



CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

**Analysis of Senate Bill 1157: Prohibiting
Disability Insurers from Excluding Coverage of
Losses Sustained While Insured Individuals Are
Intoxicated or Under the Influence of Controlled
Substances**

A Report to the 2003-2004 California Legislature
April 27, 2004
Revised October 8, 2004



Established in 2002 to implement the provisions of Assembly Bill 1996 (*California Health and Safety Code*, Section 127660, et seq.), the California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates. The statute defines a health insurance benefit mandate as a requirement that a health insurer and/or managed care health plan (1) permit covered individuals to receive 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 during 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, made up of 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 sound scientific evidence relevant to the proposed mandate 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 CHBRP's Web site, www.chbrp.org.

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PREFACE

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 1157, a proposal to repeal Section 10369.12 of the *California Insurance Code*. Under the proposed legislation, health insurers would no longer be able to write 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. A proposed amendment would modify SB 1157 to prohibit only health insurers from using the exclusion, allowing the exclusion to continue for other types of insurance. In response to a request from the California Senate Committee on Insurance on March 4, 2004, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the provisions of Assembly Bill 1996 (2002) as chaptered in Section 127660, et seq., of the *California Health and Safety Code*.

Harold Luft, PhD, Wade Aubry, MD, and Edward Yelin, PhD, all of the University of California, San Francisco (UCSF), coordinated the preparation of this report and prepared the medical effectiveness section. Gerald Kominski, PhD, Miriam Laugesen, PhD, and Nadereh Pourat, PhD, all of the University of California, Los Angeles, prepared the cost impact section. Helen Halpin, PhD, and Sara McMenamin, PhD, of the University of California, Berkeley, prepared the public health impact section. Robert Cosway, FSA, MAAA, and Jay Ripps, FSA, MAAA, both of Milliman, Inc., provided actuarial analysis. Other contributors include Patricia Franks and Noelle Lee of UCSF, and Rebecca R. Paul, MPH, MA of CHBRP staff. Katrina Mather, freelance editor, copy edited this report. In addition, a balanced subcommittee of CHBRP's National Advisory Council (see final pages of this report), 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 CHBRP:

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Revision:

October 8, 2004: Added a standard preface and appendix to appear in all CHBRP reports, identifying individual contributions to the analysis.



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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 1157

Senate Bill (SB) 1157 proposes to repeal Section 10369.12 of the California Insurance Code. Under the proposed legislation, disability insurers[‡] would no longer be able to write 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. A proposed amendment would modify SB 1157 to prohibit only health insurers from using the exclusion, allowing the exclusion to continue for other types of insurance.

Under the provisions of Assembly Bill 1996 (*California Health and Safety Code* Section 127660 *et seq.*), the California Legislature has asked the California Health Benefits Review Program to conduct an evidence-based assessment of the medical, cost, and public health impacts of the proposed legislation. Because Assembly Bill 1996 requires that California Health Benefits Review Program analyses focus on health insurance benefit mandates, this analysis focuses only on the use of the exclusion in Section 10369.12 by health insurers. Hence, the proposed amendment would not change the analysis.

I. Medical Effectiveness

- It was not possible to assess the medical effectiveness of SB 1157 because this bill does not mandate coverage of a particular health care service, but rather prohibits coverage exclusions, and there is a lack of published data on the medical effects of removing such coverage exclusions.
- No published evidence of assessments of the impacts of health insurance coverage exclusions related to intoxication, or of the repeal of such exclusions, on physician behavior or on the use of particular health care services was found.
- No published evidence of denial of health insurance claims under Section 10369.12 in California or under similar provisions in other states was identified.

II. Utilization, Cost, and Coverage Impacts

- No evidence that California health insurers either use the exclusion in Section 10369.12 or deny claims based on it was found.
- No evidence of California consumer complaints about having a claim denied based on Section 10369.12 was found.

[‡] Disability insurers'' are described in the California Insurance Code as including health insurers, California Insurance Code, Division 1, Section 106.



- There are no utilization or cost impacts for this bill because Section 10369.12 is not used to exclude payments for health care or that its existence affects provider behavior.

III. Public Health Impacts

- It is estimated that SB 1157 would have no measurable effects on the health of the people of California. This assessment results from the lack of evidence related to the medical effectiveness of the provision's repeal and the lack of evidence that the public is currently affected by the ability of insurers to use the exclusion permitted by Section 10369.12 of the California Insurance Code.

INTRODUCTION

Senate Bill (SB) 1157 proposes to repeal Section 10369.12 of the California Insurance Code, which contains an exclusion that disability insurers in California can use. “Disability insurers” are described in the California Insurance Code as including health insurers,¹ and the California Health Benefits Review Program’s (CHBRP’s) analysis is concerned with the impact of SB 1157 on health insurers only. 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 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.²

Under the proposed legislation, disability 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 unless administered on the advice of a physician. A proposed amendment would modify SB 1157 to prohibit only health insurers from using the exclusion. Since CHBRP’s analysis addresses the impact of SB 1157 on health insurers only, such an amendment would not affect the analysis. Because of this focus, the following analysis does not address any potential impacts SB 1157 might have on other insurers and policies.

SB 1157 is unlike most proposed legislation reviewed by CHBRP in that it does not mandate coverage of a specific service, procedure, or device, but rather restricts insurers’ ability under specific conditions to deny payment for an unknown range of services. The analysis that follows describes the background of the model law—the UPPL—that contains the exclusion and identifies constraints on an analysis of medical effectiveness; utilization, cost, and coverage impacts; and public health impacts relevant to SB 1157.

The Original 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 addresses the need to coordinate regulation of multistate insurers by developing model laws and regulations that states can adopt. The original provision of the UPPL, which was the model for Section 10369.12 of the California Insurance Code, read as follows:

¹ California Insurance Code, Division 1, Section 106.

² California Insurance Code, Division 2, Section 10369.



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 provision (Ensuring Solutions, 2004).

The New Model UPPL

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 emergency department physicians believed that insurers would deny payment for intoxication-related claims, emergency they 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.

I. MEDICAL EFFECTIVENESS

It was not possible to assess the medical effectiveness of SB 1157 because this bill does not mandate coverage of a particular health care service, but rather prohibits coverage exclusions, and there is a lack of published data on the medical effects of removing such coverage exclusions. One peer-reviewed article relating to the denial of health insurance claims based on use of intoxicants and narcotics was found (Rivara et al., 2000). No published evidence of assessments of the impacts of UPPL intoxication-related exclusions, or of the repeal of such exclusions, on physician behavior or on the use of particular health care services was found. No published evidence of denial of health insurance claims under Section 10369.12 in California or under UPPL provisions in other states was identified.

Some materials produced by advocates for repeal of this UPPL provision assert that screening for alcohol intoxication and controlled substance use and counseling of patients in the emergency room are effective interventions. SB 1157, however, is silent on the issues of screening and counseling, and there was no evidence that medical professionals in California are less likely to perform such services because of the ability of insurers to use the exclusion. Therefore, analysis of the medical effectiveness of SB 1157 does not include an assessment of screening or counseling services.

II. UTILIZATION, COST, AND COVERAGE IMPACTS

Seven of the 16 California health insurers with the largest number of covered lives were queried about their use of the exclusion in Section 10369.12; all responded that they have neither used the exclusion in their health insurance products nor denied claims based on it. Moreover, no evidence of California consumer complaints about such denials was found. Accordingly, it is estimated that the cost impact of the repeal would be insignificant. In the absence of such evidence, a quantitative cost analysis is not appropriate.

Present Baseline Cost and Coverage

Current utilization levels and costs of the mandated benefit (Section 3(h))

In the absence of evidence on the exclusion of payment for services related to use of alcohol or other controlled substances, no baseline utilization or cost data could be developed.

Current coverage of the mandated benefit (Section 3(i))

A survey of seven of the 16 health insurers with the most covered lives in the state identified no health insurance policies that included the exclusion in Section 10369.12 of the California Insurance Code.

Public demand for coverage (Section 3(j))

There is no evidence of public demand for this mandate.

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? (Section 3(a))

SB 1157 is unlikely to have any measurable impact on the benefits or per-unit cost of services, for reasons discussed above.

How will utilization change as a result of the mandate? (Section 3(b))

There is no evidence that health insurers in California refuse payment for health services when alcohol or a controlled substance is involved. There is also no evidence that the existing law affects physician behavior in California. Expert opinion from practicing emergency department physicians in California suggests that physician behavior is guided primarily by treatment need and appropriateness. Consequently, there is no evidence that repeal of Section 10369.12 would impact utilization of services.



To what extent does the mandate affect administrative and other expenses? (Section 3(c))
There are no expected effects of the bill on administrative and other costs.

Impact of the mandate on total health care costs (Section 3(d))
There is no expected impact of the bill on total health care costs.

Costs or savings for each category of insurer resulting from the benefit mandate (Section 3(e))
There are no expected costs or savings for various categories of insurers resulting from this mandate.

Current costs borne by payers (both public and private entities) in the absence of the mandated benefit (Section 3(f))
Because no incremental costs are expected as a result of this bill, there are no costs borne by other payers.

Impact on access and health service availability (Section 3(g))
There is no expected impact of the bill on access or service availability.

III. PUBLIC HEALTH IMPACTS

Assessing the public health impact of the proposed legislation requires two pieces of information: (1) baseline or premandate health outcomes in the California population as they relate to the legislation, and (2) the expected change in health outcomes postmandate, based on evidence identified in the review of the scientific literature. In the case of SB 1157, no evidence was found that health insurers in California are denying claims for health care associated with alcohol- or controlled substance–related injuries. Also, no was evidence identified in the literature on the effects of removing the provision in the state insurance code that permits health insurers to deny claims involving alcohol or controlled substance use. Thus, it is estimated that SB 1157 would have little or no effect on the health of the people of California.

APPENDIX

Methods of Analysis

To determine whether there was any evidence relevant to the assessment of Senate Bill 1157, several approaches were taken.

The first approach was to examine the literature for studies that might have assessed the impact of the Uniform Accident and Sickness Policy Provision Law (UPPL) intoxication and narcotics provision, as well as repeal of this UPPL provision, on physician behavior, health care use, and patient outcomes as related to care of patients who are intoxicated or under the influence of controlled substances. Evidence was also sought in the literature for studies that assessed whether insurers use or enforce the UPPL provision with respect to health care, whether physicians alter their behavior based on UPPL provisions, and whether patients have been affected by the UPPL provisions. The literature search focused on the effects of UPPL related to intoxication and narcotic use on physician practice and insurance claim denials in California and other states. The search was limited to English abstracts. The MEDLINE database was searched for studies published from 1994 to 2004, using a combination of Medical Subject Headings (MeSH) and text words aimed at locating meta-analyses, systematic reviews, individual randomized controlled trials, and clinical practice guidelines.

The second approach was to assess whether insurers include the exclusion in their health policies. Staff contacted seven of the 16 largest insurers in California with respect to whether they include the allowed provisions in their policies and, if so, whether they enforce them with respect to health care. Insurers indicated they do not currently include this exclusion in their policies and, therefore, do not deny claims based on it.

The third approach was to query physicians about the impact of this UPPL provision. Although a formal survey of physicians with respect to whether this UPPL provision affects their behavior was not conducted, several senior physicians in the state involved in emergency medicine practice and policy were contacted. When asked whether the UPPL provision was an issue in clinical practice, the physicians said either the provision was not an issue or that they did not know about the provision and later confirmed its lack of impact after discussing it with their administrative staff.

The fourth approach was to explore whether denials under this UPPL provision were problematic for patients. Both the Health Rights Hotline and the California Department of Insurance (CDI) were queried about receipt of complaints about denials for alcohol-related emergency room claims. The Health Rights Hotline had never received such a complaint. CDI reported that no one in their consumer services department could remember this type of complaint ever surfacing. CDI staff also queried their database of hotline calls and formal written complaints; this database tracks general information about the calls received by the hotline and more detailed information about all written complaints and requests for assistance. CDI reported no complaints about having claims denied for health care services because the insured was intoxicated or under the influence of a controlled substance.



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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 CHBRP's 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 CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman USA, to assist in assessing the financial impact of each benefit mandate bill. Milliman USA also helped with the initial development of CHBRP's 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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