

AMERICAN BAR ASSOCIATION

ADOPTED BY THE HOUSE OF DELEGATES

August 8-9, 2005

RESOLVED, That the American Bar Association urges all state, territorial and local legislative bodies and governmental officials to repeal laws and discontinue practices that permit insurers to deny coverage for alcohol or drug related injuries or losses covered by accident and sickness insurance policies that provide hospital, medical and surgical expense coverage.

FURTHER RESOLVED, That the American Bar Association supports the 2001 Amendment by the National Association of Insurance Commissioners to its model law, the Uniform Accident and Sickness Policy Provision Law, permitting coverage for injuries in cases involving alcohol or drugs in accident and sickness insurance policies that provide hospital, medical and surgical expense coverage.

REPORT

I. A POLICY GENESIS

People with alcohol or other drug dependency disease face public and private policies that restrict their access to appropriate health care, employment and public benefits. In 2002, the Standing Committee launched an initiative entitled, “Substance Abuse, Addiction and Discrimination” to examine discrimination against individuals in recovery. The project addresses discrimination in access to health care services, employment and public benefits. Work has been conducted, and will continue, with Join Together. Join Together, founded in 1991 by a grant from The Robert Wood Johnson Foundation to the Boston University School of Public Health, supports community-based efforts to reduce substance abuse. In the spring of 2002, Join Together formed a national policy panel to address discrimination against people with alcohol or other drug disease. Join Together was assisted by the Standing Committee, which facilitated a panel and public hearing on discrimination at the American Bar Association’s (“ABA’s”) Annual Meeting in August 2002. The panel, chaired by Kurt L. Schmoke, Esq., a former Mayor of Baltimore and current Dean of Howard University School of Law, included leaders from law, medicine, business and journalism. The panelists developed the principles and recommendations included in the 2003 report, “Ending Discrimination Against People with Alcohol and Drug Problems.”¹

The panelists agreed upon two guiding principles and ten policy recommendations in the report that address discrimination.² In August 2004, the House of Delegates adopted the two guiding principles and three of the ten policy recommendations as ABA policy.³

This Report addresses a fourth recommendation from the Join Together report: “Insurers should not be allowed to deny claims for the care of any injury sustained by an insured person if he or she was under the influence of alcohol or other drugs at the time of injury.”

¹ Join Together. Boston University School of Public Health. *Ending Discrimination Against People with Alcohol and Drug Problems*. April 2003.

² The two principles are: (1) Addiction to alcohol or other drugs is a treatable chronic disease that should be viewed and addressed as a public health issue; and (2) People seeking treatment or recovery from alcohol or other drug disease should not be subject to legally imposed bans or other barriers based solely on their addiction. Such bans should be identified and removed. From these principles, the panel established ten policy recommendations, which address access to health care, employment and public benefits.

³ The policy resolution was approved by the House of Delegates at the 2004 Annual Meeting as Resolution 112. The two guiding principles are: (1) Addiction to alcohol or other drugs is a treatable chronic disease that should be viewed and addressed as a public health issue; and (2) People seeking treatment or recovery from alcohol or other drug disease should not be subject to legally imposed bans or other barriers based solely on their addiction. Such bans should be identified and removed. The three policy recommendations are: (1) People with drug convictions but no evidence of current drug use should not be denied or hindered in obtaining student loans, other grants, scholarships, or access to government training programs; (2) Persons with non-violent drug convictions but no evidence of current drug use should not be banned from receiving government cash assistance and food stamps; and (3) Public housing agencies and providers of Section 8 and other federally assisted housing should use the discretion given to them in public housing laws to help people get treatment, rather than permanently barring them and their families from subsidized housing, provided that the person seeking or in treatment poses no threat to other persons, including family members.

II. TRAUMA AND SUBSTANCE ABUSE

Today, there is greater recognition and acceptance than ever before of the fact that addiction is a treatable, chronic illness.⁴ Though alcohol or other drug use is voluntary, research has demonstrated that chronic use causes biological, psychological and behavioral changes including demonstrable alteration of brain chemistry.⁵ As a result of such changes, an individual may be unable to end his or her use of alcohol and drugs without treatment.

The resulting addiction is a compulsion to seek and to use alcohol or other drugs. Effective care can produce control of this chronic illness, similar to the successful treatment of other chronic illnesses such as diabetes, hypertension and asthma. Given the extent of alcohol and substance abuse and the opportunity for Level I trauma centers⁶ to identify at-risk patients with an alcohol or drug dependence, many medical experts recommend that all trauma patients be screened for alcohol problems with a combination of blood alcohol levels and a brief behavioral questionnaire.⁷ In practice, however, nearly 50% of trauma centers do not routinely measure blood alcohol concentrations in injured patients; fewer than five percent formally assess patients for alcohol use disorders. Alcohol counseling as a routine component of trauma care is also rarely provided.⁸

Physicians at present often avoid screening injured patients for alcohol or other drug use because insurance companies will deny claims for reimbursement for treatment of an injury if alcohol or drugs are involved. Insurers take the position that these injuries are self-inflicted. Such denial gains support from the 1947 Uniform Accident and Sickness Policy Provision Law (“UPPL”), a model statute promulgated by the National Association of Insurance Commissioners (“NAIC”). According to an optional provision in the UPPL, health insurers are allowed to deny coverage for alcohol or drug related injuries: “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.”⁹ When insurance companies have adopted such an exclusion, courts generally uphold them as valid and not unreasonable with or without a statute.¹⁰

⁴ As early as 1972, the American Bar Association’s House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, which recognized that treatment, rather than criminal penalties, were the appropriate response to alcoholism.

⁵ See, for example, Leshner, A. I. “Addiction is a Brain Disease.” *Issues in Science and Technology Online*, 17(3): Spring 2001.

⁶ American Hospital Association, 2003 AHA Annual Survey Health Forum, L.L.C., page 13, item 41B. A certified trauma center is defined as: “A facility to provide emergency and specialized intensive care to critically ill and injured patients. Level 1: A regional resource trauma center, which is capable of providing total care for every aspect of injury and plays a leadership role in trauma research and education. Level 2: A community trauma center, which is capable of providing trauma care to all but the most severely injured patients who require highly specialized care. Level 3: A rural trauma hospital, which is capable of providing care to a large number of injury victims and can resuscitate and stabilize severely injured patients so that they can be transported to level 1 or level 2 facilities.”

⁷ Rivara, F.P., Tollefson, S., Tesh, E., Gentilello, L.M. Screening Trauma Patients for Alcohol Problems: Are Insurance Companies Barriers? *Journal of Trauma: Injury, Infection and Critical Care*. 2000; 48:115.

⁸ Rivara et al., page 115.

⁹ Rivara et al., page 118.

¹⁰ Sara Rosenbaum, Henry Van Dyck, Mandy Bartoshesky, Joel Teitelbaum. SAMHSA Policy Brief (Working Draft). Analysis of State Laws Permitting Intoxication Exclusions in Insurance Contracts and their Judicial

Acute alcohol impairment, according to numerous studies, results in an increased risk of trauma, including motor vehicle crashes, pedestrian injuries, drowning, residential fire-related injuries and fatalities, slips and falls among the elderly and violence-related injuries.¹¹ Studies have also demonstrated that 40% to 50% of trauma patients admitted to Level I trauma centers test positively for blood alcohol at the time of their injuries.¹² As many as 44% of patients, when administered an alcoholism screening questionnaire, demonstrate chronic alcohol abuse.¹³ Therefore, chronic alcohol abuse is the single most common chronic illness in trauma patients.¹⁴

The use of brief, motivational interventions designed to assist patients with alcohol abuse or mild symptoms of alcohol dependency to reduce or eliminate their alcohol consumption has been the focus of various recent studies.¹⁵ Randomized controlled trials conducted in a variety of settings demonstrate a reduction in alcohol consumption after such interventions.¹⁶ One study found that brief interventions were effective in the setting of acute trauma centers, with a 50% reduction of alcohol consumption and repeated injuries one year following such a brief intervention.¹⁷ Recent research supported by the National Institute on Drug Abuse (“NIDA”), National Institutes of Health (“NIH”), demonstrated that a 20-minute intervention by an addiction peer counselor at the time of a routine doctor visit, with a follow-up telephone call, can motivate abusers of cocaine and heroin to reduce their drug use.¹⁸

III. STATEMENT OF THE PROBLEM

The Model UPPL developed in 1947 by the NAIC was subsequently adopted as law by 42 states.¹⁹ This occurred at a time when public intoxication was regarded as criminal activity, addiction treatment and advocacy centers were not as widespread as today and knowledge and treatment of alcohol and drug problems were less advanced than they are now.²⁰ Reacting to

Enforcement. The George Washington University Medical Center, School of Public Health and Health Services. February 2004, page 3.

¹¹ Rivara et al., page 115.

¹² Rivara et al., page 115.

¹³ Rivara et al., page 115.

¹⁴ Rivara et al., page 115.

¹⁵ Rivara et al., page 115.

¹⁶ Rivera et al., page 115.

¹⁷ Rivera et al., page 115.

¹⁸ Join Together Online (www.jointogetheronline.org). Boston University School of Public Health. January 5, 2005. The study, by Dr. Judith Bernstein and Dr. Edward Bernstein at Boston University Schools of Medicine and Public Health, was conducted among 1,175 men and women who had tested positive for cocaine or heroin abuse. Participants were randomly assigned to an intervention group. Intervention involved a motivational interview with a substance abuse outreach worker who is also in recovery, referrals to drug abuse treatment programs, a written list of treatment options, and a follow-up telephone call 10 days later. Members of the control group received only the written list. Six months post-intervention, the researchers found that among those who abused cocaine, 22.3 percent of the intervention group were abstinent from the drug, compared with 16.9 percent of the control group; among those who abused heroin, 40.2 percent of the intervention group were abstinent from the drug, compared with 30.6 percent of the control group. For abusers of both drugs, 17.4 percent of the intervention group was drug free, in contrast to 12.8 percent of the control group.

¹⁹ National Conference of Insurance Legislators. NCOIL Report on Uniform Accident and Sickness Policy Provision Law. 2004. page 1.

²⁰ Advocacy Document Supporting Repeal of the Uniform Accident and Sickness Policy Provision Law, American Medical Association, Advocacy Resource Center, August 4, 2004, page 1.

more contemporary realities and understandings, the National Conference of Insurance Legislators adopted a *Resolution in Support of Amending the NAIC Uniform Accident and Sickness Policy Provision Law* in March 2001.²¹ In June 2001, the NAIC, in response to these advances in the treatment of alcohol and drug addiction and related research, amended its model law to permit coverage for treatment of alcohol-related injuries.²² The amendment to the UPPL states:

- (1) This provision may not be used with respect to a medical expense policy (2) For purposes of this provision, “medical expense policy” means an accident and sickness policy that provides hospital, medical and surgical expense coverage.²³

Thus, the 2001 amendment to the 1947 Model UPPL reverses the position taken in the original and prohibits insurers from denying benefits in cases involving alcohol or drugs.

To date, some form of a UPPL provision exists in 37 states.²⁴ Few states have replaced the 1947 Model UPPL with an express prohibition of exclusionary clauses.²⁵ Eight states have statutes that are silent with no exclusion of coverage.²⁶ However, though state law may be silent with regard to any exclusion of coverage for injuries resulting from drug or alcohol intoxication, insurers in the state may still write policies that include the intoxication exclusion.²⁷ In *Bishop v. National Health Insurance Company*,²⁸ the United States Court of Appeals for the Second Circuit in 2001 upheld an exclusionary intoxication clause in an individual health insurance coverage contract purchased in Connecticut (one of the eight states silent on the issue of exclusion of coverage). This decision suggests that judicial decisions frequently favor the insurer in this area.²⁹

A state’s repeal of its exclusionary law does not necessarily ensure that insurance companies in those states will end the practice of excluding all medical treatment in connection with injuries sustained while intoxicated. In states without a statute expressly prohibiting exclusion, insurers are not prevented from including an intoxication exclusion provision in

²¹ Personal correspondence from Senator William J. Larkin, Jr. (New York), President, National Conference of Insurance Legislators to Kurt L. Schmoke, Esq., Chair, Discrimination Policy Panel, Join Together. August 1, 2002.

²² Ensuring Solutions to Alcohol Problems. The George Washington University Medical Center. *Challenging a Hidden Obstacle: Little-Known Insurance Laws Thwart Screening in Emergency Rooms*. March 2004, page 2.

²³ National Association of Insurance Commissioners. Uniform Individual Accident and Sickness Policy Provision Law. 2001. Model # 180, page 11.

²⁴ The 37 states are: Alabama; Alaska; Arizona; Arkansas; California; Delaware; Washington, D. C.; Florida; Georgia; Hawaii; Idaho; Illinois; Indiana; Kansas; Kentucky; Louisiana; Maine; Minnesota; Mississippi; Missouri; Montana; Nebraska; Nevada; New Jersey; New York; North Dakota; Ohio; Oklahoma; Oregon; Pennsylvania; Rhode Island; South Carolina; South Dakota; Tennessee; Texas; Virginia; and Wyoming.

²⁵ NCOIL Report on Uniform Accident and Sickness Policy Provision Law, page 1. As of April 2004, the states of Washington, Maryland, North Carolina, Vermont and Iowa have adopted the new NAIC model. The state of South Dakota also adopted the NAIC amended model but with limitations, to exclude coverage if a felony was committed.

²⁶ Utah, Colorado, Connecticut, Massachusetts, Michigan, New Hampshire, New Mexico and Wisconsin have not enacted legislation permitting the exclusion of coverage by insurers for injuries sustained as a result of drug or alcohol intoxication.

²⁷ Rosenbaum et al., page 11.

²⁸ 344 F.3d 305 (2d Cir., 2003).

²⁹ Rosenbaum et al., pages 1-2.

insurance policies.³⁰ Unless a court decides from the actions or the inactions of the state or territorial legislature that a drug and alcohol provision is prohibited, insurance companies can continue to deny coverage and to enforce drug and alcohol exclusions³¹ or may include the exclusions in accidental death and dismemberment, disability, auto and property and casualty insurance contracts.³²

The original 1947 Model UPPL serves as a barrier to treatment for patients with an alcohol or drug disease. Emergency room physicians test for blood alcohol content whenever such testing is appropriate. However, when injuries require surgery or the administration of medication, many emergency room physicians believe, as currently provided by the laws of most states, that insurance companies can deny coverage for an injury if alcohol or drugs are involved, as in the case of the denial of coverage for self-inflicted trauma.³³ The unfortunate consequence is that patients are not receiving proper comprehensive care for substance abuse, i.e., screening, counseling and referral.³⁴

Importantly, perhaps contrary to one's intuitive assumption, the exclusions under the 1947 Model UPPL have not reduced insurance costs, clearly the original intent. Since the 1947 Model UPPL has the effect of limiting the number of patients who are screened and subsequently treated for alcohol and substance abuse problems, these laws actually increase health costs eventually incurred to treat alcohol-related injuries, which costs have been estimated to approximate \$19 billion.³⁵ Screening and motivationally based interventions at the time of trauma result in reduced drinking and the prevention of further injuries³⁶ and have the potential to save \$327 million in direct medical costs over five years.³⁷

³⁰ Rosenbaum et al, page 11.

³¹ Rosenbaum et al., page 8.

³² Rosenbaum et al., page 11.

³³ Advocacy Document Supporting Repeal of the Uniform Accident and Sickness Policy Provision Law, American Medical Association, page 1.

³⁴ Rivara et al., page 116.

³⁵ Advocacy Document Supporting Repeal of the Uniform Accident and Sickness Policy Provision Law, American Medical Association, pages 1-2. Patients not receiving needed intervention continue to abuse alcohol and drugs, resulting in injuries and readmission to the emergency room and hospital. If untreated, these patients may develop alcohol related medical conditions including cirrhosis, heart disease and some forms of cancer.

³⁶ Gentilello, L.M., Rivara, F.P., Donovan, D.M., Jurkovich, G. J., Daranciang, E., Dunn, C.W., Villaveces, A., Copass, M., and Ries, R. R. 1999. Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence. *Annals of Surgery* 230(4):473-483, 1999. The three-year study examined the impact of alcohol screening followed by brief counseling on trauma patients. The study divided 760 trauma patients into two groups: those that received 30 minutes of post-screening counseling; and those that did not receive alcohol counseling. The treatment group experienced a 48% reduction in readmission to the hospital and a 50% reduction in return visits to the emergency room. The control group (patients who did not receive counseling) did not reduce their alcohol consumption. Patients in the intervention group reported a reduction in the consumption of alcohol by 28 drinks per week.

³⁷ National Conference of Insurance Legislators. Resolution in support of amending the NAIC Uniform Accident and Sickness Policy Provision Law. Adopted on March 2, 2001. According to the NCOIL resolution, actuarial analysis demonstrates that routine implementation of alcohol screening and intervention in trauma centers will result in an estimated five-year net national savings of \$327,250,000 in direct medical costs.

A recent study of emergency-room patients in Tennessee found that fewer than 10 percent of patients needing addiction treatment received treatment for substance abuse.³⁸ According to the research results, Tennessee patients with unmet treatment needs are 81 percent more likely to be admitted during their emergency visits and 46 percent more likely to have reported making at least one emergency department visit in the prior 12 months.³⁹ As a result, patients with unaddressed addictions accounted for \$777.2 million in additional hospital charges for the state in 2000 or \$1,568 per patient.⁴⁰ A cost-benefit analysis conducted at the University of Washington demonstrates that emergency room alcohol and drug screening and intervention will result in an estimated three year net national savings of \$1.82 billion in direct medical costs with \$3.81 saved for every dollar invested in emergency room screening and intervention for substance abuse problems.⁴¹ Thus, early intervention and treatment not only help the addicted; such actions can also result in significant medical cost savings.

The outdated 1947 Model UPPL, in permitting denial of benefits in cases involving alcohol and drugs, conflicts with the contemporary recommendations of national medical associations and federal agencies. The American Medical Association (“AMA”) has adopted a resolution recommending that such exclusionary laws and practices be eliminated.⁴² In addition, the Centers for Disease Control, National Highway Traffic Safety Administration and the American College of Emergency Physicians all support greater screening for alcohol problems in emergency rooms.⁴³ When the exclusionary provisions have been repealed or reversed, the AMA and other health care providing organizations should ensure that their members are well advised of the changes and that proper screening for alcohol and drug use is provided in all appropriate cases.

IV. RECOMMENDATION TO AMEND THE UPPL

The 1947 Model UPPL provision permitting exclusion serves as a barrier to treatment for emergency room patients with an alcohol or drug disease. The 2001 amendment reverses that provision. State and territorial statutes should not exclude coverage for treatment of injuries in a trauma patient with positive alcohol or drug blood levels. With an increasingly highly managed

³⁸ Join Together Online (www.jointogether.online). Boston University School of Public Health. Emergency Room Patients with Addictions Cost More. January 5, 2005.

³⁹ Join Together Online, Emergency Room Patients with Addictions Cost More. January 5, 2005.

⁴⁰ Join Together Online, Emergency Room Patients with Addictions Cost More. January 5, 2005.

⁴¹ Gentilello, L.M., Ebel, B.E., Wickizer, T.A., Salkever, D.S., Rivara, F.P. Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals: A Cost Benefit Analysis. *Annals of Surgery* 241(4):541-550, 2005. According to the study, an estimated 27% of all injured adult patients are candidates for a brief alcohol intervention. The net cost savings of the intervention was \$89 per patient screened, or \$330 for each patient offered an intervention. The net cost savings are based on the expected cost of subsequent emergency department visits and hospital admissions.

⁴² At its 2003 Interim Meeting, the American Medical Association adopted Resolution 912, which called for the American Medical Association to support state and specialty medical societies and the public health associations in their efforts to repeal state laws modeled after the Uniform Accident and Sickness Policy Provision Law.

⁴³ Ensuring Solutions to Alcohol Problems, *Challenging a Hidden Obstacle: Little-Known Insurance Laws Thwart Screening in Emergency Rooms*. page 3.

health care delivery system, the existence of even one insurance company that routinely excludes coverage will influence how physicians treat all patients.⁴⁴

V. RELATED ABA POLICY

The American Bar Association has several policies that address long-term solutions to alcohol or other drug disease and the attendant discrimination.

At the 1972 Midyear Meeting, the House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, which provides for treatment of alcoholics and intoxicated persons instead of subjecting such persons to criminal penalties, establishes facilities and machinery for treatment of such persons, and provides for voluntary commitment to a treatment facility or involuntary commitment by court order.

At the 1975 Midyear Meeting, the American Bar Association reaffirmed its support for the Uniform Alcoholism and Intoxication Treatment Act drafted by the National Conference of Commissioners on Uniform State Laws and urged states that have not already done so to utilize the newly available federal funding (P. L. No. 93-282) to implement its provisions. The American Bar Association also generally reaffirmed its support for the principle of decriminalization of alcoholism.

At the 1994 Midyear Meeting, the House of Delegates approved a policy supporting development of a comprehensive, systemic approach to addressing the needs of defendants with drug and alcohol problems through multidisciplinary strategies that include coordination among the criminal justice, health, social service and education systems, and the community; urge the courts to adopt certain treatment-oriented, diversionary drug court programs as one component of a comprehensive approach. The policy urges bar associations to facilitate the development of such programs that result in dismissal of drug-related charges upon the completion of drug rehabilitation.

At the 1995 Annual Meeting, the House of Delegates endorsed the U. S. Sentencing Commission's proposal to amend federal sentencing guidelines to eliminate differences in sentences based on drug quantity for offenses involving crack versus powder cocaine, and assign greater weight in drug offense sentencing to other factors that may be involved in the offense, such as weapons used, violence, or injury to another person.

At the 1995 Annual Meeting, the House of Delegates approved a policy urging bar associations to join the American Bar Association in developing and encouraging initiatives aimed at preventing inhalant abuse.

At the 1997 Annual Meeting, the House of Delegates approved a policy supporting the removal of legal barriers to the establishment and operation of approved needle exchange programs that include drug counseling and drug treatment referrals in order to further scientifically-based public health objectives to reduce HIV infection and other blood-borne diseases and in support of the American Bar Association's long-standing opposition to substance abuse.

⁴⁴ Rivara et al., pages 117-118.

At the 2004 Annual Meeting, the House of Delegates approved a policy urging federal, state, territorial and local governments to eliminate policies that sanction discrimination against people seeking treatment or recovery from alcohol or other disease, including specific recommendations in the area of public benefits.

VI. CONCLUSION

People with alcohol or other drug dependency disease face public and private policies and prejudices that restrict their access to appropriate health care, employment and public benefits, thus discouraging them from seeking treatment, robbing them of hope for recovery and costing the U. S. economy billions of dollars. The economic cost of substance abuse to the U. S. economy is estimated at \$276 billion (as of 1995) according to a 2001 report published by the Robert Wood Johnson Foundation.⁴⁵ This cost, undoubtedly higher today, includes the loss of productivity caused by premature death and the inability to perform usual activities, as well as costs related to crime, destruction of property and other losses.⁴⁶

State, territorial and local law making bodies, insurance commissioners and other governmental officials should adopt policies that prohibit exclusion of insurance coverage of alcohol or drug related injuries.

The recommendation is consistent with several of the American Bar Association's missions and goals, including Goal I (To promote improvements in the American System of Justice) and Goal III (To provide ongoing leadership in improving the law to serve the changing needs of society). Adoption of the report with recommendations will enhance the American Bar Association's ability to encourage a review of and change in state, territorial and local insurance laws and policies that discriminate against individuals with chemical dependency.

Respectfully submitted,

Barbara J. Howard
Chair
Standing Committee on Substance Abuse
August 2005

⁴⁵ *Substance Abuse: The Nation's Number One Health Problem*. Princeton, New Jersey: The Robert Wood Johnson Foundation, February 2001, pages 18, 45. Of the total estimated economic cost of \$414 billion, \$138 billion is attributable to the costs of substance abuse related to cigarette smoking.

⁴⁶ The Robert Wood Johnson Foundation, *Substance Abuse: The Nation's Number One Health Problem*, page 18.

GENERAL INFORMATION FORM

To Be Appended to Reports with Recommendations
(Please refer to instructions for completing this form.)

Submitting Entity: Standing Committee on Substance Abuse

Submitted By: Barbara J. Howard, Esq., Chair

1. Summary of Recommendation(s).

This recommendation urges all state, territorial and local legislative bodies and governmental officials to repeal laws and discontinue practices that permit insurers to deny coverage in accident and sickness insurance policies for alcohol or drug related injuries or losses.

The recommendation also supports the 2001 Amendment by the National Association of Insurance Commissioners to its model law, the Uniform Accident and Sickness Policy Provision Law, permitting coverage in accident and sickness insurance policies for injuries in cases involving alcohol or drugs.

2. Approval by Submitting Entity.

Approved by the Standing Committee on Substance Abuse on February 12, 2005.

3. Has this or a similar recommendation been submitted to the House or Board previously?

No.

4. What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?

The proposed recommendation will supplement the following American Bar Association (“ABA”) policies:

- A. The ABA’s approval of the Uniform Alcoholism and Intoxication Treatment Act, which provides for treatment of alcoholics and intoxicated persons instead of subjecting such persons to criminal

penalties, establishes facilities and machinery for treatment of such persons, and provides for voluntary commitment to a treatment facility or involuntary commitment by court order, adopted February 1972;

- B. The ABA's reaffirmation of support for the Uniform Alcoholism and Intoxication Treatment Act drafted by the National Conference of Commissioners on Uniform State Laws, adopted February 1975;
- C. The ABA's reaffirmation of its support for the principle of decriminalization of alcoholism, adopted February 1975;
- D. The ABA's support of the development of a comprehensive, systemic approach to addressing the needs of defendants with drug and alcohol problems through multidisciplinary strategies that include coordination among the criminal justice, health, social service and education systems, and the community and urge the courts to adopt certain treatment-oriented, diversionary drug court programs as one component of a comprehensive approach, adopted February 1994;
- E. The ABA's endorsement of the U. S. Sentencing Commission's proposal to amend federal sentencing guidelines to eliminate differences in sentences based on drug quantity for offenses involving crack versus powder cocaine, and assign greater weight in drug offense sentencing to other factors that may be involved in the offense, such as weapons used, violence, or injury to another person, adopted August 1995;
- F. The ABA's urging bar associations to join the ABA in developing and encouraging initiatives aimed at preventing inhalant abuse, adopted August 1995;
- G. The ABA's support of the removal of legal barriers to the establishment and operation of approved needle exchange programs that include drug counseling and drug treatment referrals in order to further scientifically-based public health objectives to ABA's long-standing opposition to substance abuse, adopted August 1997; and
- H. The ABA's urging federal, state, territorial and local governments to eliminate policies that sanction discrimination against people seeking treatment or recovery from alcohol or other disease, including specific recommendations in the area of public benefits, adopted August 2004.

5. What urgency exists which requires action at this meeting of the House?

State legislatures are considering statutes to amend the 1947 Uniform Accident and Sickness Policy Provision Law and prohibit the exclusion of insurance coverage of alcohol and drug related injuries. Action at this meeting of

the House will allow the ABA, in coordination with state and local bar associations, to participate in the debate in state legislatures.

6. Status of Legislation. (If applicable.)

As of February 2005, the following state legislatures have introduced bills to repeal the Uniform Accident and Sickness Policy Provision Law: California (SB573); Nevada (AB63); Rhode Island (H5778 and S0779); and Texas (HB949).

7. Cost to the Association. (Both direct and indirect costs.)

Not applicable.

8. Disclosure of Interest. (If applicable.)

Not applicable.

9. Referrals.

In April and May 2005, this Report with Recommendation was referred to the following ABA entities for review and support:

Commission on Lawyer Assistance Programs
Health Law Section
Tort Trial and Insurance Practice Section
Section of Individual Rights and Responsibilities
Section of Criminal Justice
Commission on Homelessness and Poverty
Commission on Domestic Violence
Section of Family Law
Section of Labor and Employment Law
Section of Litigation
Section of General Practice, Solo and Small Firm
Standing Committee on Legal Aid and Indigent Defendants
Standing Committee on Pro Bono and Public Service
Commission on Mental and Physical Disability Law
Consortium on Legal Services and the Public
Steering Committee on the Unmet Legal Needs of Children
Young Lawyers Division
Senior Lawyers Division
Law Student Division
Commission on Women in the Profession
Council on Racial and Ethnic Justice

10. Contact Person. (Prior to the meeting.)

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11. Contact Person. (Who will present the report to the House.)

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