high, or related illness or injury—they frequently visit the ED to receive medical service (Thornquist et al., 2002). It is important to note that the literature reviewed in this section does not take into account health insurance status, and it is possible that the rates among the insured population or the population affected by AB 1461 would look different from what is presented in the literature.

Alcohol-Related ED Visits

Data from the National Hospital Ambulatory Medical Care Survey for 1992 through 2000 estimated that across the United States, 7.9 million ED visits per year were attributable to alcohol-related diagnoses (McDonald et al., 2004). This translates to a rate of 28.7 per 1,000 U.S. population. Applying this rate to California, it is estimated that there are approximately 1 million alcohol-related ED visits in California each year. The number of alcohol-related visits increased 18% during 1992-2000 (McDonald et al., 2004). In 2000, it was estimated that 7.8% of all ER visits were alcohol-related (McDonald et al., 2004).

Drug-Related ED Visits

Overall, 1.3% of ED visits in the United States are attributable to drug use (SAMHSA, 2007), which would translate into nearly 200,000 visits annually in California. Of drug-related ED visits across the United States, 31% were associated with cocaine use, 17% were associated with marijuana use, 11% were associated with heroin use, and 11% were associated with the use of stimulants such as amphetamines and methamphetamines (SAMHSA, 2007). In addition, 27% of visits involved the abuse of pharmaceuticals (SAMHSA, 2007).

Impact of the Proposed Mandate on Public Health

Impact on Community Health Where Gender and Racial Disparities Exist

Men are more likely to have an alcohol-related visit to the ED than women. In 2000, national data show that rates of alcohol-related visits among men were 7.9 per 1,000 population compared to a rate among women of 2.9 per 1,000 (McDonald et al., 2004). In addition, blacks are more likely to have an alcohol-related ED visit compared to whites, with rates of 8.8 and 4.6 per 1,000 population, respectively (McDonald et al., 2004).

Amphetamine and methamphetamine-related ED visits are more likely to be for males (58%) compared to females (42%) (SAMHSA, 2004a). Whites were more likely to have a methamphetamine-related ED visits compared to other racial/ethnic groups (Richards et al., 1999).

Although gender and racial disparities have been found in terms of alcohol-related and methamphetamine-related ER visits, no evidence was found to indicate that AB 1461 would affect physician behavior in providing alcohol or drug use-related interventions in the ED or change the way patients are treated for illness or injuries. Therefore, we conclude that this mandate will not have an impact on gender or racial disparities in substance abuse.

Overall Impact on Public Health

As presented in the Utilization, Cost, and Coverage Impacts section, there is evidence to suggest that the UPPL exclusion is being used in California in policies held by approximately 0.3% of the insured population and that claims have been denied under the exclusion. As presented in the Medical Effectiveness section, CHBRP found no compelling evidence that AB 1461 would change physician practice patterns in terms of screening and counseling for alcohol and substance abuse, or treatment for illness and injuries sustained in conjunction with alcohol or substance abuse. Therefore, we conclude that this mandate would have no impact on overall public health outcomes, on the reduction of gender or ethnic disparities in regards to substance abuse, in the reduction of premature death, or the reduction of economic loss associated with disease.

APPENDICES

Appendix A: Text of Bill Analyzed

AB 1461 Introduced on February 23, 2007 by Assembly Member Krekorian

In response to a request from the California Assembly Committee on Health on February 28, 2007, CHBRP analyzed the relevant portion of AB 1461 that amends the Insurance Code. The relevant excerpt is included here.

An act to add Article 4.5 (commencing with Section 11774) to Chapter 1 of Part 2 of Division 10.5 of the Health and Safety Code, and to amend Section 10369.12 of the Insurance Code, relating to alcohol and drug abuse.

...

SEC. 3. Section 10369.12 of the Insurance Code is amended to read:

10369.12. (a) A disability policy may contain a provision in the form set forth herein.

Intoxicants and controlled substances: 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 controlled substance unless administered on the advice of a physician.

(b) Subdivision (a) shall not apply to a health insurance policy.

Appendix B: Literature Review Methods

Appendix B describes methods used in the medical effectiveness literature review for AB 1461. This literature review updates the reviews CHBRP conducted for SB 573 in 2005 and SB 1157 in 2004. This appendix also describes the structured interviews conducted with emergency medicine physicians and trauma surgeons in California.

AB 1461 differs from most legislation that CHBRP analyzes. Most bills CHBRP analyzes would *mandate coverage* for specific services or diseases or conditions. AB 1461 would instead prevent insurers from *excluding coverage* for illnesses or injuries sustained while an enrollee is intoxicated or under the influence of a controlled substance not prescribed by a physician. Ascertaining the effectiveness of legislation that would prohibit coverage exclusions is difficult, because most research in health care focuses on evaluating the impact of preventive, diagnostic, or therapeutic interventions.

Literature search

This literature search included meta-analyses, systematic reviews, randomized controlled trials, controlled clinical trials, and observational studies. The PubMed and PsycInfo databases were searched. Web sites of government agencies, professional associations, and other organizations that address alcohol and substance abuse were also searched. The search was limited to articles that were written in English.

The medical effectiveness literature review focused on articles in peer-reviewed scientific journals that discussed the UPPL exclusion. At least two reviewers screened the title and abstract of each citation returned by the literature search to determine eligibility for inclusion. Full text articles were obtained, and reviewers reapplied the initial eligibility criteria.

Thirty-two abstracts were reviewed for the literature review for AB 1461: 19 articles were retrieved and 14 were selected for inclusion in the review.

The literature review did not uncover any studies with strong research designs that analyzed the impact of prohibiting the UPPL exclusion on access to care for persons affected by this law or on screening and counseling for alcohol and substance abuse. Two studies explored whether health professionals believe that screening for alcohol and substance abuse would jeopardize reimbursement. Four studies described individual cases of denials of health insurance claims due to the UPPL exclusion in states other than California. One study presented the results of a national survey that assessed the prevalence of denials of claims due to alcohol or substance abuse.

In making a “call” regarding the effect of prohibiting the UPPL exclusion, CHBRP considered the number of studies as well the strength of the evidence. To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design
- Statistical significance
- Direction of effect
- Size of effect
- Generalizability of findings

The grading system also contains an overall conclusion that encompasses findings in the five categories listed above. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention’s effect on an outcome.

The search terms used to locate studies relevant to the AB 1461 appear below.

PubMed and Cochrane Library

MeSH terms:

Alcohol Drinking/legislation & Jurisprudence
Alcoholic Intoxication
Alcoholic Intoxication/economics
Alcoholic Intoxication/prevention & control
Alcoholism
Cost-Benefit Analysis
Counseling
Emergency Service, Hospital
Insurance/Legislation & Jurisprudence
Insurance Coverage
Insurance, Health
Insurance, Health, Reimbursement/legislation & jurisprudence
Mass Screening
Outcome and Process Assessment (Health Care)
Physician's Practice Patterns
Practice Guidelines
Referral and Consultation
Substance Abuse Detection/legislation & jurisprudence
Substance-Related Disorders/prevention & control
Trauma Centers
Treatment Outcome
Wounds and Injuries

Keywords:

alcohol exclusion law, alcohol screening, alcoholism, barrier*, intervention*,counseling, effect*, emergency, ER, illness, impact, injur*, insurance, insurance coverage, insurance exclusion law*, intoxication exclusion*, law*, obstacle*, refuse*, reimbursement, screening, substance abuse, trauma care, trauma center*, uniform individual accident and sickness policy provision law, UPPL, wound*

* indicates truncation

PsycINFO

Thesaurus:

Alcohol Abuse
Alcoholism
Counseling
Drug Abuse
Health Care Costs
Health Insurance
Injuries
Intervention
Laws
Physical Disorders
Screening
Treatment Barriers
Wounds

Keywords:

alcohol exclusion law, alcohol screening, alcoholism, barrier*, intervention*,counseling, effect*, emergency, ER, illness, impact, injur*, insurance, insurance coverage, insurance exclusion law*, intoxication exclusion*, law*, obstacle*, refuse*, reimbursement, screening, substance abuse, trauma care, trauma center*, uniform individual accident and sickness policy provision law, UPPL, wound*

* indicates truncation

Web Search

Keywords:

alcohol exclusion law, alcohol screening, alcoholism, barrier*, intervention*,counseling, effect*, emergency, ER, illness, impact, injur*, insurance, insurance coverage, insurance exclusion law*, intoxication exclusion*, law*, obstacle*, refuse*, reimbursement, screening, substance abuse, trauma care, trauma center*, uniform individual accident and sickness policy provision law, UPPL, wound*

* indicates truncation

Structured interviews

In addition, structured interviews were conducted with 12 emergency medicine physicians and trauma surgeons in 8 public, university-affiliated, and private hospitals in several regions of California. Physicians were asked: (1) if they are familiar with current law in California that permits health insurers to use the UPPL exclusion; (2) if they are familiar with AB 1461, which would prohibit use of this exclusion; (3) if they are aware of whether patients coming to the hospital's ED or trauma center have health insurance, the type of insurance, or whether their insurance policies exclude coverage for alcohol or drug related injuries or illnesses; 4) what their standard practice was in terms of ordering toxicology screens to determine whether patients have used alcohol or a controlled substance; (5) what their standard practice was regarding substance abuse counseling; (6) whether knowledge that a patient's health plan excluded coverage for injuries and illnesses caused by alcohol and controlled substance use would affect their decisions regarding diagnostic tests and treatment.

A list of interviewees, their positions, and their institutional affiliations appears below.

American College of Emergency Physicians

Larry Bedard, MD
Former President

American College of Emergency Physicians, State Chapter of California

R. Myles Riner, MD
President

California Pacific Medical Center, San Francisco

Peter Sullivan, MD
Emergency Physician and Vice Chairman of the Department

Los Angeles County & University of Southern California Medical Center

Kathryn R. Challoner, MD
Associate Professor, Clinical Emergency Medicine

Saint Francis Hospital, San Francisco

Phillip Piccinini, MD
Director, Emergency Department

Scripps Mercy Hospital, San Diego

Michael Sise, MD
Head, Trauma Center, Division of Trauma and Emergency Medicine

University of California, Davis Medical Center

John Richards, MD

Professor, Emergency Medicine

David Wisner, MD

Vice Chair, Surgery

Chief, Trauma Surgery

University of California, Irvine Medical Center

Shahram Lotfipour, MD

Professor, Department of Emergency Medicine

Federico Vaca, MD

Assistant Professor, Department of Emergency Medicine

University of California, Los Angeles Medical Center

Marshall Morgan, MD

Chair, Emergency Medicine

University of California, San Diego Medical Center

David Guss, MD

Chair, Emergency Medicine

Appendix C: Summary Findings on Medical Effectiveness

This appendix is not included in the report on AB 1461 because no studies provided compelling evidence that prohibiting the use of the UPPL exclusion would affect health outcomes.

Appendix D: Cost Impact Analysis: Data Sources, Caveats, and Assumptions

This appendix describes data sources, and general and mandate-specific caveats and assumptions used in conducting the cost impact analysis. For additional information on the cost model and underlying methodology, please refer to the CHBRP Web site at www.chbrp.org/costimpact.html.

The cost analysis in this report was prepared by the Cost Team, which consists of CHBRP task force members and staff, specifically from the University of California, Los Angeles, and Milliman Inc. (Milliman). Milliman is an actuarial firm and provides data and analyses per the provisions of CHBRP authorizing legislation.

Data Sources

In preparing cost estimates, the Cost Team relies on a variety of data sources as described below.

Private Health Insurance

1. The latest (2005) California Health Interview Survey (CHIS), which is utilized to estimate insurance coverage for California's population and distribution by payer (i.e., employment-based, privately purchased, or publicly financed). The biannual CHIS is the largest state health survey conducted in the United States, collecting information from over 40,000 households. More information on CHIS is available at www.chis.ucla.edu/
2. The latest (2006) California Employer Health Benefits Survey is utilized to estimate:
 - size of firm,
 - percentage of firms that are purchased/underwritten (versus self-insured),
 - premiums for plans regulated by the DMHC (primarily HMOs),
 - premiums for policies regulated by the CDI (primarily PPOs), and
 - premiums for high deductible health plans (HDHP) for the California population covered under employment-based health insurance.

This annual survey is released by the California Health Care Foundation/Center for Studying Health System Change (CHCF/HSC) and is similar to the national employer survey released annually by the Kaiser Family Foundation and the Center for Studying Health System Change. More information on the CHCF/HSC is available at <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=127480>.

3. Milliman data sources are relied on to estimate the premium impact of mandates. Milliman's projections derive from the Milliman Health Cost Guidelines (HCGs). The HCGs are a health care pricing tool used by many of the major health plans in the United States (see www.milliman.com/tools_products/healthcare/Health_Cost_Guidelines.php). Most of the data sources underlying the HCGs are claims databases from commercial health insurance plans. The data are supplied by health insurance companies, Blue Cross and Blue Shield plans, HMOs, self-funded employers, and private data vendors. The data are mostly from loosely managed healthcare plans, generally those characterized as preferred provider plans or preferred provider organizations (PPOs). The HCGs currently

include claims drawn from plans covering 4.6 million members. In addition to the Milliman HCGs, CHBRP's utilization and cost estimates draw on other data, including the following:

- The MEDSTAT MarketScan Database, which includes demographic information and claim detail data for approximately 13 million members of self-insured and insured group health plans.
 - An annual survey of HMO and PPO pricing and claim experience, the most recent survey (2006 Group Health Insurance Survey) contains data from six major California health plans regarding their 2005 experience.
 - Ingenix MDR Charge Payment System, which includes information about professional fees paid for healthcare services, based upon approximately 800 million claims from commercial insurance companies HMOs and self-insured health plans.
 - These data are reviewed for generalizability by an extended group of experts within Milliman, but are not audited externally.
4. An annual survey by CHBRP of the seven largest providers of health insurance in California (Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, Kaiser Foundation Health Plan, and PacifiCare) to obtain estimates of baseline enrollment by purchaser (i.e., large and small group and individual), type of plan (i.e., DMHC or CDI-regulated), and cost-sharing arrangements with enrollees and average premiums. Enrollment in these seven firms represents 82 percent of enrollees in full service health plans regulated by DMHC and 46 percent of lives covered by comprehensive health insurance products regulated by CDI.

Public Health Insurance

5. Premiums and enrollment in DMHC- and CDI-regulated plans by self-insured status and firm size are obtained annually from CalPERS for active state and local government public employees and their family members who receive their benefits through CalPERS. Enrollment information is provided for fully-funded, Knox-Keene- licensed health care service plans—which is about 75% of CalPERS total enrollment. CalPERS self-funded plans—approximately 25% of enrollment—are not subject to state mandates. In addition, CHBRP obtains information on current scope of benefits from health plans' evidence of coverage (EOCs) publicly available at www.calpers.ca.gov.
6. Enrollment in Medi-Cal Managed Care (Knox-Keene licensed plans regulated by DMHC) is estimated based on CHIS and data maintained by the Department of Health Services (DHS). DHS supplies CHBRP with the statewide average premiums negotiated for the Two-Plan Model, as well as generic contracts which summarize the current scope of benefits. CHBRP assesses enrollment information online at www.dhs.ca.gov/admin/ffdmb/mcss/RequestedData/Beneficiary%20files.htm.
7. Enrollment data for other public programs: Healthy Families, AIM, and MRMIP are estimated based on CHIS and data maintained by the Major Risk Medical Insurance Board (MRMIB). The basic minimum scope of benefits offered by participating plans under these programs must comply with all requirements of the Knox-Keene Act, and

thus these plans are affected by changes in coverage for Knox-Keene licensed plans. CHBRP does not include enrollment in the Post-MRMIB Guaranteed-Issue Coverage Products as these individuals are already included in the enrollment for individual health insurance products offered by private carriers. Enrollment figures for AIM and MRMIP are included with enrollment for Medi-Cal in presentation of premium impacts. The enrollment information is obtained online at www.mrmib.ca.gov. Average statewide premium information is provided to CHBRP by MRMIB staff.

General Caveats And Assumptions

The projected cost estimates are estimates of the costs that would result if a certain set of assumptions were exactly realized. Actual costs will differ from these estimates for a wide variety of reasons, including:

- Prevalence of mandated benefits before and after the mandate may be different from CHBRP assumptions.
- Utilization of mandated services before and after the mandate may be different from CHBRP assumptions.
- Random fluctuations in the utilization and cost of health care services may occur.

Additional assumptions that underlie the cost estimates presented in this report are:

- Cost impacts are shown only for people with insurance.
- The projections do not include people covered under self-insured employer plans because those plans are not subject to state-mandated minimum benefit requirements.
- Employers and employees will share proportionately (on a percentage basis) in premium rate increases resulting from the mandate. In other words, the distribution of the premium paid by the subscriber (or employee) and the employer will be unaffected by the mandate.
- For state sponsored programs for the uninsured, the state share will continue to be equal to absolute dollar amount of funds dedicated to the program.
- When cost savings are estimated, they reflect savings realized for one year. Potential long-term cost savings or impacts are estimated if existing data and literature sources are available and provide adequate detail for estimating long-term impacts. For more information on CHBRP's criteria for estimating long-term impacts please see www.chbrp.org/documents/longterm_impacts_final011007.pdf.

There are other variables that may affect costs, but which CHBRP did not consider in the cost projections presented in this report. Such variables include, but are not limited to:

- Population shifts by type of health insurance coverage. If a mandate increases health insurance costs, then some employer groups or individuals may elect to drop their coverage. Employers may also switch to self-funding to avoid having to comply with the mandate.
- Changes in benefit plans. To help offset the premium increase resulting from a mandate, members or insured may elect to increase their overall plan deductibles or copayments. Such changes would have a direct impact on the distribution of costs between the health plan and the insured person, and may also result in utilization reductions (i.e., high levels

of patient cost sharing result in lower utilization of health care services). CHBRP did not include the effects of such potential benefit changes in its analysis.

- Adverse selection. Theoretically, individuals or employer groups who had previously foregone insurance may now elect to enroll in an insurance plan postmandate because they perceive that it is to their economic benefit to do so.
- Health plans may react to the mandate by tightening their medical management of the mandated benefit. This would tend to dampen the CHBRP cost estimates. The dampening would be more pronounced on the plan types that previously had the least effective medical management (i.e., PPO plans).
- Variation in existing utilization and costs, and in the impact of the mandate, by geographic area and delivery system models. Even within the plan types CHBRP modeled (HMO, including HMO and POS plans; and non-HMO, including PPO and FFS policies), there are likely variations in utilization and costs by these plan types. Utilization also differs within California due to differences in the health status of the local commercial population, provider practice patterns, and the level of managed care available in each community. The average cost per service would also vary due to different underlying cost levels experienced by providers throughout California and the market dynamic in negotiations between health plans and providers. Both the baseline costs prior to the mandate and the estimated cost impact of the mandate could vary within the state due to geographic and delivery system differences. For the purposes of this analysis, however, CHBRP has estimated the impact on a statewide level.

Bill Analysis-Specific Caveats and Assumptions

- Coverage assumptions
 - The number of denied claims, the type of claims denied, and the average cost of denied claims are based on data reported by the largest health plan applying the UPPL exclusion. Three other plans who reported applying this exclusion to a small number of enrollees did not provide such data. CHPRP has estimated number of denying claims, the distribution of claims denied, and the costs for these latter plans. It is likely that these plans have a different experience than that reported by the largest health plan applying the UPPL exclusion. Furthermore, it is also likely, though not expected, that additional plans with this exclusion exist and are not accounted for in this analyses. However, any such plans will most likely have few enrollees.
- Assumptions Underlying Utilization and Cost Impact Estimates
 - CHBRP assumes no administrative costs due to AB 1461. This assumption is because plans applying the UPPL exclusion are expected to spend resources to deny such claims, such as requesting additional documentation and processing these denials. After AB 1461 and in the absence of the exclusion, the administrative costs are estimated to remain the same since resources will be spent by plans in processing and paying claims previously denied. Depending on the health insurance company, administrative costs may even be reduced in the absence of UPPL exclusion. However, CHBRP does not account for this likelihood due to lack of data indicating such a reduction.

- CHBRP did not have data on whether health insurance companies that apply the UPPL exclusion required members to pay at the plan's contracted rates for services, or whether members paid for the full charges billed by providers. In the absence of such data, CHBRP assumes that the providers accepted payments at the contracted rates prior to AB 1461 and did not require the individual to pay the full charges for services.
- Currently, claims that are denied under the UPPL exclusion become the individual insured's obligation. CHBRP's analysis assumed that the insured would actually pay these amounts out of pocket. It is possible that some of the larger claims, including those for inpatient hospital care, may not be paid for by the patients. Providers, in an effort to recoup this uncompensated care, may attempt to charge other privately insured patients more. In the event of such cost shifting, health insurance companies may also attempt to reduce payment to providers to avoid loss. However, because the denied claims resulting from the UPPL exclusion would be expected to make up an immaterial percentage of the uncompensated care in California, CHBRP assumes that the mandate would not have a material impact on cost shifting by providers and the subsequent provider payment rates.

Appendix E: Information Submitted by Outside Parties

In accordance with CHBRP policy to analyze information submitted by outside parties during the first two weeks of the CHBRP review, the following parties chose to submit information.

Ensuring Solutions for Alcohol Problems, at the George Washington University Medical Center provided the following information during the March 12, 2007, to March 26, 2007.

- Alcohol Exclusion Laws Toolkit available publicly on their Web site at www.ensuringsolutions.org/resources/resources_list.htm?cat_id=986.
- Center for Substance Abuse Treatment. California Insurance Loophole Increases Taxpayer Costs, Prevents Treatment and Denies Insurance Benefits. UPPL State Series Fact Sheet. DHHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration. 200X. *Submitted for publication.*
- Center for Substance Abuse Treatment. Alcohol Exclusion Laws May Run Counter to Safety and Health Goals. UPPL Stakeholders Series Fact Sheet: Policymakers. DHHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration. 200X. *Submitted for publication.*
- Center for Substance Abuse Treatment. Alcohol Exclusion Laws May Prevent Reimbursement for Treatment of Serious Injury Cases. UPPL Stakeholders Series Fact Sheet: Healthcare Providers. DHHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration. 200X. *Submitted for publication.*
- Center for Substance Abuse Treatment. Alcohol Exclusion Laws Interfere with Arrest and Prosecution of Impaired Drivers. UPPL Stakeholders Series Fact Sheet: Law Enforcement Officers. DHHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration. 200X. *Submitted for publication.*
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- Mauery DR, Goplerud EN, Anderson D, and Clark TC. UPPL Exclusion Language in Commercial Health Insurance Policies: Do State Laws Make a Difference? March 12, 2007 Draft. *Submitted for publication.*

In addition the following individuals provided information through personal communication:

- David Anderson, MGA, Communications Director, Ensuring Solutions for Alcohol Problems, March 15, 2007.
- Timmen Cermak, MD, Member At-Large, Executive Committee, California Society of Addiction Medicine, March 15, 2007.

- Larry M. Gentilello, F.A.C.S., M.D., C. James Carrico, M.D. Distinguished Chair in Surgery for Trauma & Critical Care, Professor, University of Texas, Southwestern Medical Center, March 28, 2007.

For information on the processes for submitting information to CHBRP for review and consideration please visit www.chbrp.org/requests.html.

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The CHBRP **staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others.

As required by the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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