# REPORT ON

# HEALTH INSURANCE COVERAGE FOR

# ALCOHOL DRUG ADDICTION TREATMENT

# FOR VIRGINIA STATE EMPLOYEES

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO 4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF PURCHASES AND SUPPLY
RICHMOND
1979

# HEALTH INSURANCE COVERAGE FOR ALCOHOL DRUG ADDICTION TREATMENT FOR VIRGINIA STATE EMPLOYEES: A FEASIBILITY EVALUATION

Department of Personnel and Training

and

Department of Mental Health and Mental Retardation

July, 1978

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF PERSONNEL AND TRAINING
and
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

RICHMOND, VIRGINIA

JULY 1, 1978

TO: The Honorable John N. Dalton, Governor of Virginia
and
Members of the General Assembly of Virginia

The 1977 General Assembly adopted Senate Joint Resolution 121 which requested the Department of Personnel and Training to develop, in coordination with the Division of Substance Abuse of the Department of Mental Health and Mental Retardation, an employee assistance program for State employees with performance problems. The Resolution also requested a study of the feasibility of including comprehensive substance abuse treatment benefits under health insurance coverage provided State employees. This report represents the combined efforts of the Department of Personnel and Training and the Division of Substance Abuse and provides recommendations for future action.

Effective March 1, 1978, the State initiated, on a pilot basis, an employee assistance program to serve State employees working in agencies located in the Richmond area. The State Employee Assistance Service (SEAS) provides a structured setting for the early identification, referral and treatment of substance abusing and other employees whose job performance has deteriorated. As of July, 1978, thirty employees have been accepted into the program.

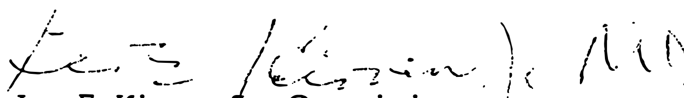
Based upon available evidence, the long-term benefits to the Commonwealth of providing treatment to alcoholic and drug-dependent employees appear substantial. It is anticipated that savings resulting from reduced utilization in health care benefits for substance abuse related/caused illnesses and improved job performance will cover the cost of the additional insurance coverage needed to pay for treatment.

The inclusion, on a trial basis, of substance abuse benefits for treatment as an inpatient in either a general or psychiatric hospital, or a free-standing residential facility, and as an outpatient is recommended. To evaluate the cost effectiveness of providing this coverage, a two-year utilization and cost study should be initiated as a joint venture by the Commonwealth of Virginia and Blue Cross and Blue Shield of Virginia using data available from the State Employee Assistance Service. Such data will guide the Department of Personnel and Training in deciding whether to recommend permanent inclusion of these benefits under the State's health care coverage.

It is further recommended that sufficient funds be appropriated to cover the cost of purchasing the necessary health insurance coverage.

Respectfully submitted,

Kenneth B. Yancey
Director of Personnel and Training



Leo E. Kirven, Jr., Commissioner
Department of Mental Health and Mental Retardation

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# I. Summary

It has been estimated that the economic effects of alcoholism in the United States cost society over $42 Billion each year, approximately $12.7 billion of which goes toward health and medical costs for the treatment of alcoholism and alcohol-related conditions, while almost $20 billion is attributable to lost production.[1] Alcoholism is the second leading disease in the United States with an estimated 10,000,000 victims.[2]

The National Council on Alcoholism estimates that 5.3% of the nation's employed population have a drinking problem.[3] Using this figure there are estimated to be over 4,000 Virginia State employees who have an alcohol problem. Furthermore, studies show that alcoholism is only one among many problems (drug dependence, medical, mental, familial, etc.) troubling employees, resulting in lost production and increased health care costs. Based on research among problem employees in an industrial setting, there is estimated to be an additional 4,000 state employees suffering from one of these other problems. In terms of dollar losses, existing alcoholism and alcohol problems among state employees alone are estimated to cost the Commonwealth about $11 million annually as a result of absenteeism, accidents, and alcohol related illnesses.

Based on claims to Blue Cross and Blue Shield of Virginia for 1976, and a survey of locally based substance abuse treatment resources, it is estimated that at least 200 state employees working in the Richmond area and 1,000 state employees statewide suffer from alcohol or drug abuse problems that require treatment. There are of course many other employees whose addiction is not discovered and goes untreated.

With the establishment of a pilot employee assistance program for state employees working in the Richmond area, the Commonwealth has taken a necessary step in providing complete health care services to its employees. Employees needing treatment, however, must currently be referred to a hospital for inpatient treatment in order for the treatmeant to be covered under existing health insurance coverage. The same treatment, however, could be provided at much less cost at free-standing residential facilities or through outpatient counseling if included under health insurance coverage provided state employees.

During its 1977 session, the General Assembly enacted SJR 121 which requested the State Department of Personnel and Training to develop, in cooperation with the Division of Substance Abuse, an employee assistance program and to study the feasibility of including comprehensive substance abuse treatment benefits under health insurance coverage provided state employees. This report represents the Department's efforts and provides recommendations.

Alcoholism and drug addiction are medical illnesses, which should be treated like any other medical illness. State law (§38.1-348.7) defines "mental, emotional, or nervous disorders" as including the physiological and psychological dependence upon alcohol and drugs.

While the number of treatment facilities is not now extensive, adequate facilities appear to be available (this includes available out-of-state programs) and licensing and program standards have been, or will soon be, developed to assure minimum levels of quality. Research based on similar pilot programs in California and Michigan demonstrate that a full range of substance abuse benefits can be purchased at relatively low cost. Additionally, Blue Cross and Blue Shield of Virginia estimates that the coverage outlined in §38.1-348.8 of the Code of Virginia will cost an additional 14¢ per individual and 36¢ per family each month. The annual cost of providing this coverage to all state employees would be about $201,120.

The long-term benefits to the Commonwealth of treating alcoholic and drug dependent employees appear substantial, as shown by studies conducted in industrial and other private settings, and it is anticipated that savings will cover, or nearly cover, the state's cost of the additional insurance coverage needed to pay for treatment.

Because alcoholism and drug addiction are medical illnesses requiring treatment, and because utilization and cost of such treatment by state employees is expected to be relatively low, the inclusion of substance abuse benefits including inpatient treatment in either a general or psychiatric hospital, or a free-standing residential facility, and outpatient counseling, on a trial basis, appears to be feasible. To evaluate the cost-effectiveness of providing this type of coverage, a two year utilization and cost study should be initiated as a joint venture by the Commonwealth of Virginia and Blue Cross and Blue Shield of Virginia using data available from the State Employee Assistance Service.

## II. INTRODUCTION

It has been estimated that the economic effects of alcoholism in the United States cost society over $42 billion each year, approximately $12.7 billion of which goes toward health and medical costs for the treatment of alcoholism and alcohol-related conditions, while almost $20 billion is attributable to lost production.[1] Alcoholism is the second leading disease in the United States with an estimated 10,000,000 victims.[2]

Other nationwide statistics provide additional evidence of the severity of the alcohol problem. Alcohol contributes to thousands of deaths each year. Approximately 35,000 accidental deaths at home, at work, or in recreation settings involve the use of alcohol. Alcohol use is also a factor in about 9,000 suicides (one-third of all reported suicides), 10,600 homicides (one-half of the total), and 23,000 motor vehicle accident deaths (one-half of the total) each year. Twenty-five percent of all pedestrians killed by motor vehicles had been drinking. Alcoholism also shortens life expectancy by an estimated 10 to 12 years, mainly by engendering other serious diseases.[3]

Alcoholism is also linked with nutritional deficiencies contributing to neurological and digestive diseases, and alcoholics are known to have a greater incidence of mental, blood and heart disorders, as well as muscle, respiratory and other tissue diseases.[4] In Virginia, during 1975, nearly 14,000 persons were convicted for driving while intoxicated and an additional 5,000 persons were referred to the Virginia Alcohol Safety Action Program for education, counseling, or treatment. Also during 1975, there were about 19,000 automobile crashes and 215 fatalities involving drinking drivers. Statistics for 1974-75 show that 2,250 persons were admitted to the state's four mental hospitals for alcoholism and a total of 29% of all mental hospital admissions during that year were for alcoholism. Representatives of the National Association of State Mental Health Program Directors testified before the Special Subcommittee on Alcoholism and Narcotics of the Senate Committee on Labor and Public Welfare on May 25, 1970, that approximately 30% of the 1.5 million patients being treated under all state mental health programs were alcoholics. Also, of the nearly 700,000 admissions to Virginia's general hospitals during 1974, approximately 97,000 involved alcoholism as the primary disease.

Alcoholism and drug addiction are recognized as mental disorders by the American Psychiatric Association and are listed as such in the International Classification of Diseases. Alcoholism was recognized as a disease by the World Health Organization in 1951, by the American Medical Association in 1956, and the U. S. Department of Health, Education and Welfare in 1966. Additionally, many professional groups such as the National Institute of Mental Health and the National Council on

Alcoholism have taken similar official positions.[5] Finally, the Code of Virginia (§38.1-348.7 (C)) when referring to health insurance coverage for mental illness states that "Mental, emotional and nervous disorders . . .shall include physiological and psychological dependence upon alcohol and drugs."

"Underwriters of health and disability insurance are currently incurring substantial costs due to alcoholism among their policy holders."[6] It has been estimated by the American Hospital Association that as many as 50% of all inpatients in specific service areas, such as orthopedic or general medicine, were admitted because of alcohol. Physicians and hospitals often treat alcoholism under other diagnoses either from not identifying the primary problem of alcoholism or intentionally to protect regulations or obtain insurance benefits.

Numerous studies have additionally demonstrated that alcoholics utilize a disproportionately large share of health benefits. In a five-year mortality study of alcoholics by Pell and D'Alanzo, the mortality rate for alcoholics was shown to be 3.2 times that of non-alcoholics. Alcoholic employees were also found to experience two or three times the number of illnesses of other employees in specific health disorders and the alcoholic employee cost employers three times the sickness benefits of other employees.[7]

In the past, drug and alcohol abuse treatment has generally been outside the mainstream of the health care delivery and financing systems. Although private health insurance carriers have served as a primary means of financing health care within general health delivery systems, there has been to date little financial support of the alcohol/drug abuse treatment sector by the insurance industry. Where alcohol/drug abuse treatment has been covered, it has traditionally been on an inpatient basis in a general or mental hospital setting. The insurance industry has looked with apprehension upon typical alcohol/ drug abuse treatment facilities and has questioned the qualifications of professionals providing treatment.

In recent years, this attitude has begun to change as evidence substantiates that limitations on alcoholism treatment are actually counter-productive. Several nationwide insurance carriers, including Prudential Insurance Company of America, Kemper, Employers Insurance of Wausau, and the Hartford Insurance Group, have in the past several years taken steps to broaden their coverage of alcoholism treatment. More recently some Blue Cross plans have also begun to take an active part in expanding coverage. Blue Cross of Maryland in 1975, for example, expanded its group health coverage to include treatment at State-licensed non-hospital residential facilities, as well as outpatient care.[8]

Capitol Blue Cross of Harrisburg, Pennsylvania, initiated a pilot benefit program in 1974 to test the feasibility of including benefits for the treatment of alcoholism in its regular benefits package. This was done with no increase in rates and is provided to all of its sub-

scribers. Coverage is provided for rehabilitation in approved free-standing residential facilities whose main purpose is the rehabilitation of alcoholics. Specifically, they intend to test the proposition that rehabilitation of alcoholics can, in fact, reduce future medical costs by eliminating many of the serious medical conditions associated with prolonged alcoholism. After two years, 366 Blue Cross subscribers made use of these benefits. The average length of stay was about 25 days and the average cost was $962 or about 17¢ per year per subscriber.[9]

The National Institute of Alcohol Abuse and Alcoholism (NIAAA) in cooperation with the Blue Cross Association, is currently studying health insurance coverage for alcoholism treatment, and together they have recently developed a proposed model benefits package to be used by Blue Cross plans nationwide. (See section VIII on model benefits.) Beginning in July, 1976, the Blue Cross Association began an NIAAA-sponsored project to develop the tools and techniques needed to test the feasibility of offering comprehensive benefits for alcohol abuse and alcoholism treatment nationwide through Blue Cross organizations. A second phase of the project is a three-year field testing of the model benefit by Blue Cross plans.

Currently, the National Institute of Drug Abuse (NIDA) has also negotiated a contract with the Blue Cross Association to conduct a similar feasibility study to deliver a drug abuse benefit package through Blue Cross plans nationwide. Phase I of the project will be the development of a model benefit, and marketing and administrative packages. The second phase will test the benefit model at different sites around the country, and if this field test shows the feasibility of a drug treatment benefit it will be implemented nationwide.

Another study, which recently completed its second year, is a pilot program developed in California to test the "feasibility of health insurance payment for alcoholism care by providing coverage to: (1) all employees of the State of California, and (2) employees of certain public and county municipalities..."[10] As implemented, this program is very similar to the pilot project operated by Virginia's Department of Personnel and Training and the Department of Mental Health and Mental Retardation. A uniform set of inpatient, intermediate-care, and outpatient benefits was developed and made available statewide by nine participating insurance carriers. Results of the project are presented later in this report.

As a result of nearly two years of study by the Joint Subcommittee on Alcohol and Drug Abuse, the Virginia General Assembly passed legislation during its 1977 session (amended during 1978) which will require that health insurance carriers make coverage for alcoholism and drug addiction available to all group policy holders beginning July, 1978. It is hoped that this will encourage employers to purchase coverage for substance abuse treatment and emphasize the need for providing comprehensive treatment services for alcoholics and drug addicts by requiring that the offered coverage include minimum benefits for inpatient, intermediate, and outpatient care. It is also hoped that this action will help stimulate the expansion of treatment services by offering the possibility of increased third-party support for substance abuse treatment.

A companion piece of legislation was Senate Joint Resolution 121 directing the Department of Personnel and Training and the Division of Substance Abuse to study the feasibility of purchasing complete coverage for alcoholism and drug abuse treatment for all state employees and to develop a program for identifying employees with a drinking or drug abuse problem and encouraging them to enter treatment. Again, it is hoped that this example will encourage other employers in the state to expand their health insurance coverage for the treatment of alcoholism and drug addiction and establish similar employee assistance programs.

This report examines the feasibility of purchasing comprehensive health insurance coverage for the treatment of alcoholism and drug abuse among state employees as directed by SJR 121. Among the criteria which will be given consideration are (1) development of an adequate benefit model package; (2) the availability of adequate treatment slots; (3) assurances of program quality through licensing standards, certification of counselors, and certificate of need requirements; (4) development and successful operation of an employee assistance program; and (5) assurances that costs will be reasonable.

## III. ESTIMATES OF ALCOHOLISM AMONG STATE EMPLOYEES

As a means of measuring alcohol amd drug abuse among state employees and its resulting cost to the Commonwealth, the Department of Personnel and Training surveyed all state agencies in August, 1977. (See appendix for copy of the survey). The survey asked agency heads to estimate the number of employees whose erratic or deteriorating job performance may be caused, or contributed to, by alcoholism or drug addiction. Also asked was the number of employees that have either sought help from their supervisor or been counseled by their supervisor for alcohol or drug addiction.

Because most agencies are poorly equipped to identify and document alcoholism and drug abuse among employees, and because it is characteristic for the alcoholic to hide his/her drinking problem and deny the existence of a problem, these results are expected to understate the problem. Nevertheless out of 42,350 employees covered by the survey, 3,173 (7.5%) were reported to have missed more than one day per month of work.[a] Four hundred ninety-four (494) employees were reported experiencing erratic or deteriorating job performance. This is about 16% of those missing more than one day of work per month, or 1.4% of total employees (This excludes Virginia Commonwealth University because of non-reporting). Agencies identified or estimated a total of 551 employees (1.3% of all employees) with an alcohol or drug abuse problem.

### Use of Sick Leave and Health Benefits

Data on the utilization of sick leave and general health care benefits are useful in defining the scope of the general at-risk population among state employees. For example, sickness, whether the employee's own or that of another family member, can create tension within the family and contribute to other family problems and adversely affect the employee's job performance. Employees whose health care substantially exceeds the mean for all state employees may require or benefit from counseling and assistance.

A survey completed by the Department of Personnel and Training during the spring, 1977 shows that state employees used an average of 7.2 days of sick leave during 1976. Approximately 13% of all state employees used no sick leave, while 15% used more than 15 days of sick leave each year.

[a]This is under-reported because Virginia Commonwealth University with 6,235 employees did not answer this question. If the total of these agencies are subtracted from the 42,350 employees, then 9.8% of employees missed more than one day of work per month. It should also be noted here that many of these absences were for reasons unrelated to alcohol or drug abuse.

Utilization of Health Benefits for Alcoholism and Drug Addiction

Because it is likely that many problem drinkers would not be identified by agency personnel, information was requested of Blue Cross and Blue Shield of Virginia (the state's health care insurer) on the number of health insurance claims for alcoholism or drug addiction treatment paid under the state's contract. During 1976, there were seven outpatient cases and 91 inpatient cases of alcoholism and drug addiction for which Blue Cross and Blue Shield made reimbursement. The 91 inpatient cases received 1,268 days of care (an average of 13.9 per case) at a total cost of $180,416.25, of which $107,192.78 was paid by Blue Cross. The average cost per alcohol/drug case was $1,177.94. This compares with $478 per case for all types of illnesses.[1]

Again, this understates the magnitude of the problem. It shows only those employees who, on their own, were motivated enough to seek treatment. It does not include those individuals who seek treatment in facilities in which treatment is not covered by Blue Cross. Another problem is that these figures do not include the many alcoholics who are treated under other diagnoses, and who are treated repeatedly for the symptoms and illnesses associated with alcoholism, such as gastritis and pancreatitis, without ever having the alcoholism itself treated.

Utilization of Community-Based Treatment

Because Blue Cross and Blue Shield of Virginia does not reimburse for treatment provided by free-standing community-based alcoholism or drug addiction treatment programs, the Division of Substance Abuse surveyed state supported programs to determine how many state employees received treatment. Only programs in the Greater Richmond-Petersburg-Williamsburg-Fredericksburg area were included because it represents the service area for the Pilot State Employee Assistance Service (SEAS), being established by the Division of Substance Abuse and the Department of Personnel and Training. Approximately 16,000 state employees (about one-fifth of all state employees) are covered by this region.

Programs were requested to submit the number of state employees or their dependents entering the program during a three month period in the fall of 1977. Out of 10 treatment programs, six reported no state employees in treatment for that three month period, although several reported they had previously served state employees. The remaining four programs reported 16 employees. From this the number of state employees in the greater Richmond area entering community treatment programs each year can be estimated to be about 64 (16 represents one-quarter of those treated during the year).

Additionally the two Alcohol Safety Action Programs (ASAP) in the greater Richmond area (Richmond ASAP and Petersburg ASAP) were requested to report the number of state employees or their dependents, identified and referred to treatment (classified as level III by ASAP). These two programs reported a total of 27 such cases. Again, this provides an

estimated 108 state employees in the Greater Richmond Area identified as needing alcoholism treatment each year (4 x 27).

STATE EMPLOYEES ENTERING TREATMENT FOR ALCOHOLISM/DRUG ADDICTION
September 15, 1977 - December 15, 1977

| Program | State Employees |
|---|---|
| Richmond Local Alcoholism Services | 3 |
| Petersburg Local Alcoholism Services | 8 |
| Fredericksburg Local Alcoholism Services | 0 |
| Willow Oaks-Cartersville | 0 |
| Adapts - Richmond | 0 |
| Realhouse - Petersburg | 0 |
| Rubicon - Richmond | 0 |
| Rappahannock Drug Abuse | 0 |
| Bacon St. - Williamsburg | 1 |
| Jumpstreet - Richmond | 4 |
| | 16 |

Conclusion

Although it is evident that the extent of alcoholism among state employees cannot be accurately defined, there are indications that the problem is sizeable. Based on generally accepted formulae among alcoholism professionals, Virginia may have as many as 4,000 employees suffering from an alcohol abuse problem. Currently, these employees must find treatment on their own, and if they are unable to control their drinking, and job performance continues to deteriote, release from employment is likely. Often this occurs after many years of valuable service to the Commonwealth.

Because personnel supervisors are generally not trained or prepared to identify alcoholism or drug addiction among their employees, the use of information surveys is of limited value in defining the problem. Nevertheless, at least 200 employees (91 identified by Blue Cross and Blue Shield of Virginia and 108 identified by ASAP) among the approximate 16,000 state employees in the greater Richmond area (one-fifth of all state employees) are treated annually for either a drug abuse or alcoholism problem. It is further estimated, based upon the above data, that 1,000 state employees statewide suffer from an alcohol or drug abuse problem.

## IV. TREATMENT CONSTRAINTS

Before health insurance coverage for drug and alcohol abuse is provided to state employees, treatment programs of adequate quality must be available. Related to the availability of treatment are three issues which will be discussed separately: (1) the accessability of treatment, (2) assurances of quality, and (3) treatment effectiveness. If the state should decide to purchase alcoholism and drug addiction coverage for which the state would pay the entire additional premium, there needs to be assurances that these services are available. Adequate numbers of treatment facilities, therefore, needs to be accessible to all areas of the state, so that employees can utilize the services for which the Commonwealth is paying. There also needs to be reasonable assurances that the available services are effective or the Commonwealth will be paying for services that provide no help.

### Accessibility

As of December, 1977, a system of 72 community-based treatment services within the state's system of treatment for alcoholism and drug addiction existed throughout the state which provided treatment to approximately 22,000 clients during 1976-77.

Within the alcohol component of the Commonwealth's substance abuse program there are 16 outpatient Local Alcoholism Services (LAS), three newly established community services efforts, a state inpatient program at The Medical College of Virginia, and 21 alcoholism residential treatment facilities. The LAS's provide primary outpatient treatment, public education and information, and agency consultation, and serve as a community catalyst for the development of community involvement in the establishment of local programs and services. The services provided treatment to about 16,000 clients during 1976-77 with length of stay ranging from three to 18 months. The State inpatient program located at the Medical College of Virginia Hospital provides detoxification, residential and outpatient treatment to about 1,000 alcoholics annually. The 21 residential treatment facilities, totaling approximately 414 beds, provide a protective environment where alcoholics receive an array of counseling services aimed at recovery and self-sufficiency. Managed by private corporations, they are of two types: sub-acute detoxification (a five-day average stay) wherein clients withdraw from the toxic effects of alcohol under medical supervision, and residential rehabilitation wherein clients receive individual and group counseling aimed at reentry into society by beginning to work and reestablishing family relationships (average stay is two to six months). These community-based facilities are inequitably distributed in the state. In most of these existing resources, there are currently long waiting lists of clients who have either volunteered for or have been court-ordered to be treated.

The Commonwealth's drug services system currently consists of five methadone clinics, seven residential treatment facilities, 29 outpatient drug-free service components and a treatment alternatives to street crime (TASC) program. Prevention, crisis intervention and referral services are offered by these as well as numerous private agencies. The five methadone clinics provide medically supervised detoxification or maintenance to clients experiencing opiate addiction and other needed support services. These programs are located in the major metropolitan areas, specifically Portsmouth, Norfolk, Richmond, Alexandria and Hampton where opiate use is most prevalent. Current capacity for these programs is 936 treatment slots.

The residential facilities provide an array of services, including individual, group and family counseling, educational services, vocational and job placement counseling, referrals for health care medically and nonmedically supervised detoxification, psychiatric, and legal services. The current residential treatment capacity in Virginia is 364 service units.

The outpatient drug-free treatment services provided by programs in Virginia are similar to but generally less intensive than those provided in residential facilities. Outpatient treatment units number 2,185.[1]

In addition to the publicly supported community-based system of care, there exist private hospital and psychiatric facilities which provide inpatient treatment for both alcoholism and drug addiction. As of January, 1978, there were 14 licensed private psychiatric hospitals in Virginia with a total bed capacity of 1,248, 21 private general hospitals with psychiatric facilities with an inpatient bed capacity of 632, and three comprehensive mental health services totaling 196 beds.[2]

Another treatment source is the state mental hospital system. Currently it is estimated that about 30% of all admissions to the state's four mental hospitals have a problem in which alcohol is a major or contributing factor. The state's four hospitals serve about 4,800 patients, 2,300 of whom are estimated to have some type of alcohol or drug abuse problem. Eastern State Hospital has an 88 bed alcohol/drug abuse unit, Central State has 59 beds and Western State Hospital has 47 beds for alcohol/drug abuse. While Southwestern State Hospital has not set aside a special unit, they treated 423 patients for alcoholism or drug addiction during 1976-77. Tables 1 and 2 provide a geographic distribution (by Health Services Area) of the various treatment facilities.

While not every area of the state has equal access to all types of care, all areas do have access to some type of care. Many facilities, however, especially the alcoholism treatment programs, already are experiencing waiting lists of court-ordered or voluntary clients. Of particular concern are the individuals identified by Virginia's Alcohol Safety Action Program, for whom very limited treatment resources exist.

Table 1

NUMBER OF INPATIENT PSYCHIATRIC BEDS IN PRIVATE LICENSED FACILITIES

January, 1978

| Type Facility | Health Services Area I | II | III | IV | V | Total |
|---|---|---|---|---|---|---|
| Psychiatric Facilities- Comprehensive MH Centers | | | | | 196 | 196 |
| General Hospital | 55 | 101 | 119 | 284 | 73 | 632 |
| Psychiatric Hospital | 50 | 191 | 261 | 324 | 422 | 1,248 |
| Total | 105 | 292 | 380 | 608 | 691 | 2,076 |

Table 2

NUMBER OF COMMUNITY-BASED ALCOHOL AND DRUG TREATMENT FACILITIES

December, 1977

| Type Treatment | Health Services Area I | II | III | IV | V | Total |
|---|---|---|---|---|---|---|
| Alcoholism | | | | | | |
| Outpatient | 6 | 3 | 6 | 2 | 7 | 24 |
| Residential | 5 | 3 | 9 | 2 | 3 | 22 |
| Inpatient | | | | 1 | | 1 |
| Drug | | | | | | |
| Outpatient (drug free) | 2 | 5 | 5 | 4 | 8 | 24 |
| Residential | 1 | 2 | 1 | 1 | 2 | 7 |
| Referral to other Resources | | | | 1 | | 1 |
| Methadone Outpatient | | 1 | | 1 | 3 | 5 |
| Total | 14 | 14 | 21 | 12 | 23 | 84[a] |

[a]Several programs provide both residential and outpatient services.

Thus, while there is a sizeable statewide treatment network already available, any actions which would encourage the planned development of additional treatment resources should be pursued.

Among the forces at work that will encourage expansion of the number and types of programs is the anticipated availability of third-party health insurance funding required by §38.1-348.8. One fear of the insurance industry, however, has been the over-stimulation of new facilities. They contend that unless tight controls are exercised, too many programs will be developed to take advantage of third-party funding. But the evidence seems to demonstrate that where insurance coverage has existed for the treatment of alcoholism and drug addiction, the experience has been one of poor utilization of benefits; an over-demand on facilities may, therefore, be an unwarranted fear. If, however, it should materialize, existing certificate of need requirements under §32-211.5 should serve to forestall the development of unnecessary programs.

## V. ASSURANCES OF MINIMUM STANDARDS

While most insurance carriers will agree to provide whatever benefits a subscriber group wishes to purchase, unless there are assurances that treatment facilities/providers meet minimum standards of quality, insurance purchasers may only be wasting money by authorizing insurance carriers to reimburse such treatment providers. Only through a process that certifies that programs meet minimum standards can policy holders be certain of what they are purchasing and will insurance carriers be willing to offer treatment benefits. There are several methods used to insure quality treatment: (1) licensing, (2) counselor certification, and (3) program standards.

### Licensing

Licensure is the process by which an individual, group, or institution is given legal permission to operate a facility by meeting minimum regulations; generally such regulations address health, safety, and minimum program issues. The legislation making available insurance coverage for the treatment of mental illness, alcoholism and drug addiction, passed by the 1976 and 1977 sessions of the General Assembly, requires that before an alcohol or drug treatment facility can be eligible for third-party insurance reimburements it must be licensed by the Commonwealth.

In Virginia, the licensing of alcohol and drug treatment facilities is the responsibility of the Department of Mental Health and Mental Retardation. Section 37.1-179 states that the Mental Health and Mental Retardation Board "may annually license any suitable person to establish, maintain and operate, or to have charge of any facility or institution which provides care or treatment for...persons addicted to the intemperate use of narcotic drugs, alcohol or other stimulants." Further, §37.1-183.1 states that no person shall establish or operate any facility for the care or treatment of "persons addicted to the intemperate use of narcotic drugs, alcohol or other stimulants, including the detoxification, treatment or rehabilitation of drug addicts through the use of the controlled drug methadone, without first being duly licensed..." Licensing regulations for drug abuse treatment facilities became effective April 1, 1976, and as of January, 1978, 25 drug facilities were licensed: five residential and 20 non-residential programs. The Department of Mental Health and Mental Retardation began working on standards for alcoholism facilities in the fall, 1977, and it is anticipated that they will be ready by the end of 1978.

With the advent of licensed facilities, it becomes feasible for groups to purchase insurance coverage for treatment in alcohol and drug treatment facilities and remain assured that there will be eligible facilities in which minimum levels of care will be maintained.

## Certification of Counselors

Certification is a process by which an individual is recognized as having met certain predetermined educational and/or experiential qualifications considered sufficient to assure compctency. In the case where the certifying organization is a governmental agency, certification may be a requirement for permission to practice.

Section 38.1-348.8(1) of the Code of Virginia defines the type of alcoholism and drug dependence treatment which is to be made available under optional health care insurance, beginning July 1, 1978. Treatment by the following providers is to be covered: (1) certified alcoholism counselor, (2) certified drug counselor, (3) professional counselor, (4) psychologist, (5) social worker, and (6) licensed physician.

In 1976, the Virginia General Assembly established the Virginia Board of Behavioral Science to regulate the social science professions. Development of certification procedures is progressing, and it is anticipated that the Board will begin certifying alcoholism counselors during fall of 1978 and drug counselors in the spring of 1979. In addition to considering an applicant's educational and experiential backgrounds, all applicants will be required to take a written test in order to be certified.

In addition to certified alcohol and drug counselors, the Board has also decided to create an area of specilization under "professional counselor" for substance abuse. Licensure as a professional counselor, with a speciality in substance abuse, will require 60 graduate credits of work in counseling after January 1, 1982. Prior to that licensure will require a master's degree in counseling and two year's of supervised post master's degree experience. Again, with the development and implementation of counselor licensure standards, health insurance purchasers can be assured that the treatment meets acceptable minimum standards.

## Program Standards

While licensure and certification are necessary if treatment programs are to become eligible for third-party insurance approval, another procedure being developed to assess program quality is program standards. Program standards are currently under development by the Department of Mental Health and Mental Retardation and are now being reviewed. While licensure is the traditional method of regulating facilities, it deals primarily with life/safety issues. Program standards are designed to address issues of treatment quality, and are meant to assure a higher level of treatment than licensure. Eventually, programs will be required to become certified under program standards in order to be eligible for federal and state funding support. Standards are expected to be completed by December, 1978, and implementation to occur soon thereafter. Certification offers group insurance purchasers an alternative quality care measure.

## Conclusion

Development of licensure, certification and program standards is expected to be completed this year. There will, however, be some delay between development of these standards and actual licensure or certification.

Because of this, some difficulty might initially be experienced in finding eligible treatment facilities in which to place state employees needing treatment. To lessen the impact of this lag it is recommended that the Commonwealth provide its health insurance carrier (Blue Cross/Blue Shield) with a list of approved facilities in which it will authorize reimbursement for treatment. This should be done as a temporary measure until such time as licensing standards are implemented and treatment facilities have had time to comply.

## VI. TREATMENT EFFECTIVENESS

In addition to the existence and availability of sufficient numbers of quality treatment programs, as defined by licensing and program standards, the effectiveness of treatment needs to be considered when assessing the feasibility of health insurance. It should not, however, be the sole criterion. There are many other diseases such as some forms of cancer, which cannot always be treated successfully, and for which health insurance carriers provide reimbursement as long as treatment meets accepted medical standards.

Unfortunately, very little evidence documenting substance abuse treatment effectiveness exists, and where studied it often is in socio-economic terms, such as income or job performance, and not medical terms. Another problem with examining treatment effectiveness is the difficulty in defining success. In some ways a strict medical recovery may not be possible. There are many alcoholism treatment professionals who believe that an alcoholic never recovers; that the best that can be done is to maintain sobriety. A definition of success, using this criterion, would be whether the alcoholic can remain sober for some stated period of time, for example two years. A similar definition might be used for drug addiction. Another criterion of success which is often used depends on the patient's ability to function. If the patient can return to work, or again function socially, then he/she is better.

The 1975-76 Comprehensive Community Alcoholism Plan, prepared by the Virginia Department of Health, reported that the state's 15 local alcoholism treatment programs saw improvement among 3,255 (38%) of their clients, while 2,479 (22%) were reported recovered. Recovery was defined as maintaining sobriety for three or more months and returning to a responsible life pattern.[1]

A study of costs and benefits prepared for the NIAAA in 1976 examined treatment of clients entering NIAAA alcoholism treatment centers. Benefits were estimated by comparing health care costs before and after six months of treatment. Among 4,777 clients, there were 352 hospitalizations during the month prior to treatment and only 120 hospitalizations (a decrease of 66%) after six months of treatment. Health care costs likewise decreased from $6,957,513 to $2,117,108.[2]

A follow-up study among clients of five drug abuse treatment programs was conducted for the Northern Virginia Planning District Commission. The study focused on clients treated during the period 1969 through 1975 in five Northern Virginia Programs. A total sample of 818 clients was selected, and a 39% (320) response rate was achieved. The report warns that the low response rate might bias the results and that the absence of a control group makes it difficult to distinguish between program-induced changes and changes caused by maturation among clients. There was, nonetheless, documented improvement found among respondents.

Most clients reported the use of more than one drug, including alcohol, prior to treatment. Half reported use of drugs other than alcohol or marijuana on a daily basis: 44% reported daily use of heroin, and 13% reported daily use of barbiturates or amphetamines. (Sixty-seven percent reported some use of barbiturates and 62% reported some use of amphetamines). Follow-up results show that while a high percentage of clients (30-40%) were still using drugs after treatment, there was considerable improvement, as measured by reduced use of drugs: daily heroin use declined from a range of 44-73% to 12%, and all use of heroin declined from a range of 61-69% to 27%; daily barbiturate use decreased from 13-77% to 3%, and total use of barbiturates declined from about two-thirds to 21%; daily use of amphetamines declined from 13-85% to 2%, and total use of amphetamines declined from 60-62% to 25% of the clients. The use of both marijuana and alcohol, however, remained high.[3]

Employment and Health Insurance Studies

One area in which data on treatment outcomes are available is from employee assistance programs. A number of studies have been completed showing that treating alcoholic or drug-abusing employees results in overall savings to the employer. A study of the Illinois Bell Telephone Company alcoholism program shows that 57% of their program referrals were rehabilitated (stopped drinking completely for one year or more) while another 15% were improved by treatment (able to function satisfactorily on the job although they had not completely stopped drinking). An evaluation of job efficiency showed that poor job performance dropped from 28% to 12% while good job performance increased from 22% to 58%. In the area of sickness/accidents, the study group of 402 employees had 662 cases of sickness disability absences in the five years prior to program participation and only 356 cases in the subsequent five years, a 46% reduction. Likewise, during the five years before treatment there were 75 cases of off-duty accidents compared to 28 cases afterwards. On-duty accidents also decreased from 57 to 11.[4]

An evaluation of alcohol and drug recovery program operated by General Motor's Oldsmobile Division was conducted by Michigan State University's School of Labor and Industrial Relations. The project included 117 hourly workers who participated in the rehabilitation program. A control group of 24 employees who were known to have drug or alcohol problems but who did not volunteer for the program was selected. Prior to treatment the program group used $38,381 in sickness and accident benefits compared to $25,661 after treatment, a 33% decline. The control group, however, experienced an increase in benefit utilization from $12,196 to $20,240.[5]

In the Kennecott Copper Study it was found that for those individuals going through their employee assistance program there was a 52% drop in absenteeism; before treatment they averaged 3.18 days' absence per month while after treatment this dropped to 1.54 days per month. Likewise, weekly indemnity payments prior to treatment totaled $23,474 for the 150 person test group while afterwards this dropped to $5,967 (a

75% decrease). Medical/surgical costs also decreased by 55%, from $93 per man-month to $42.[6]

The Kelsey-Hayes Company found that the number of days worked after treatment increased by 23.9%. An examination of 58 employees actively involved in their program between 1972 and 1973 showed that they worked a total of 76,746 hours prior to treatment in 1972 and 95,071 hours after treatment in 1973, (an increase of 18,325 hours). At $5.15/hour wage, this represented $94,374 in recovered costs.[7]

A study of short-term inpatient treatment by Pittman and Tate[8] noted improvement in social stability after treatment. Of 78 patients, only 26% were employed at time of admission while 51% were employed at time of follow-up. In another study of inpatients being treated for alcoholism, Pokorny reports that among 88 patients, all of whom were unemployed prior to entering treatment, 73% were employed one year after discharge.[9]

A study of job efficiency ratings among personnel participating in the Navy's inpatient alcoholism program shows that since it began, about 4,000 enlisted men and officers have been referred for treatment. About 70% have shown improvement in their work performance and have reduced their number of relapses into problem drinking.[10]

Another study, this one among outpatients being treated for alcoholism, measured treatment success by controlled drinking, absenteeism, and supervisor appraisal of job performance. Of 340 identified problem drinkers, 220 (65%) were reported to have controlled their drinking. There was a similar improvement in job attendance and job performance. Prior to treatment, the average time lost among the group was three days per month while after treatment the average time lost was three and three-quarters hours. Supervisors also reported the elimination of "needless on-the-job direction for the treated employees."[11]

Scovill Manufacturing Company in Waterbury, Connecticut employs 6,500 employees. The Scovill employee program processed 180 employees over a three-year period. They estimate their annual savings at $186,550. Importantly, 78% of those problem drinking employees referred for treatment were rehabilitated.[12]

Economics Laboratory, Inc., of St. Paul, Minnesota has an employee population of 3,500 in the United States. They have a rehabilitation success rate of 80% for employees and 50% for employee dependents. Additionally, the company reduced treatment costs 60% to 65% by utilizing non-hospital facilities such as alcoholism treatment centers.[13]

The De Paul Industrial Alcoholism Project of Milwaukee, Wisconsin receives referrals from 23 companies in the Milwaukee area. This population is composed primarily of blue-collar skilled and unskilled factory workers. In conducting a nine-month follow-up study of problem drinkers treated, 46% reported total abstinence and 25% a partial reduction in drinking, for a total of 71% significantly improved.[14]

The Philadelphia Fire Department established a referral program for its 3,410 employees in 1972. For those problem drinkers referred to outpatient care, sick leave was reduced by 55% and injuries were reduced by 67%. Both of these factors indicate a significant decrease in health insurance utilization.[15]

The following table is reproduced to present a brief summary of results attributed to some of the previously discussed company programs.

| Company | Employee Rehabilitation Success Rate | Problem Drinker Reduction in Claims Payments |
|---|---|---|
| Scovill | 78% | - |
| Economics Lab. | 80% | 65% |
| De Paul Alcoholism Project | 71% | - |
| Illinois Bell | 57% | 46% |
| Philadelphia Fire Dept. | | 55% |
| Kennecott Copper | | 55% |
| Oldsmobile | | 33% |
| William Darrin Study | 65% | - |

In July 1974, the State of California initiated a pilot program of health benefits for alcoholism treatment for its employees. The purpose of the project was to evaluate the feasibility of providing such coverage on a permanent basis. By providing a program of assistance to state employees and reimbursement for the cost of health insurance coverage for the treatment of alcoholism, it was expected that there would be savings to the state through reduced absenteeism and lost-time due to accidents, lower rates of sick leave usage, fewer adverse personnel actions, and improved morale. During the 23 months that the program operated, 766 persons received treatment, representing .5% of California's 140,757 public employees enrolled in the health insurance plans. Three hundred thirty-nine (339) persons received inpatient care, 542 received outpatient care, and 15 had recovery home stays. Total cost of all services provided amounted to $677,577, of which $596,444 (88%) were covered by insurance benefits. The average cost per client was $779.[16]

A longitudinal study of the Pilot Program has been completed by H-2 Incorporated for NIAAA, which examined the health status of 462 clients (240 families) before and after treatment. The study was designed to test the hypothesis that total medical care will decrease after treatment of alcoholism. The study shows that there was a shift from use of inpatient to outpatient benefits. The number of inpatient visits per month for the alcoholic family member declined from .23 to .18; costs also declined from $141 to $100 per month. The number of outpatient visits increased from .61 to .78 per month while outpatient costs rose from $24 to $27 per month. The report concludes, "The frequency of inpatient care for the total family and its alcoholic member decreases following initial treatment of the problem drinking member for alcoholism."[17]

The report goes on to state that the alcoholic will enter the hospital less often and stay longer, suggesting that inpatient treatment was increased as a result of undiagnosed and untreated alcoholism, or because specific treatment for alcoholism replaces previous inpatient care under secondary diagnoses.

In August of 1974, the State of Michigan implemented an Employee Service Program as a pilot project for the employees of their Departments of Management and Budget, and Public Health. Between August, 1974 and August, 1975, 76 employees were seen by the program. Of this number, 39 full-time employees were selected for evaluation. Absenteeism rates among these 30 employees for the four months prior to referral were compared with the four-month period following referral (time off-the-job for inpatient treatment, if needed, was subtracted from the after-referral absences). The 39 employees averaged 12.2 hours per month off-the-job prior to referral. This decreased to 6.4 hours after referral, a 48% reduction in absenteeism. Sixteen employees were diagnosed as having an alcohol abuse problem, while 15 were experiencing emotional problems. Absenteeism among the alcoholics declined from an average of 12.9 hours per month to 5.6, while those with emotional problems declined from 15.5 to 7.7 hours per month.[18]

Conclusion

While few data exist to document the medical success of alcoholism/drug addiction treatment, there is considerable evidence that such treatment is good business practice and personnel policy, and is profitable to the employer. Based upon the previously mentioned studies, the Commonwealth might expect about a 50% reduction in absenteeism among alcoholic employees (see report on Kennecott Copper and study of state employees in Michigan), and an overall reduction in health insurance claims among alcoholic employees ranging from 33% to 65%.

## VII. STATE EMPLOYEE ASSISTANCE SERVICE

In cooperation with the Department of Mental Health and Mental Retardation, the Department of Personnel and Training established on a pilot basis an employee assistance program for state employees working in agencies located in the Richmond area. This action was taken in response to SJR 121, adopted by the 1977 Session of the General Assembly.

The State Employees Assistance Service (SEAS) provides a structured approach for the early identification, referral and treatment of substance abusing and other employees whose job performance and/or behavior has deteriorated and who have not responded favorably to the supervisor's normal corrective action. The SEAS is now functional in the Richmond area for state employees and will provide the following services.

1. Identification

   Because the early stage substance abuser exhibits a variety of repetitive job performance or behavior symptoms which are indicative of a non-job related personal problem, such problems can be observed and identified by an alert and informed supervisor. Through a supervisor orientation program supervisors will learn to identify the presence of personal, behavioral, or medical problems based upon objective documentation of the employee's job performance or behavior.

2. Motivation

   Once a definite pattern of problem performance has been documented the supervisor will follow established procedures for exercising what is commonly called supportive confrontation. The problem employee is advised of his/her recurring performance/ behavior discrepancy and offered assistance through the SEAS office in finding outside help.

   The alternative to correcting the chronic job performance problem, either alone or with the help of the SEAS is to accept appropriate disciplinary actions which could include termination of employment. Such diciplinary action constitutes an extremely effective motivational tool, which can break through the denial system of the abuser. Motivation occurs when all the significant others in the problem employee's total environment work in concert to bring the employee to a point of accepting help or discipline. This degree of motivation, when supported by the other basic services provided by SEAS, is unique to the work site and is responsible for the high success rates such programs have with the substance abuser.

3. Referral

The employee assistance program insures that efficient referral takes place by developing clear procedures for the supervisor to use, and by offering assistance to the supervisor in confrontating the problem employee. Unless supervisors can make a referral without suffering loss of prestige, position or control of their employee, or if they feel that referral will be harmful to the employee, they will not utilize the program. Referral of the employee is made to an employee counselor who evaluates the apparent problem and offers assistance in using outside helping resources to restore normal productivity.

SEAS will also accept troubled employees who voluntarily seek assistance. Often the employee will voluntarily seek help rather than await the inevitable "shape up or ship out" ultimatum. The experience of many employee programs indicates that from 25-40% of all clients are self-referred.

4. Treatment

It is essential that referral be made to appropriate treatment which will maximize recovery potential and reduce costs to both the employee and employer.Early intervention will permit the use of less costly outpatient treatment and will reduce the risk of relapse. Treatment for later stage substance abuse normally occurs on an inpatient or perhaps intensive outpatient basis. True recovery, however, takes place in the societal, familial, and work settings. Thus, the treatment of substance abuse as well as many other behavioral/medical problems is not complete with the termination of an initial treatment regimen, but requires continued follow-up services.

5. Follow-up

It is only after the emmploee returns to the job and family that recovery occurs. The supervisor will observe the recovering employee's overall performance and will have access to the supportive involvement of the SEAS coordinator.

The pilot program for state employees embodies these five basic services, with ancillary components applicable to state governmental operations. A formal policy was issued February 22, 1977; referral procedures have been established; a neutral office location has been secured; a program coordinator/counselor is available, and liaison has been established with various treatment resources.

The Department of Personnel and Training and the Division of Substance Abuse of the Department of Mental Health and Mental Retardation, have cooperated in the development and initiation of the Employee Assistance Service, and through the Management Development and Training Service a series of supervisor orientation programs is being conducted. Also, in cooperation with the Department of Mental Health and Mental Retardation's statistical and management information personnel, appropriate records and evaluation systems are being initiated. An evaluation of the entire program, with emphasis on its effect upon insurance claims for state employees with substance abuse problems, will be conducted with recommendations for further application of the model to all state employees.

Evaluation of Pilot SEAS

In addition to the humanitarian and management benefits of establishing SEAS for state employees, this program will provide a data base for the future assessment of the costs and benefits to the Commonwealth of providing rehabilitative services to employees with deteriorating job performance. SEAS provides a structured setting for the identification and referral of employees to appropriate assistance/treatment. The program has, therefore, two objectives: (1) to identify employees with substandard job performance, refer to or motivate such employees to seek appropriate assistance/treatment, and provide continuing support and follow-up to the employee; and (2) to restore employees whose job performance has been adversely affected by a substance abuse, mental health, or other personal, behavioral, or medical problem to full productivity.

The evaluation of the program will address both the success at reaching employees needing assistance and getting them into treatment and the impact of the treatment/assistance on state employees. The data system for evaluating SEAS must, therefore, serve both evaluation objectives, as well as to provide necessary management information. At the time of client intake, as much background data as possible is gathered on each client including a sickness/accident history. In the case of officially referred employees the client is given a release form, permitting supervisors to provide the required management and outcome data. When the client is a voluntary referral no request for information is made to the employee's supervisor.

Upon completion of treatment, the employee is referred back to the program coordinator for follow-up monitoring and services. During this period additional data is gathered on the client's work behavior.

Management Issues

By examining client referrals it will be possible to assess the program's success at outreach and visibility. Among the measures used to assess program visibility and utilization are (1) the number of disciplinary cases referred to the program, (2) the number of voluntary cases, (3) a comparison of the number of cases with an objective standard or experience of other employee assistance programs.

The number of voluntary cases is an indication of how well state employees are informed about the program. A low percentage of such cases would show that more needs to be done to publicize the program, while an examination of how many clients are coming from various agencies will indicate whether more work needs to be done in particular locations.

The number of formal referrals (disciplinary cases) is an indication of how well accepted or understood the program is by agency supervisors/managers. If supervisors are not using the program then additional or different training must be contemplated. Also, as with voluntary cases, an examination of which agencies make referrals will show where more work needs to be done.

Outcome Issues - The second objective by which program success will be determined is its outcome. This will be done by monitoring changes in various indicators of employee job performance, including absenteeism, sicknesses/accidents, use of health insurance, grievances, suspensions, promotions/demotions, status at completion of treatment, and job performance evaluations. As mentioned earlier, data on job performance and absenteeism will be requested of the employee's supervisor. Data on utilization of health insurance will be requested of Blue Cross and Blue Shield of Virginia with the permission of the employee.

Program Results - Because SEAS did not begin receiving clients until March, 1978, the earliest date by which preliminary results of program effectiveness can be assessed will be July, 1979. This will permit a minimum of one-year follow-up on those clients served by the program to date.

## VIII. HEALTH INSURANCE BENEFITS

### Coverage Currently Available

While it has been traditional for health insurance carriers either to exclude or to limit severely coverage for the treatment of alcoholism or drug addiction, there is a growing trend toward more and better coverage. At first coverage, when available, was generally limited to inpatient treatment in a general hospital, and often the benefit period was very limited, e.g. 30 days. Just 10 years ago, a report released by the National Center for the Prevention and Control of Alcoholism found that slightly over 60% of the general hospitals excluded the admissions of persons needing alcoholism treatment, while about 40% of the Blue Cross and Blue Shield plans excluded alcoholism from coverage.[1]

To provide an accurate picture of existing benefits available for use by occupational programming personnel, a survey of 31 large companies, averaging 34,000 employees, which have an occupational program was conducted. The existence of an occupational program for employees indicates that these are companies interested in providing assistance to their employees, and are therefore more likely to provide adequate health insurance coverage including treatment of alcoholism and drug addiction. Thirty of the companies provided inpatient care for alcholism. About three-fourths provided coverage for treatment in special treatment centers such as an alcoholism treatment center. Only 15 companies had outpatient coverage, two included treatment in a halfway house and one provided no care. In nine cases, inpatient treatment was limited to under 30 days.[2]

In 1972 the National Underwriters conducted a national survey of 278 commercial health insurance policies issued by 91 companies, which showed that while only 22 policies (8%) explicitly excluded alcoholism coverage, sixty-nine policies contained broader exclusions (e.g. nervous and/or mental disorders) which frequently eliminated alcoholism benefits. Thus, nearly 33% of the policies excluded alcoholism treatment from coverage. A more common practice, however, was to place limitations on the coverage available. Twenty-five policies specifically provided limits to their alcoholism coverage while 117 policies limited alcoholism benefits through limitations on their coverage of mental disorders.[3]

In Virginia, the former Division of Drug Abuse Control conducted a survey during early 1976 of insurance carriers doing business in the Commonwealth for the purpose of determining the extent of coverage for alcoholism and drug addiction. While only 14 usable questionnaires out of 32 mailed out were returned, some generalizations were evident.[4] Drug/alcoholism treatment was not covered by separate policies. Most einsurance carriers considered drug addiction and alcoholism as illnesses covered either under their general policy or major medical benefits, although specific benefits varied greatly.

All but one company covered alcohol/drug treatment on an inpatient basis, usually in a general hospital. Another common restriction was that many companies covered only care of the medical complications of substance abuse. Fewer companies provided coverage on an outpatient basis (approximately two-thirds of the respondents). Common restrictions were, (1) care of medical complications, (2) hospital outpatient program, (3) treatment by a physician, and (4) psychiatric care only. Residential care and detoxification were provided by about two-thirds of the respondents while only one-fourth said that coverage for methadone maintenance was provided. From this information it is evident that existing coverage for alcohol/drug treatment remains very limited.

One reason for placing exclusions and limitations on alcoholism and drug addiction benefits has been the presumption that coverage would increase costs. Another factor is often the view that alcoholism and drug addiction are self-inflicted and that any benefit program would be used by the addicted to overcome only the immediate effects of the addiction without entering into a program of treatment. An overlooked factor may be resistance by non-addicted persons to sharing the costs of providing treatment. This reluctance also often stems from the belief that the disease is self-inflicted and that addicted persons simply lack the will power necessary to quit.[5] Such arguments neglect to consider that many illnesses such as heart attacks and lung cancer are in some ways also self-inflicted, and are covered by health insurance despite the evidence linking them to such behavioral traits are poor diets, smoking, lack of exercise, or excessive drinking.

Virginia state employees currently have up to 120 days of coverage for inpatient treatment of nervous and mental illnesses, including alcoholism and drug addiciton. Treatment must be considered medically necessary by a physician. Outpatient services are included under employees major medical plan, but treatment must be provided by a physician. Not covered is residential intermediate-care, or outpatient counseling by an alcoholism or drug addiction counselor.

## Model Benefit Packages

With expanded interest in health insurance coverage for the treatment of alcoholism or drug addiction, a wide range of benefit packages have been developed. Part of the problem in setting a standard benefit is the great variety of treatment modalities and settings found in both the alcoholism and drug treatment fields.

In 1974 the "Second Special Report to the U. S. Congress on Alcohol and Health from the Secretary of Health, Education and Welfare" recommended the following maximum lengths of stay as the basis for treatment:[6]

| | |
|---|---|
| Emergency care | 6 days |
| Inpatient care | 14 days |
| Intermediate care, short term | 30 days |
| Intermediate care, long term | 60 to 90 days |
| Outpatient care | 30 |

Developing a benefits package for the treatment of alcoholism and drug addiction should be done with two conditions in mind: (1) the coverage should be broad enough to provide for adequate treatment, and (2) the benefit structure should encourage use of less expensive and effective treatment settings.

Recently, New Jersey enacted legislation mandating health insurance coverage for the treatment of alcoholism. The benefits provided are to be the same as for any other sickness benefits under the same contract. Included is treatment as an inpatient or outpatient of a licensed hospital, in a licensed detoxification facility, and as an inpatient or outpatient of a residential, intermediate-care facility. Unlike most legislative efforts made by other states, there are no special restrictions placed on treatment benefits. Treatment, however, is very much limited to medical personnel. Treatment must be prescribed by a physician, and residential facilities must meet minimum standards equivalent to those set forth by the Joint Commission on Accreditation of Hospitals.

Although it has not passed legislation providing either optional or mandated coverage, as have Virginia and New Jersey, California purchased health insurance coverage for its employees as part of a pilot program. Coverage included 6 days detoxification, 21 days of inpatient hospital care, 30 days residential care, and 45 outpatient visits. An evaluation of the pilot project concluded that alcoholism treatment could be provided and paid for under the benefits of a variety of health plans. A concern of insurance carriers prior to initiation of the program was whether it was possible to separate a diagnosis of alcoholism from the effects of alcoholism. The report concluded that "a primary diagnosis of alcoholism could be made and that health plan benefits could be applied accordingly."[7] At the conclusion of the pilot program two plans (Kaiser North and Kaiser South), which cover 36% of enrolled state employees in California, added the same broad range of benefits for alcoholism treatment to their basic and supplemental benefits.[8]

The report recommended that instead of extending regular plan benefits to alcoholism (i.e. ending the exclusion of alcoholism treatment from plan benefits), specific health care benefits for alcoholism should be developed. The reason given is that although alcoholism is classified as a disease it appears to have characteristics which distinguish it from other diseases. Additionally, much of the treatment (both inpatient and outpatient) that is available is provided by special facilities devoted to alcoholism treatment. Simply removing existing exclusions would not cover these facilities.[9]

The coverage recommended in the legislation passed by the Virginia General Assembly in 1977, and amended in 1978, is similar to both the NIAAA benefits model and the California pilot program. It specifies 45 days inpatient hospital and residential-intermediate care (includes detoxification), and 45 outpatient visits. The legislation also states that treatment may be provided by a certified alcoholism counselor, certified drug counselor, professional counselor, psychologist, social

worker, or physician. When preparing the legislation, much consideration was given to providing adequate coverage and making sure that it was broad enough to provide coverage for non-medical treatment, i.e. treatment provided by alcoholism or drug counselors. While alcoholism and drug addiction are medical diseases, the most effective treatment often is that provided by the non-medical professional.

Because there are currently not enough free-standing residential programs, any benefit plan recommended for state employees should initially allow for adequate hospital-based treatment. It should also be flexible enough to allow for treatment in either a hospital or intermediate-care setting, and it is recommended that the benefits outlined in S38.1-348.8 of the Code of Virginia represent an acceptable model. It provides adequate treatment allowance for inpatient (hospital and intermediate-care) and outpatient treatment; it requires that treatment be medically necessary; and it permits suitably qualified persons, other than a physician, to provide treatment (see Appendix for copy of legislation).

There is concern, however, that the elimination of a separate benefit for intermediate-care will not provide sufficient encouragement of the use of intermediate-care facilities in lieu of hospital care as a means of reducing the cost of substance abuse treatment. It is, therefore, suggested that the State Employee Assistance Service be encouraged to make use of the least expensive appropriate level of care by giving priority to appropriate residential intermediate-care facilities. These measures, however, should only be temporary. At some future date, when adequate intermediate-care facilities are available, inpatient benefits should be reviewed with the intent of providing separate coverage for these facilities.

Cost of Drug/Alcohol Coverage

A major concern of many insurance carriers has been the belief that insurance for alcoholism and drug addiction will increase costs. Accurate estimates, however, are difficult since there are so many variables to consider, although it is possible to look at costs and rate increases in places where third-party payments for alcoholism and drug addiction have already been made.

Capitol Blue Cross of Harrisburg, Pennsylvania initiated a program in 1974 whereby their one million subscribers were provided alcoholism treatment benefits. This was done as an experiment at no increased cost to subscribers. Capitol Blue Cross will pay for treatment in approved non-hospital residential care facilities. They report that while it is too soon to state whether the program will pay off in reduced hospital costs for alcoholics, during the first two years 366 persons received benefits under the program at a cost of $344,300 (approximately 35¢ per subscriber per year).[a] The average cost of treatment per client was $941. This does not take into account any savings as a result of reduced medical expenses for other illnesses.[10]

[a]This figure includes only the cost of providing treatment, and not the costs of administering the program.

Michigan - The United Auto Workers negotiated alcohol/drug abuse benefits effective October, 1975 for its 1.3 million members with Blue Cross and Blue Shield of Michigan. Benefits include 45 days of residential treatment in either a licensed hospital or free-standing facility and 35 outpatients visits yearly (maximum of 170 during a life time).[11] The monthly cost of this benefit package is 28¢ per member and 53¢ per family.[12] During 1976, 46 facilities were approved and provided treatment services to 734 patients (.06% of group members), of which 311 (42%) were treated for alcoholism and 423 (58%) were treated for drug dependency. Also, 208 patients (28%) were treated in residential centers and 526 (72%) received outpatient care. The following table shows utilization and costs of substance abuse benefits for 1976.[13]

UTILIZATION AND PAYMENTS BY LOCATION OF TREATMENT
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
(1976)

| | Number of Clients | Days/ Visits | Payments | Av. Length of Stay | Av. Cost Client |
|---|---|---|---|---|---|
| Residential | 208 | 2,732 | $350,551 | 13.1 | $1,685 |
| Outpatient | 526 | 3,420 | 109,182 | 6.5 | 208 |
| Total | 734 | | $459,733 | | $ 626 |

Source: Gordon Taafe. An Exploratory Study of Psychiatrics and Substance Abuse Utilization Under Prepaid Health Insurance (Detroit: Blue Cross and Blue Shield of Michigan), June 1977.

In October, 1977 a Detroit health maintenance organization (Metropolitan Health Plan, owned by Blue Cross of Michgan) began offering more liberal alcoholism treatment benefits to its 75,000 members. Benefits initially covered 20,000 HMO members, but has since been extended to about one-half of its members. New benefits include up to 30 days inpatient care for detoxification and unlimited outpatient services. The cost of these services is 19¢ a month ($2.28 per year) per contract.[14]

California - Cost data are also available from the pilot program operated for California State employees. During 23 months of operation, 766 persons were provided care under the program at a cost of $677,577.[15] The five carriers participating in the program charged a monthly premium ranging from 10¢ per member to 35¢ per member[16] (see following table). The average cost per outpatient visit was $16.57 while the daily cost per inpatient care was $123.21. Inpatient costs varied from $115.85 per day at an alcoholism treatment unit to $169.72 per day in a general hospital.[17]

PREMIUMS REQUIRED BY MAJOR CARRIERS
FOR THE CALIFORNIA PILOT PROGRAM

| Carrier | Premium |
|---|---|
| CalWestern/Occidental Life | $0.35 per member |
| Blue Shield | $0.35 per member |
| Kaiser-North | $0.10 per member |
| | $0.20 per member and one dependent |
| | $0.30 per member and two or more dependents |
| Kaiser-South[a] | $0.13 per member |
| | $0.26 per member and one dependent |
| | $0.39 per member and two or more dependents |

Source: Jerome B. Hallan, et. al. Historical Development of the California Pilot Program to Provide Health Insurance Coverage For Alcoholism (Cary, N.C.: H-2, Inc.) November, 1975, p. II-9.

Virginia - Blue Cross and Blue Shield of Virginia estimates that the monthly cost of the coverage specified in §38.1-348.8, as amended by the 1978 General Assembly, should be 14¢ per individual and 36¢ per family.[18] The Coverage would include 45 days of inpatient treatment in either a hospital or intermediate-care residential facility and 45 outpatient visits. The total annual cost of providing this coverage to all state employees is estimated to be about $201,120.[b]

Additionally, when the Reynolds Metal Company expanded employee health insurance benefits for alcoholism and drug addiction to cover treatment in a residential facility, they experienced a monthly premium increase of only 8¢ per employee.[19]

Hospital vs. Residential Care

One of the purposes of broadening health insurance coverage to include treatment in a residential settting and outpatient care is that this type of treatment is much less expensive than and as effective as the traditional hospital inpatient treatment. At present, however, the state's contract with Blue Cross and Blue Shield of Virginia does not cover treatment in free-standing residential facilities. If it did, the same or equivalent treatment could be provided at less cost per diem.

[a]These charges are in addition to existing outpatient costs of $0.04, $0.08, and $0.12 respectively.

[b]There are approximately 71,000 state employees enrolled under BCBS (40,000 individual and 31,000 family policy subscribers).

As understanding of alcoholism and drug addiction expands, and treatment modalities develop, more and more professionals agree that the general hospital setting is not necessarily the best environment for treatment, while it is found to be the most expensive form of treatment (see following table). An NIAAA study[20] found that within the inpatient emergency care modality, general hospital treatment is over three times as expensive as a specialized alcoholism hospital. Information also revealed that within the intermediate-care modality, partial hospitalization treatment costs more than twice as much as the other settings such as non-medical residential center and specialized alcoholism hospital. This is true even when the stay at the other treatment facilities is two to three times longer than the general hospital stay.

MEDIAN TOTAL COSTS OF SERVICE

| | Cost per Client Day | Cost Per Client Stay |
|---|---|---|
| Inpatient Emergency Care | | |
| -General Hospital | $172 | $589 |
| -Specialized Alcoholism Hospital | 58 | 231 |
| Inpatient Care | | |
| -General Hospital | 87 | 766 |
| -Specialized Alcoholism Hospital | 34 | 270 |
| Intermediate Care | | |
| -Partial Hospitalization | 74 | 1,274 |
| -Residential Facility | 21 | 736 |
| -Specialized Alcoholism Hospital | 27 | 793 |
| Outpatient Care | | |
| -Hospital Based Outpatient Clinic | 20 | 60 |
| -Neighborhood Alcoholism Center | 16 | 220 |
| -Community MH Centers | 32 | 301 |

Source: NIAA, "Median Total Costs of Service." data prepared by Booz, Allen, and Hamilton, 1974.

Cost figures for Virginia are available from the Division of Substance Abuse and through Blue Cross and Blue Shield of Virginia for 1976-77. During 1976 Blue Cross paid for the treatment of 91 state employees for alcoholism and drug addiction at an average cost of $1,173. (Average length of stay was 13.9 days and the cost per client day was $84.) This is nearly identical to the $87 per client day shown by the NIAAA cost study, but much less than the daily cost found in California or Michigan.

Although data are scarce and incomplete, it is evident that residential treatment in either a special alcoholism or free-standing facility is less expensive on a daily basis than inpatient treatment in a general hospital. There is also some evidence provided by the NIAAA cost analysis that total treatment costs for free-standing facilities are less than for general hospital care.

Utilization of Benefits

Two major concerns of many health insurance carriers have been the development of unneeded treatment facilities and the over-utilization of facilities by individuals. Without strict controls on the development of new facilities, it is feared that the availability of insurance coverage for substance abuse treatment would over-stimulate the supply of treatment facilities with the result being an over-supply of treatment slots/beds, and increased treatment costs. This concern has been met with legislation (§32-211.5 of the Code of Virginia) that requires all alcohol and drug treatment facilities to obtain a certificate of need before being allowed to operate.

The over-utilization of treatment, however, is not likely to materialize. Where this type of coverage has been made available to employees, utilization of benefits has been relatively low. Capitol Blue Cross of Harrisburg, Pennsylvania found that during the first two years of their program, only 366 (.04%) subscribers out of an approximate enrollment of one million made use of this benefit.

The State of California's Pilot Program, with an approximate enrollment of 140,000 employees, had only 766 (.55%) persons take advantage of the program. In Michigan, Blue Cross and Blue Shield of Michigan found that during 1976 only 734 persons, or .06% of a total enrollment of 1.3 million, made use of substance abuse benefits.

Because of the stigma still attached to alcoholism, and because it is a characteristic of the disease for the alcoholic to deny his/her problem, utilization of benefits for treatment will continue to be low. It is extremely unlikely that the availability of third-party payments for alcoholism, and even drug addiction, treatment would result in much of an increase in utilization. From this experience it is estimated that as many as 418 (.55%) state employees might make use of substance

abuse benefits each year if made available, and that the pilot program serving state employees working in the Richmond area could expect to serve about 88 employees per year. This agrees with the estimates of alcoholism among employees presented earlier, when it was estimated that about at least 200 state employees in the greater Richmond area have a drug or alcohol abuse problem.

Overall Savings in Health Care Costs

An argument for providing health insurance benefits for treatment of alcoholism and drug addiction as a primary diagnosis has been that there will be an eventual reduction in overall health care costs. Substance abuse, especially alcoholism, is a causal or contributing factor in many other illnesses which are regularly diagnosed, treated, and paid for by health insurance. Treatment of the primary diagnosis, alcoholism or drug addiction, should result in a lessening in the incidence of related illnesses with a resulting decrease in health insurance utilization.

This claim is supported by several of the occupational health studies reported on earlier. The study of the Illinois Bell Telephone Company showed a 46% reduction in the incidence of accidents/illnesses among treated employees. General Motor's Oldsmobile Division reported a 33% decline in the use of sickness and accident benefits. Medical surgical costs among Kennecott Copper employees were reduced by 55%.

Statistics available from California's Pilot Program, while they did not show an overall reduction in health care utilization, did show a reduction in the incidence of alcohol related diseases (see following table).

FREQUENCY OTHER DIAGNOSES ARE USED AS A PROXY FOR
ALCOHOLISM AMONG FAMILIES PARTICIPATING IN CALIFORNIA PILOT PROGRAM

| Diagnosis | Before Treatment | After Treatment |
|---|---|---|
| Gastrointestinal | 61 | 8 |
| Cardiac | 0 | 0 |
| Skin | 10 | 1 |
| Neurologic and Psychiatric | 13 | 7 |
| Muscle | 0 | 0 |
| Hemotologic | 4 | 1 |
| Vitamin Deficiency Disease | 1 | 1 |
| Metabolic | 0 | 2 |
| Acute Alcohol Poisoning | 2 | 0 |
| Total | 91 | 20 |

Source: Harold D. Holder and Jerome B. Hallan. Logitudinal Study of Health Care Costs and Utilization for Families Participating in the State of California Pilot Project (Raleigh: H-2, Incorporated) December, 1976, p. 17.

As can be seen from the table, in all but two groups of diagnoses (Metabolic and Vitamin Deficiency) the number of all diagnoses used prior to initiation of the program is greater than following program initiation.

Among the direct and indirect costs to an employer of alcoholism are absenteeism, accidents, lowered employee morale and work efficiency, discharges and early retirement. While some of these costs are not readily quantifiable, estimates of loss are as high as 44% of the average salary of alcoholic employees. A more conservative estimate, which is generally accepted, is provided by the National Council on Alcoholism. They estimate that 25% of an employee's salary is lost to the employer as a result of alcoholism.[21]

Using this figure as the estimated loss, the average alcoholic state employee costs the Commonwealth $2,800 annually (based on an average salary of $11,200). If we assume that there are at least 1,000 state employees, as concluded in section III, who are suffering from an alcohol or drug problem, the Commonwealth is losing about $2.8 million annually as a result of substance abuse among its employees.

Among the studies reported on earlier were several that showed employee rehabilitation rates ranging from 57%-80% (page 19). Additionally, in an analysis of potential cost savings resulting from the establishment of an employee alcoholism program for federal employees, the United States Government Accounting Office in 1970 estimated that for every 100 alcoholic employees in the work force 62 would participate in the program and 54 would be likely to recover.[22] This is an 87% recovery rate for participating employees.

The State Employee Assistance Services is expected to serve approximately 100 clients the first year. Assuming an expected recovery rate ranging from 57% to 87%, the state could recover from $159,600 to $243,000 annually as a result of providing treatment. Depending upon the actual rate of recovery this may be enough to cover the estimated cost of the health insurance coverage ($201,120) as well as the cost of the employee assistance program ($25,000). There will, however, continue to be many employees who seek treatment on their own (91 employees or dependents received inpatient treatment for substance abuse during 1976 at an average cost of $1,178), which should easily make the entire project cost-beneficial assuming similar rehabilitation rates.

Based on experience elsewhere and the evidence of medical/treatment professionals that documents that alcoholics are frequently admitted and treated under other diagnoses without receiving treatment for their primary illness, alcoholism, it appears that the cost of providing comprehensive substance abuse insurance coverage will be recovered, in

whole or in part, because of an eventual reduction in health care and other costs among employees receiving treatment. A long-term evaluation of the pilot State Employee Assistance Service operating in the greater Richmond area is designed to provide additional information on possible savings.

Conclusion

Because alcoholism and drug addiction are medical illnesses requiring treatment, and because utilization of such treatment by state employees is expected to be relatively low and the costs of additional insurance coverage relatively small, it is recommended that existing health insurance benefits for substance abuse treatment be extended, on a trial basis, to include inpatient treatment in either a general or psychiatric hospital, or a free-standing residential facility, and outpatient group, family, or individual counseling. Additionally, to evaluate the cost-effectiveness of providing this type of health coverage, a utilization and cost study should be initiated as a joint venture by the Commonwealth of Virginia and Blue Cross and Blue Shield of Virginia using data available from the State Employee Assistance Service.

A benefits package for substance abuse treatment should be broad enough to provide adequate and appropriate treatment, and should encourage the use of less expensive treatment settings such as intermediate-care programs and outpatient care. While there are now a number of model benefit packages that have been developed and used, which demonstrate the feasibility of providing such coverage, it is recommended that a substance abuse rider be modeled after the benefits outlined in §38.1-348.8 of the Code of Virginia, because it will allow, at least initially, adequate coverage of hospital-based treatment.

APPENDICES

LD6643

1 SENATE JOINT RESOLUTION NO. 121
2 Offered January 24, 1977
3 *Requesting the Division of Personnel to study the feasibility of obtaining coverage for*
4 *alcoholism and drug addiction in the group insurance policy obtained for State*
5 *employees.*
6
7 Patrons—Edmunds, Walker, Holland, Gartlan, and Truban
8
9 Referred to the Committee on Rules
10
11 WHEREAS, alcohol is the most widely used and abused drug,
12 and alcoholism is the Commonwealth's most serious drug problem;
13 and
14 WHEREAS, alcoholism and drug addiction are medical
15 illnesses, which can be treated; and
16 WHEREAS, an estimated four thousand five hundred or six per
17 centum of all State employees have a alcohol problem and are in
18 need of treatment; and
19 WHEREAS, alcoholism costs the State approximately twelve
20 million one hundred twenty-three thousand dollars each year as a
21 result of absenteeism, accidents, sickness and illness, and the health
22 costs of alcoholism-related illness; and
23 WHEREAS, State employees do not now have adequate health
24 insurance coverage for the treatment of alcoholism and drug
25 addiction; now, therefore, be it
26 RESOLVED by the Senate, the House of Delegates concurring,
27 That the Department of Personnel is requested to study the
28 feasibility of obtaining coverage for alcoholism and drug addiction
29 in State health insurance policies which would include as minimum
30 coverage: (i) fourteen days of inpatient treatment in a hospital or
31 detoxification center; (ii) thirty days of inpatient treatment in an
32 intermediate-care facility; and (iii) forty-five one-hour outpatient
33 visits for individual, group, or family counseling.
34 In addition, the Division of Personnel, in cooperation with the
35 Division of Substance Abuse of the Department of Mental Health
36 and Mental Retardation, is requested to develop a program for
37 identifying and encouraging State employees who are either

1 alcoholics or drug addicts to enter treatment and to evaluate the
2 effectiveness of such treatment, giving particular attention to the
3 costs of providing treatment and potential savings. The Division of
4 Personnel shall prepare a report to the Governor and General
5 Assembly no later than January one, nineteen hundred seventy-
6 nine.
7

HOUSE COMMITTEE AMENDMENT AGREED TO BY HOUSE AND SENATE
PAGE 2, ENG. BILL, LINE 5, AFTER THE WORD THAN
STRIKE OUT JANUARY ONE, NINETEEN HUNDRED SEVENTY-NINE
AND INSERT JULY ONE, NINETEEN HUNDRED SEVENTY-EIGHT

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31 Official Use by Clerks

| Agreed to By The Senate | Agreed to By The House of Delegates |
|---|---|
| with / without amendment | with / without amendment |
| Date: ..................................... | Date: ..................................... |
| Clerk of the Senate | Clerk of the House of Delegates |

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36
37

# COMMONWEALTH *of* VIRGINIA

*Department of Personnel and Training*

302 STATE FINANCE BUILDING

POST OFFICE BOX 654
RICHMOND, VIRGINIA 23205
(804) 786 3801

August 3, 1977

MEMORANDUM

TO THE HEADS OF STATE AGENCIES IN THE RICHMOND AREA:

Senate Joint Resolution No. 121, a copy of which is enclosed, directs the Department of Personnel and Training to study the feasibility of obtaining certain coverage not now included in our health insurance program for employees afflicted with alcoholism or drug addiction. This is currently being studied.

The resolution, you will note, further directs the Department of Personnel and Training, in cooperation with the Division of Substance Abuse of the Department of Mental Health, (1) to develop a program for identifying and encouraging State employees who are either alcoholics or drug addicts to enter treatment, (2) to evaluate the effectiveness of such treatment, and (3) to prepare a report to the Governor and the General Assembly by July 1, 1978.

This action by the General Assembly was apparently based on national statistics which indicate that six percent of the nation's work force have one or the other of these problems. Applying the national average to the State service, the General Assembly concluded that approximately five thousand State employees may be affected and estimated that alcoholism may cost the Commonwealth more than twelve million dollars each year as a result of absenteeism, accidents, sickness, and the health costs of alcoholism-related illness. Several individual cases have been reported to the Division of Substance Abuse of the Department of Mental Health and Mental Retardation whose staff have worked successfully with them. Because of the very small number of such cases which have been reported to this office, we need your help in identifying the probable extent of the problem.

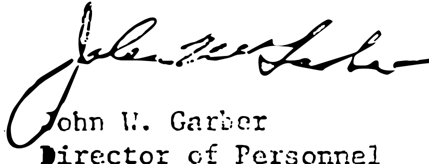
We would like you to tell us (a) the number of these problems of which you are aware in your agency; (b) whether or not you think there might be such problems in your agency which have not been reported; and (c) whether you feel there is need for a formal program for dealing with such problems.

The General Assembly has indicated its desire to have such a program for State employees. While the resolution presumes that the Commonwealth will benefit from the program proposed, a better understanding of the extent of such benefit is needed as a basis for determining the scope of the program

to be developed. We plan to initiate a pilot program in the Richmond area where the results can be closely monitored.

We are enclosing a questionnaire which we will appreciate your completing and returning to us by August 15, 1977. If you feel it would be helpful in completing the questionnaire, reproduce it and request managers and supervisors in your agency to fill it out. Your replies to the questions should be based on the replies you receive from your managers and supervisors; return only one questionnaire to us. Your comments which we ask you to include on a separate sheet will be of particular interest to us.

Your assistance is greatly appreciated.



John W. Garber
Director of Personnel

Enclosures

# EMPLOYEE ASSISTANCE QUESTIONNAIRE

Agency Name ____________________

1. How many salaried employees are there in your agency? ________

2. How many employees in your agency miss more than one day per month from work? ________

3. How many employees in your agency are experiencing erratic or deteriorating job performance? ________

4. In your opinion, how many of the attendance and performance problems reported in Questions 2 and 3 may be caused or contributed to by alcoholism or drug addiction? ________

5. In the past three months, how many employees, on their own initiative, have discussed with or sought help from their supervisor regarding a problem which may have been caused or contributed to by alcoholism or drug addiction? ________

6. In the past three months, how many employees, on their supervisor's initiative, have been counseled by the supervisor regarding a problem which may have been caused or contributed to by alcoholism or drug addiction? ________

7. Do you feel that employees with problems related to alcoholism or drug addiction would seek help if they were assured that participation in a program designed to help them would be kept confidential and would not become a part of their personnel record? ________

8. Would you and your managers and supervisors be willing to work with employees who entered a program designed to treat alcoholic or drug addicted employees? ________

9. To your knowledge, have any employees in your agency voluntarily entered courses of treatment available for alcoholism or drug addiction? ________
   If you know the number, enter it here.________

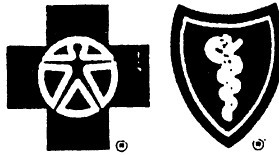
10. Did their attendance and/or job performance improve after such treatment? ________
    If in some but not all cases, indicate the number of cases in which attendance and/or performance improved.________

Include on a separate sheet comments required by the memorandum which transmitted this questionnaire or which you care to make regarding the program required by Senate Joint Resolution 121.

Signature of person completing questionnaire ____________________

Title ____________________

Blue Cross
Blue Shield
of Virginia



2015 Staples Mill Road
Post Office Box 27401
Richmond, Virginia 23279
804/359-7000

March 14, 1978

Mr. John W. Garber
Director of Personnel
Commonwealth of Virginia
P.O. Box 654
Richmond, Virginia 23205

Dear Mr. Garber:

Enclosed are estimated rates for three substance abuse programs. The first is SB489, the second is referred to by Mr. Hardenbergh as the "Modified California Plan", and the third is SB502.

These estimates are based on limited data, numerous assumptions, and judgements as follows:

1. Blue Cross regular in-patient experience for 1977 was used to estimate in-patient utilization and cost.

2. Community Substance Abuse Services in Virginia experience for 1976-1977 was used to estimate residential and out-patient utilization. An assumption was made that state employees' utilization rate would be 25% of the utilization rate for the total population.

3. The cost per service for residential and out-patient services is based in part on a 1974 study by Booz , Allen, & Hamilton and by judgement. These facilities currently use a sliding scale based on the patient's income and family size. This would probably not be the reimbursement mechanism for Blue Cross and Blue Shield of Virginia. The estimated cost per visit can probably be refined after the reimbursement mechanism has been determined.

If there are any questions regarding this estimation of rates, please do not hesitate to call.

Sincerely,

Jim Convery

James R. Convery
Supervisor, Special Rating & Underwriting

JC:gdt

cc: Mr. Don Hardenbergh ✓
Mr. H. Richard Forrest

# ESTIMATED RATES

## SUBSTANCE ABUSE

## SB489

Benefits

Hospital - In-patient Detoxification:
Hospital - In-patient Rehabilitation:
Total: 14 Days
Residential Treatment Facility: 30 Days
Out-Patient: 45 Visits

| | | Individual | Family |
|---|---|---|---|
| 1. | In-Patient and Out-Patient | | |
| | a. Annual Frequency | .00022 | .00059 |
| | b. Cost per Patient | x $1,592 | x $1,592 |
| | c. Annual Cost | $ .350 | $ .939 |
| 2. | In-Patient Only | | |
| | a. Annual Frequency | .00118 | .00316 |
| | b. Cost per Patient | x $1,124 | x $1,124 |
| | c. Annual Cost | $1.326 | $3.552 |
| 3. | Residential and Out-Patient | | |
| | a. Annual Frequency | .00011 | .00030 |
| | b. Cost per Patient | x $1,615 | x $1,615 |
| | c. Annual Cost | $ .178 | $ .485 |
| 4. | Residential Only | | |
| | a. Annual Frequency | .00034 | .00090 |
| | b. Cost per Patient | x $1,147 | x $1,147 |
| | c. Annual Cost | $ .390 | $1.032 |
| 5. | Out-patient Only | | |
| | a. Annual Frequency | .00171 | .00458 |
| | b. Cost per Patient | x $ 468 | x $ 468 |
| | c. Annual Cost | $ .800 | $2.143 |
| 6. | Sum 1c through 5c | $3.044 | $8.151 |
| 7. | Current In-Patient Benefit | | |
| | a. Annual Frequency | .00140 | .00375 |
| | b. Cost per Patient | x $1,408 | x $1,408 |
| | c. Annual Cost | $1.971 | $5.280 |
| 8. | 6 less 7.c | $1.073 | $2.871 |
| 9. | Monthly Pure Premium (÷ 12) | $ .089 | $ .239 |
| 10. | Administrative Expense and Reserves | $ .005 | $ .014 |
| 11. | Estimated Rates | $ .094 | $ .253 |
| 12. | Rounded Rates | $ .10 | $ .26 |

## ESTIMATED RATES

## SUBSTANCE ABUSE

## MODIFIED CALIFORNIA MODEL

### Benefits

Hospital - In-patient Detoxification: 6 Days
Hospital - In-patient rehabilitation: 30 Days
Residential Treatment Facility: 30 Days
Out-patient: 45 visits

| | Individual | Family |
|---|---|---|
| 1. In-Patient and Out-Patient | | |
| a. Annual Frequency | .00022 | .00059 |
| b. Cost Per Patient | x $1,851 | x $1,851 |
| c. Annual Cost | $ .407 | $1.092 |
| 2. In-Patient Only | | |
| a. Annual Frequency | .00118 | .00316 |
| b. Cost Per Patient | x $1,383 | x $1,383 |
| c. Annual Cost | $1.632 | $4.370 |
| 3. Residential and Out-Patient | | |
| a. Annual Frequency | .00011 | .00030 |
| b. Cost Per Patient | x $1,615 | x $1,615 |
| c. Annual Cost | $ .178 | $ .485 |
| 4. Residential Only | | |
| a. Annual Frequency | .00034 | .00090 |
| b. Cost Per Patient | x $1,147 | x $1,147 |
| c. Annual Cost | $ .390 | $1.032 |
| 5. Out-Patient Only | | |
| a. Annual Frequency | .00171 | .00458 |
| b. Cost Per Patient | x $ 468 | $ 468 |
| c. Annual Cost | $ .800 | $2.143 |
| 6. Sum 1.c through 5.c | $3.407 | $9.122 |
| 7. Current In-Patient Benefit | | |
| a. Annual Frequency | .00140 | .00375 |
| b. Cost Per Patient | x $1,408 | x $1,408 |
| c. Annual Cost | $1.971 | $5.280 |
| 8. 6 less 7.c | $1.436 | $3.842 |
| 9. Monthly Pure Premium (÷ 12) | $ .120 | $ .320 |
| 10. Administrative Expense and Reserves | $ .006 | $ .015 |
| 11. Estimated Rates | $ .126 | $ .335 |
| 12. Rounded Rates | $ .12 | $ .34 |

ESTIMATED RATES

SUBSTANCE ABUSE

SB502

Benefits

Hospital - In-patient Detoxification:
Hospital - In-patient Rehabilitation:
Residential Treatment Facility:
Total: 45 Days
Out-patient: 45 Visits

| | | Individual | Family |
|---|---|---|---|
| 1. | In-Patient and Out-Patient | | |
| | a. Annual Frequency | .00022 | .00059 |
| | b. Cost per Patient | x $1,876 | x $1,876 |
| | c. Annual Cost | $ .413 | $1.107 |
| 2. | In-Patient Only | | |
| | a. Annual Frequency | .00118 | .00316 |
| | b. Cost Per Patient | x $1,408 | x $1,408 |
| | c. Annual Cost | $1.661 | $4.449 |
| 3. | Residential and Out-Patient | | |
| | a. Annual Frequency | .00011 | .00030 |
| | b. Cost Per Patient | x $1,743 | x $1,743 |
| | c. Annual Cost | $ .192 | $ .523 |
| 4. | Residential Only | | |
| | a. Annual Frequency | .00034 | .00090 |
| | b. Cost Per Patient | x $1,275 | x $1,275 |
| | c. Annual Cost | $ .434 | $1.148 |
| 5. | Out-Patient Only | | |
| | a. Annual Frequency | .00171 | .00458 |
| | b. Cost Per Patient | x $ 468 | x $ 468 |
| | c. Annual Cost | $ .800 | $2.143 |
| 6. | Sum 1.c through 5.c | $3.50 | $9.370 |
| 7. | Current In-Patient Benefit | | |
| | a. Annual Frequency | .00140 | .00375 |
| | b. Cost Per Patient | x $1,408 | x $1,408 |
| | c. Annual Cost | $1.971 | $5.280 |
| 8. | 6 less 7.c | $1.529 | $4.090 |
| 9. | Monthly Pure Premium (÷ 12) | $ .127 | $ .341 |
| 10. | Administrative Expense and Reserves | $ .006 | $ .015 |
| 11. | Estimated Rates | $ .133 | $ .356 |
| 12. | Rounded Rates | $ .14 | $ .36 |

# ENGROSSED

1 **SENATE BILL NO. 502**
2 Senate Amendments in [ ] - February 16, 1978
3 *A BILL to amend and reenact §§ 38.1-348.7 and 38.1-348.8 of the*
4 *Code of Virginia, relating to accident and sickness insurance*
5 *coverage for certain disorders.*
6
7 Patrons—Truban and Edmunds
8
9 Referred to the Committee on Commerce and Labor
10
11 Be it enacted by the General Assembly of Virginia:
12 1. That §§ 38.1-348.7 and 38.1-348.8 of the Code of Virginia are
13 amended and reenacted as follows:
14 § 38.1-348.7. Coverages for mental, emotional or nervous
15 disorders.—A. All individual and group accident and sickness
16 insurance policies providing coverage on an expense incurred basis
17 and individual and group service or indemnity type contracts issued
18 by a nonprofit corporation which provide coverage for a family
19 member of the insured or the subscriber shall, in the case of
20 benefits based upon treatment as an inpatient in a mental hospital
21 or a general hospital, provide coverage for mental, emotional or
22 nervous disorders, with limits that are not more restrictive than for
23 any other illness except that such benefits may be limited to thirty
24 days of active treatment in any policy year. [ *The requirements of*
25 *this section shall apply to all insurance policies and subscriber*
26 *contracts delivered, issued for delivery, reissued, or extended, or at*
27 *any time when any term of the policy or contract is changed or*
28 *any premium adjustment is made.* ]
29 B. Every insurer which proposes to issue a group hospital policy
30 or a group major medical policy in this State and every nonprofit
31 hospital and medical service plan corporation which proposes to
32 issue hospital, medical or major medical service plan contracts
33 which provide coverage for the insured or the subscriber shall, in
34 the case of outpatient benefits, make available additional benefits as
35 specified herein for the care and treatment of mental, emotional or
36 nervous disorders subject to the right of the applicant for such
37 policy or contract to select any alternative level of benefits as may

1 be offered by the insurer or service plan corporation. Outpatient
2 benefits shall consist of durational limits, dollar limits, deductibles
3 and co-insurance factors that are not less favorable than for physical
4 illness generally, except that the co-insurance factor need not exceed
5 fifty per centum or the co-insurance factor applicable for physical
6 illness generally, whichever is greater, and the maximum benefit for
7 mental, emotional or nervous disorders in the aggregate during any
8 applicable benefit period may be limited to not less than one
9 thousand dollars.
10 This subsection B shall apply to policies or contracts delivered or
11 issued for delivery in this State on or after November one, nineteen
12 hundred seventy-seven; but shall not apply to blanket, short-term
13 travel, accident only, limited or specified disease, individual
14 conversion policies, or contracts, nor to policies or contracts
15 designed for issuance to persons eligible for coverage under Title
16 XVIII of the Social Security Act, known as Medicare, or any other
17 similar coverage under State or federal governmental plans.
18 As used in this section, the following terms shall have the
19 meanings indicated below.
20 (1) "Outpatient benefits" means only those payable for (i)
21 charges made by a hospital for the necessary care and treatment of
22 mental, emotional or nervous disorders furnished to a covered
23 person while not confined as a hospital inpatient, (ii) charges for
24 services rendered or prescribed by a physician or a psychologist
25 duly licensed to practice in Virginia for the necessary care and
26 treatment for mental, emotional or nervous disorders furnished to a
27 covered person while not confined as a hospital inpatient, or (iii)
28 charges made by a mental health treatment center, as defined
29 herein, for the necessary care and treatment of a covered person
30 provided in such treatment center.
31 (2) "Mental health treatment center" means a treatment facility
32 organized to provide care and treatment for mental illness through
33 multiple modalities or techniques pursuant to a written plan
34 approved and monitored by a physician or a psychologist duly
35 licensed to practice in Virginia and which facility is also: (i)
36 licensed by the State, or (ii) funded or eligible for funding under
37 federal or State law, or (iii) affiliated with a hospital under a

1 contractual agreement with an established system for patient
2 referral.
3 C. "Mental, emotional or nervous disorders" as used in this
4 section shall include physiological and psychological dependence
5 upon alcohol and drugs *; provided, however, that in instances where*
6 *the optional coverage made available pursuant to § 38.1-348.8 B. is*
7 *accepted by or on behalf of the insured or subscriber and included*
8 *in a policy or contract "mental, emotional or nervous disorders"*
9 *shall not include coverage for incapacitation by, or physiological or*
10 *psychological dependence upon, alcohol or drugs* .
11 ~~In the event any such policy or contract includes coverage for~~
12 ~~incapacitation by, or physiological or psychological dependence upon,~~
13 ~~alcohol or drugs as provided in §38.1 348.8, then "mental, emotional~~
14 ~~or nervous disorders" as used in this section shall not include~~
15 ~~coverage for incapacitation by, or physiological or psychological~~
16 ~~dependence upon, alcohol or drugs.~~
17 § 38.1-348.8. Coverages for alcohol and drug dependence.—A. As
18 used in this section:
19 1. "Treatment" includes diagnostic evaluation, medical,
20 psychiatric and psychological care, counseling and rehabilitation for
21 incapacitation by, or physiological or psychological dependence upon,
22 alcohol or drugs which is determined to be necessary by and is
23 provided by a certified alcoholism counselor, certified drug
24 counselor, professional counselor, psychologist, or social worker
25 licensed or certified pursuant to Chapter 28 (§ 54-923 et seq.) of
26 Title 54, or by a licensed physician.
27 2. "Alcoholism or drug addiction facility" means a facility in
28 which is provided a State-approved program for the treatment of
29 alcoholism or drug addiction and which is (i) a facility licensed by
30 the State Board of Health pursuant to Chapter 16 of Title 32 (§
31 32-297 et seq.) or by the State Mental Health and Mental
32 Retardation Board pursuant to Chapter 8 (§ 37.1-179 et seq.) or
33 Chapter 11 (§ 37.1-203 et seq.) of Title 37.1; (ii) an office or clinic
34 of a licensed physician or clinical psychologist; (iii) a State agency
35 or institution or (iv) a facility accredited by the Joint Commission
36 on Accreditation of Hospitals.
37 3. "Intermediate care facility" means a duly licensed, residential

1 public or private alcoholism or drug addiction facility which is not a
2 hospital and which is operated primarily for the purpose of
3 providing a continuous, structured twenty-four-hour-a-day
4 State-approved program of inpatient treatment and care for inpatient
5 alcoholics or drug addicts.

6 B. No [ ~~individual or~~ ] group accident and sickness insurance
7 policy providing coverage on an expense incurred basis and no [
8 ~~individual or~~ ] group service or indemnity type contract issued by a
9 nonprofit corporation which provides coverage of a family member
10 of the insured or the subscriber, shall be delivered or issued for
11 delivery in this State on or after July one, nineteen hundred
12 seventy-eight, unless coverage for incapacitation by, or physiological
13 or psychological dependence upon, alcohol or drugs as hereinafter
14 provided was made available as an option. Such coverage made
15 available as an option shall have no limits that are more restrictive
16 than for any other illness and shall include as a minimum (i)
17 treatment as an inpatient in any alcoholism or drug addiction
18 facility ~~other than an~~ *and* intermediate care facility for a minimum
19 of ~~fourteen~~ *forty-five* days during any given policy year [ *or*
20 *calendar year* ] ~~or calendar year, (ii) treatment as an inpatient in~~
21 ~~any intermediate care facility for a minimum of thirty days during~~
22 ~~any given policy year or calendar year~~ , and ~~(iii)~~ *(ii)* outpatient
23 treatment in any alcoholism or drug addiction facility consisting of a
24 minimum of forty-five [ ~~hours~~ *sessions* ] of individual, group, or
25 family counseling during any given policy year or calendar year.
26 ~~Coverage for individual and family counseling visits in excess of five~~
27 ~~hours may be limited to the rates established for group counseling.~~
28 ~~Each person covered shall be entitled to inpatient treatment in an~~
29 ~~intermediate care facility for two days or to two hours of outpatient~~
30 ~~individual, group or family counseling for each unused day of~~
31 ~~treatment as an inpatient in an alcoholism and drug addiction~~
32 ~~facility other than an intermediate care facility, and entitled to one~~
33 ~~hour of outpatient individual, group or family counseling for each~~
34 ~~unused day of treatment as an inpatient in an intermediate care~~
35 ~~facility. Benefits payable to each person covered may be limited to~~
36 ~~twice the minimums set forth in this subsection during the life of~~
37 ~~such person.~~

1 C. The provisions of this section shall not be applicable to
2 short-term travel, accident only, limited or specified disease,
3 individual conversion policies, or contracts, nor to policies or
4 contracts designed for issuance to persons eligible for coverage
5 under Title XVIII of the Social Security Act, known as Medicare, or
6 any other similar coverage under State or federal governmental
7 plans.
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| Passed By The Senate | | Passed By The House of Delegates | |
|---|---|---|---|
| without amendment | ☐ | without amendment | ☐ |
| with amendment | ☐ | with amendment | ☐ |
| substitute | ☐ | substitute | ☐ |
| substitute w/amdt | ☐ | substitute w/amdt | ☐ |

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35 Date: ____________ Date: ____________
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37 Clerk of the Senate Clerk of the House of Delegates

# NOTES

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