

Effect of the Uniform Accident and Sickness Policy Provision Law on Alcohol Screening and Intervention in Trauma Centers

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Background: Alcohol screening and intervention in trauma centers is widely recommended. The Uniform Accident and Sickness Policy Provision Law (UPPL) exists in most states, and allows insurers to refuse payment for treatment of injuries in patients with a positive alcohol or drug test. This article analyzed the UPPL's impact on screening and reimbursement, measured the knowledge of legislators about substance use problems in trauma centers, and determined their opinions about substance use-related exclusions in insurance contracts for trauma care.

Methods: A nationwide survey of members of the American Association for the Surgery of Trauma was conducted. A separate survey of legislators who are members of the Senate, House, or Assembly and serve in some leadership role on committees responsible for insurance in their state was also performed.

Results: Ninety-eight trauma surgeon and 56 legislator questionnaires were analyzed. Surgeons' familiarity with the UPPL was limited; only 13% believed they practiced in a UPPL state, but 70% actually did. Despite lack of knowledge of the statute, 24% reported an alcohol- or drug-related insurance denial in the past 6 months. This appeared to affect screening practices; the majority of surgeons (51.5%) do not routinely measure blood alcohol concentration, even though over 91% believe blood alcohol concentration testing is important. Most (82%) indicated that if there were no insurance barriers, they would be willing to establish a brief alcohol intervention program in their center. Legislators were aware of the impact of substance use on trauma centers. They overwhelmingly agreed (89%) that alcohol problems are treatable, and 80% be-

lieved it is a good idea to offer counseling in trauma centers. As with surgeons, the majority (53%) were not sure whether the UPPL existed in their state, but they favored prohibiting alcohol-related exclusions by a 2:1 ratio, with strong bipartisan support.

Conclusions: The study documents strong support for screening and intervention programs by both trauma surgeons and legislators. Surgeons experience alcohol-related insurance denials but are not familiar with the state law that sanctions this practice. A majority of legislators are also not familiar with the UPPL but support elimination of insurance statutes that allow exclusion of coverage for trauma care on the basis of intoxication.

Key Words: Trauma, Injury, Alcohol, Intervention, Insurance, Trauma centers

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Screening injured patients for the presence of an alcohol problem, and providing a brief intervention to those with a positive result, has been shown to reduce subsequent alcohol use, hospital readmissions, and related consequences.^{1–4} Broad support for implementing screening and intervention programs in trauma centers exists among trauma surgeons.⁵ A number of federal agencies have issued reports that recommend routine trauma center screening and intervention, including the

Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and the National Highway Traffic Safety Administration.^{6–8} Increasing the proportion of injured patients who receive an intervention is also included in *Healthy People 2010*, the nation's public health agenda.⁹

The majority of trauma centers currently do not provide this service.⁵ One potential barrier is physician awareness that performing a blood alcohol test or urine toxicology screen on an injured patient may prompt the patient's insurer to deny payment if the result is positive. The Uniform Accident and Sickness Policy Provision Law (UPPL) is a legal statute that allows insurance carriers to exclude coverage for alcohol- and drug-related injuries. The statute reads, "Intoxicants and Narcotics—The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."¹⁰

The National Association of Insurance Commissioners (NAIC) is an organization composed of state insurance com-

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missioners from the 50 states, the District of Columbia, and the four U.S. territories. It was created to address the need to regulate multistate insurers.⁵ Its primary tools for encouraging uniformity across states are model laws and regulations. Model laws are drafted and provided to states, which may adopt, modify, or ignore them. The UPPL was developed as a model law by the NAIC in 1947. Prevailing societal attitudes may have led to its development as a morals clause, as a means of reducing insurance costs, or as a method to reduce drunk driving by increasing the associated financial risks.¹¹ Rivara and colleagues conducted a survey of state insurance commissioners in 50 states and the District of Columbia.¹² Overall, 39 states had adopted the UPPL model, and 4 adopted it with minor modifications.

Information on whether or not a patient was intoxicated or under the influence of any narcotic typically depends on the decision of the physician to measure a blood alcohol concentration (BAC) or urine toxicology screen, or on written documentation in the medical record that the patient was under the influence of alcohol or drugs. Trauma centers may choose not to comply with recommendations to measure BAC or screen for substance use disorders if this information can be used as a reason to refuse to pay them for their services.

Screening questionnaires such as the CAGE or AUDIT do not ask the patient whether they were intoxicated at the time of injury. However, combined use of screening questionnaires and a BAC increases diagnostic sensitivity and specificity.^{6,7} Also, increasing a trauma patient's motivation to change their drinking habits usually involves exploring the relationship between their level of intoxication and their injury. The UPPL, therefore, may hamper implementation and performance of alcohol screening and intervention programs in trauma centers.

The purpose of this article is to analyze the effect of the UPPL on blood alcohol testing and substance use disorder screening by trauma surgeons, to measure the knowledge of legislators about the burden of alcohol and drug problems in trauma centers, and to determine their opinions about alcohol-related exclusions in insurance contracts that provide coverage for trauma care. This information will be important in determining whether insurance statutes limit the availability of alcohol screening and intervention programs in trauma centers and reduce alcohol and drug testing in injured patients, and may provide useful guidance to policy makers and health care payers considering legislative change and insurance contract provisions.

PATIENTS AND METHODS

Trauma Surgeons

A nationwide survey of trauma surgeons was conducted. The survey contained questions designed to collect several different types of information from respondents: demographics, knowledge of the UPPL, and trauma surgeons' opinions on the usefulness of BAC testing and screening for alcohol

use disorders in the trauma center setting. The survey was approved by Harvard Medical School's Office for Research Subject Protection.

Candidates for the survey were members of the American Association for the Surgery of Trauma (AAST), the leading academic organization devoted to care of the injured patient. Members were considered eligible if they primarily treated adult patients, were general surgeons, and were actively engaged in trauma care during the 6 months before receiving the survey. We used the 2002 AAST meeting abstract book to identify members, and mailed a survey to 407 randomly chosen (50%) names on this unscreened list that contains both active and inactive AAST members. Anonymous self-report questionnaires were mailed along with a preaddressed, stamped envelope. Responses were recorded by a person unfamiliar with individual members and who could not identify specific persons from the demographic information provided. Approximately 30 days after the initial mailing, a second survey was sent to nonrespondents.

Legislators

A separate survey was provided to state legislators. Legislators were eligible for the survey if they were members of the Senate, House, or Assembly, and served as chair, vice chair, or in some other leadership role on committees responsible for insurance, and resided in a state that is a member of the National Conference of Insurance Legislators (NCOIL). NCOIL is an organization of state legislators that brings together representatives of academic institutions, consumer groups, insurance industry organizations, state insurance commissioners, and leading members of Congress for meetings designed to help state legislators make informed decisions on insurance issues that affect their constituents.¹³

The Insurance Legislators Foundation, an organization that provides nonpartisan research and technical information to state legislators on insurance-related public policy issues, conducted the surveys. Surveys were anonymously constructed, and were distributed to legislators by electronic mail. A hard copy was mailed to nonrespondents. Those who did not respond to these mailings were provided with a copy of the survey at each of three NCOIL meetings over a 1-year period.

RESULTS

Trauma Surgeons

Of 407 mailed surveys, 41 were returned unopened because they could not be delivered (because of death or because they had moved and left no forwarding address). Surgeons who did not receive the survey were considered noncontacts and were removed from the sample, leaving 366 potential respondents. Seventy-eight surveys (21%) were returned by individuals who were no longer involved in trauma care or were not general surgeons (orthopedists, pediatric surgeons, neurosurgeons) and thus were not eligible. Of the remaining 288 surveys, 98 (34%) were completed and re-

turned by an eligible surgeon and 190 were not returned and were presumably discarded.

We cannot calculate the true response rate because the proportion of noneligible surgeons among the 190 who discarded the survey is unknown. One approach recommended by the Council of American Survey Research Organizations is to assume that the proportion of eligible and ineligible cases among the cases whose eligibility status is known would also apply to the cases of indeterminate eligibility.^{14,15} Under the assumption that a similar proportion (21%) of the discarded questionnaires were sent to surgeons who were noneligible as were sent to eligible surgeons, the estimated survey response rate is 40%.

The results were primarily restricted to Level I trauma centers, as 98.6% of respondents indicated that they worked in a Level I trauma center, and the remaining 1.4% did not provide information about their trauma center status. The demographic composition of the sample was reflective of the trauma surgery profession. The mean age was 49.7 years, and 93% were men. Over half (58%) had been working as a trauma surgeon for 16 or more years, and 88% worked at a university-affiliated hospital.

Alcohol and drug problems were commonly seen in trauma centers, and respondents reported high rates of trauma center readmission. Over 30% indicated that they expect more than 10% of their trauma patients to be readmitted to their center with another injury within 5 years. Most surgeons (89%) indicated that alcohol is a major burden on their trauma center, and 76% considered patient drug use a significant burden. In addition, 63% of respondents estimated that more than 30% of patients admitted to their hospital would test positive for alcohol use if tested.

Most trauma surgeons were not familiar with the UPPL and its provisions. As shown in Table 1, only 13% believed they practiced in a state where the UPPL was in effect. However, 70% of respondents actually worked in UPPL states. Despite their lack of awareness of the UPPL, a large percentage of surgeons reported having felt its effects: 24% reported that during the past 6 months their hospital had been denied payment by an insurance company on the basis of a patient being under the influence of alcohol or drugs. Although most trauma surgeons did not seem to be aware that there are state laws that specifically sanction these denials, their screening practices appeared to be influenced by a fear of potential insurance repercussions. For example, less than half of trauma surgeons (48.5%) reported that they routinely measure the blood alcohol concentration of their patients (i.e., 75% or more of patients), even though 91% believe that it is important to measure BAC. Only 37% reported that half or more of patients with alcohol problems receive counseling, and only 20% work at a center that provides counseling to at least 75% of patients who screen positive for alcohol.

When information about a patient's BAC is required for patient management, medical concerns appear to take precedence over reimbursement: most surgeons appeared willing

to assume the risk of nonreimbursement, as only 7% indicated that they never test for intoxicants. Most trauma surgeons (75%) reported having no experience in administering alcohol-screening questionnaires and were unfamiliar with the most common alcohol screening instruments (Table 2).

Despite their lack of experience and practical knowledge about alcohol screening, most recognized the potential value of screening their patients for alcohol and drugs. Over 75% asserted their belief that trauma centers have a responsibility to screen patients for an alcohol problem, 61% felt that their trauma center was not doing enough to address alcohol problems in their patients, over half (55%) believed that a brief alcohol intervention is an effective means of reducing reinjury rates in trauma patients, and 82% indicated that if there were no insurance barriers, they would be willing to help their center establish a brief alcohol intervention program if provided with a clinical kit to guide them.

Legislator Surveys

NCOIL has 33 member states. A total of 56 legislators from 26 states completed the survey, representing a 79% response rate. Party affiliation indicated that 33 were Republican (59%), 20 were Democrat (36%), and 3 (5%) did not provide this information. Legislators appeared to be well aware of the impact of alcohol and drugs on trauma centers. Half estimated that more than a third of patients admitted to trauma centers are under the influence of alcohol and/or illicit drugs, and 80% believed that 20% or more of trauma patients are injured while under the influence of one or more intoxicants. Most (74%) indicated that alcohol use disorders are a matter of medical concern to trauma surgeons and not simply a law enforcement issue. Legislators overwhelmingly agreed (89%) that alcohol problems are treatable and that counseling can help patients with alcohol use disorders to recover. Most (80%) also believed it is a good idea to offer alcohol counseling to intoxicated motor vehicle crash patients admitted to a trauma center.

As with surgeons, the majority of legislators (53%) were not sure whether the UPPL existed in their state. Also, 64% of those who indicated that the UPPL did not exist in their state were incorrect and were from UPPL states. Overall, legislators favored prohibiting alcohol-related exclusions in medical expense policies by a 2:1 ratio, with 62% in favor, 30% against, and 8% with no opinion. This issue crossed party lines, as a majority of both parties were in favor: Democrats by a 3.75:1 ratio and Republicans by a 1.6:1 ratio. As shown in Table 3, 50% of legislators believe that if the UPPL were repealed, trauma surgeons would be more likely to screen and recommend alcohol counseling programs to their patients.

Of legislators in favor of repealing the UPPL, the reasons most commonly cited were as follows: prohibiting alcohol-related exclusions in trauma patients would improve medical management (93%); a life-threatening injury is a good time to offer substance abuse counseling (86%); it would decrease

Table 1 Trauma Surgeons' Screening Perceptions and Practices

Survey Item	Response (%) (n = 98*)
UPPL law exists in my state	
Yes	12.6
No	37.9
Not sure	49.5
My hospital was denied payment during the past 6 months based on alcohol screening results	
Yes	23.7
No	67.7
My hospital does not routinely screen	8.6
Alcohol use disorders among patients is a significant burden on my trauma center	
Agree	88.6
No Opinion	7.3
Disagree	4.1
Drug abuse among patients is a significant burden on my trauma center	
Agree	76.1
No Opinion	14.6
Disagree	9.3
Estimated percentage of patients who would test positive for alcohol	
30% or less	37.2
31–45%	38.1
46% or more	24.7
Estimated percentage of patients who would test positive for drugs	
15% or less	27.4
16–30%	49.5
31% or more	23.2
It is the physician's responsibility to screen for alcohol use disorders	
Agree	76.3
No opinion	8.2
Disagree	15.5
My trauma center currently does enough to address alcohol problems	
Agree	29.9
No opinion	9.3
Disagree	60.8
Brief alcohol intervention is an effective means of reducing reinjury in trauma patients	
Agree	55.2
No opinion	24.0
Disagree	20.8
Percentage of patients screened for alcohol with BAC	
Never screen	7.2
0–49%	30.9
50–74%	13.4
75% or more	48.5
Percentage of patients with alcohol problem who receive counseling	
75% or more	20.1
50–74%	16.8
25–49%	15.8
0–24%	34.7
None	12.6
Traumatic injury increases a patient's motivation to accept a brief alcohol intervention	
Agree	65.0
No opinion	11.3
Disagree	23.7
My experience with administering alcohol screening questionnaires is:	
No experience	74.5
Some experience	19.4
Moderate experience	5.1
Extensive experience	1.0
Assuming no legal barriers, I would be willing to work with my trauma center to establish a brief alcohol intervention service if I were provided a clinical kit detailing how to establish such a program	
Agree	82.3
No opinion	11.5
Disagree	6.2

*Because of missing observations, some items have fewer than 98 respondents; the minimum was 95.

Table 2 Trauma Surgeons' Familiarity with Common Alcohol Screening Methods

	BAC (%)	MAST (%)	CAGE (%)	AUDIT (%)	CRAFFT (%)
Not familiar	30	74	62	87	90
Somewhat familiar	12	17	11	9	6
Moderately familiar	18	6	14	3	4
Very familiar	40	3	12	1	0

BAC, blood alcohol concentration; MAST, Michigan Alcohol Screening Test; CAGE, screening questionnaire (composed of the following questions: Have you ever Cut down your drinking, do you get Angry about criticism of your drinking habits, do you ever feel Guilty about your drinking? Have you ever had an Eye-opener (drink in the morning?); AUDIT, Alcohol Use Disorders Identification Test; CRAFFT, screening questionnaire (analogous to CAGE but used with adolescents: have you ever ridden in a Car driven by someone [including yourself] who was high? Do you ever use alcohol or drugs to Relax, feel better about yourself, or fit in? Do you ever use alcohol or drugs while you are Alone? Do your family or Friends ever tell you that you should cut down on your drinking or drug use? Do you ever Forget things you did while using alcohol or drugs? Have you gotten into Trouble while you were using alcohol or drugs?).

repeat offenders and recidivism (79%); treatment for substance use disorders helps some patients (76%); it would

enable more patients to receive counseling for substance use disorders (72%); it is important for trauma and emergency department physicians to identify patients with a substance use disorder (62%); and trauma surgeons do not document alcohol use in the medical record in jurisdictions where it leads to insurance denials, so insurance companies pay for alcohol-related injuries anyway (51%). No particular reason stood out as a cause of why the UPPL should not be amended for those who were not in favor, as no reason was cited by over 50% of this group of legislators. The most common reasons were that people without substance abuse problems will end up paying the insurance costs for those with substance abuse problems (42%), a trauma center is not an appropriate place to offer substance abuse counseling (36%), and even though it may lead to denial of payment, doctors should measure the blood alcohol concentration and screen for substance abuse disorders anyway (29%). Other reasons were that it will not decrease recidivism (29%) or increase the number of patients who receive counseling (14%), and the legal system, not the medical system, should deal with patients with alcohol-related injuries (14%). The majority of legislators, regardless of their opinions about the UPPL, did not believe that it helps limit insurance costs. A list of states

Table 3 Legislators' Perceptions of Alcohol, Trauma Centers, and UPPL (n = 56)

Survey Item	Strongly Agree (%)	Somewhat Agree (%)	No Opinion/No Answer (%)	Somewhat Disagree (%)	Strongly Disagree (%)
Alcohol use disorders are a private matter, and not a matter of medical concern to the trauma surgeon.	2 (3.6)	8 (14.3)	6 (10.7)	17 (30.3)	23 (41.1)
Alcohol intoxication in motor vehicle crash or violence victims is a law enforcement issue only, and not a medical one.	5 (8.9)	6 (10.7)	1 (1.8)	17 (30.4)	27 (48.2)
Alcohol problems are treatable and counseling can help some patients recover.	22 (39.3)	28 (50.0)	1 (1.8)	3 (5.4)	2 (3.6)
It is a good idea to offer alcohol counseling to intoxicated motor vehicle crash patients admitted to a trauma center.	21 (37.5)	24 (42.9)	5 (8.9)	3 (5.4)	3 (5.4)
It is not a trauma center's responsibility to screen for alcohol and/or drug use.	3 (5.4)	7 (12.5)	7 (12.5)	24 (42.8)	15 (26.8)
The effect of a life-threatening injury may motivate patients to be more receptive toward receiving substance abuse counseling.	20 (35.7)	33 (58.9)	2 (3.6)	1 (1.8)	0 (0)
Injured patients referred for substance abuse counseling are less likely to injure themselves or others in a future crash.	7 (12.5)	29 (51.8)	17 (30.3)	3 (5.4)	0 (0)
If the UPPL were repealed, trauma physicians would be more likely to screen and recommend alcohol counseling programs.	11 (19.6)	17 (30.4)	22 (39.3)	5 (8.9)	1 (1.8)
The UPPL helps insurance companies to reduce insurance costs.	6 (10.7)	9 (16.1)	33 (58.)	6 (10.7)	2 (3.6)
The UPPL does not decrease insurance costs because, where it is enforced, emergency physicians avoid screening and documentation of substance abuse in the medical record.	3 (5.4)	12 (21.4)	36 (64.3)	4 (7.1)	1 (1.8)

Table 4 States with UPPL Provisions as of April 15, 2004

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

that permit alcohol- and drug-related insurance exclusions in health care policies is provided in Table 4.

DISCUSSION

Survey Results

Legislators appeared to be well aware of the burden of alcohol and drug problems on trauma centers. The surveys documented that approximately 80% of both trauma surgeons and legislators believe that trauma centers should screen injured patients for alcohol and drug use and offer counseling to those who screen positive. However, one of four trauma surgeons reported having recently been denied payment by an insurance company because alcohol or drug use was documented. If both surgeons and legislators believe that screening and intervention represents best practice, statutes that allow denial of payment to trauma centers that treat alcohol-related injuries are in conflict with this belief. This survey documented a discrepancy between the level of support for alcohol screening and intervention in trauma centers as expressed by trauma surgeons and the number of centers that

currently provide the service. Although surgeons lacked technical screening skills, 82% indicated that, if there were no insurance barriers, they would support starting an alcohol screening and intervention service at their center. This suggests that insurance statutes are more important barriers than lack of screening skills. The majority of surgeons appeared to be willing to risk nonreimbursement when alcohol or drug screening is required to manage the patient's injuries, as less than 10% indicated that they never obtain a BAC or urine toxicology test. A BAC or toxicology screen may be required to clarify the cause of a patient's abnormal mental status, to identify patients at risk for withdrawal syndromes, or to identify patients who require objective diagnostic testing because self-reported symptoms of abdominal or spinal column pain may be unreliable in intoxicated patients.¹⁶

Because 35% to 50% of trauma patients are under the influence of one or more intoxicants, trauma centers could not absorb the amount of uncompensated care that would result from routine UPPL enforcement. Insurers are either not enforcing this provision, or surgeons do not measure BAC in trauma centers where the threat of enforcement is perceived as real, thus protecting their patients and their trauma center from the financial consequences. Some combination of these factors is the most likely reason why the NAIC now believes that amending the UPPL by prohibiting alcohol-related insurance denials is not a cost issue for insurers.¹⁷

If the trauma surgeon does not document alcohol intoxication, it is unlikely that an insurance company will detect it by other means such as a police report. Intoxicated drivers, when stopped by the police, are detected in over 90% of cases through use of breath analyzers and field sobriety tests.¹⁸ However, law enforcement personnel cannot document alcohol use when a person is injured and unable to cooperate, or when transport to the hospital takes precedence over legal concerns. Unless police officers accompany the ambulance to the emergency department and wait until they can collect evidence, the intoxicated driver typically escapes all legal consequences, even after a crash that results in property damage or personal injury. Studies demonstrate that 85% to 96% of drunk drivers involved in a crash avoid detection if they are transported to a trauma center.^{19,20} The "safe haven" effect of trauma centers has been called the Achilles heel of efforts to detect drunk driving.²¹

Less than half of all drivers involved in a crash where there is a death, injury, or property damage are tested for alcohol, even in states with mandatory testing laws. Insurance laws that affect reimbursement to physicians and hospitals that perform BAC testing may contribute to this low testing rate. Documentation of alcohol use after a crash is important to many public safety organizations because it informs public policy, motivates legislative reform, and helps in the evaluation of anti-drunk driving efforts. For these reasons, elimination of alcohol-related insurance exclusions is a key legislative priority for Mothers Against Drunk Driving.²²

A recent federal court ruling determined that insurers may issue policies that deny coverage for alcohol-related injuries even in states that never adopted the UPPL. This occurred in Connecticut, when an underage intoxicated driver in a motor vehicle crash was taken to a Level I trauma center and generated a \$245,235 medical bill. The insurance company's refusal to pay the medical claim was upheld by the 2nd U.S. Court of Appeals.²³

The legal system has not provided clarity with respect to the meaning of the words, "in consequence of the insured's being intoxicated." Some courts have required clear evidence of a causal link to the injury, whereas others have not. In the Connecticut case, the court ruled, "We see no justification for requiring such a showing. The policy excludes any loss incurred while the insured was intoxicated and does not suggest that the loss must have been proximately caused by the intoxication."²³ A federal appeals court in Florida provided a conflicting opinion. An intoxicated patient was struck by a motor vehicle and incurred over \$350,000 in medical bills.

The insurer denied payment, but the patient won the case on appeal when the court ruled, "Two types of injuries may result from one's intoxication: direct injury such as acute alcohol poisoning or liver damage; and indirect injuries, such as accidental injuries caused by the behavior of the person while intoxicated. The claimant's injuries were clearly the latter kind—indirect injuries. The trial court found, and we agree, that the language of the policy was not specific enough to exclude from coverage indirect injuries as well as direct injuries."²⁴

Court decisions are equally conflicting with respect to whether or not a specific blood alcohol level is required to support an alcohol-related insurance exclusion. Some courts have defined intoxication using criminal drunk driving statutes, whereas others have ruled that criminal law does not apply.

National Association of Insurance Commissioners

In June 2000, the NAIC held a hearing to discuss the effect of the UPPL on alcohol and drug screening in trauma centers.²⁵ Experts in trauma care, addiction medicine, emergency nursing, public health, and health care economics testified that the UPPL adversely affects trauma care and injury prevention efforts and increases health care costs. Representatives from traffic safety organizations such as the National Commission Against Drunk Driving and Mothers Against Drunk Driving testified that the UPPL reduces blood alcohol testing, thereby affecting development, implementation, and evaluation of efforts to combat drinking and driving.

Representatives from the insurance lobby testified that the NAIC should leave the UPPL unchanged. Their position was that if trauma surgeons believe that interventions are warranted, they can, and are perhaps obligated to, provide them regardless of whether they receive third-party reimbursement for the service. They also took the position that insurers should be able to retain their right to exclude cov-

erage for losses caused by alcohol and drug abuse, that people who do not abuse alcohol and drugs should not be required to pay for losses caused by abusers, and that abusers should not be shielded from the consequences of their actions.

The NAIC noted that trauma surgeons were not requesting reimbursement for interventions, only for the trauma care that they were obligated to provide. The NAIC asked insurers for claims data to support their position that the UPPL provision was a cost issue and gave them 6 months to respond. After an additional 6-month extension, the insurance industry reported that they were unable to provide such data. In June 2001, the NAIC unanimously amended the UPPL by adding a provision suggesting that insurers could not provide claims data to support their position because physicians have already reduced or eliminated BAC testing in jurisdictions where the UPPL is enforced and therefore denials are rare.²⁵

¹⁸ that prohibits its application to medical expense policies, while retaining it as an option for other types of insurance (e.g., life insurance). As with the original model, states are free to adopt it, but there is no requirement to do so. As of April 2004, the states of Washington, Maryland, North Carolina, South Dakota, Vermont, and Iowa have adopted the new model.

SUMMARY

The surveys reported here document broad support for alcohol screening and intervention programs by both trauma surgeons and legislators responsible for insurance legislation. Recent alcohol-related denials of insurance claims were reported by nearly one of four surgeons. A strong, bipartisan majority of legislators surveyed support elimination of insurance statutes that allow such exclusions of coverage. In 1943, 4 years before the UPPL was drafted, only 6% of the American public viewed alcohol problems as a disease.¹¹ A report by the Institute of Medicine, court decisions, and actions by both federal and state governments have changed the view of alcohol and drug problems from a moral one requiring punishment to one that considers the role of medical, genetic, environmental, and social factors, and recognizes the value of identification and treatment, not only for the individual, but also for society. Trauma surgeons and the legislators who represent them appear to endorse this viewpoint. Thus, the continued enforcement of alcohol-related insurance exclusions appears to be a result of anachronistic legislation.

References

1. Gentilello LM, Rivara FP, Donovan DM, et al. Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Ann Surg.* 1999;230:1–11.
2. Monti PM, Colby SM, Barnett NP, et al. Brief intervention for harm reduction with alcohol positive older adolescents in a hospital emergency department. *J Consult Clin Psychol.* 1999;67:989–994.
3. Longabaugh R, Woolard RF, Nirenberg TD, et al. Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department. *J Stud Alcohol.* 2001;62:806–816.

4. Zatzick D, Roy-Byrne P, Russo J, et al. A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. *Arch Gen Psychiatry*. 2004;61:498–506.
5. Schermer CR, Gentilello LM, Hoyt DB, et al. National survey of trauma surgeons' use of alcohol screening and brief intervention. *J Trauma*. 2003;55:849–856.
6. Hungerford DW, Pollock DA, eds. *Alcohol Problems Among Emergency Department Patients: Proceedings of a Research Conference on Identification and Intervention*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2002.
7. TIP 16: Alcohol and Other Drug Screening of Hospitalized Trauma Patients. Treatment Improvement Protocol (TIP) Series 16. Peter O. Rostenberg, M.D. DHHS Publication No. (SMA) 95-3039. Center for Substance Abuse Treatment. Rockwall 11, 5600 Fishers Lane, Rockville, MD 20857, 1995.
8. Developing Best Practices of Emergency Care for the Alcohol-Impaired Patient: Recommendations from the National Conference. National Highway Traffic Safety Administration (NHTSA), US Department of Transportation, 2000. National Technical Information Service, Springfield, Virginia 22160.
9. U.S. Department of Health and Human Services. *Healthy People 2010. 2nd ed.* With Understanding and Improving Health and Objectives for Improving Health. Chapter 26-5. Washington, DC: U.S. Government Printing Office, November 2000.
10. NAIC Model Laws Regulations And Guidelines. National Association of Insurance Commissioners: Model Regulation Service. Kansas City, MO: Uniform Individual Accident and Sickness Policy Provisions Law. 2004;II-180-1.
11. National Council on Alcoholism and Drug Dependence. Historical Highlights. Accessed at: http://www.ncadd.org/sixty/detailed_history.html. Accessed
12. Rivara FP, Tollefson S, Tesh E, Gentilello LM. Screening trauma patients for alcohol problems: are insurance companies barriers? *J Trauma*. 2000;48:115–118.
13. National Conference of Insurance Legislators [Web site]. Available at: <http://www.ncoil.org>. Accessed
14. Lessler J, Kalsbeek WD. *Nonsampling Error in Surveys*. New York: John Wiley & Sons; 1992:115.
15. Hidioglou MA, Drew JD, Gray GB. A framework for measuring and reducing nonresponse in surveys. *Survey Methodol*. 1993;19:81–94.
16. Jurkovich GJ, Rivara FP, Gurney JG, et al. Effects of alcohol intoxication on the initial assessment of trauma patients. *Ann Emerg Med*. 1992;21:704–708.
17. NAIC Minutes June 2000: Discussion of Alcohol and Drug Exclusion Provision in the Uniform Individual Accident and Sickness Policy Provision Model. NAIC Executive Headquarters, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662.
18. Grossman DC, Mueller BA, Kenaston T, et al. The validity of police assessment of driver intoxication in motor vehicle crashes leading to hospitalization. *Accid Anal Prev*. 1996;28:435–442.
19. Schermer CR, Apodaca TR, Albrecht RM, et al. Intoxicated motor vehicle passengers warrant screening and treatment similar to intoxicated drivers. *J Trauma*. 2001;51:1083–1086.
20. Biff WL, Schiffman JD, Harrington DT, et al. Legal prosecution of alcohol-impaired drivers admitted to a level I trauma center in Rhode Island. *J Trauma*. 2004;56:24–29.
21. *Drunk Drivers Escaping Detection Through the Emergency Department. Report of the BAC Reporting Group Consensus Meeting*. Silver Spring, MD: National Commission Against Drunk Driving; 1999. Accessed at: http://www.ncadd.com/tr_reports.cfm.
22. Rating The States 2002 - Report Card. Mothers Against Drunk Driving. Appendix D. Accessed at <http://www.madd.org/stats/10,1056,5546,00.h/ml>.
23. Oliver Bishop, III and Oliver Bishop, IV V. National Health Insurance Company. United States Court Of Appeals For The Second Circuit. Docket No. 02-9032. Decided: September 22, 2003.
24. Blue Cross and Blue Shield of Florida, Inc. v. Steck, 778 So. 2d 374 (Fla. App. 2 Dist.) 2001.
25. NAIC Minutes, March 2001 Discussion of Alcohol and Drug Exclusion Provision in the Uniform Individual Accident and Sickness Policy Provision Model Act.