Social Work and the Uniform Accident and Sickness Policy Provision Law: A Pilot Project

Gerald Cochran and King Davis

The Uniform Accident and Sickness Policy Provision Law (UPPL) is a statute existing in 26 states that permits health insurance companies to deny payment for claims made by individuals who have sustained injuries as a result of drug or alcohol use. This law presents a series of complicated clinical and ethical dilemmas for social workers and other medical personnel. The majority of contributions to the national discussion regarding the UPPL have been produced by the medical, nursing, and policy/legal disciplines. Social work has, however, remained silent. It is paramount that social workers add their perspective and insight to this debate. This article discusses the first survey, to the authors' knowledge, of social workers practicing in health care settings regarding their knowledge and beliefs about the UPPL.

KEY WORDS: *health insurance; medical social work; substance abuse; substance abuse policy*

Twenty-four percent to 31 percent of annual emergency department (ED) visits and 50 percent of severe traumatic injuries seen in hospitals in the United States are related to alcohol intoxication (D'Onofrio & Degutis, 2002; Gentilello et al., 1999). However, only 4 percent of visits to EDs have been found to be related to drug use (Cherpitel & Ye, 2008). Because of the prevalence of alcohol and drug use by patients, medical settings represent a feasible venue for clinical interventions. Research trials over the past 30 years have supported the efficacy of screening and brief interventions (SBIs) in reducing future alcohol use and creating improved health care outcomes, such as reductions in injury recidivism (D'Onofrio & Degutis, 2002; Nilsen et al., 2008). Support for SBIs is such that the American College of Surgeons (ACS) requires that trauma centers deliver these services to receive level 1 accreditation (ACS, n.d.).

Within clinical settings, a variety of professionals see and treat individuals who suffer injuries related to alcohol and drug use. Among these professionals are social workers, who play an important role in the care of injured patients. In particular, social workers are often trained and charged with alcohol and drug use screenings and interventions—including SBIs (ACS, n.d.; Bliss & Pecukonis, 2009). Regardless of whether substance abuse–related services are delivered by social workers or trauma surgeons, a law existing in many states allows insurers to deny health care claims for people injured as a result of alcohol or drug intoxication. This law has serious repercussions for the nation's health care system, health care professionals, and their individual patients.

BACKGROUND

The National Association of Insurance Commissioners created a model state statute (template law) in 1947 named the Uniform Accident and Sickness Policy Provision Law (UPPL). The original text of the law stated, "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" (Alcohol Policy Information System, 2008). The purpose of this law was to exempt health insurance companies from paying medical expenses for individuals who suffered injuries related to alcohol or drug intoxication (Chezem, 2004; Gentilello et al., 2005).

After the UPPL was authored, it was subsequently passed into law in 38 states and provisionally passed (narcotics only) in four states (Gentilello et al., 2005; Rivara, Tollefson, Tesh, & Gentilello, 2000). Over the past 50 years, 16 states have repealed or amended the statute, and today 26 states (see Table 1) continue with the

doi: 10.1093/sw/swr003

Table 1: Active UPPL States

State	Reference
AL	Ala. Code s. 27-19-26
AK	Alaska Stat. s. 21.51.260
AZ	Ariz. Rev. Stat. s. 20-1368
AR	Ark. Code Ann. s. 23-85-126
DE	Del. Code Ann. tit. 18, s. 3325
FL	Fla. Stat. ch. 627.629
GA	Ga. Code Ann. s. 33-29-4
HI	Haw. Rev. Stat. s. 431:10A-106
ID	Idaho Code s. 41-2127
KS	Kan. Stat. Ann. s. 40-2203
KY	Ky. Rev. Stat. Ann. s. 304.17-290
LA	La. Rev. Stat. Ann. s. RS 22:975
MS	Miss. Code Ann. s. 83-9-5
MO	Mo. Rev. Stat. s. 376.777
MT	Mont. Code Ann. s. 33-22-231
NE	Neb. Rev. Stat. s. 44-710.04
NJ	N.J. Rev. Stat. s. 17B:26-2
NY	N.Y. Ins. Law s. 3216
ND	N.D. Cent. Code s. 26.1-36-04
PA	40 Pa. Cons. Stat. s. 753
SC	S.C. Code Ann. s. 38-71-370
TN	Tenn. Code Ann. s. 56-26-109
TX	Tex. Code s. 1201.227
VA	Va. Code Ann. s. 38.2-3504
WV	W. Va. Code s. 33-15-5
WY	Wyo. Stat. Ann. s. 26-18-126

Note: UPPL = Uniform Accident and Sickness Policy Provision Law

UPPL in force in their health insurance codes (Baker, 2009). Recent content analyses of each of these 26 states' UPPL statutes demonstrated that the statutory language remains highly similar in form and intent to the original (1947) UPPL text, and the law has experienced few, if any, changes in these 26 states since its inception (Cochran, 2010).

Unfortunately, empirical research about how much and how frequently payment for substance use–related injuries is denied by insurers is not present within the literature. Nevertheless, despite this absence of data, the threat of the UPPL has been substantiated by findings from a survey reporting that nearly 25 percent of surgeons sampled had seen a denial of insurance payment for substance use–related injuries within the previous six months of their practice (Gentilello et al., 2005). The seriousness of claim denials is also reflected in the policy priority of the ACS that aims to overturn the law in the states in which it exists (ACS, 2009), anecdotal victim accounts (Zimmerman, 2003), and state insurance lobbyist testimony (Texas House of Representatives, 2007).

Despite the reality of the UPPL, some may insist that current federal laws exist to protect individuals who have received substance abuse treatment services—as might be delivered in medical settings following substance use–related injuries. The Code of Federal Regulations (42 CFR) is one such law that protects the identity, diagnosis, prognosis, or treatment information of individuals receiving substance abuse treatment. The purpose behind 42 CFR is to ensure that individuals who seek assistance for substance abuse problems are not at a higher level of risk of having their medical and treatment records disclosed to outside entities than those who choose not to receive treatment (Code of Federal Regulations, 2009).

However, 42 CFR protections of information are not applicable in instances in which those who are insured have granted authorization for a third party to view their records (Code of Federal Regulations, 2009). Many private insurance policies require that when individuals enroll in plans they sign, as part of the standard contractual process, an agreement authorizing insurers to view their records (American Medical Association, 2009; Privacy Rights Clearing House, 2008). As a consequence, although 42 CFR may be able to assist some individuals, those who have private health care plans and have signed such standard agreements are afforded no protection against insurance companies using diagnoses, prognoses, and treatments related to substance abuse to deny claims.

Beyond current federal protections, some may assert that the health care reform legislation passed in 2010, the Patient Protection and Affordable Care Act (PPACA), could provide relief from the UPPL. Although substance abuse–related injury or the UPPL are not specifically addressed in the reform bill, insurance plans offered from the exchanges mandated in PPACA must provide emergency and hospitalization coverage. PPACA also mandates private insurers to provide coverage commensurate to that provided by exchanges, which includes emergency care and hospitalization (National Association of Insurance Commissioners, 2010). Such reforms to private health insurance could translate into broader changes that remove power from state UPPL statutes. However, such potential alterations to state law are currently unknown. More important, PPACA reforms to health plans will not go into effect until 2014 (National Association of Insurance Commissioners,

2010), and therefore, until then (and potentially after), patients who suffer injuries related to substance use will be exposed to the full repercussions of the UPPL.

In frank terms, in states where UPPL statutes exist today, the only respite for individuals who suffer injuries while under the influence is federally funded insurance programs. These programs mandate coverage for hospital care or other medical services that would be associated with accidental injuries (Department of Veterans Affairs, 2009a, 2009b; Kaiser Family Foundation, 2005, 2010). However, individuals who have private insurance are afforded no such protections from insurers.

UPPL Repercussions

The UPPL has serious repercussions for the clinical practice of health care professionals in those states in which the law is maintained. Within trauma and emergency care settings, apprehension related to UPPL ramifications has been observed to be a barrier for physicians ordering alcohol or drug screening tests for injured patients (Gentilello et al., 2005; Rivara et al., 2000). If physicians do not screen for the presence of alcohol or drug use, patients could be at risk for lethal complications related to the interactions of drugs (Culver & Walker, 1999; Singh, Dimich, & Shamsi, 1994) or alcohol (Brown, 1987; Vagts, Iber, & Noldge-Schomburg, 2003) with medications given to manage pain or anesthetize. Physicians failing to request screenings could risk malpractice suits. If not screened, patients with risky or dependent substance use patterns could miss out on needed interventions and treatment referrals. As was noted, one example of helpful interventions comes from the past 30 years of clinical trials of SBIs for patients (with and without injures) who present with risky alcohol use patterns. Interventions with these individuals have shown meaningful and significant reductions in future drinking behaviors and injury recidivism (D'Onofrio & Degutis, 2002; Nilsen et al., 2008).

In contrast, if physicians order screenings and the results are positive for substance intoxication, patients could face financial ruin as a result of not being able to afford the cost of care, with the average cost of an alcohol-positive traumatic injury being nearly $10,500 (O'Keeffe, Shafi, Sperry, & Gentilello, 2009). Researchers have noted that a major contributor to personal bankruptcy is unpaid debt related to medical treatment (Dranove & Millenson, 2006; Himmelstein, Warren, Thorne, & Woolhandler, 2005; Jacoby, Sullivan, & Warren, 2001). Furthermore, uncompensated care also represents an annual multi-billion-dollar expenditure for hospitals (American Hospital Assocation, 2008), with costs eventually trickling down to taxpayers (Hadley & Holahan, 2004) and health insurance policyholders.

Physicians are not the lone practitioners whose clinical practices can be influenced by UPPL repercussions. The importance and relevance of this issue to social work centers on the fact that social workers are among those staff members who routinely perform intervention services, such as SBIs for injured patients (ACS, n.d.; Bliss & Pecukonis, 2009). Because of their professional obligations, social workers may likewise be hesitant to carry out screening and interventions due to the potential financial, health, and legal consequences faced by patients. If social workers responsible for SBI services do not screen or perform interventions, patients are placed into perilous situations of missing out on appropriate care and referrals for treatment after discharge. Decisions about withholding services certainly raise ethical dilemmas as well as practice issues (Cochran, 2010).

Synthesis

The UPPL has many serious implications for health care practice and service delivery—implications to which the social work profession is not immune. The preponderance of contributions to the national discussion regarding the UPPL have been produced by the medical, nursing, and policy/legal disciplines. However, social work has remained silent. It is paramount that social workers add their perspective and insight to this debate. Before such input can be offered, however, research must be conducted within the profession to gain an understanding of what social workers practicing in health care settings know and believe about the UPPL. This article describes the first survey, to our knowledge, on this topic.

METHOD

Design

To assess social worker knowledge and beliefs regarding the UPPL, a cross-sectional online survey was

administered over a two-month period to the national membership of a professional association for social workers practicing in health care settings. The national membership list of the organization contained the e-mail addresses of 619 individuals. However, following the first emailing, 24 of the e-mail addresses were unable to receive mail. Therefore, the total number of social workers solicited for participation in this project was 595.

Each of the 595 received an e-mail introducing the project and containing a link to a cover letter for Internet research and the online survey. Part of the introductory e-mail and cover letter gave an overview of the research project and a brief explanation of the UPPL. The research team designed the brief explanation of the UPPL to adequately inform participants regarding the law (if they were not previously aware of the UPPL) in order to answer the survey questions. The research team also designed the explanation to not provide information that would potentially bias participant responses. The survey asked participants to provide demographic information, their work and education history, the state in which they practice as social workers, and their knowledge and beliefs with respect to the UPPL. The UPPL questions included in the survey were created by project investigators and were conceptualized, derived, or modified from previous research literature (Gentilello et al., 2005; Terrell et al., 2008).

Analyses

At the end of the second month of survey administration, the survey was closed, and the data were exported to the SPSS 16.0 for analysis (SPSS, 2007). Descriptive statistics were applied to describe the respondents' demographic information and to analyze responses to the UPPL questions. Independent sample *t* tests and two-sample tests of proportions were used to examine differences within the sample.

RESULTS

Respondent Demographics

A total of 241 individuals responded to the survey, a response rate of 40 percent. Most respondents were female ($n = 203$), and the average age of all participants was 51 years. Respondents reported to be Caucasian ($n = 206$, 86.2 percent), black or African American ($n = 19$, 7.9 percent), Asian ($n = 5$, 2.1 percent), and "other" ($n = 9$, 3.7 percent). Nine participants indicated they identified themselves as Hispanic or Latino/a. Most respondents held master's degrees ($n = 206$, 85.5 percent), followed by doctorate degrees ($n = 26$, 10.8 percent), bachelor's degrees ($n = 6$, 2.5 percent), and high school or GED diplomas ($n = 1$, 0.4 percent). The average years of practice reported was 24, and the majority of respondents indicated they were licensed, accredited, certified, or possessed some degree of professional status in the field of social work ($n = 218$, 98.4 percent). The most common work setting reported was hospitals ($n = 177$, 73.4 percent), followed by institutions of higher education ($n = 13$, 5.4 percent), clinics ($n = 12$, 5 percent), hospice ($n = 6$, 2.5 percent), nursing homes/physical rehabilitation centers ($n = 4$, 1.7 percent), psychiatric hospitals ($n = 1$, 0.4 percent), and "other" health- or mental health-related locations ($n = 24$, 10.0 percent).

One item regarding work setting must be noted. As is common in many professions, social workers often practice in multiple settings. For the descriptive statistics above, if respondents indicated they worked in a hospital and another location, only the hospital was counted and reported. This decision was made to simplify reporting and because receiving survey responses from social workers in hospital locations was a priority of this project due to the survey topic more directly affecting hospital-based professionals than those in other settings.

Knowledge of Social Workers Regarding the UPPL

The first six questions (see Table 2) asked participants about their knowledge of the UPPL. Most social workers surveyed were not familiar with the UPPL in general and had not witnessed UPPL repercussions. Nonetheless, some respondents indicated being aware of actual claim denials for alcohol ($n = 33$, 14.1 percent) or drug ($n = 24$, 10.3 percent) use.

In addition to the knowledge of all those who responded to the survey, the knowledge of social workers practicing in states with a UPPL statute compared with those in states without a UPPL statute was of interest because injury patients seen by professionals in states a with UPPL statute are those with the most

Table 2: Participant Knowledge of the UPPL

Question	Yes Response		No Response		
	No.	(%)	No.	(%)	*n*
Are you aware of a patient whose insurance company denied paying his/her health care claim because the patient was injured in an accident resulting from his/her alcohol use?	33	(14.1)	201	(85.9)	234
Are you aware of a patient whose insurance company denied paying his/her health care claim because the patient was injured in an accident resulting from his/her drug use?	24	(10.3)	210	(89.7)	234
Are you aware of a hospital that has been denied payment based on a patient's blood alcohol level test results?	20	(8.6)	213	(91.4)	233
Are you aware of a hospital that has been denied payment based on a patient's drug toxicology results?	16	(6.8)	218	(93.2)	234
Are you familiar with the Uniform Accident and Sickness Policy Provision Law (UPPL)?	31	(13.2)	203	(86.8)	234
Does a UPPL statute exist in your state?	30	(24.4)	93	(75.6)	123

present threat. However, when examined, no significant differences ($p > .05$) existed in the proportions of participants' responses from states with a UPPL statute compared to those in states without a UPPL statute with respect to their knowledge of the statute.

Whether respondents possessed an accurate knowledge of a UPPL statute in their state was also of interest to the study. To answer this question, the research team identified if the states in which respondents worked possessed a UPPL statute. A cross-tabulation analysis was then carried out with this information and participants' answers as to whether they believed that a UPPL statute existed in their state. Responses to this question ($n = 120$) indicated that 20 individuals accurately knew their state possessed a UPPL statute, and 59 individuals accurately knew their state did not have a UPPL statute. However, 32 respondents did not believe there was a UPPL statute in their state when their actually was, and nine reported that there was a UPPL statute in their state when there was not. Aggregating these responses shows that 79 respondents accurately reported the existence of a UPPL statute within their state, and 41 participants inaccurately reported the existence of the statute in their state. In other words, 34.2 percent of participants who answered the question did not accurately know whether they had a UPPL statute in their state.

The answer choices regarding participants' belief of whether there was a UPPL statute in their state were "Yes" and "No." In being forced to provide a yes or no response, a number of participants ($n = 118$) chose not to answer the question, resulting in complete data for only 123 individuals. To test whether the proportions of responses differed for those who answered accurately regarding the existence of a UPPL statute in their state compared with those who inaccurately responded regarding the UPPL in their state, a two-sample test of proportions was carried out. Results of the test showed there was a significantly greater proportion of individuals who accurately answered regarding the existence of a UPPL statute in their state ($z = 3.12$, $p = .001$) than of individuals who did not answer accurately.

These results could have a number of implications related to accurate participant knowledge pertaining to the existence of a UPPL statute in their state, two of which stand out. The first is the possibility that if more survey respondents had answered the question those additional respondents would have accurately reported a UPPL statute in their state. In contrast, the second implication is that there was a response bias for those who answered the question. Those respondents who answered the question might have felt surer of their knowledge of the status of the UPPL statute in their state and, therefore, been more comfortable providing an answer. However, those who did not know the status of the UPPL in their state may have left the question blank as a result of not knowing.

Beliefs of Social Workers about the UPPL

The subsequent survey questions (see Table 3) asked participants to indicate their level of

agreement (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree) with respect to 15 statements concerning the UPPL. On average, respondents mostly disagreed that it was common knowledge that insurance companies could deny payment for medical claims for injuries caused by alcohol ($M = 2.3$) or drug use ($M = 2.3$). Participants also disagreed ($M = 1.8$) that social workers should aid in proving substance use was related to injuries in order to assist insurance companies in denying claims. Survey participants were neutral regarding the hesitancy of physicians in screening for alcohol ($M = 3$) or drug use ($M = 3$) disorders, but social workers somewhat agreed that physicians have a responsibility to screen for alcohol ($M = 3.8$) or drug use ($M = 3.8$) disorders.

Respondents agreed with relative strength that social workers should be aware of UPPL issues ($M = 4.5$) and be more involved in understanding the issue ($M = 4.2$) and that more research should be done to inform clinical practice ($M = 4.2$) and policy ($M = 4.2$). Respondents also somewhat agreed that social workers should help protect patients at risk for claim denial ($M = 3.8$), provide information to other health professionals about the UPPL ($M = 3.8$), and advocate for the elimination of the UPPL within states ($M = 3.8$).

Comparing the attitudes of practitioners in states with a UPPL statute with those of practitioners in states without a UPPL statute was also of interest. Attitudes of social workers in states with a UPPL statute were similar to those of social workers in states without a UPPL statute, meaning there were no significant differences ($p > .05$) between the two groups' responses, with one exception. Scores for practitioners working in states with a UPPL statute ($M = 3.16$) were

Table 3: Participants' Beliefs about the UPPL

Statement	Mean Level of Agreement	*n*
It is common knowledge that insurance companies in some states may deny payment for medical claims for injuries caused by drug use.	2.3	217
It is common knowledge that insurance companies in some states may deny payment for medical claims for injuries caused by alcohol use.	2.3	215
It would be important for social workers to know about a law that would allow insurance companies to deny payment for health care claims based on substance screening results.	4.5	217
It would be important for social workers to assist in proving that an injury from an accident was related to substance use in order to help insurance companies deny insurance claims.	1.8	216
It would be important for social workers to help protect injured patients if their insurance claims may be denied as a result of a positive substance screening.	3.8	214
It would be appropriate for social workers to provide information to medical professionals who were unaware insurance claims could be denied for injures related to substance screening results.	3.8	216
It is the physician's responsibility to screen for alcohol use disorders.	3.8	216
It is the physician's responsibility to screen for drug use disorders.	3.8	217
Some physicians are hesitant to order alcohol screenings for injured patients because they believe insurance claims might be denied.	3.0	209
Some physicians are hesitant to order drug screenings for injured patients because they believe insurance claims might be denied.	3.0	209
Social workers should become more involved in understanding the UPPL issue because of its potentially harmful effects on patients.	4.2	214
Social workers should not become involved with the UPPL issue because it only involves physicians, their patients, and does not affect social workers.	1.8	216
It would be a good idea for social workers to advocate for the elimination of the UPPL in their state.	3.8	213
More research should take place in order to understand the UPPL issue so as to inform clinical practice.	4.2	217
More research should take place in order to understand the UPPL issue so as to inform state policy.	4.2	218

significantly [$t(202) = -2.37$, $p = .01$] higher than those for practitioners in states without a UPPL statute ($M = 2.90$) in reporting social worker perceived hesitancy of physicians in ordering screening tests for alcohol as a result of doctors' beliefs that insurance claims might be denied. Similarly, social workers in states with a UPPL statute reported significantly higher [$t(202) = -2.57$, $p = .01$] scores ($M = 3.19$) of perceived physician hesitancy in ordering drug screenings than those in states without a UPPL statute ($M = 2.90$) as a result of doctors' beliefs that insurance claims might be denied. However, despite these significant differences, effect sizes were weak (hesitancy to screen for alcohol, $\eta^2 = .03$; hesitancy to screen for drugs, $\eta^2 = .03$). In spite of these weak effect sizes, the significant findings are nevertheless somewhat intuitive in that social workers in states with a UPPL statute may in reality observe more hesitancy of doctors to order tests as potential denials are a threat in these states.

LIMITATIONS

In addition to the challenge related previously regarding social worker knowledge of a UPPL statute in their states, two further limitations should be mentioned. Although most survey participants worked in hospital settings, 25.6 percent reported working in nonhospital settings. Nevertheless, responses from nonhospital health care social workers were included in the results because these professionals could still provide services to individuals who suffered injuries related to substance intoxication. For instance, if an individual were in a car accident because he or she was intoxicated, that person might be required to undergo care at a physical rehabilitation/nursing care facility. Therefore, social work staff at that facility might be faced with UPPL repercussions and would have opinions related to the law.

Similarly, responses to the survey from participants practicing in states not possessing a UPPL statute were also included. Individuals who experience a claim denial could at some point receive services outside the state where their claim was denied. Therefore, social workers practicing in any state could potentially be confronted with UPPL repercussions and therefore would have an opinion on the law. Furthermore, social workers practicing in states in which a UPPL statute is not currently active could have practiced previously in a state with an active statute, or the state in which the social worker is practicing could have repealed the statute at some point in the past. Therefore, these social workers' opinions regarding the UPPL would also carry weight.

DISCUSSION AND FUTURE DIRECTIONS

The results depict beginning images of social workers in health care settings and their knowledge and beliefs regarding the UPPL. Most social workers in health care settings were not familiar with the UPPL or its potential repercussions. Therefore, preservice social work education, continuing education programs, and journals might benefit from information about the UPPL. This lack of familiarity with the UPPL could be further supported by the potential response bias noted earlier. As reported, a larger proportion of social workers answered accurately when responding to the question that asked if a UPPL statute existed in their state. Although it is possible that nonrespondents could have provided accurate responses if they had provided answers to the question, it seems more plausible that the reason so many participants did not respond was because they were unsure if a UPPL statute existed in their state. Therefore, the inclusion of information about the UPPL in social work education and scholarship is likely appropriate and falls succinctly within the scope of NASW's (2009) policy statement on alcohol, tobacco, and other drugs, which emphasize the importance of including such topics in social work education.

Despite the finding that most social workers in the survey were not aware of the UPPL, some individuals reported being aware of insurance denials to patients for alcohol ($n = 33$) and drug use ($n = 24$). It is interesting to note that further analysis of these results revealed that 27 of the individuals who reported that they were aware of insurance denials for alcohol use and 21 who were aware of denials for drug use worked in hospital settings. These findings are potentially meaningful because they support the idea that UPPL denials have occurred and it is hospital social workers who have been aware of them. Moreover, these findings, combined with those regarding the observations of social workers in states with a UPPL statute of the hesitancy of doctors to screen patients, point to the fact that some social work professionals could be keenly aware of the UPPL

and its repercussions. A future qualitative study with social workers aware of denials could elicit detailed accounts of what has happened in denial cases with patients.

Also notable is the social work perspective toward the UPPL. The highest level of agreement ($M = 4.5$) of all responses given to survey items was to this statement: "It would be important for social workers to know about a law that would allow insurance companies to deny payment for health care claims based on substance screening results." Comparing these results with those of the statement with the most disagreement ($M = 1.8$) —"Social workers should not become involved with the UPPL issue because it only involves physicians, their patients, and does not affect social workers"—demonstrates a sense of interest and responsibility social workers feel regarding the UPPL. Adding to this perspective are participant responses indicating that social workers should help protect ($M = 3.8$) and not incriminate ($M = 1.8$) patients at risk for UPPL denials. Respondents also indicated that social workers should advocate for the elimination of the UPPL in their state ($M = 3.8$). Altogether, these responses underscore the social work profession's compassion for individuals in need of appropriate substance abuse interventions and treatment. Further, these findings tentatively support that social workers in health care settings are not interested in potentially compounding problems for patient care that may result from positive substance screenings.

These attitudes and sentiments of social workers align with the NASW (2009) policy statement on alcohol, tobacco, and other drugs. Substance abuse treatment should be delivered with equal access and facility, similar to other health and mental health services, and social workers should work to establish a prevention- and treatment-centered approach to substance misuse problems. Increasing social worker knowledge of and involvement with this issue could result in actions toward these goals.

Social workers in states with a UPPL statute could connect with representatives from organizations for which UPPL repeal is a priority. One such organization is the ACS, which includes UPPL repeal among its top policy priorities for states (ACS, 2009). If such partnerships were formed, repeal legislation sponsors from state legislatures could be identified and strategies for bill passage could be created. One of the key contributions social workers could offer to this process is helping to put a human face on the repercussions of such laws on patients, as social workers are among those professionals frequently delivering substance abuse interventions, referrals to treatment, and other case management services to patients. Such grassroots and personalized efforts are integral components of successful public policy advocacy (Baumgartner, 2009; Spitfire Strategies, 2006).

Practitioners also agreed with some strength to statements that more research on the implications of the UPPL for policy ($M = 4.2$) and social work practice ($M = 4.2$) should be carried out. Pursuit of this line of research would benefit social work as well as other allied health care professions. As noted, the literature remains silent with respect to the magnitude of this law in terms of claim denials, the depth and breadth of the personal financial consequences of the UPPL, and the long-term substance abuse treatment repercussions of failing to screen. Research that would specifically address these areas could be based on analyses of billing records from health insurance companies. Insurance companies are likely to retain information regarding claims and reasons for denials. An examination of insurance claim records could be effective in uncovering the frequency and depth of this issue within states. However, such data are considered proprietary by insurance companies and would not likely be easily accessed. If such a line of investigation with insurance companies was not feasible, a research project could be undertaken with hospitals and health care providers to identify patients who have been denied payment for insurance claims from within provider records or state traumatic injury registries. Once patients are indentified, researchers could assess financial or treatment impacts of claim denial.

CONCLUSION

The percentage of patients with traumatic injuries associated with alcohol or drug use is significant in American EDs and hospitals. At the point of admission or treatment in a medical setting, these patients face complex health care and financial challenges owing to the 1947 policy in place in many states that exempts insurers from payment if

alcohol or drugs are causally implicated in the injury. Although several states have repealed or modified this policy, it remains in force in 26 states.

In those states where the UPPL remains a part of the state's health insurance laws, it presents a series of complicated clinical and ethical dilemmas for social workers and other medical personnel. Confirmation that an injury occurred as a result of alcohol or drug use could result in denial of payments, which financially affects both the patient and the medical setting. It is noted that increased medical debt is a primary cause of an escalation of bankruptcy in the United States. However, failure to screen for and clinically acknowledge the presence of alcohol or drugs could result in a lower standard of care, increased health risks, ethical breech, denial of needed treatment, and charges of malpractice. Patients may also have a heightened risk of death.

This pilot project attempted to gain a greater understanding of the knowledge and attitudes of social workers toward the UPPL and to potentially establish a starting place for the profession to become more involved with the issue. On the basis of the findings, it seems clear that social workers in health settings are not adequately familiar with the existing policy and its implications for patients, providers, or medical settings. Findings and recommendations herein should help to establish research agendas for social workers to continue to explore the meaning and influence of the UPPL for patient populations and social workers practicing in health care settings.

Benefits to social work clients will likely emerge as social work researchers and practitioners continue to examine, learn about, and become involved with this issue. By doing so, it seems possible that social workers could help alter or reverse this long-term policy, which increases the risk to injured patients. With the threat of the UPPL mitigated or removed, individuals in need of substance misuse treatment who suffer injuries will be identified with greater frequency in ED and trauma settings. Subsequently, these individuals will have greater access to SBIs and other evidence-based interventions to reduce use and other risk behaviors related to alcohol or drug use. SW

REFERENCES

Alcohol Policy Information System. (2008). *Insurers' liability for losses due to intoxication ("UPPL"): Policy description.* Retrieved from http://www.alcoholpolicy.niaaa.nih.gov/Insurers_Liability_for_Losses_Due_to_Intoxication_UPPL.html

American College of Surgeons. (2009). *ACS grassroots advocacy: State legislative priorities.* Chicago: Author.

American College of Surgeons. (n.d.). *Alcohol screening and brief intervention (SBI) for trauma patients.* Chicago: Author.

American Hospital Assocation. (2008). *Uncompensated hospital care cost: Fact sheet.* Chicago: Author.

American Medical Association. (2009). *Patient confidentiality.* Retrieved from http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/patient-confidentiality.shtml

Baker, M. (2009). *Summary of UPPL/alcohol exclusion law repeal efforts.* Chicago: American College of Surgeons.

Baumgartner, F. R. (2009). *Lobbying and policy change: Who wins, who loses, and why.* Chicago: University of Chicago Press.

Bliss, D. L., & Pecukonis, E. (2009). Screening and brief intervention practice model for social workers in non-substance-abuse practice settings. *Journal of Social Work Practice in the Addictions, 9*(1), 21–40.

Brown, D. L. (1987). Anesthetic agents in trauma surgery: Are there differences? *International Anesthesiology Clinics, 25*(1), 75–90.

Cherpitel, C. J., & Ye, Y. (2008). Trends in alcohol- and drug-related ED and primary care visits: Data from three U.S. national surveys (1995–2005). *American Journal of Drug and Alcohol Abuse, 34*, 576–583.

Chezem, L. (2004). Legal barriers to alcohol screening in emergency departments and trauma centers. *Alcohol Research & Health, 28*(2), 73–77.

Cochran, G. (2010). Analysis of the Uniform Accident and Sickness Policy Provision Law: Lessons for social work practice, policy, and research. *Social Work in Health Care, 49*, 647–668.

Code of Federal Regulations 42: Public Health PART 2—Confidentiality of alcohol and drug abuse patient records, 2009 C.F.R. (2009).

Culver, J. L., & Walker, J. R. (1999). Anesthetic implications of illicit drug use. *Journal of PeriAnesthesia Nursing, 14*, 82–90.

Department of Veterans Affairs. (2009a). *VA health care eligibility & enrollment: General exclusions.* Retrieved from http://www4.va.gov/healtheligibility/coveredservices/GeneralExclusions.asp

Department of Veterans Affairs. (2009b). *VA health care eligibility & enrollment medical benefits package (standard benefits).* Retrieved from http://www4.va.gov/healtheligibility/coveredservices/StandardBenefits.asp

D'Onofrio, G., & Degutis, L. (2002). Preventive care in the emergency department: Screening and brief intervention for alcohol problems in the emergency department: A systematic review. *Academic Emergency Medicine, 9*, 627–638.

Dranove, D., & Millenson, M. L. (2006). Medical bankruptcy: Myth versus fact. *Health Affairs, 25*, W74–W83.

Gentilello, L., Donato, A., Nolan, S., Mackin, R., Liebich, F., Hoyt, D., et al. (2005). Effect of the Uniform Accident and Sickness Policy Provision Law on alcohol screening and intervention in trauma centers. *Journal of Trauma, 59*, 624–631.

Gentilello, L., Rivara, F., Donovan, D., Jurkovich, G., Daranciang, E., Dunn, C., et al. (1999). Alcohol

interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery, 230*, 473.
Hadley, J., & Holahan, J. (2004). *The cost of care for the uninsured: What do we spend, who pays, and what would full coverage add to medical spending.* Washington, DC: Kaiser Family Foundation.
Himmelstein, D. U., Warren, E., Thorne, D., & Woolhandler, S. (2005). Illness and injury as contributors to bankruptcy. *Health Affairs, 24*, 63–73.
Jacoby, M. B., Sullivan, T. A., & Warren, E. (2001). Rethinking the debates over health care financing: Evidence from the bankruptcy courts. *New York University Law Review, 76*, 375.
Kaiser Family Foundation. (2005). *Medicaid: An overview of spending on "mandatory" vs. "optional" populations and services.* Menlo Park, CA: Author.
Kaiser Family Foundation. (2010). *Medicare: A primer.* Menlo Park, CA: Author.
National Association of Insurance Commissioners. (2010). *Patient Protection and Affordable Care Act of 2009: Health insurance market reforms.* Washington, DC: National Association of Insurance Commissioners.
National Association of Social Workers. (2009). Alcohol, tobacco, and other drugs. *Social work speaks: National Association of Social Workers policy statements, 2009–2012* (pp. 29–37). Washington, DC: NASW Press.
Nilsen, P., Baird, J., Mello, M. J., Sr., Nirenberg, T., Woolard, R., Bendtsen, P., et al. (2008). A systematic review of emergency care brief alcohol interventions for injury patients. *Journal of Substance Abuse Treatment, 35*, 184–201.
O'Keeffe, T., Shafi, S., Sperry, J. L., & Gentilello, L. M. (2009). The implications of alcohol intoxication and the uniform policy provision law on trauma centers: A national trauma data bank analysis of minimally injured patients. *Journal of Trauma, 66*, 495–498.
Privacy Rights Clearing House. (2008). *Fact sheet 8: Medical records privacy.* Retrieved from http://www.privacyrights.org/fs/fs8-med.htm#C
Rivara, F. P., Tollefson, S., Tesh, E., & Gentilello, L. M. (2000). Screening trauma patients for alcohol problems: Are insurance companies barriers? *Journal of Trauma, 48*, 115–118.
Singh, P., Dimich, I., & Shamsi, A. (1994). Intraoperative pulmonary oedema in a young cocaine smoker. *Canadian Journal of Anaesthesia 41*, 961–964.
Spitfire Strategies. (2006). *Discovering the activation point.* Washington, DC: Author.
SPSS. (2007). *SPSS 16.* Chicago: SPSS Inc.
Terrell, F., Zatzick, D. F., Jurkovich, G. J., Rivara, F. P., Donovan, D. M., Dunn, C. W., et al. (2008). Nationwide survey of alcohol screening and brief intervention practices at US level I trauma centers. *Journal of the American College of Surgeons, 207*, 630–638.
Texas House of Representatives. (2007). *House committee insurance.* Austin: Texas Legislature.
Vagts, D., Iber, T., & Noldge-Schomburg, G. (2003). Alcohol—A perioperative problem of anaesthesia and intensive care medicine. *Anästhesiologie, Intensivmedizin, Notfallmedizin, Schmerztherapie: AINS, 38*, 747–761.
Zimmerman, R. (2003, February 26). Why emergency rooms rarely test trauma patients for alcohol, drugs. *Wall Street Journal*, pp. B1–B5.

Gerald Cochran *is a PhD candidate, and* ***King Davis, PhD,*** *is professor and the Robert Lee Sutherland Chair in Mental Health and Social Policy, School of Social Work, University of Texas at Austin. Address correspondence to Gerald Cochran, School of Social Work, University of Texas at Austin, 2501 Lake Austin Boulevard, K101, Austin, TX 78703; e-mail: jcochran@mail.utexas.edu.*

Original manuscript received January 15, 2010
Final revision received June 22, 2010
Accepted June 24, 2010
Advance Access Publication May 22, 2012