HB
383

HOUSE BILL NO. 383

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE IVAN

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to reimbursement by the state to municipalities and certain
2 e[illegible] villages for services provided to individuals incapacitated by alcohol;
3 and providing for an effective date."

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

5 * Section 1. AS 47.37.170(j) is amended to read:
6 (j) For purposes of (b) and (k) of this section, "incapacitated by alcohol"
7 means a person who, as the result of consumption of alcohol, is rendered unconscious
8 or has judgment or physical mobility so impaired that the person cannot readily
9 recognize or escape conditions of apparent or imminent danger to personal health or
10 safety. The definition in AS 47.37.270 applies to other portions of this chapter.
11 * Sec. 2. AS 47.37.170 is amended by adding a new subsection to read:
12 (k) A municipality or a traditional village council of an established village is
13 eligible for reimbursement from the state through the Department of Community and
14 Regional Affairs for services provided under this section by the municipality or

1 established village to individuals incapacitated by alcohol. To obtain a reimbursement
2 payment, the municipality or traditional village council shall apply by January 15 to
3 the Department of Community and Regional Affairs for payment for the immediately
4 preceding year on forms and in the manner prescribed by the Department of
5 Community and Regional Affairs. Each applicant shall submit with the application
6 evidence satisfactory to the Department of Community and Regional Affairs for
7 determination of the amount of reimbursement the applicant qualifies to receive.
8 Money in the mental health trust settlement income account established in
9 AS 37.14.036 may be appropriated for reimbursement payments under this subsection.
10 If appropriations are not sufficient to fully fund reimbursement payments, the amount
11 available shall be distributed pro rata among eligible applicants. For purposes of this
12 subsection, "established village" has the meaning given in AS 47.37.045(e).
13 * Sec. 3. This Act takes effect July 1, 1996.

9-LS1447\F
Cook
2/21/96

CS FOR HOUSE BILL NO. 383( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES IVAN, Brown

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to municipal taxation of alcoholic beverages; increasing and
2 requiring annual adjustment of the tax on alcoholic beverages; relating to
3 reimbursement by the state to municipalities and certain established villages for
4 services provided to individuals incapacitated by alcohol; and providing for an
5 effective date."

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

7 * Section 1. AS 04.21.010(c) is amended to read:
8 (c) A municipality may not impose taxes on alcoholic beverages except a
9 (1) property tax on alcoholic beverage inventories;
10 (2) sales tax on alcoholic beverage sales; a sales tax imposed on
11 alcoholic beverage sales may be equal to, higher, or lower than a sales tax, if any,
12 [IF SALES TAXES ARE] imposed on other sales within the municipality; and
13 (3) [SALES TAX ON ALCOHOLIC BEVERAGE SALES THAT WAS
14 IN EFFECT BEFORE JULY 1, 1985; AND

1 (4)] sales and use tax on alcoholic beverages if the sale of alcoholic
2 beverages within the municipality has been prohibited under AS 04.11.491(a)(1), (4), or
3 (5).
4 * Sec. 2. AS 43.60.010(a) is amended to read:
5 (a) Every brewer, distiller, bottler, jobber, retailer, wholesaler, or manufacturer
6 who sells alcoholic beverages in the state or who consigns shipments of alcoholic
7 beverages into the state, whether or not the alcoholic beverages are brewed, distilled,
8 bottled, or manufactured in the state, shall pay on all malt beverages (alcoholic content
9 of one percent or more by volume), wines, and hard or distilled alcoholic beverages, the
10 following taxes:
11 (1) malt beverages at the rate of <u>**$1.05**</u> [35 CENTS] a gallon or fraction
12 of a gallon;
13 (2) wine or other beverages of 21 percent alcohol by volume or less, at
14 the rate of <u>**$2.50**</u> [85 CENTS] a gallon or fraction of a gallon; and
15 (3) other beverages having a content of more than 21 percent alcohol by
16 volume at the rate of <u>**$8.50**</u> [$5.60] a gallon.
17 * Sec. 3. AS 43.60.010 is amended by adding a new subsection to read:
18 (c) The department shall on July 1 of each year adjust the tax rates imposed
19 under (a) of this section to reflect increases in the Consumer Price Index for all urban
20 consumers for all items for the Anchorage metropolitan area compiled by the Bureau of
21 Labor Statistics, United States Department of Labor, for the second half of the preceding
22 calendar year. The semiannual index for the second half of 1994 is the reference base
23 index. The department shall round the amount adjusted under this subsection to the
24 nearest cent. The revised tax rates shall be provided to the legislature and each brewer,
25 distiller, bottler, jobber, retailer, wholesale, or manufacturer who sells alcoholic beverages
26 in the state, and made available to the public.
27 * Sec. 4. AS 47.37.170(j) is amended to read:
28 (j) For purposes of (b) <u>**and (k)**</u> of this section, "incapacitated by alcohol"
29 means a person who, as the result of consumption of alcohol, is rendered unconscious
30 or has judgment or physical mobility so impaired that the person cannot readily
31 recognize or escape conditions of apparent or imminent danger to personal health or
32 safety. The definition in AS 47.37.270 applies to other portions of this chapter.

1 * **Sec. 5.** AS 47.37.170 is amended by adding a new subsection to read:

2 (k) A municipality or a traditional village council of an established village is
3 eligible for reimbursement from the state through the Department of Revenue for
4 services provided under this section by the municipality or established village to
5 individuals incapacitated by alcohol. To obtain a reimbursement payment, the
6 municipality or traditional village council shall apply by January 15 to the Department
7 of Revenue for payment for the immediately preceding year on forms and in the
8 manner prescribed by the Department of Revenue. Each applicant shall submit with
9 the application evidence satisfactory to the Department of Revenue for determination
10 of the amount of reimbursement the applicant qualifies to receive. Money from the
11 tax on alcoholic beverages under AS 43.60.010 may be appropriated for reimbursement
12 payments under this subsection. If appropriations are not sufficient to fully fund
13 reimbursement payments, the amount available shall be distributed pro rata among
14 eligible applicants. For purposes of this subsection, "established village" has the
15 meaning given in AS 47.37.045(e).

16 * **Sec. 6.** Notwithstanding sec. 7 of this Act and AS 43.60.010(c), enacted in sec. 3 of this
17 Act, the Department of Revenue shall, by June 1, 1997, determine the increase in tax rates
18 resulting from implementation of AS 46.60.010(c), enacted in sec. 3 of this Act, and impose
19 the new tax rates beginning July 1, 1997.

20 * **Sec. 7.** This Act takes effect July 1, 1996.

Alaska State House of Representatives
House District 39

Session
Alaska State Capital
Juneau, Alaska 99801-1182
Phone: (907) 465-4942

Interim
P.O. Box 137
Akiak, Alaska 99552
Phone: (907) 765-7526

Representative Ivan M. Ivan

SPONSOR STATEMENT - CSHB 383 (CRA)

Widespread alcohol abuse not only damages Alaska's families and society, but also drains public coffers at an alarming rate. Local governments constantly struggle under the financial burden of their efforts to cope with alcohol problems.

Those problems include the many public inebriates evident in our municipalities.

Under AS 47.37.170, local police take into protective custody a person who appears to be intoxicated and incapacitated in a public place and place that person in an approved public treatment or detention facility. A licensed physician or other qualified health practitioner must then examine the inebriate as soon as possible. If the person is found to be incapacitated by alcohol, he or she is detained for no more than 48 hours in a health facility or for no more than 12 hours in a detention facility. Tremendous costs accrue to municipalities and public health facilities due to this program.

By two methods, House Bill 383 will reduce or eliminate the financial burden that local governments and public health facilities bear each year fulfilling this unfunded mandate.

First, the bill provides for direct state grants to municipalities and traditional village councils to reimburse them for the cost of dealing with inebriates.

Second, the bill gives local governments the power to set taxes on alcoholic beverages at whatever rate they want, regardless of whether or not they tax other sales.

To help defray the state's granting costs as well as closing the fiscal gap, reducing alcohol consumption and fighting crime, the bill raises the alcohol excise tax for the first time since 1983.

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House District 39

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Representative Ivan M. Ivan

SPONSOR STATEMENT - HOUSE BILL 383

Under AS 47.37.170, a person who appears to be intoxicated and incapacitated in a public place will be taken into protective custody and placed in an approved public treatment facility or a state or municipal detention facility. This person must then be examined by a licensed physician or other qualified health practitioner as soon as possible. If the person is found to be incapacitated by alcohol, the person is detained for no more than 48 hours in a health facility or for no more than 12 hours in a detention facility. The costs of this program to the municipalities and the public health facilities are tremendous.

I introduced House Bill 383 to offer a solution that will reduce or eliminate the fiscal responsibilities the municipalities and public health facilities bear each year undertaking this unfunded mandate.

STATE OF ALASKA
1996 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO: CSHB 383( )
9-LS1447\C (Revised)

Revision Date:		Dept. Affected:	Revenue
Title:	Reimburse for Local Service of Inebriates	BRU:	Revenue Operations
		Component:	Income and Excise Audit
Sponsor:	Rep. IVAN, Brown		
Requestor:	(H) CRA	COMPONENT SERIAL NO.	113

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	20.0	20.0	20.0	20.0	20.0	20.0
TRAVEL						
CONTRACTUAL	1.0	1.0	1.0	1.0	1.0	1.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	**21.0**	**21.0**	**21.0**	**21.0**	**21.0**	**21.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (GF)	**15,035.4**	**16,102.1**	**17,194.9**	**18,385.3**	**19,605.2**	**20,854.5**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	21.0	21.0	21.0	21.0	21.0	21.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other						
TOTAL	**21.0**	**21.0**	**21.0**	**21.0**	**21.0**	**21.0**

Estimate of any current year (FY96) cost $ 0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

(See Attached Analys')

Prepared by:	Paul E. Dick	Phone:	465-2320
Division:	Income and Excise Audit Division	Date:	2/22/96
Approved by Commissioner:	Wilson L. Condon	Date:	2/22/96
Agency:	Department of Revenue		

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Bill Analysis

Section 1 amends AS 04.21.010(c) to authorize a municipality to impose sales taxes on alcoholic beverages at a rate equal to, higher, or lower than the sales tax imposed by the municipality.

Section 2 amends AS 43.60.010 to increase the alcoholic beverages tax rates as follows.

Alcohol Type	*(Per Gallon)*		
	Current Rate	**Proposed Rate**	**Increase**
Beer	$.35	$1.05	$.70
Wine	$.85	$2.50	$1.65
Liquor	$5.60	$8.50	$2.90

Section 3 adds a new subsection to AS 43.60.010 to authorize the Department of Revenue to adjust the alcoholic beverages tax rates each July 1 based on the change in the Consumer Price Index for the Anchorage metropolitan area. The semiannual index for the second half of 1994 would be the reference base index. Amounts would be rounded to the nearest cent.

Section 4 amends the definition of "incapacitated by alcohol" to include a new subsection proposed under section 5 of this bill.

Section 5 adds a new subsection to AS 47.37.170 pertaining to reimbursement by the state to municipalities or village councils for services provided by individuals incapacitated by alcohol.

Section 6 directs the Department of Revenue to determine the increase in tax rates resulting from the amendment in section 3 above.

Section 7 provides for an effective date of July 1, 1996.

Operating Costs

Although the Department is not requesting an additional position, the Department requests funding of $20.0 for part-time funding of a vacant tax examiner position in Juneau. With over $35 million in total collections per year, additional compliance efforts of a tax examiner would be required to ensure that the proper amount of taxes are being collected and that all taxpayers are filing returns. The Department is requesting $1.0 in contractual for costs of printing and mailing revised forms reflecting rate changes.

Revenue

Based on FY 95 consumption, tax rate increases would generate approximately $15 million additional revenue in FY 97. Revenue increase calculations for FY 97 and subsequent years and CPI-indexed rate are provided on the attached spreadsheets. Revenue projections do not include factors for reductions in consumption which may result from tax rate increases.

Department of Revenue

Income and Excise Audit Division

Fiscal Note Analysis

CSHB 383( )
WORK DRAFT
9-LS1447\C (Revised)
February 22, 1996

(Amounts in 'Revenue' columns are the product of FY 95 gallons and respective rates.)

		FY 97		FY 98		FY 99		FY 00		FY 01		FY 02	
	FY 95 Gallons	*Rate*	*Revenue*	*Rate*	*Revenue*	*Rate*	*Revenue*	*Rate*	*Revenue*	*Rate*	*Revenue*	*Rate*	*Revenue*
Beer	13,653,700	$1.05	$14,336,385	1.08	$14,765,043	1.11	$15,193,701	1.15	$15,649,598	1.18	$16,105,495	1.21	$16,561,392
Wine	1,256,700	$2.50	3,141,750	2.57	3,235,688	2.65	3,329,627	2.73	3,429,534	2.81	3,529,442	2.89	3,629,350
Liquor	1,092,900	$8.50	9,289,650	8.75	9,567,411	9.01	9,845,171	9.28	10,140,582	9.55	10,435,993	9.82	10,731,404
Total			26,767,785		27,568,142		28,368,499		29,219,714		30,070,930		30,922,145
FY 95 Revenue			11,969,200		11,969,200		11,969,200		11,969,200		11,969,200		11,969,200
Increase			14,798,585		15,598,942		16,399,299		17,250,514		18,101,730		18,952,945
Population Growth Adjustment			1.016		1.032		1.049		1.066		1.083		1.100
Adjusted Increase			*$ 15,035,362*		*$ 16,102,101*		*$ 17,194,861*		*$ 18,385,322*		*$ 19,605,187*		*$ 20,854,456*

Population growth adjustment is 1.016 per year (*Source: Office of Management and Budget*).

Note: Revenue projections do not include factors for reductions in consumption which may result from tax rate increases.

Prepared by Paul Dick
2/22/96

Department of Revenue
Income and Excise Audit Division

Fiscal Note Analysis

CSHB 383( )
WORK DRAFT
9-LS1447\C (Revised)
February 22, 1996

Fiscal Year	CPI Change*	Cumulative Change	Tax Rate: Beer	Tax Rate: Wine	Tax Rate: Liquor
97	2.99%	2.99%			
Proposed Base Rate			1.05	2.50	8.50
New Rate Calculation			1.081395	2.57475	8.75415
7/1/97 New Rate (Rounded)			**1.08**	**2.57**	**8.75**
97	2.99%				
98	2.99%	5.98%			
Proposed Base Rate			1.05	2.50	8.50
New Rate Calculation			1.11279	2.6495	9.0083
7/1/98 New Rate (Rounded)			**1.11**	**2.65**	**9.01**
97	2.99%				
98	2.99%				
99	3.18%	9.16%			
Proposed Base Rate			1.05	2.50	8.50
New Rate Calculation			1.14618	2.729	9.2786
7/1/99 New Rate (Rounded)			**1.15**	**2.73**	**9.28**
97	2.99%				
98	2.99%				
99	3.18%				
00	3.18%	12.34%			
Proposed Base Rate			1.05	2.50	8.50
New Rate Calculation			1.17957	2.8085	9.5489
7/1/00 New Rate (Rounded)			**1.18**	**2.81**	**9.55**
97	2.99%				
98	2.99%				
99	3.18%				
00	3.18%				
01	3.18%	15.52%			
Proposed Base Rate			1.05	2.50	8.50
New Rate Calculation			1.21296	2.888	9.8192
7/1/01 New Rate (Rounded)			**1.21**	**2.89**	**9.82**

**Source: Brad Pierce, Office of Management and Budget*

Prepared by Paul Dick
2/22/96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO: HB 383

Revision Date: January 11, 1996
Title: An Act relating reimbursement by the state to municipalities and certain established ...
Sponsor: Rep. Ivan
Requestor: Rep. Ivan

Dept. Affected: Community & Regional Affairs
BRU: Admin & Support
Component: Administrative Services
COMPONENT SERIAL NO. 684

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	42.8	44.1	45.4	46.8	48.2	49.6
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	42.8	44.1	45.4	46.8	48.2	49.6
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE:						

FUNDING: (Thousands of Dollars)

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
1002 Federal Receipts						
1003 GF Match						
1004 GF	42.8	44.1	45.4	46.8	48.2	49.6
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	42.8	44.1	45.4	46.8	48.2	49.6

POSITIONS:

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
FULL-TIME	1	1	1	1	1	1
PART-TIME						
TEMPORARY						

Estimate of current (FY96) impact $ none

ANALYSIS: (Attach a separate page if necessary)
Establishes a new program in DCRA that provides for reimbursement to municipalities and certain unincorporated communities for the costs of services provided to individuals who are incapacitated by alcohol. The new program would entail a substantial application and evaluation process related to reliable determination of eligible local expenditures. Existing program administration staff are working at full capacity. An additional support staff person (range 13, Administrative Assistant or Grant Administrator) would be needed, under the supervision of the existing Grant Administrator, to operate this new program effectively.

Prepared by: Remond Henderson, Director *Remond Henderson* Phone: 465-4708
Division: Division of Administrative Services Date: 1/11/96
Approved by Commissioner: *Mike Irwin* Date: 1/11/96
Agency: Community & Regional Affairs

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Representative Ivan M. Ivan

SECTIONAL ANALYSIS - CSHB 383 (CRA)

Section 1. Amends AS 04.21.010(c). Allows municipalities to impose a sales tax on alcoholic beverage sales. The tax may be equal to, higher than or lower than other sales tax, if any. Deletes provisions in current law that restrict municipal alcoholic beverage taxes to municipalities that have other sales taxes, to rates equal to other sales taxes or to municipalities that had alcoholic beverage sales taxes prior to July 1, 1985.

Section 2. Amends AS 43.60.010(a). Increases the state alcoholic beverage tax on:
Malt beverages from $.35 to $1.05 a gallon or a fraction of a gallon;
Wine or other beverages of 21% alcohol by volume or less from $.85 to $2.50 a gallon or fraction of a gallon; and,
Beverages over 21% alcohol by volume or less from $5.60 a gallon to $8.50 a gallon.

Section 3. Adds a new subsection to AS 43.60.010. Provides for an increase in the alcohol tax rate by the annual rate of increase of the consumer price index for Anchorage.

Section 4. Amends AS 47.37.170(j). Describes incapacitated by alcohol, particularly for the new subsection which is found in Section 5 of this bill.

Section 5. Adds a new subsection to AS 47.37.170. Establishes a reimbursement program for services provided by municipalities or established villages to individuals incapacitated by alcohol. Funds from the alcoholic beverage tax may be appropriated for reimbursement payments to municipalities or established villages. The program is to be administered by the Department of Revenue.

Section 6. Directs the Department of Revenue to determine on June 1, 1997, what will be the alcoholic tax rate for fiscal year 98 and to impose that rate beginning July 1, 1997.

Section 7. Effective date of July 1, 1996.

Alaska Native Health Board

1345 Rudakof Circle, Suite
Anchorage, Alaska 99508
Phone: (907) 337-0028
FAX: (907) 333-2001

February 21, 1996

Representative Ivan Ivan
Co-Chair, House Community and Regional Affairs Committee
Room 503, State Capitol
Juneau, Alaska 99801-1182

RE: HOUSE BILL NO. 383

Dear Representative Ivan:

The Alaska Native Health Board voted recently to support House Bill No. 383, and would like to state for the record why it supports this Bill.

As you know, the cost of providing health care to inebriates comprises one of the largest components of the health care budgets of our tribal and tribal consortia membership. Often times, our health care facilities become repositories of inebriates if local authorities do not have the means or desire to deal with the issue. Your Bill would permit our membership to seek reimbursement for the costs of providing health care services to inebriates, and therefore help to ensure that increasingly limited health care dollars are spent on health promotion and disease prevention.

In addition, local taxes for services imposed on some of our membership further divert limited health care dollars. For this reason, it becomes even more critical for our facilities to be reimbursed for the cost of local services provided to inebriates in order to compensate for this loss of health care dollars.

We commend your sponsorship of this Bill, and would be happy to work with you and your staff in its passage.

Sincerely,

Anne M. Walker
Executive Director

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
KODIAK AREA NATIVE ASSOCIATION
MANIILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
NORTH SLOPE BOROUGH
NORTON SOUND HEALTH CORPORATION
SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

January 12, 1996

Representative Ivan Ivan, Co-Chair
Representative Alan Austerman, Co-Chair
Committee on Community & Regional Affairs
Alaska State Legislature
Juneau, AK 99801-1182

Re: Support, HB 383, Public Inebriates

Dear Rep. Ivan & Rep Austerman:

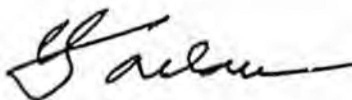
Members of the Alaska State Hospital & Nursing Home Association strongly support the "intent" of HB 383, relating to municipal and village reimbursement for services provided to individuals incapacitated by alcohol. We want to thank Mr. Ivan for bringing this matter to the attention of the Legislature and Governor.

The challenge of caring for the public inebriate, along with the cost of providing that care is of serious concern to community hospital administrators throughout Alaska. Attached is a "discussion paper" on this issue written by Ed Myers, administrator of the Kodiak Island Hospital. Ed is 1996 ASHNHA Chair.

Members of the Association are aware of the budget shortfall faced by all Alaskans at this session of the Legislature. We don't know if funding this program through the mental health trust is feasible or not, but we do know that the human suffering of the public inebriate and their families, and the cost of meeting the health care needs of these individuals must be addressed by the Legislature.

Caring for the public inebriate is a factor in the overall cost of care. When the public inebriate does not or cannot pay, that cost is shifted to those individuals or programs that do pay their medical bills. We look forward to working with you in finding ways to resolve this very serious Alaska problem.

Sincerely,



Harlan R. Knudson
President/CEO

Attachment (1)

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

March 19, 1995

DISCUSSION PAPER
HOSPITAL EXAMINATION OF PUBLIC INEBRIATES

By:
Edmon Myers, Administrator
Kodiak Island Hospital/Care Center

Examination of public inebriates in the Emergency Room at Kodiak Island Hospital and Care Center has been an ongoing problem for several years, and to date, there has been no resolution to this problem. The basic problem in Kodiak lies in the fact that the Police Department believes that under the current law, they are required to pick up and transport any public inebriates to the Hospital for examination prior to incarceration or other disposition. An often cited case is one several years ago in Anchorage, whereby an individual died without being examined for other injuries.

The following facts and issues characterize the situation at Kodiak Island Hospital and Care Center.

1. Police either bring public inebriates or call an ambulance to transport public inebriates to the Hospital for examination. The use of the public ambulance service has arisen because of the legal issues for payment surrounding protective custody. KIH/CC has sought legal determination regarding responsibility for payment when police bring inebriates to the Hospital. The legal determination received was that the Police Department is acting in the same capacity as a guardian of a minor in those cases, and therefore, would be responsible for payment. To circumvent this, the Police Department has resorted to calling an ambulance to bring public inebriates to the Hospital on the theory that the Hospital must then take care of examining the inebriates, the same as any other patient arriving by ambulance, and the protective custody issue is thereby avoided.

2. In other cases when the Police pick up inebriates and bring them to the Hospital, the Police usually release them "on their own recognizance" at the Emergency Room door and after examination, rearrest them as they leave the Hospital. Again, the City has indicated this then removes the protective custody issue, and do not have to pay for the examination of the patient.

3. In those cases where prisoners are brought in from the jail, the Police again usually release prisoners on their own recognizance and rearrest them after they are released from the Hospital, requiring the Hospital to call them prior to release so they may await them at the door when they leave. This has occurred, even in the case of "dangerous" patients, in which the Hospital is required to provide its own security to protect the staff.

4. KIH/CC has written off several hundred thousand dollars over the past few years in providing care and treatment of patients brought to the Hospital as a result of inebriation. In most of these cases, treatment is not required, but merely an evaluation of whether there is any medical condition which would prohibit incarceration or other disposition by the Police Department.

This is a serious financial problem to the Hospital, and I suspect it is in other communities, based upon my discussion with other Hospitals. I have offered on several occasions to enter into a contract with the City for examinations providing "deep discounts". This is an area which I would like to see improved, as I believe it is unreasonable to expect Hospitals to provide examinations which are not requested by the patient without reimbursement.

\# # # #

City of Homer

FAX Transmission

From: Patti J. Whalin, City Manager
To: Tom Wright
Company: Representative Ivan's Ofc.

Date: January 12, 1996
Time: ~~10:17 AM~~ 10:54Am
FAX #: (907) 465-4589

Message:

Senator Torgerson's Office faxed us a copy of HB 383. We are very interested in this bill as we have experienced many problems with any kind of reimbursement for Title 47 detainees. The City of Homer has consistently attempted to work with our local hospital to house individuals severely incapacited by alchohol or drugs (not under arrest) but likewise, they too are concerned about getting any reimbursement for holding these individuals, and generally will not hold them.

As an outcome, the police department has reviewed the current law and I forward our suggestions to you for consideration in working with HB 383.

If you have any questions, please do not to hesitate to call me or Chief of Police Dennis Oakland at (907) 235-3150.

5 pages

VOICE: FAX: (907) 235-3148

491 E. Pioneer Avenue, Homer, AK 99603

9-LS1447\A

HOUSE BILL NO. 383

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE IVAN

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to reimbursement by the state to municipalities and certain
2 established villages for services provided to individuals incapacitated by alcohol;
3 and providing for an effective date."

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

5 * Section 1. AS 47.37.170(j) is amended to read:
6 (j) For purposes of (b) and (k) of this section, "incapacitated by alcohol"
7 means a person who, as the result of consumption of alcohol, is rendered unconscious
8 or has judgment or physical mobility so impaired that the person cannot readily
9 recognize or escape conditions of apparent or imminent danger to personal health or
10 safety. The definition in AS 47.37.270 applies to other portions of this chapter.
11 * Sec. 2. AS 47.37.170 is amended by adding a new subsection to read:
12 (k) A municipality or a traditional village council of an established village is
13 eligible for reimbursement from the state through the Department of Community and
14 Regional Affairs for services provided under this section by the municipality or

treatment facility or health facility

1 established village to individuals incapacitated by alcohol. To obtain ~~a reimbursement~~
2 payment, the municipality, ~~or~~ traditional village council, shall apply by January 15 to
3 the Department of Community and Regional Affairs for payment for the immediately
4 preceding year on forms and in the manner prescribed by the Department of
5 Community and Regional Affairs. Each applicant shall submit with the application
6 evidence satisfactory to the Department of Community and Regional Affairs for
7 determination of the amount of reimbursement the applicant qualifies to receive.
8 Money in the mental health trust settlement income account established in
9 AS 37.14.036 may be appropriated for reimbursement payments under this subsection.
10 If appropriations are not sufficient to fully fund reimbursement payments, the amount
11 available shall be distributed pro rata among eligible applicants. For purposes of this
12 subsection, "established village" has the meaning given in AS 47.37.045(e).
13 * Sec. 3. This Act takes effect July 1, 1996.

New Text Underlined

Sec. 47.37.170 Treatment and services for intoxicated persons and persons incapacitated by alcohol or drugs. (a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help or a person who appears to be intoxicated in or upon a licensed premise where intoxicating liquors are sold or consumed who refuses to leave upon being requested to leave by the owner, an employee or a peace officer, may be taken into protective custody and assisted by a peace officer or a member of the emergency service patrol to the person's home, an approved public treatment facility, an approved private treatment facility, or another appropriate health facility for treatment and medically supervised protective custody (if that treatment or health facility has a secure detention room) until the person is no longer intoxicated or incapacitated by alcohol or drugs, or for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under this section at any time to the custody of a responsible adult.. If all of the preceeding facilities, including the person's home, are determined to be unavailable, a person taken into protective custody and assisted under this subsection may be taken to a state or municipal detention facility in the area.

(b) A person who appears to be incapacitated by alcohol or drugs in a public place shall be taken into protective custody by a peace officer or a member of the emergency service patrol and immediately brought to an approved public treatment facility, an approved private treatment facility, or another appropriate health facility or service for emergency medical treatment and medically supervised protective custody (if that treatment or health facility has a secure detention room) until the person is no longer intoxicated or incapacitated by alcohol or drugs, or for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under this section at any time to the custody of a responsible adult.. If no treatment facility or emergency medical service is available, a person who appears to be incapacitated by alcohol or drugs in a public place shall be taken to a state or municipal detention facility in the area, if that appears necessary for the protection of the person's health or safety.

(c) A person who voluntarily appears or is brought to an approved public treatment facility shall be examined by a licensed physician or other qualified health practioner as soon as possible. The department shall, by regulation, determine which health practioners may be authorized to perform the examination. After the examination, the person may be admitted as a patient or referred to another health facility. The approved public treatment facility which refers the person shall arrange for transportation.

(d) A person who, after medical examination, is found to be incapacitated by alcohol or drugs at the time of admission or to have become incapacitated at any time after admission, may not be detained at a facility after the person is no longer incapacitated by alcohol or drugs. A person may not be detained at a facility if that person remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless the person is committed under AS 47.37.180. A person may consent to remain in the facility as long as the physician in charge considers it appropriate.

(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds , may be taken to the person's home, if any. If the person has no home, the approved public treatment facility shall assist the person in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, family or next of kin shall by promptly notified. If an adult patient who is not incapacitated requests that there be no notifiction of next of kin, request shall be granted.

(g) A person may not bring an action for damages based on the decision under this section to take or not to take an intoxicated person or a person incapacitated by alcohol or drugs into protective custody, unless the action is for damages caused by gross negligence or intentional misconduct. A person may not bring an action for damages based on their having been involuntarily detained in protective custody at any public or private treatment facility, medical facility, or state or municipal detention facility under (a) or (b) of this section absent gross negligence or intentional misconduct.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, an attempt shall be made to encourage the patient to submit to further diagnosis and appropriate voluntary treatment.

(i)A person taken to a detention facility under (a) or (b) of this section may be detained only (1) until a treatment facility or emergency medical service is made available, or (2) until the person is no longer intoxicated or incapacitated by alcohol or drugs, or (3) for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under (a) or (b) of this section at any time to the custody of a responsible adult. A peace officer or a member of the emergency service patrol, in detaining a person under (a) or (b) of this section and in taking the person to a treatment facility, an emergency medical service or a detention facility, is taking the person into protective custody and the oficer or patrol member shall make reasonable efforts to provide for and protect the health and safety of the detainee. In taking a person into protective custody under (a) and (b) of this section, a detaining officer, a member of the emergency service patrol or a detention facility official may take reasonable steps for self protection, including a full protective search of the person of a detainee. Protective custody under (a) and (b) of this section does not constitute an arrest and no entry or other record may be made to indicate that the person detained has been arrested or charged with a crime, except that a confidential record may be made which is necessary for the administrative purposes of the facility to which the person has been taken or which is necessaryfor statistical purposes where the person's name may not be disclosed.

(j) For purposes of (b) of this section, "incapacitated by alcohol or drugs" means a person who, as the result of consumption of alcohol or drugs, is rendered unconscious or has judgment or physical mobility so impaired that the person cannot readily recognize or escape conditions of apparent or imminent danger to personal health or safety. The definition in AS 47.37.270 applies to other portions of this chapter.

Official Business

COMMITTEE: House Community and Regional Affairs

DATE: January 16, 1996

SIGN-IN

Subject of meeting: HB 383 REIMBURSE FOR LOCAL SERVICE TO INEBRIATES

PLEASE PRINT!

NAME	ADDRESS (MAILING) & (ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
Kim Metcalfe Helmar	PO Box 112100 Juneau 99811	465-4898	DCRA	yes ✓
Pat Clusby CLUSBY	Care System North	463-6753		NO
Loren Jones	Box 110607 Juneau	465-2071	DHSS / Division of Alcoholism & Drug Abuse	yes ✓
Don Dapcevich	Box 110608 Juneau	465-4667	Advisory Board on Alcoholism	no
Bill Rolfzen	DCRA	4733	DCRA	No
Mary Elizabeth Rider	3601 C St Ste 742 Anch 99503	(907) 269-7960	Ak Mental Health Trust Authority	NO
HARLAN Knudson	319 Second #11 Juneau 99801	6-1790	AK ST Hospital Assn	yes

Additional Analysis
HB 383

"An Act relating to reimbursement by the state to municipalities and certain established villages for services provided to individuals incapacitated by alcohol;"

This bill amends AS 47.30.170 by amending one section and adding a new section.

AS 47.30.170(j) is amended by adding reference to AS 47.37.170(k) a new section.

AS 47.37.170 is amended by adding a new section (k) which states that a municipality or established village is "eligible" for state reimbursement for services provided under this section to individuals "incapacitated by alcohol." They will be reimbursed by the Department of Community and Regional Affairs (DCRA).

There are many issues with this legislation. It is assumed that the primary purpose of this bill is to get funds to municipalities to pay for medical and corrections costs associated with care of such persons. This would be for both local municipal detention centers and medical facilities.

BACKGROUND

The issue is that under AS 47.37.170 an incapacitated person may be taken into protective custody by a peace officer or member of a local community service patrol. When taken into custody the options are:

person's home	AS 47.37.170(a)*
an approved public treatment facility	AS 47.37.170(a) and (b)**
an approved private treatment facility	AS 47.37.170(a) and (b)
another appropriate health facility	AS 47.37.170(a)
or service for emergency medical treatment	AS 47.37.170(b)

* section (a) deals with an intoxicated person
** section (b) deals with an incapacitated person

Under (a) if "all...preceding facilities, including the persons home, are determined to be unavailable, a person...may be taken to a state or municipal detention facility..." (emphasis added)

Under (b) if "no treatment facility or emergency medical services is available, a person...shall be taken to a state or municipal detention facility...if that appears necessary for the protection of the person's health or safety." (emphasis added).

One is permissive, the other is mandatory.

Most detention facilities either will not accept someone in this condition unless they have been cleared by a medical person to be medically acceptable for detention OR they have a protocol that determines when a person should be brought to a medical facility for examination.

Under AS 29.60.120 DCRA already can pay municipalities money for health facilities. In the case of alcohol and drug abuse facilities it is based on the number of beds. Thus major municipalities that have residential treatment beds already receive certain funds from DCRA. I know that over time these funds have not been fully funded at the $2,000 per bed. DCRA states that the average pro-rating amounts to about $600 per year. That money is already available to a municipality to use for such care. This appropriation could simply be increased to raise that amount paid closer to the statute limit of $2,000 per bed.

Under AS 29.60.120 DCRA also sends funds to communities for hospitals. However, hospitals operated by Native Health Corporations are not licensed by the State and thus are not eligible for this funding. Thus Dillingham, Bethel, Kotzebue, Barrow, Sitka receive no money for the hospital in those communities. In Anchorage they receive only for Providence as Alaska Regional is a for profit and not eligible.

In the legislature this year there are several bills to increase the excise tax on alcohol. This Department is on record (memo to OMB for the Long Range Financial Planning group) suggesting that some of this increase in revenues be refunded/shared back to communities. This money could then be used for the purposes stated in this legislation. It is estimated that the tax bill would raise an additional $19 million. Added to the current $11 million and then 50% shared back would amount to a pool of $14 million to share back to communities.

The fix then would be to draft language that would change:

- DCRA to Department of Revenue
- change the section to reflect the rebate/sharing of taxes as proposed in the Department memo
- include language that specifies that the first call on the funds is for cost of medical services provided to incapacitated persons followed by CSP/Police costs and/or detention costs

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. HB 383

Revision Date:
Title: Reimbursement to Local Gov't /Villages for costs of Title 47
Sponsor: Ivan
Requestor: House CRA

Dept. Affected: Health and Social Services
BRU: Alcohol and Drug Abuse Svcs
Component: Alcohol/Drug Abuse Grants
COMPONENT SERIAL NO. 1239
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY97	FY98	FY99	FY00	FY01	FY02
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $0.0

POSITIONS:

	FY97	FY98	FY99	FY00	FY01	FY02
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This bill has no fiscal impact on the component.

Prepared by: Loren A. Jones, Director
Division: Alcoholism and Drug Absue
Phone: 465-2071
Date: 01/11/96

Approved by Com: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 1/12/96

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Dillingham not alone in Title 47 problem

By Colleen Kelly
BayTimes Staff

The problem of what to do with public inebriates isn't one that's unique to Dillingham. At least that's what some state officials and law enforcement officers are saying.

A particular aspect of the state's Title 47 law that requires law enforcement officials to take public inebriates into protective custody has drawn a particular amount of attention recently in Dillingham.

The board of Bristol Bay Area Health Corp. stated its intention last month to sue the city for an estimated $176,000 in charges rung up since July 1993 at Kanakanak Hospital. The bills are for treating Title 47 individuals brought there by the Dillingham police.

"Almost every place in the state has public inebriates that are taken to the hospital," according to Loren Jones, director of the Division of Alcoholism and Drug Abuse with the Alaska Department of Health and Human Services.

"In most cases the hospital can collect from the patient unless there's insurance or Medicare or Medicaid that will pay," he said. "In a lot of communities, that care goes uncompensated in hospitals."

In Ketchikan, the city set aside money to pay the hospital for Title 47 screening, but the fund was used up in four or five months, Jones said.

"I agree completely with the hospital that they should not be responsible for paying the bills," said Brent Moody, chief of the Dillingham Police Department. He said Title 47 "is a state law and it's a state responsibility. I think the state is remiss in its responsibility."

But in the absence of state funding, Moody said he's confused by the hospital's position that it won't pay for Title 47 medical screening or admission of its beneficiaries.

Moody considers alcoholism a disease. "We're bringing people with a disease to the hospital and if they're Native, what's the problem?"

Jones said the community has to look at how its services are currently set up and possibly redirect some of its resources.

"Either we pay the money or look at how we can cut down on our number of problems," Jones said.

He continued, "In the short term it's a financial issue in Dillingham. In the long term, I think the hospital and the corporation should look at its array of services" to see if they're meeting the community's needs.

The number of Title 47 protective custody cases in Dillingham has declined in recent years. In 1990, the number was 1,092. Four years later it was 533, and during the first 11 months of 1995 the number was 244, according to police department statistics.

Jones said he attributes the improved picture in part to the work that BBAHC has done with alcoholism programs in its villages and the establishment of Jake's Place.

For about four years the state had a contract with Dillingham to pay the costs for a community service patrol that picked up Title 47 cases. The annual funding was about $168,000, according to Jon Sorensen, administrative assistant for the city. The state program ended in July 1994, and the patrol has since disbanded.

According to Jones, "It was the only place in the state where the Division (of Alcoholism and Drug Abuse) had a grant for this."

The program's demise came because the division has been experiencing funding decreases, he said. The cut in the Dillingham program came because "no other place in the state had such a grant, not because the service wasn't effective or needed," Jones said.

Chief Moody said he doesn't have any easy answers for the situation. "How do we stop the drain on city funds due to the consumption of alcohol. Do we make the city dry? Do we deal with it more as a disease and get a center for detoxification?"

A factor that can't be ignored, he said, is that Dillingham is a regional hub for alcohol consumption. "And Dillingham taxpayers are paying for it."

He continued, "Almost 100 percent of our crimes are due to people who've been drinking. When you keep that in mind, the financial burden alcohol has on this community is incredible."

Another Moody criticism regarding Title 47 is that a person taken to a detention facility, such as the Dillingham jail's two holding cells, can be held no longer than 12 hours. "In Minnesota, it's a mandatory 72 hours," he said.

When the body metabolizes alcohol at the rate of .015-.017 per hour, individuals with a .35 percent BAC are still legally drunk when they're released, Moody said.

Some health care information lists individuals with a .39 BAC or above as probably experiencing a state of unconsciousness. But in Dillingham it's not unusual for police to pick up individuals with a .40 or higher BAC who are still walking and talking, the chief said.

"I think the state of Alaska is very phony in their concern for the inebriacy issue," Moody said. He contends the state has placed an incredible responsibility on the city, "especially when they haven't provided detoxification centers for cities like Dillingham. I'd like to have a detoxification center in Dillingham, or a wing in the hospital."

The police department has two holding cells — one for males and one for females — each with a capacity of six to eight people.

Police statistics show that an average of 34 people per month have been taken into protective custody the past two years. Just over 90 percent are held in the city holding cells, with about 9 percent admitted to the hospital.

According to City Manager Chris Hladick, during Dillingham Beaver Round-Up in March, the two cells are full for the entire week. "There are times during the summer months when the facility is at capacity," he added.

The city bills Title 47 individuals $200 for their overnight stay in the holding cell. Since January 1994, the bills total $182,000. The collection rate is poor, Hladick said, with only 18 percent — or $33,863 — being paid.

"The perception in town is that we garnish the inebriate's permanent fund. In reality we ask the individuals to sign over their permanent fund, but few actually comply," Hladick wrote in a recent report.

The $176,457 in bills from Kanakanak Hospital only covers the inebriates brought to the hospital for medical screening and those individuals requiring hospital admittance (usually due to medical complications).

In an agreement created by the hospital and the police department, any public inebriate under protective custody with a breath alcohol content over .25 percent receives medical screening at the hospital.

Statistics since January 1994 show that of the 777 individuals taken into protective custody, 360 had a BAC greater than .25 and were screened at Kanakanak. Of this number, 67 were admitted to the hospital.

An additional 10 hospital admissions came from the 153 inebriates who refused to submit to a BAC test, police department statistics show.

The need for medical screening is a valid concern, Moody said. "The city of Dillingham has had a death in the jail of a person brought in under Title 47."

Peter Hamilton Jr., 64, was found dead in his cell on July 8, 1992, according to a story in the July 17, 1992 BayTimes. Preliminary autopsy results showed that he died of a coronary problem.

After being sued by Hamilton's heirs, the city agreed to a $25,000 settlement in June 1993.

Colleen Kelly/BayTimes

Taxable or not?

One of the disputes the city of Dillingham and the Bristol Bay Area Health Corp. are working on is whether housing units, such as those pictured here, are subject to the city's 5 percent sales tax on rental income. City officials, BBAHC representatives and attorneys began negotiations Tuesday in Anchorage.

Bay clinic serves all residents

By Colleen Kelly
BayTimes Staff

Camai Clinic, owned by Bristol Bay Borough and operated by a contract provider, has been serving Natives and non-Natives alike for 13 years. Its patients usually pay for treatment through private insurance, Medicare, Medicaid or cash.

Camai is not an approved Indian Health Service operator, according to Glen Vernon, borough manager. "We've tried to work with (the Bristol Bay Area Health Corp.) so that if their beneficiaries would utilize our facilities their treatment costs would be covered."

At this point, there isn't any preauthorization agreement between BBAHC and Camai. Without such an arrangement, Natives who go to Camai must either use a private insurance provider or pay out of their own pocket for treatment.

A number of people from Lake and Peninsula Borough villages regularly use the clinic. Camai has the only emergency room on the east side of Bristol Bay, according to Janice Sellers, clinic administrator. She cited instances of people flying in from Levelock and Egegik for treatment.

"We don't charge any additional fee for people who aren't Bristol Bay Borough residents," Borough Manager Vernon said.

At one time the borough operated the family-practice clinic, but the past five years a private contractor has operated the outpatient facility, whose employees include a full-time physician and a full-time nurse practitioner.

The borough still provides a subsidy, Vernon said, in part, to ensure the availability of a steady work force. The busy summer months provide a solid financial base, but the slower winter months are a different story, he said.

The King Salmon sub-regional clinic built in 1978 by the Bristol Bay Area Health Corp. was precursor to the Camai Clinic in Naknek. BBAHC has since discontinued the Bay & Peninsula Clinic, and now serves its Naknek area beneficiaries through community health aide offices in King Salmon and South Naknek.

BBAHC beneficiaries in need of further treatment have some options, including going to the Camai Clinic, at their own expense, or going to BBAHC's Kanakanak Hospital in Dillingham where treatment costs are covered.

The cost of airfare to Dillingham in most routine cases is not reimbursed by the health corporation, according to Christine DeCourtney, BBAHC spokeswoman. Some prenatal visits are covered.

The health corporation has a patient travel policy, which deals with travel to Kanakanak Hospital from BBAHC's 31 outlying villages as well as travel to the Alaska Native Medical Center in Anchorage, she said.

Although Camai doesn't have a contract with BBAHC to serve health corporation beneficiaries, there are instances when the clinic does provide reimbursable care.

DeCourtney compares the situation as similar to an HMO (health maintenance organization).

"It's not reimbursable from IHS unless it's preauthorized," she said. If it's an emergency and they call ahead, it is possible that BBAHC will cover the cost for one of its beneficiaries getting medical treatment at Camai, she added.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM January 12, 1996

SUBJECT: Reimbursement to municipalities for services to individuals incapacitated by alcohol (HB 383)

TO: Representative Ivan Ivan
Attn: Tom

FROM: Tamara Brandt Cook
Director TBC

HB 383 provides for state reimbursement of money spent by a municipality or village for services provided on the local level to individuals incapacitated by alcohol. A specific provision authorizes appropriations from the mental health trust settlement income account for the reimbursement payments. You have asked whether the legislature may make appropriations from that account. Clearly the legislature has the power as a matter of constitutional law to appropriate and the use of the money in this instance would appear to be for a mental health purpose.

I cannot say whether the provision in HB 383 violates the terms of the mental health trust settlement. Note, however, that the Uniform Alcoholism and Intoxication Treatment Act, which this bill would be part of if enacted, already contains a provision authorizing appropriations from the mental health trust income settlement account. AS 47.37.125 states, "Subject to appropriation by the legislature, money in the mental health trust income account established in AS 37.14.036 may be used to support a service provided under the authority given in this chapter."

TBC:glc
96-014.glc

Sec. 47.37.170. TREATMENT AND SERVICES FOR INTOXICATED PERSONS AND PERSONS INCAPACITATED BY ALCOHOL.

(a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help or a person who appears to be intoxicated in or upon a licensed premise where intoxicating liquors are sold or consumed who refuses to leave upon being requested to leave by the owner, an employee or a peace officer, may be taken into protective custody and assisted by a peace officer or a member of the emergency service patrol to the person's home, an approved public treatment facility, an approved private treatment facility, or another appropriate health facility. If all of the preceding facilities, including the person's home, are determined to be unavailable, a person taken into protective custody and assisted under this subsection may be taken to a state or municipal detention facility in the area.

(b) A person who appears to be incapacitated by alcohol in a public place shall be taken into protective custody by a peace officer or a member of the emergency service patrol and immediately brought to an approved public treatment facility, an approved private treatment facility, or another appropriate health facility or service for emergency medical treatment. If no treatment facility or emergency medical service is available, a person who appears to be incapacitated by alcohol in a public place shall be taken to a state or municipal detention facility in the area, if that appears necessary for the protection of the person's health or safety.

(c) A person who voluntarily appears or is brought to an approved public treatment facility shall be examined by a licensed physician or other qualified health practitioner as soon as possible. The department shall, by regulation, determine which health practitioners may be authorized to perform the examination. After the examination, the person may be admitted as a patient or referred to another health facility. The approved public treatment facility which refers the person shall arrange for transportation.

(d) A person who, after medical examination, is found to be incapacitated by alcohol at the time of admission or to have become incapacitated at any time after admission, may not be detained at a facility after the person is no longer incapacitated by alcohol. A person may not be detained at a facility if the person remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless the person is committed under AS 47.37.180. A person may consent to remain in the facility as long as the physician in charge considers it appropriate.

(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds, may be taken to the person's home, if any. If the person has no home, the approved public treatment facility shall assist the person in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, family or next of kin shall be promptly notified. If an adult patient who is not incapacitated requests that there be no notification of next of kin, request shall be granted.

(g) A person may not bring an action for damages based on the decision under this section to take or not to take an intoxicated person or a person incapacitated by alcohol into protective custody, unless the action is for damages caused by gross negligence or intentional misconduct.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, an attempt shall be made to encourage the patient to submit to further diagnosis and appropriate voluntary treatment.

(i) A person taken to a detention facility under (a) or (b) of this section may be detained only (1) until a treatment facility or emergency medical service is made available, or (2) until the

person is no longer intoxicated or incapacitated by alcohol, or (3) for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under (a) or (b) of this section at any time to the custody of a responsible adult. A peace officer or a member of the emergency service patrol, in detaining a person under (a) or (b) of this section and in taking the person to a treatment facility, an emergency medical service or a detention facility, is taking the person into protective custody and the officer or patrol member shall make reasonable efforts to provide for and protect the health and safety of the detainee. In taking a person into protective custody under (a) and (b) of this section, a detaining officer, a member of the emergency service patrol or a detention facility official may take reasonable steps for self-protection, including a full protective search of the person of a detainee. Protective custody under (a) and (b) of this section does not constitute an arrest and no entry or other record may be made to indicate that the person detained has been arrested or charged with a crime, except that a confidential record may be made which is necessary for the administrative purposes of the facility to which the person has been taken or which is necessary for statistical purposes where the person's name may not be disclosed.

(j) For purposes of (b) of this section, "incapacitated by alcohol" means a person who, as the result of consumption of alcohol, is rendered unconscious or has judgment or physical mobility so impaired that the person cannot readily recognize or escape conditions of apparent or imminent danger to personal health or safety. The definition in AS 47.37.270 applies to other portions of this chapter.

History -

(sec. 1 ch 207 SLA 1972; am sec. 1-4 ch 101 SLA 1976; am sec. 2 ch 68 SLA 1989; am sec. 1 ch 62 SLA 1990)

Revisors Notes -

Enacted as AS 47.37.110. Renumbered in 1972.

Cross References -

For legislative intent in connection with the 1989 amendment of (g) of this section, see sec. 1, ch. 68, SLA 1989 in the Temporary and Special Acts.

Editors Notes -

Section 3, ch. 68, SLA 1989 provides that the 1989 amendment of (g) of this section "applies to causes of action that accrue on or after May 31, 1989."

Decisions -

Constitutionality. - For case holding that this section as it existed prior to the 1976 amendment, which among other things rewrote subsection (b), did not countenance an unreasonable search in violation of the 4th amendment to the United States Constitution, see Peter v. State, 531 P.2d 1263 (Alaska 1975).

Actionable duty imposed on municipality. - This section imposes upon a municipality an actionable duty to take persons incapacitated by alcohol in a public place into protective custody. Busby v. Municipality of Anchorage, 741 P.2d 230 (Alaska 1987).

Quoted in Kanayurak v. North Slope Borough, 677 P.2d 893 (Alaska 1984).

Sec. 47.37.045. COMMUNITY ACTION AGAINST SUBSTANCE ABUSE GRANT FUND.

(a) The community action against substance abuse grant fund is created as an account in the general fund. The fund consists of appropriations, grants, and contributions to the fund. The division may make grants from the fund to school districts, municipalities, nonprofit organizations, local governing bodies of established villages, and community organizations established under municipal charter or ordinance.

(b) A school district, municipality, nonprofit organization, local governing body of an established village, or community organization may file an application with the division for a community action against substance abuse grant. The application must include a description of the purpose for which grant funds will be used, goals to be achieved by the program or project, methods of measuring achievement of goals, a proposed budget, and statements of the need for and support of the proposed program or project.

(c) Community action against substance abuse grant funds awarded under this section may be used for

(1) Police-In-School Liaison programs staffed by officers that are certified by the Alaska Police Standards Council;

(2) technical assistance for neighborhood based substance abuse prevention or treatment programs;

(3) coordinators for court ordered community service;

(4) preventative or educational programs for youth that involve the community, parents, youth, and local schools;

(5) programs or projects that the division determines are effective in preventing or treating substance abuse at the community level; or

(6) supervised youth recreation programs that focus on preventing or treating substance abuse.

(d) A proposed program or project that includes matching local funds or in-kind contributions shall have priority over a proposed program or project that does not include matching local funds or in-kind contributions. Grants awarded under this section are subject to the restrictions on use provided under AS 37.05.321.

(e) In this section,

(1) "established village" means an unincorporated community that is in

(A) the unorganized borough and that has 25 or more permanent residents; or

(B) an organized borough, has 25 or more permanent residents, and

(i) is on a road system and is located more than 50 miles outside the boundary limits of a unified municipality, or

(ii) is not on a road system and is located more than 15 miles outside the boundary limits of a unified municipality;

(2) "local governing body" has the meaning given in AS 04.21.080(b);

(3) "nonprofit organization" means an organization that qualifies for exemption from taxation under 26 U.S.C. 501(c)(3) or (4) (Internal Revenue Code).

History -

(sec. 2 ch 81 SLA 1990; am sec. 68 ch 101 SLA 1995)

Cross References -

For legislative purpose in enacting this section, see sec. 1, ch. 81, SLA 1990 in the Temporary and Special Acts.

Amendment Notes -

The 1995 amendment, effective July 1, 1995, rewrote subsection (e)

Sec. 47.30.056. USE OF MONEY IN THE MENTAL HEALTH TRUST INCOME ACCOUNT.

(a) The money in the mental health trust income account established in AS 37.14.036 shall be used as provided in AS 37.14.041, including to

(1) provide an integrated comprehensive mental health program as required by this section;

(2) meet the authority's annual administrative expenses; and

(3) offset the effect of inflation on the mental health trust fund.

(b) Expenditures under (a)(1) of this section shall provide for a reasonable level of necessary services to

(1) the mentally ill;

(2) the mentally defective and retarded;

(3) chronic alcoholics suffering from psychoses;

(4) senile people who as a result of their senility suffer major mental illness; and

(5) other persons needing mental health services, as the legislature may determine.

(c) The integrated comprehensive mental health program for which expenditures are made under this section

(1) shall give priority in service delivery to persons who, as a result of a mental disorder or of a disorder identified in (b) of this section;

(A) may require or are at risk of hospitalization; or

(B) experience such major impairment of self-care, self-direction, or social and economic functioning that they require continuing or intensive services;

(2) may, at the discretion of the board, include services to persons who are not included under (b) or (c)(1) of this section.

(d) In (b)(1) of this section, "the mentally ill" includes persons with the following mental disorders:

(1) schizophrenia;

(2) delusional (paranoid) disorder;

(3) mood disorders;

(4) anxiety disorders;

(5) somatoform disorders;

(6) organic mental disorders;

(7) personality disorders;

(8) dissociative disorders;

(9) other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed in this subsection; and

(10) persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder listed in this subsection.

(e) In (b)(2) of this section, "the mentally defective and retarded" includes persons with the following neurologic or mental disorders:

(1) cerebral palsy;

(2) epilepsy;

(3) mental retardation;

(4) autistic disorder;

(5) severe organic brain impairment;

(6) significant developmental delay during early childhood indicating risk of developing a disorder listed in this subsection;

(7) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

(f) In (b)(3) of this section, "chronic alcoholics suffering from psychoses" includes persons with the following disorders:

(1) alcohol withdrawal delirium (delirium tremens);

(2) alcohol hallucinosis;

(3) alcohol amnestic disorder;

(4) dementia associated with alcoholism;

(5) alcohol-induced organic mental disorder;

(6) alcoholic depressive disorder;

(7) other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

(g) In (b)(4) of this section, "senile people who as a result of their senility suffer major mental illness" includes persons with the following mental disorders:

(1) primary degenerative dementia of the Alzheimer type;

(2) multi-infarct dementia;

(3) senile dementia;

(4) presenile dementia;

(5) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

(h) The authority shall adopt regulations defining the disorders identified in this section to reflect revisions in the diagnostic nomenclature of the health professions serving the beneficiaries of the trust. The authority shall review and revise the regulations as necessary. Regulations adopted under this subsection must be in the long term best interest of the trust and of persons with disorders equivalent to those identified in (b) and (c) of this section.

(i) In this section, "an integrated comprehensive mental health program"

(1) means public health programs and services that, on December 16, 1994, are separately recognizable and administered, without regard to the administrative unit directly responsible for the delivery of the service; among the services included are services for the mentally ill, community mental health services, services for the developmentally disabled, alcoholism services, and services for children, youth, adults, and seniors with mental disorders;

(2) includes, at a minimum, each of the following services as appropriate:

(A) emergency services on a 24-hour basis;

(B) screening examination and evaluation services required to complete the involuntary commitment process under AS 47.30.700 - 47.30.815;

(C) inpatient care;

(D) crisis stabilization services, which may include:

(i) active community outreach;

(ii) in-hospital contact;

(iii) mobile crisis teams of mental health professionals;

(iv) crisis beds to provide a short term residential program for persons experiencing an acute episode of mental illness that requires temporary removal from a home environment;

(E) treatment services, which may include

(i) diagnosis, testing, and evaluation of medical needs;

(ii) medication monitoring;

(iii) physical examinations;

(iv) dispensing psychotropic and other medication;

(v) detoxification;

(vi) individual or group therapy;

(vii) aftercare;

(F) case management, which may include

(i) evaluation of needs;

(ii) development of individualized treatment plans;

(iii) enhancement of access to available resources and programs;

(iv) development of interagency contacts and family involvement;

(v) advocacy;

(G) daily structure and support, which may include

(i) daily living skills training,

(ii) socialization activities;

(iii) recreation;

(iv) transportation;

(v) day care services;

(vi) client and care provider education and support services;

(H) residential services, which may include

(i) crisis or respite care;

(ii) board and care;

(iii) foster care, group homes, halfway houses, or supervised apartments;

(iv) intermediate care facilities;

(v) long-term care facilities;

(vi) in-home care;

(I) vocational services, which may include

(i) prevocational services;

(ii) work adjustment;

(iii) supported work;

(iv) sheltered work;

(v) training in which participants achieve useful work experience;

(J) outpatient screening, diagnosis, and treatment services, including individual, family, and group psychotherapy, counseling, and referral;

(K) prevention and education services, including consultation with organizations, providers, and the public; and

(L) administrative services, including appropriate operating expenses of state agencies and other service providers.

(j) The authority shall adopt regulations regarding the services described in (i) of this

section to reflect advances in the appropriate professions. The authority shall review and revise the regulations as necessary. Regulations adopted under this subsection must be in the long term best interest of the mental health trust.

History -

(sec. 26 ch 66 SLA 1991; am sec. 28 ch 5 FSSLA 1994)

Cross References -

For transitional provisions related to development of mental health income account mechanism, see sec. 43, ch. 5, FSSLA in the Temporary and Special Acts.

Amendment Notes -

The 1994 amendment, in subsection (a), in the introductory language, substituted "The money" for "If appropriated by law, the money" at the beginning and inserted "as provided in AS 37.14.041, including" and substituted "mental health trust fund" for "corpus of the trust" at the end of paragraph (3).

STATE OF ALASKA

DEPARTMENT OF CORRECTIONS

TONY KNOWLES, GOVERNOR

REPLY TO:

4500 DIPLOMACY DRIVE
ANCHORAGE, ALASKA 99508-5918

October 26, 1995

RECEIVED OCT 30 1995

Mr. Don Dapcevitch
Executive Director
State of Alaska Advisory Board
on Alcoholism & Drug Abuse
Post Office Box 10608
Juneau, Alaska 99811-0608

Re: Title 47 Admissions

Dear Don:

Steve Schwartz, DOC Research Analyst, recently compiled more information on the Title 47 Admissions. I believe it will be helpful in understanding who the Title 47's are:

Glossary for Non-Criminal Admission by FY Year, Location & Month

(1)

Page one is the total number of Non-Criminal admissions for the last five fiscal years. The table further indicates the facility where the admissions occurred and the month of occurrence for each of the last five fiscal years. Admissions are totaled by location for the fiscal year as well as by month. A grand total for each fiscal year is also computed.

(2)

Page two is the total number of Non-Criminal admissions for the last five fiscal years by gender and race. Totals for race and gender are computed as well as a total for the fiscal year. A grand total for all five fiscal years is also computed.

(3)

Pages three, four, and five are the total number of Non-Criminal admissions for the last five fiscal years by race and age group. Totals for race and age group are computed as well as a total for the fiscal year. A grand total for all five fiscal years is also computed for race and age group.

D. Dapcevitch
Re: Title 47's
October 26, 1995
Page 2

(4)

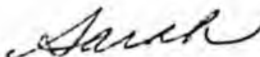
Pages six, seven, and eight are the frequency of Non-Criminal admissions for individuals by fiscal year, for the last five fiscal years. In other words in fiscal year 1991 1,176 individuals were admitted one time under title 47, 235 individuals were admitted twice under title 47 in 1991. One individual was admitted 58 times in 1991 under title 47.

(5)

Page nine is a grand total for the frequency of Non-Criminal admissions for individuals for the entire five year period. Frequency totals, percentage of the total, cumulative frequency and cumulative percent for frequency of admission is computed for the five year period.

Please feel free to give me(269-7417) or Steve Schwartz(269-7392) a call if you have any questions regarding the data.

Yours truly,



Sarah Williams
Substance Abuse Program Coordinator

SW:dc

cc: Margaret Pugh, Commissioner
Frank Sauser, Director, Division of Institutions
Lynda Zaugg, Director, Community Corrections
Bob Cole, Director, Administrative Services
Loren Jones, Executive Director, ADA

Non-Criminal Admissions by FY Year, Location and Month

FY 1995

	July	August	September	October	November	December	January	Febuary	March	April	May	June	Yearly Total
ANCHORAGE- 6TH AVE.	33	26	29	51	37	49	34	43	25	22	26	14	389
ANVIL MTN CC	25	27	14	32	25	20	24	19	30	25	17	15	273
FAIRBANKS CC	105	181	116	92	57	95	57	66	111	140	82	90	1,112
KETCHIKAN CC	1	1	3	2	2	0	1	1	1	1	3	1	17
LEMON CREEK CC	10	14	12	15	7	12	11	10	19	22	21	18	171
MATSU PRE-TRIAL	2	2	6	2	3	0	3	1	2	3	4	0	28
WILDWOOD PT	9	6	4	4	0	7	6	5	5	7	2	4	59
YUKON-KUSKOKWIM CC	93	103	65	124	76	81	50	69	75	89	56	82	963
Total	278	280	249	322	207	264	186	214	268	309	211	224	3,012

FY 1994

	July	August	September	October	November	December	January	Febuary	March	April	May	June	Yearly Total
ANCHORAGE- 6TH AVE.	18	30	30	28	31	43	44	64	123	124	66	40	641
ANVIL MTN CC	11	10	8	8	18	6	6	2	8	7	5	6	93
FAIRBANKS CC	63	72	87	61	87	47	57	64	82	91	75	84	850
KETCHIKAN CC	3	7	4	3	5	4	3	0	1	2	0	3	35
LEMON CREEK CC	19	8	10	22	8	8	8	6	6	4	6	9	114
MATSU PRE-TRIAL	3	1	2	0	4	2	2	0	0	1	0	1	16
WILDWOOD PT	7	5	7	6	6	4	6	3	2	3	5	6	60
YUKON-KUSKOKWIM CC	106	113	60	71	108	64	28	55	60	54	68	56	843
Total	230	246	188	199	263	178	154	194	282	286	225	207	2,652

FY 1993

	July	August	September	October	November	December	January	Febuary	March	April	May	June	Yearly Total
ANCHORAGE- 6TH AVE.	30	27	34	25	45	34	29	49	50	54	25	24	426
ANVIL MTN CC	7	11	10	7	9	17	9	9	11	15	14	17	136
FAIRBANKS CC	83	63	53	63	66	71	62	54	92	71	66	66	810
KETCHIKAN CC	9	8	7	3	8	5	5	11	2	6	6	1	71
LEMON CREEK CC	9	12	10	15	17	5	16	8	14	14	13	16	149
MATSU PRE-TRIAL	4	4	5	6	1	4	8	4	1	1	3	3	44
WILDWOOD PT	6	10	8	7	1	4	5	3	5	3	7	3	64
YUKON-KUSKOKWIM CC	76	93	72	63	101	101	59	55	80	71	99	67	937
Total	226	228	199	189	248	241	193	193	255	235	233	197	2,637

FY 1992

	July	August	September	October	November	December	January	Febuary	March	April	May	June	Yearly Total
ANCHORAGE- 6TH AVE.	36	35	31	48	46	32	54	42	37	20	22	17	420
ANVIL MTN CC	14	15	11	8	15	11	9	9	14	13	18	10	147
FAIRBANKS CC	58	60	62	45	33	43	48	31	55	45	69	70	619
KETCHIKAN CC	13	9	14	10	5	6	9	7	15	15	4	3	110
LEMON CREEK CC	19	29	27	18	31	17	10	13	16	5	14	21	220
MATSU PRE-TRIAL	13	20	10	11	14	16	11	8	4	3	6	7	123
WILDWOOD PT	12	5	3	5	4	3	3	2	5	10	9	3	64
YUKON-KUSKOKWIM CC	66	84	43	47	74	29	38	44	50	47	33	54	609
Total	231	257	201	192	222	157	182	150	196	158	175	185	2,312

FY 1991

	July	August	September	October	November	December	January	Febuary	March	April	May	June	Yearly Total
ANCHORAGE- 6TH AVE.	41	40	54	62	72	80	75	101	93	55	42	36	751
ANVIL MTN CC	9	11	25	14	10	12	7	16	12	19	21	15	171
FAIRBANKS CC	45	80	60	51	64	42	45	39	73	60	47	32	658
KETCHIKAN CC	14	12	25	9	12	7	7	6	7	4	3	9	115
LEMON CREEK CC	16	19	25	19	11	12	13	23	28	19	23	12	220
MATSU PRE-TRIAL	6	15	17	7	9	10	6	7	7	6	8	11	109
WILDWOOD PT	8	2	2	3	3	1	1	4	2	5	1	2	34
YUKON-KUSKOKWIM CC	110	103	70	77	84	68	56	53	52	47	41	49	620
Total	249	282	278	242	275	232	210	249	274	235	186	166	2,878

Title 47 Admissions by Fiscal Year
Sex and Race

Fiscal Year 1991	Asian	Black	Hispanic	Native American	White	Total
Female	0	3	1	524	74	602
Male	3	26	17	1,733	498	2,277
Unknown	0	0	0	0	0	0
Total	3	29	18	2,257	572	2,879

Fiscal Year 1992	Asian	Black	Hispanic	Native American	White	Total
Female	0	3	0	421	52	476
Male	3	10	22	1,383	419	1,837
Unknown	0	0	0	0	0	0
Total	3	13	22	1,804	471	2,313

Fiscal Year 1993	Asian	Black	Hispanic	American	White	Total
Female	1	10	1	498	75	585
Male	4	11	14	1,586	437	2,052
Unknown	0	0	0	0	0	0
Total	5	21	15	2,084	512	2,637

Fiscal Year 1994	Asian	Black	Hispanic	American	White	Total
Female	1	6	2	516	74	599
Male	3	12	18	1,528	491	2,052
Unknown	0	0	0	0	0	1
Total	4	18	20	2,044	565	2,652

Fiscal Year 1995	Asian	Black	Hispanic	American	White	Total
Female	2	7	0	650	64	723
Male	8	32	14	1,755	477	2,286
Unknown	0	0	0	0	0	3
Total	10	39	14	2,405	541	3,012
Grand Totals	25	120	89	10,594	2,661	13,493

Title 47 Admissions by Fiscal Year
Race and Age

Fiscal Year 1995	Asian	Black	Hispanic	Native American	White	Total
18 and Under	0	0	0	13	4	17
19 to 20	0	1	0	28	5	34
21 to 24	0	3	2	185	21	211
25 to 29	1	5	1	260	69	336
30 to 34	0	2	2	459	96	559
35 to 39	0	2	1	409	113	525
40 to 44	1	16	3	365	92	477
45 to 49	8	7	0	216	80	311
50 to 54	0	0	0	182	29	211
55 to 59	0	1	4	139	21	165
60 to 64	0	1	1	73	5	80
65 and Older	0	1	0	76	6	83
Unknown						3
Total	10	39	14	2,405	541	3,012
Grand Total	25	120	89	10,592	2,661	13,487

Title 47 Admissions by Fiscal Year
Race and Age

Fiscal Year 1993	Asian	Black	Hispanic	Native American	White	Total
18 and Under	0	0	0	18	5	23
19 to 20	0	1	0	33	6	40
21 to 24	0	1	1	153	24	179
25 to 29	0	2	2	351	48	403
30 to 34	1	1	5	326	109	442
35 to 39	1	10	3	354	112	480
40 to 44	0	3	1	251	111	366
45 to 49	2	0	0	198	49	249
50 to 54	1	0	3	120	15	139
55 to 59	0	1	0	146	28	175
60 to 64	0	0	0	53	1	54
65 and Older	0	2	0	81	4	87
Total	5	21	15	2,084	512	2,637

Fiscal Year 1994	Asian	Black	Hispanic	Native American	White	Total
18 and Under	0	0	0	17	4	21
19 to 20	0	1	1	18	4	24
21 to 24	0	0	1	127	19	147
25 to 29	0	2	2	283	31	318
30 to 34	1	8	4	394	123	530
35 to 39	0	2	3	336	155	496
40 to 44	0	1	7	278	94	380
45 to 49	2	4	0	206	82	294
50 to 54	0	0	2	114	25	141
55 to 59	0	0	0	134	14	148
60 to 64	0	0	0	74	3	77
65 and Older	1	0	0	63	11	75
Unknown						1
Total	4	18	20	2,044	565	2,652

Title 47 Admissions by Fiscal Year
Race and Age

Fiscal Year 1991	Asian	Black	Hispanic	Native American	White	Total
18 and Under	0	0	0	21	2	23
19 to 20	0	1	0	40	5	46
21 to 24	1	8	0	196	32	237
25 to 29	0	5	4	390	74	473
30 to 34	1	4	6	426	103	540
35 to 39	1	3	7	304	117	432
40 to 44	0	7	0	259	104	370
45 to 49	0	1	1	194	46	242
50 to 54	0	0	0	128	38	166
55 to 59	0	0	0	134	25	159
60 to 64	0	0	0	66	16	82
65 and Older	0	0	0	98	10	108
Total	3	29	18	2,256	572	2,878

Fiscal Year 1992	Asian	Black	Hispanic	Native American	White	Total
18 and Under	0	0	0	15	3	18
19 to 20	0	0	0	23	7	30
21 to 24	1	2	2	153	37	195
25 to 29	1	0	2	316	51	370
30 to 34	1	3	2	276	99	381
35 to 39	0	4	5	293	130	432
40 to 44	0	3	3	188	59	253
45 to 49	0	0	0	170	29	199
50 to 54	0	1	8	93	27	129
55 to 59	0	0	0	118	14	132
60 to 64	0	0	0	59	2	61
65 and Older	0	0	0	99	13	112
Total	3	13	22	1,803	471	2,312

Title 47 Admissions by Fiscal Year

Fiscal Year 1991

Number of Admissions	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1	1,176	72.3	1,176	72.3
2	235	14.4	1,411	86.7
3	87	5.3	1,498	92.1
4	45	2.8	1,543	94.8
5	22	1.4	1,565	96.2
6	15	0.9	1,580	97.1
7	10	0.6	1,590	97.7
8	9	0.6	1,599	98.3
9	5	0.3	1,604	98.6
10	4	0.2	1,608	98.8
11	2	0.1	1,610	99
12	2	0.1	1,612	99.1
13	4	0.2	1,616	99.3
14	1	0.1	1,617	99.4
15	1	0.1	1,618	99.4
16	1	0.1	1,619	99.5
17	1	0.1	1,620	99.6
18	2	0.1	1,622	99.7
19	1	0.1	1,623	99.8
25	1	0.1	1,624	99.8
31	1	0.1	1,625	99.9
36	1	0.1	1,626	99.9
58	1	0.1	1,627	100

Fiscal Year 1992

Number of Admissions	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1	1,026	73.8	1,026	73.8
2	195	14	1,221	87.8
3	79	5.7	1,300	93.5
4	29	2.1	1,329	95.5
5	18	1.3	1,347	96.8
6	11	0.8	1,358	97.6
7	9	0.6	1,367	98.3
8	4	0.3	1,371	98.6
9	6	0.4	1,377	99
10	3	0.2	1,380	99.2
11	1	0.1	1,381	99.3
12	4	0.3	1,385	99.6
13	1	0.1	1,386	99.6
16	2	0.1	1,388	99.8
19	1	0.1	1,389	99.9
21	1	0.1	1,390	99.9
65	1	0.1	1,391	100

Title 47 Admissions by Fiscal Year

Fiscal Year 1993

Number of Admissions	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1	1,139	72.6	1,139	72.6
2	241	15.4	1,380	88
3	79	5	1,459	93
4	47	3	1,506	96
5	15	1	1,521	96.9
6	14	0.9	1,535	97.8
7	6	0.4	1,541	98.2
8	3	0.2	1,544	98.4
9	6	0.4	1,550	98.8
10	3	0.2	1,553	99
11	5	0.3	1,558	99.3
12	1	0.1	1,559	99.4
13	2	0.1	1,561	99.5
16	1	0.1	1,562	99.6
17	1	0.1	1,563	99.6
19	1	0.1	1,564	99.7
20	1	0.1	1,565	99.7
22	1	0.1	1,566	99.8
23	1	0.1	1,567	99.9
25	1	0.1	1,568	99.9
47	1	0.1	1,569	100

Fiscal Year 1994

Number of Admissions	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1	1,172	73	1,172	73
2	224	14	1,396	87
3	87	5.4	1,483	92.4
4	49	3.1	1,532	95.5
5	26	1.6	1,558	97.1
6	15	0.9	1,573	98
7	6	0.4	1,579	98.4
8	8	0.5	1,587	98.9
9	4	0.2	1,591	99.1
10	2	0.1	1,593	99.3
11	3	0.2	1,596	99.4
12	2	0.1	1,598	99.6
14	2	0.1	1,600	99.7
18	2	0.1	1,602	99.8
21	1	0.1	1,603	99.9
24	1	0.1	1,604	99.9
27	1	0.1	1,605	100

Title 47 Admissions by Fiscal Year

Fiscal Year 1995

Number of Admissions	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1	1,192	70.6	1,192	70.6
2	245	14.5	1,437	85.1
3	106	6.3	1,543	91.4
4	39	2.3	1,582	93.7
5	24	1.4	1,606	95.1
6	23	1.4	1,629	96.5
7	17	1	1,646	97.5
8	10	0.6	1,656	98.1
9	10	0.6	1,666	98.7
10	2	0.1	1,668	98.8
11	3	0.2	1,671	99
12	5	0.3	1,676	99.3
13	2	0.1	1,678	99.4
14	4	0.2	1,682	99.6
15	1	0.1	1,683	99.7
16	1	0.1	1,684	99.8
17	1	0.1	1,685	99.8
18	1	0.1	1,686	99.9
23	1	0.1	1,687	99.9
25	1	0.1	1,688	100

Title 47 Admissions by Fiscal Year

Fiscal Year 1991 - 1995

Number of Admissions	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1	3,311	62.4	3,311	62.4
2	822	15.5	4,133	77.9
3	382	7.2	4,515	85.1
4	197	3.7	4,712	88.8
5	121	2.3	4,833	91.1
6	93	1.8	4,926	92.8
7	73	1.4	4,999	94.2
8	65	1.2	5,064	95.4
9	38	0.7	5,102	96.1
10	33	0.6	5,135	96.8
11	21	0.4	5,156	97.2
12	18	0.3	5,174	97.5
13	14	0.3	5,188	97.8
14	21	0.4	5,209	98.2
15	4	0.1	5,213	98.2
16	13	0.2	5,226	98.5
17	8	0.2	5,234	98.6
18	10	0.2	5,244	98.8
19	11	0.2	5,255	99
20	4	0.1	5,259	99.1
21	4	0.1	5,263	99.2
23	1	0	5,264	99.2
24	3	0.1	5,267	99.2
25	1	0	5,268	99.3
27	2	0	5,270	99.3
28	2	0	5,272	99.3
29	4	0.1	5,276	99.4
30	4	0.1	5,280	99.5
31	2	0	5,282	99.5
32	3	0.1	5,285	99.6
34	2	0	5,287	99.6
35	2	0	5,289	99.7
38	3	0.1	5,292	99.7
41	2	0	5,294	99.8
44	1	0	5,295	99.8
48	1	0	5,296	99.8
49	1	0	5,297	99.8
50	2	0	5,299	99.8
51	1	0	5,300	99.9
59	1	0	5,301	99.9
64	1	0	5,302	99.9
69	1	0	5,303	99.9
71	2	0	5,305	100
104	1	0	5,306	100
170	1	0	5,307	100

BARTLETT MEMORIAL HOSPITAL

3260 Hospital Drive • Juneau, Alaska 99801 • Telephone (907) 586-2611

via FAX # 465-2108

Post-it™ brand fax transmittal memo 7671	# of pages ▸
To Susan Swan	From Garth Hamblin
Co.	Co. BMH
Dept.	Phone #
Fax # 465-4589	Fax # 586-8477

January 16, 1996

Representative Kim Elton
Alaska State Legislature

Dear Representative Elton:

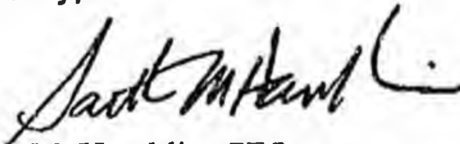
It is my understanding that the Community and Regional Affairs Committee, of which you are a member, is considering HB 383 which relates to reimbursement for services provided to individuals incapacitated by alcohol.

As you are aware, the issue of drug or alcohol related ER visits has been a concern of BMH for some time. When an individual incapacitated by drugs or alcohol is brought to our ER, we provide care for which there is often no reimbursement. While we have not looked at data recently, an extensive analysis of FY 92 data indicated total charges of nearly $219,000 for such cases. As you know this is, in most cases, care which we provide for which we receive no reimbursement.

We are supportive of efforts to provide reimbursement for treatment of such individuals.

I hope this information is useful in your deliberations. You may call me at (907) 586-8402 if you have questions or need additional information.

Sincerely,



Garth M. Hamblin, CFO

c: Representative Alan Austerman, co-chair (FAX # 465-4956)
Representative Ivan Ivan, co-chair (FAX # 465-4589)

[Sections to change underlined below]

AS. 47.37.190. INVOLUNTARY COMMITMENT.

(a) After a hearing initiated by petition of a spouse or guardian, a relative, the certifying physician, or the administrator in charge of an approved public treatment facility, a person may be committed to the custody of a private or public facility by the superior court. The petition must allege that the person is an alcoholic or other drug addict who demonstrates increased tolerance to alcohol or other drugs, who suffers from symptoms of withdrawal when alcohol or other drugs are not available, whose habitual [habitually] lack[s] of self-control is causing significant hazard to their health and continues to use despite these adverse consequences. [IN USING ALCOHOLIC BEVERAGES AND THAT THE PERSON (1) HAS THREATENED, ATTEMPTED TO INFLICT, OR INFLICTED PHYSICAL HARM ON ANOTHER AND THAT UNLESS COMMITTED IS LIKELY TO INFLICT PHYSICAL HARM ON ANOTHER; OR (2) IS INCAPACITATED BY ALCOHOL.] A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition must be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal must be alleged in the petition. The certificate must set out the physician's findings in support of the allegations of the petition.

(b) After the petition is filed, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the administrator in charge of the approved public or private treatment facility in which the committed person has been committed for emergency care; and (5) any other person the court considers appropriate. A copy of the petition and certificate shall be delivered to each person notified.

[(C) IF, NOT LESS THAN TWO DAYS BEFORE THE DATE FIXED FOR THE HEARING, THE PERSON SOUGHT TO BE COMMITTED OR THE PERSON'S COUNSEL OR ADVISOR FILES A WRITTEN REQUEST WITH THE SUPERIOR COURT, THE COURT SHALL SUMMON AND IMPANEL A JURY OF SIX ADULT RESIDENTS OF THE JUDICIAL DISTRICT IN WHICH THE COURT OFFICIATES, PREFERABLY FROM THE COURT'S JURY LIST OR THE LAST VOTERS LISTS, IF AVAILABLE, TO HEAR AND CONSIDER EVIDENCE CONCERNING THE CONDITION OF THE PERSON SOUGHT TO BE COMMITTED.]

Sec. 47.37.200. HEARING ON PETITION FOR INVOLUNTARY COMMITMENT.

(a) At the hearing required under AS 47.37.190(b), the court [or the jury, if requested under AS 47.37.190(c)], shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person whose commitment is sought shall be present unless the court believes that being present is likely to be injurious to the person, in which case the court shall appoint a guardian ad litem to represent the person

throughout the proceeding. The court may examine the person in open court, or if advisable, examine the person out of court. If the person has refused to be examined by a licensed physician, the person shall be given an opportunity to request examination by a court-appointed licensed physician. If the person fails to request a medical examination and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may issue a temporary order committing the person to a private or public facility for a period of not more than five days for purposes of a diagnostic examination.

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the private or public facility, the court [or the jury] finds that grounds for involuntary commitment have been clearly established, the court shall issue an order of commitment to the private or public facility.[A COURT MAY NOT ORDER THE COMMITMENT OF A PERSON UNLESS IT DETERMINES THAT A PRIVATE OR PUBLIC FACILITY IS ABLE TO PROVIDE ADEQUATE AND APPROPRIATE TREATMENT FOR THE PERSON.]

(c) A person committed under AS 47.37.190 - 47.37.200 shall remain in the custody of a private or public facility for treatment for a period of up to 30 days. At the end of the 30-day period, the person shall be discharged automatically unless the [DIVISION] approved program Director, before the expiration of the period, obtains a court order for recommitment upon the grounds set out in AS 47.37.190(a) for a further period of up to [90] 180 days. If [A PERSON HAS BEEN COMMITTED BECAUSE THE PERSON IS AN ALCOHOLIC LIKELY TO INFLICT PHYSICAL HARM ON ANOTHER, THE DIVISION] the condition which created the need for the initial commitment persists, the petitioner shall apply for recommitment.[IF AFTER EXAMINATION IT IS DETERMINED THAT THE]condition[STILL EXISTS.]

(d) A person recommitted under (c) of this section who has not been discharged by the private or public facility before the end of the [90]180-day period shall be discharged at the expiration of that period unless the [DIVISION]approved treatment program, before expiration of the period, obtains a court order on the grounds set out in AS 47.37.190(a) for recommitment for a further period not to exceed [90]180 days. [IF A PERSON HAS BEEN COMMITTED BECAUSE THE PERSON IS AN ALCOHOLIC LIKELY TO INFLICT PHYSICAL HARM ON ANOTHER, THE DIVISION SHALL APPLY FOR RECOMMITMENT IF AFTER EXAMINATION IT IS DETERMINED THAT THE LIKELIHOOD STILL EXISTS]If the condition which created the need for the initial commitment persists, the aproved program director shall apply for recommittment. No more than two recommitment orders may be permitted under (c) of this section and this subsection.

(e) Upon the filing of a petition for recommitment under (c) or (d) of this section, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the original petitioner under AS 47.37.190(a), if different from the petitioner for recommitment; (5) any other person the court considers appropriate. AS 47.37.180(c) applies to hearings for

recommitment under this section. At the hearing the court or the jury shall proceed as provided in (a) of this section.

(f) A private or public facility shall provide adequate and appropriate treatment for a person in its custody. A public facility may transfer a person in its custody from one approved public treatment facility to another if the transfer is medically advisable.

(g) A person committed to the custody of the [DIVISION]approved treatment program [for treatment]shall be discharged at any time before the end of the period for which the person has been committed if either of the following conditions is met:

[(1) WHEN AN ALCOHOLIC COMMITTED ON THE GROUNDS OF LIKELIHOOD OF INFLICTION OF PHYSICAL HARM ON ANOTHER IS NO LONGER CONSIDERED AN ALCOHOLIC OR THE LIKELIHOOD OF THE PERSON INFLICTING PHYSICAL HARM NO LONGER EXISTS; OR

(2) WHEN, IN THE CASE OF AN ALCOHOLIC COMMITTED ON THE GROUNDS OF THE LIKELIHOOD OF INFLICTION OF PHYSICAL HARM ON ANOTHER, EITHER]

[(A)](l) further treatment will not be likely to bring about significant improvement in the person's condition, or

[(B)](2) treatment is no longer adequate or appropriate.

(h) The court shall inform the person whose commitment or recommitment is sought of the right to contest the application, be represented by counsel at every stage of the proceedings relating to commitment and recommitment, to have counsel appointed by the court or provided by the court, if the person is unable to obtain counsel, and to a jury trial, if requested, as specified in AS 47.37.190(c). If the court believes that the person needs the assistance of counsel, the court shall require counsel, by appointment if necessary, regardless of the person's objection. The person whose commitment or recommitment is sought shall be informed of the right to be examined by a licensed physician of the person's choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician for the examination.

(i) If a private treatment facility agrees with the request of a competent patient or the patient's parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer the patient to the private treatment facility.

(j) A person committed under this chapter may at any time seek discharge from commitment by writ of habeas corpus under AS 12.75.

Sec. 47.37.270. DEFINITIONS.
In this chapter

(1) "alcoholic"[MEANS A PERSON WHO HABITUALLY LACKS SELF-CONTROL IN USING ALCOHOLIC BEVERAGES, OR USES ALCOHOLIC BEVERAGES TO THE EXTENT THAT THE PERSON'S HEALTH IS SUBSTANTIALLY IMPAIRED OR ENDANGERED, OR THE PERSON'S SOCIAL OR ECONOMIC FUNCTION IS SUBSTANTIALLY DISRUPTED;]or other drug addict" means a person who demonstrates increased tolerance to alcohol or other drugs, who suffers from withdrawal when alcohol or other drugs are not available, whose habitual lack of self

control is causing significant hazard to their health and continues to use alcohol or other drugs despite these adverse consequences.

(2) "approved private treatment facility" or "private facility" means a private agency meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(3) "approved public treatment facility" or "public facility" means a treatment agency operating under the direction and control of the division or providing treatment under this chapter through a contract with the division under AS 47.37.130(g) or through a grant awarded under AS 47.30.475, and meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(4) "commissioner" means the commissioner of health and social services;

(5) "department" means the Department of Health and Social Services;

(6) "director" means the director of the division of alcoholism and drug abuse;

(7) "division" means the division of alcoholism and drug abuse in the Department of Health and Social Services;

(8) "emergency service patrol" means a patrol established under AS 47.37.230;

(9) "hazardous volatile material or substance"

(A) means a material or substance that is readily vaporizable at room temperature and whose vapors or gases, when inhaled,

(i) pose an immediate threat to the life or health of the person; or

(ii) are likely to have adverse delayed effects on the health of the person;

(B) includes, but is not limited to,

(i) gasoline;

(ii) materials and substances containing petroleum distillates; and

(iii) common household materials and substances whose containers bear a notice warning that inhalation of vapors or gases may cause physical harm;

(10) "incapacitated by alcohol" means a person who is unconscious or whose judgment is otherwise so impaired that the person is incapable of realizing and making a rational decision with respect to a need for treatment, [AS EVIDENCED OBJECTIVELY BY EXTREME PHYSICAL DEBILITATION, PHYSICAL HARM OR THREATS OF HARM TO OTHERS OR CHRONIC INABILITY TO HOLD REGULAR EMPLOYMENT;]

(11) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(12) "inhalant abuse" means the misuse of a hazardous volatile material or substance by inhaling its vapors;

(13) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol or other drugs.;

(14) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to alcoholics and and other drug addicted persons or intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling;

(15) "work therapy"

(A) means an activity that involves a patient in basic employment skills and assists the patient in reintegration into a community;

(B) does not include

(i) activities such as personal housekeeping chores or cooperative responsibilities expected of each patient in the program; or

(ii) work that produces goods or services for sale or distribution, the proceeds of which would be returned to the owners, operators, or businesses of the rehabilitation program.

THE FOLLOWING PAGES
WERE TREATED AS A UNIT
IN THE ORIGINAL FILE

ALCOHOL BEVERAGE
EXCISE TAX
INFORMATION

DHSS - Division of Alcoholism
and
Drug Abuse

Alcohol Health & Research World

Volume 17
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1993

National Institute on
Alcohol Abuse and
Alcoholism

Prevention of Alcohol-Related Problems

Public Health
Service

National Institutes
of Health

Effects of Price on Alcohol-Related Problems

Frank J. Chaloupka, Ph.D.

Results of economic modeling suggest correlations between the prices of alcoholic beverages and the level of drinking in a population. Higher alcohol prices may lead to reductions in the medical and social consequences of heavy drinking.

This article summarizes research on the sensitivity of alcohol use and abuse to price changes, focusing on the work of the Health Economics group of the National Bureau of Economic Research. The article will also explore the potential of economic research in understanding and mitigating some of the adverse social and medical effects of alcohol.

This research is based extensively on models that use the principles of econometrics (statistical economic theory) to simulate the effects of policy options on the behavior of populations. Before describing this research, it will be helpful to explain some basic principles of this type of simulation.

Modeling and Simulation

Simulation is a means of predicting the effects of an action on an outcome. The action might be, for example, raising the price of an alcoholic beverage. The outcome might be drinking levels in a population. As in any experiment, other factors that might influence outcome must be kept constant; such factors in this case may include age, sex, race, and income. Thus, by measuring the (simulated) drinking level of a population both with and without the price increase, one can be reasonably sure that any difference in outcome is due to the price increase (or to whatever other factors the experimenter chooses to vary).

The results of a simulation can be stated as a prediction: under the specific conditions of the model, if a given action is taken, a particular outcome is likely to follow. Although these results may be expressed quantitatively, they should be taken as qualitative indications of the direction of the relation.

Because an outcome may be difficult to measure directly, a surrogate measure may be used to represent it. For example, a classic measure of alcoholism in a population is liver cirrhosis death rates. The reliability of a prediction thus depends in part on how closely a measured variable represents the outcome of interest.

A potential source of error in the simulations discussed below is the assumption made throughout that increased taxes lead to price increases equal to the tax increase. However, Cook (1981) has made the assumption that increased taxes lead to price increases that exceed the tax increase. If this is the case, then the following studies have underestimated the outcomes of their predictions.

The research reviewed in this article frequently compares the predicted effects of price and taxation strategies with the effects of an alternative strategy, namely the raising of the minimum legal drinking age (MLDA) to 21. The MLDA varied from State to State until 1988, when all States adopted a uniform MLDA of 21 in response to the Uniform Drinking Age Act. Simulations have been conducted to estimate various outcomes that might have resulted from the earlier adoption of this uniform MLDA.

Alcohol Taxes and Inflation

Federal, State, and local governments have raised taxes on alcohol modestly and infrequently, almost always with the intent of increasing revenues rather than discouraging alcohol abuse. Due in part to the stability of these taxes, the real prices

of alcoholic beverages (their prices after accounting for the effects of inflation) have declined significantly over time (figure 1). For example, between 1975 and 1990, the real price of distilled spirits fell by 32 percent, the real price of wine fell by 28 percent, and the real price of beer fell by 20 percent.

Federal excise taxes on beer and wine were increased in 1991 for the first time since 1951. Taxes on distilled spirits, increased by about 19 percent in 1984, were raised in 1991 for the second time since 1951. These increases fell far short of those needed to offset the effects of inflation since 1951. For example, in 1991, the tax on distilled spirits was raised from $2.00 to $2.16 per fifth of 80-proof liquor. This tax would have to be raised to $8.80 per fifth to reach the same real value as it had in 1951. At the same time, the tax on beer doubled, from 16 to 32 cents per six-pack, while the tax on still wine jumped from just over 3 cents per 750-milliliter bottle to about 21 cents. To reach the same real value they had in 1951, these taxes would have to be raised to 84 cents per six-pack and 18 cents per 750-milliliter bottle, respectively.

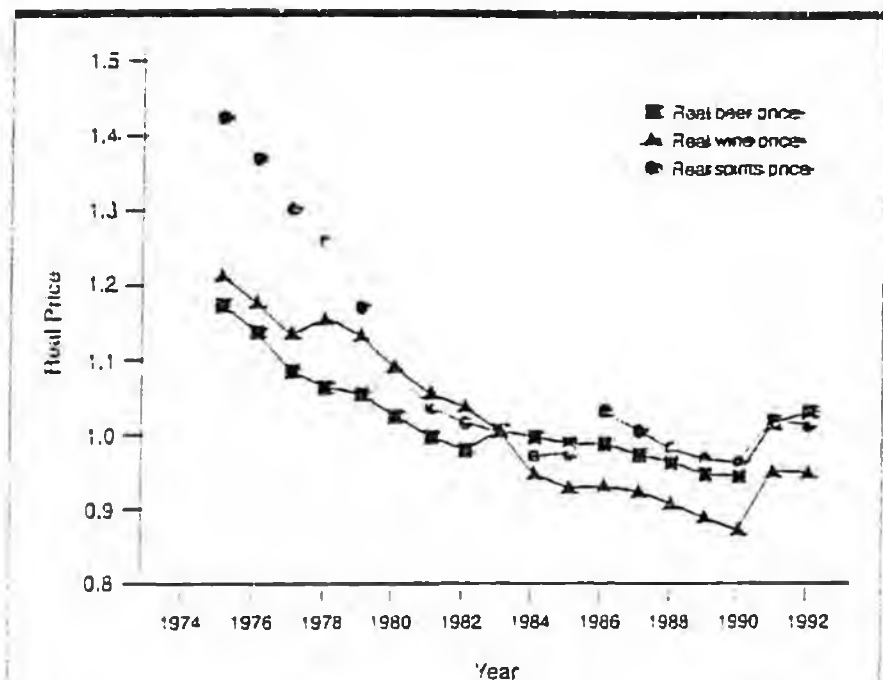

Figure 1 The decline of real prices of alcoholic beverages (their prices after accounting for the effects of inflation) between 1975 and 1992.*

* 1992 prices are for the first quarter. Distilled spirits prices from 1975 through 1977 are based on the whiskey price index. All data used for the figure are from the Bureau of Labor Statistics' *Monthly Labor Review*.

Alcohol Consumption and Price

A fundamental principle of economics is that of the downward-sloping demand curve, which demonstrates that as the price of any item rises, consumption of that item falls. Some economists have argued that the consumption of a potentially addictive item, such as alcohol, might be an exception to this rule. Numerous econometric studies confirm that this fundamental economic principle does apply to the demand for alcoholic beverages (Leung and Phelps 1991). However, further research is required on the possibility that the effects of price on alcohol consumption are not the same for all groups of drinkers. (See Cook's landmark study [1981] for a summary of the application of economic theory to the demand for alcoholic beverages and for a discussion of the methodological issues involved in econometric approaches to estimating price effects.)

Economists use the *price elasticity of demand* to describe the sensitivity of consumption to changes in price. The price elasticity of demand is the percentage change in consumption resulting from a 1-percent increase in price. For example, a price elasticity of -0.5 implies that a 10-percent increase in price would reduce consumption by 5 percent.

Leung and Phelps (1991) presented a detailed review of the extensive economics literature on the relationship between price and demand for alcoholic beverages. They concluded, based on pooled data from many studies, that the price elasticities of demand for beer, wine, and spirits are -0.3, -1.0, and -1.5, respectively. However, they also noted that recent research suggests that the demand for alcoholic beverages may be even more responsive to price than these estimates indicate. Moreover, there is considerable variation in the price elasticities reported in the articles reviewed in this study, making generalizations difficult.

I have also explored the effects of price on alcohol consumption with colleagues at the National Bureau of Economic Research. This work has focused on consumption by youths because of the high incidence of alcohol-related problems, particularly drinking and driving, among young people (National Institute on Alcohol Abuse and Alcoholism 1990).

Grossman and colleagues (1987) and Coate and Grossman (1988) provided the first estimates of the effect of price on alcohol use among young people. The first of these studies examined youth alcohol consumption as reported in cycle I of the National Health and Nutrition

Still wine is considered separately from sparkling wines and champagnes, which are taxed at a higher rate.

Frank J. Chaloupka, Ph.D., is assistant professor in the Department of Economics, University of Illinois at Chicago, and faculty research fellow at the National Bureau of Economic Research, New York, New York.

Research presented in this article has been supported by grants AA05849, AA07593, and AA08359 from the National Institute on Alcohol Abuse and Alcoholism to the National Bureau of Economic Research (NBER). This article has not undergone the review accorded official NBER publications; in particular, it has not been submitted for approval by the board of directors.

Examination Survey (NHANES I), conducted from 1971 through 1974 by the National Center for Health Statistics. The second study uses data from cycle II, conducted from 1976 through 1980 (NHANES II). Both studies focused on the frequency of beer consumption by persons ages 16 to 21, because beer is the alcoholic beverage of choice among the young in the United States (Grossman et al. 1987; Coate and Grossman 1988). The statistical procedure known as multiple regression was used to examine the effects of changes in beer prices, taxes, and MLDA's on youth alcohol demand, while holding constant other determinants of consumption, including age, sex, race, and family income.

Both studies found that the fraction of youths who consume beer fairly frequently (one to three times per week) or frequently (four to seven times per week) falls more when price rises than does the fraction of youths who drink infrequently (less than once a week).[2] The same finding applies when the price responsiveness of youths who are fairly heavy drinkers (three to five cans of beer on a typical drinking day) or heavy drinkers (six or more cans on a typical drinking day) is compared with that of light drinkers (two or fewer cans on a typical drinking day).

Based on NHANES II, Coate and Grossman (1988) predicted that increasing the tax on beer to offset the effects of inflation since 1951 would reduce the number of youths who drink beer frequently (about 11 percent of the sample) by 7.3 percent, while the number of fairly frequent drinkers (about 28 percent of the sample) would fall by 5.2 percent (figure 2). Combining this policy with one that first raises the tax on the pure alcohol in beer to the same level as that on the pure alcohol in distilled spirits could lead to much sharper reductions in consumption: a 32-percent reduction in the number of frequent drinkers and a 24-[illegible] [illegible]uction in the number of fairly fre[illegible] drinkers.

The reductions predicted from this combined tax policy were greater than those associated with an alternative policy simulation: a uniform MLDA of 21. Coate and Grossman (1988) predicted that the higher drinking age would have lowered frequent consumption by 28 percent and fairly frequent consumption by 11 percent from 1976 through 1980.

Laixuthai and Chaloupka (in press) updated this research to examine the price responsiveness of young drinkers after the change to a uniform MLDA of 21 for all alcoholic beverages. We used the 1989 nationwide survey of high school seniors conducted by the University of Michigan's Institute for Social Research as part of the Monitoring the Future program. The survey data contain drinking and sociodemographic data. Data on alcohol prices and taxes, as well as MLDA's, were added based on the young person's county of residence. Other determinants of alcohol consumption, including age, sex, race, religious participation, income, and parental characteristics, were held constant.

Three alternative measures of alcohol consumption were employed in this research. The first measure was drinking in the past year, with youths categorized as heavy drinkers (more than 30 drinking occasions, 13.7 percent of the sample), moderate drinkers (10 to 30 drinking occasions, 27.1 percent of the sample), light drinkers (1 to 9 drinking occasions, 44.4 percent of the sample), and abstainers (15.3 percent of the sample). The second measure focused on drinking in the past month, and again defined young people as heavy drinkers (more than nine occasions, 10.1 percent of the sample), moderate drinkers (six to nine occasions, 9.5 percent of the sample), light drinkers (one to five occasions, 41.2 percent of the sample), and abstainers (39.2 percent of the sample). Finally, the effect of price on heavy drinking was also examined; heavy drinking was defined by at least one episode of five or more drinks consumed in the 2 weeks before the survey (31.9 percent of the sample). These data differ from NHANES I and II in that the beverage consumed was not specified. In addition, the information on episodes of heavy drinking is unique and of particular relevance for policymakers, given that many of the adverse effects of heavy drinking, such as traffic fatalities,

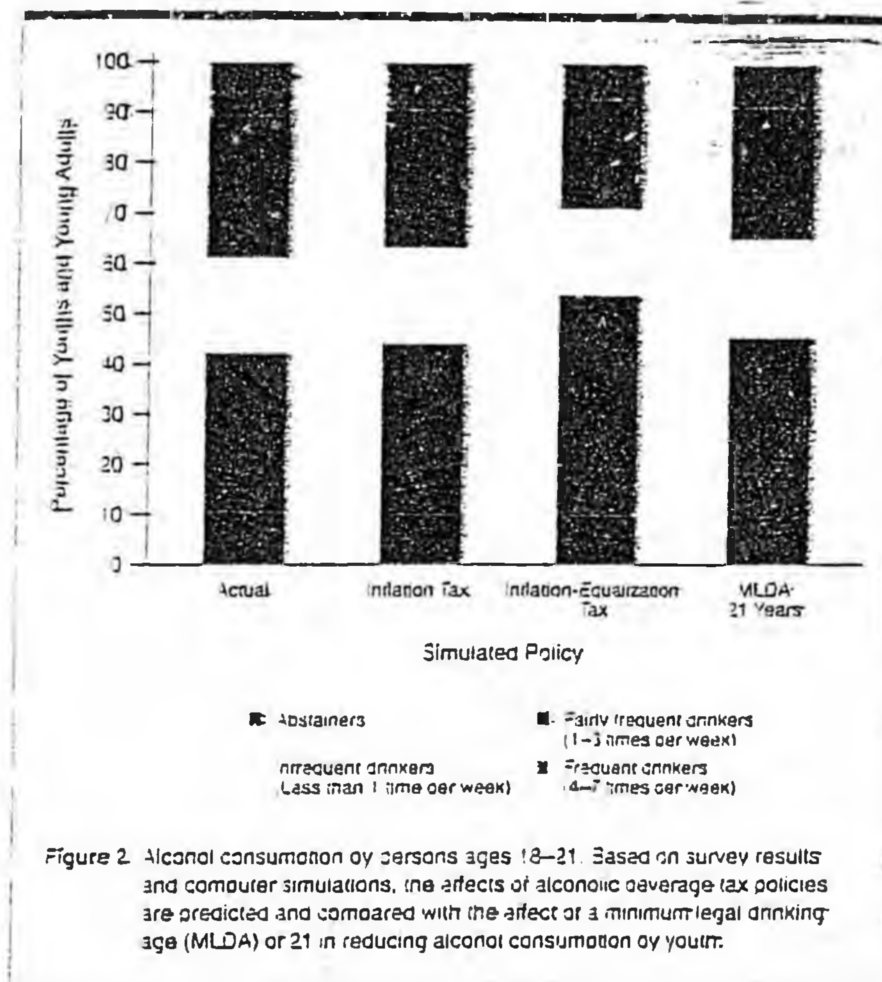

Figure 2. Alcohol consumption by persons ages 18–21. Based on survey results and computer simulations, the effects of alcoholic beverage tax policies are predicted and compared with the effect of a minimum legal drinking age (MLDA) of 21 in reducing alcohol consumption by youth.

[2] "Fraction" here refers to the fraction of all youths in the survey w[illegible] fall into each category. The fractions of frequent, fairly frequent, and infrequent drinkers and abstainers add up to 1.

are likely to be related to these types of drinking occasions.

Using the techniques of simulation, we predicted that increases in alcoholic beverage prices would lead to substantial reductions both in the frequency of youth alcohol consumption and in heavy drinking among the young. Furthermore, these reductions would not be limited to light drinkers. Large reductions in alcohol consumption were also predicted for heavy and moderate drinkers. Similarly, increases in price might significantly reduce heavy drinking episodes among young people according to this simulation.

Again, the effects of alternative price and tax policies were simulated. We predicted, for example, that increasing the beer tax to offset inflation since 1951 would have reduced the number of heavy drinkers among youth in the past year (1990) by almost 20 percent, while reducing the number of moderate drinkers by about 9 percent (figure 3a). Comparable reductions in heavy and moderate drinking in the past month were predicted to be approximately 10.6 percent and 6.6 percent, respectively (figure 3b). Finally, the model predicted that the number of youths with at least one heavy drinking episode in the past 2 weeks (almost 32 percent of the sample) would fall by 6.5 percent (figure 3c). Results of the simulation included similar reductions in the frequency of underage drinking for comparable changes in other alcoholic beverage excise taxes.

Therefore, results of these simulations are consistent with the hypothesis that increases in the Federal excise taxes on beer, wine, and distilled spirits might help reduce both overall and heavy alcohol consumption by youths. Our findings are particularly important, since discouraging youth alcohol abuse is likely to lead to substantial future reductions in alcohol abuse among adults (Rachal et al. 1980). Moreover, more frequent drinkers, or heavier drinkers, or both are likely to be responsible for a large percentage of motor vehicle crashes and deaths among youths.

Alcohol Abuse and Price

For the past several years, the National Bureau of Economic Research has been studying the effects of alcoholic beverage taxes and prices on various measures of alcohol abuse, including motor vehicle fatality rates and liver cirrhosis death rates. Some of the findings from this research are summarized below. Finally, economic research on the effects of taxes on workplace accidents is reviewed.

Drinking and Driving

Saffer and Grossman (whose work is rooted in Cook's (1981) seminal study) examined the effects of beer excise taxes and MLDA's on youth motor vehicle fatality rates using a time series of annual State cross sections for the period from 1975 through 1981.[1] Beer excise taxes were used to represent alcoholic beverage prices in general.

Fatality rates for persons ranging in age from 15 through 17, 18 through 20, and 21 through 24 were examined separately. Other determinants of alcohol consumption and fatality rates were held constant; these include real income; measures of traffic, roadway, and vehicle conditions; driver characteristics; religious participation; and the fraction of the State population residing in counties prohibiting the sale of alcoholic beverages (Saffer and Grossman 1987*a*). In addition, the experimental design controlled for the possibility that States increased their MLDA's in response to relatively high youth motor vehicle fatality rates (Saffer and Grossman 1987*b*).

Saffer and Grossman's analysis of these data used multiple regression methods that hold constant other determinants of alcohol consumption. While their findings indicated that significant reductions in youth motor vehicle fatalities for the three age groups would occur as the result of increased alcoholic beverage prices, increased MLDA's would significantly reduce fatalities only among those who could not have legally purchased alcohol only under the lower MLDA.

Simulations similar to those described above were conducted for 18- to 20-year-olds, with the following findings: A policy that maintains the real value of the

[1] A time series is a series of data on the same unit of observation (such as a person, county, State) over time. A cross section is a collection of data on a number of units of observation at a single point in time.

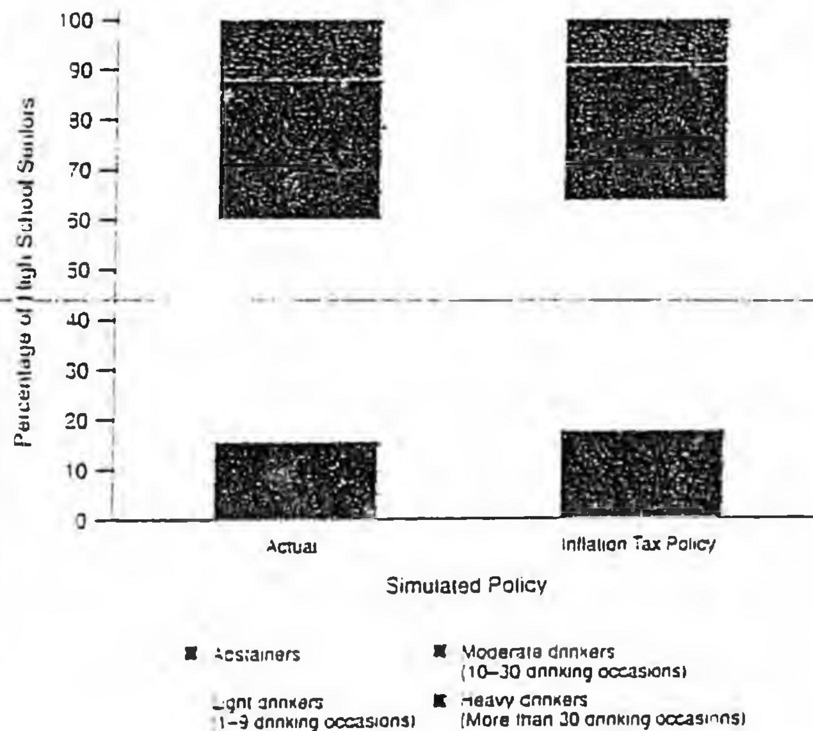

Figure 3a Alcohol consumption among high school seniors during the previous year based on a 1989 survey. The effect of increasing the beer tax to offset the effects of inflation since 1951 on the number of heavy drinkers among youth in 1989 was predicted.

Federal beer tax at its 1951 level could have reduced motor vehicle fatalities by 15 percent. A policy taxing the alcohol in beer at the same rate as that in distilled spirits could have lowered such deaths by 21 percent. The combination of the two tax policies might have caused a drop of 54 percent in the number of youths killed. And finally, a uniform MLDA of 21 by itself could have lowered the number of young people killed by 8 percent during the period from 1975 through 1981 (figure 4).

In an extension of this research, Grossman and colleagues (1991) examined motor vehicle fatality rates using a time series of annual State cross sections covering the 48 contiguous States from 1982 through 1988. Three different fatality rates were examined both for the overall population and for young people ages 18 to 20. The first is the total motor vehicle fatality rate for each age group. In an attempt to focus on alcohol involvement in these fatalities, two additional driver-specific fatality rates were defined. One is limited to drivers killed between 12:00 p.m. and 3:59 a.m. and is called the night driver fatality rate. (The National Highway Traffic Safety Administration [1986] estimates that 75 to 90 percent of these drivers had been drinking.) The other driver-specific fatality rate uses information on the blood alcohol concentration of drivers killed in traffic accidents to construct an alcohol-involved fatality rate. As in the previous studies, other determinants of alcohol consumption and motor vehicle accidents were held constant, permitting estimation of the net effect of taxes and MLDA's on fatality rates.

The effect of the recent (1991) increase in the Federal beer tax was simulated for the period 1982 through 1988. If this tax had been 32 cents per six-pack throughout this period (its current value after the recent doubling of the tax), an estimated 1,744 fewer people might have died each year as the result of motor vehicle crashes (figure 5a). Of these 1,744, an estimated 511 per year would have been 18- to 20-year-olds (figure 5b).

These increases would have equalized the taxes on beer, wine, and distilled spirits on the basis of alcohol content and would have raised Federal alcoholic beverage excise taxes to 25 cents per ounce of pure alcohol. If the beer tax had been set at 81 cents per six-pack throughout the period from 1982 to 1988 (based on a tax of 25 cents per ounce of pure alcohol), an estimated 7,142 fewer people of all ages might have been killed annually in motor vehicle crashes. This includes an estimated 2,187 fewer deaths of youths and young adults.

Simulations were then conducted to compare the estimated results of the above tax policy options with the estimated results of other policies. First, the number of traffic fatalities was simulated based on the current nationwide MLDA of 21 and then compared with the number of fatalities estimated to occur based on an MLDA of 18. Unlike the above tax policy, the effects of the drinking age policy were limited to youths and young adults. We estimated that a uniform MLDA of 21, rather than 18, might have saved, on average, 564 young lives per year. Since many States had MLDA's of 21 prior to the passage of the Uniform Drinking Age Act, the actual impact of the Federal law on youth and young adult fatalities was smaller than the simulated effect. It was estimated that a uniform MLDA of 21 during the entire 1982–1988 period would have saved approximately 166 lives per year.

In conclusion, the above simulation research on traffic fatalities suggests that increases in alcoholic beverage taxes might be an effective means of reducing alcohol-involved driving and related traffic fatalities.

Chronic Heavy Consumption and Liver Cirrhosis

Cook (1981) and Cook and Tauchen (1982) were the first to examine the possibility that long-term heavy alcohol consumption (as measured by liver cirrhosis mortality rates) might be responsive to price. They used a pooled time series of annual State cross sections for license States* over the period from 1962 through 1977 to examine the effects of State-level

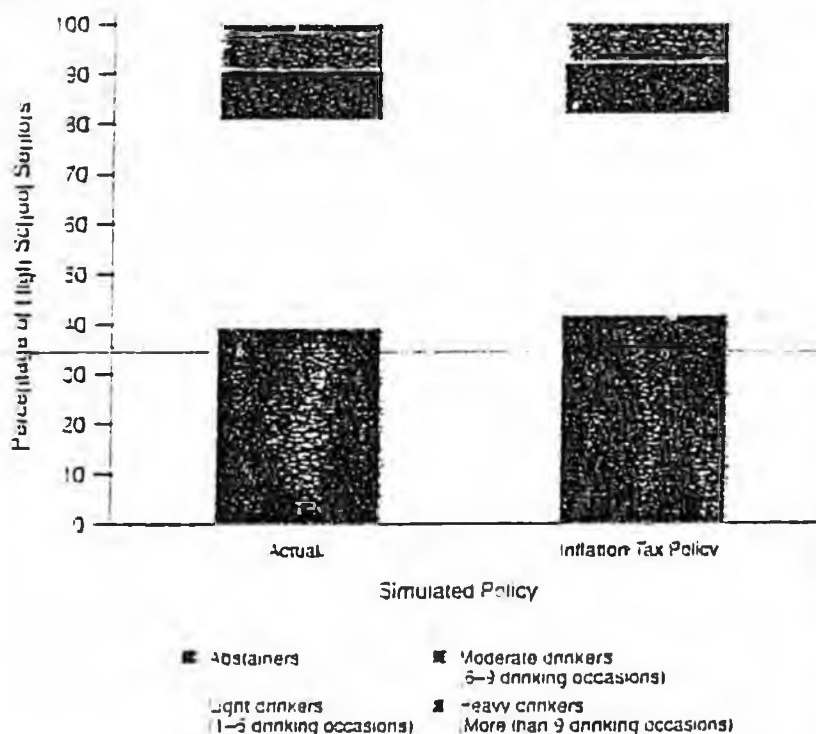

Figure 3b: Alcohol consumption among high school seniors during the previous month based on a 1989 survey. The effect of increasing the beer tax to offset the effects of inflation since 1951 on the number of heavy and moderate drinkers among youth in the month preceding the survey was predicted.

* A State where one can obtain a license to sell alcoholic beverages. This is contrasted with a control State, in which at least some alcoholic beverages (generally distilled spirits) for off-premises consumption are sold only through State-run liquor stores.

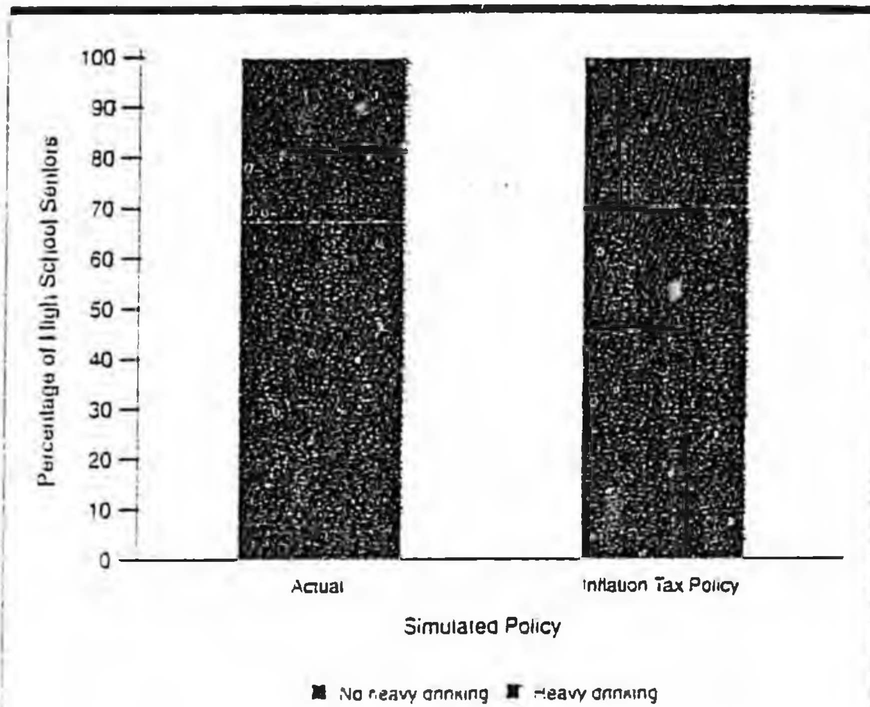

Figure 3c Alcohol consumption among high school seniors during the previous 2 weeks based on a 1989 survey. The effect of increasing the beer tax to offset the effects of inflation since 1951 on the number of youth reporting at least one heavy drinking episode (defined as five or more drinks on at least one occasion) in the 2 weeks preceding the survey was predicted.

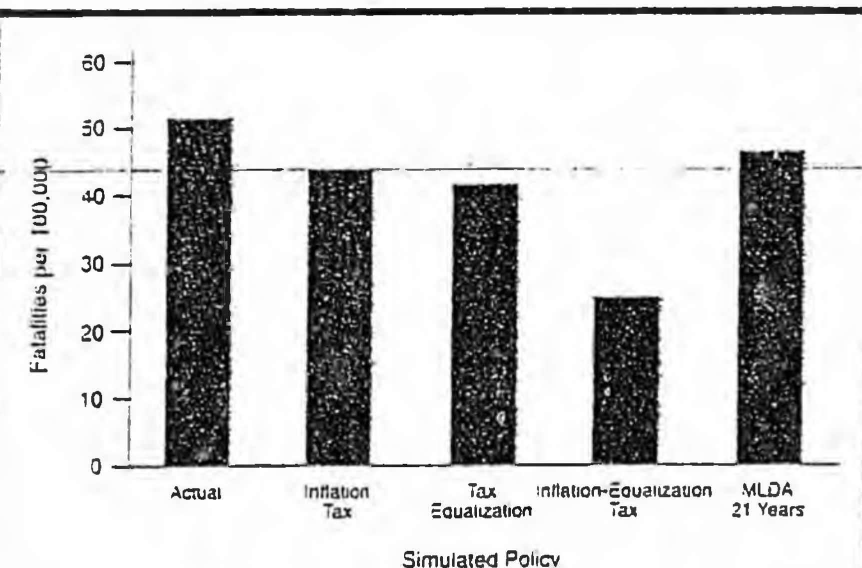

Figure 4 The simulated effects of alcoholic beverage policies on motor vehicle accident fatalities among persons ages 18–20 from 1975 through 1981. The policies include increasing the beer tax to offset the effects of inflation since 1951, equalizing the taxes on alcoholic beverages on the basis of alcohol content, and adopting in 1975 a uniform minimum legal drinking age (MLDA) of 21 (actually adopted in 1988).

distilled spirits taxes on the consumption of distilled spirits. In addition, they examined the impact of these taxes on liver cirrhosis mortality rates, a commonly used measure of long-term excessive alcohol consumption. They predicted that an increase in distilled spirits taxes would not only reduce distilled spirits consumption, but would significantly reduce deaths from liver cirrhosis. Cook and Tauchen estimated that a $1 increase in the State excise tax on distilled spirits would lower the cirrhosis death rate by approximately the same percentage as it lowered per capita consumption of distilled spirits. This finding contradicted conventional wisdom, which assumed that addictive alcohol consumption was insensitive to price.

We are currently extending this research. We are using a time series of annual State cross sections for the 50 States and Washington, DC, covering the period from 1961 through 1984, to estimate the effects of price on distilled spirits consumption, total alcohol consumption, and liver cirrhosis death rates. A State price index was used, based on the prices of three popular brands of distilled spirits over this time period. Other determinants of alcohol demand were controlled for.

We found overall alcohol demand to be responsive to price. Maintaining the distilled spirits tax at its 1951 level (to offset inflation) reduced cirrhosis deaths in this simulation by approximately 13 percent per year, an annual reduction in premature deaths of 3,905.

Workplace Accidents

Ohsfeldt and coworkers (1991) estimated the impact of an increase in the beer tax on the incidence of workplace accidents, another indicator of alcohol abuse. They estimated, based on results of a time series of States from 1975 through 1985, that a 12-cent increase in the beer tax in 1989 might have resulted in 130,000 fewer industrial injury cases among full-time employed workers. Furthermore, this tax increase might have lowered work-loss days resulting from industrial injuries by 1.5 million in 1989.

Policy Proposals

Two policy proposals that have received considerable attention are reviewed in detail below. They are followed by a brief

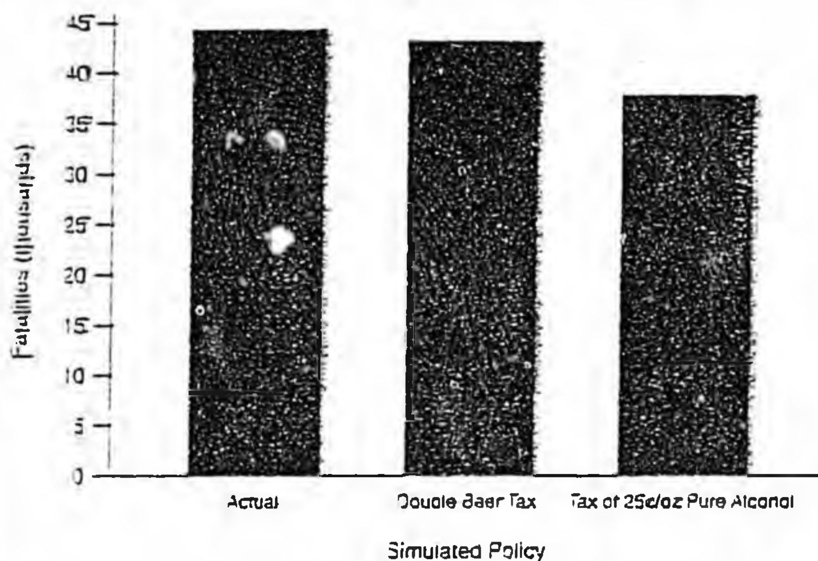

Figure 5a The simulated effect of the 1991 doubling of the Federal beer tax on total motor vehicle accident fatalities for the period from 1982 through 1988. Tax was simulated for the period 1982 through 1988. This effect is compared with the actual fatality rate for that period, and with a simulation of the effect of equalizing the Federal taxes on beer, wine, and distilled spirits on the basis of alcohol content (25 cents per ounce of pure alcohol).

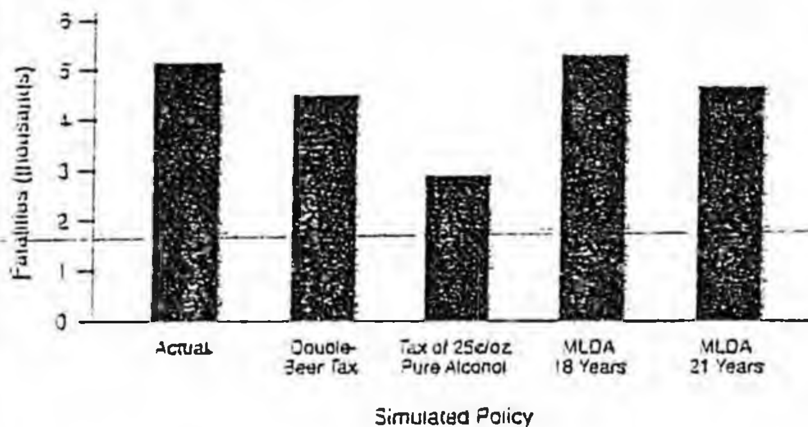

Figure 5b The simulated effect of the 1991 doubling of the Federal beer tax on motor vehicle accident fatalities among persons ages 18 to 20 for the period from 1982 through 1988. This effect is compared with the actual fatality rate for that period, and with the simulated effects of tax equalization and lowering the minimum legal drinking age (MLDA) to 18.

discussion of policy options that have received less attention.

Increased Alcoholic Beverage Taxation

Alcohol abuse imposes significant external costs. That is, at least part of the costs associated with alcohol abuse are borne by those other than the abuser. These costs include loss of life, injuries, and property damage associated with traffic accidents and violent crime; increased health care and insurance costs; and lost productivity. Pogue and Sgontz (1989) and Manning and colleagues (1989) report these external costs as approximately $175 per gallon of pure alcohol, in 1991 prices.

Therefore, one possible taxation strategy is to set alcohol taxes high enough so that the total revenues from these taxes are equal to the total external costs resulting from alcohol abuse. Thus, an "optimal" tax is one that equates tax revenues with the external costs. Cook and Moore (1991) describe this as the "user fee" concept of taxation. Under such an arrangement, the majority of the population (abstainers and light and moderate drinkers) would pay little or no tax, while the heaviest drinkers (those most likely to be creating most of the external costs) would be paying the bulk of the tax.

Based on these notions, Pogue and Sgontz (1989), Manning and coworkers (1989), and Saffer and Chaloupka (1992) estimated the "optimal" tax on alcohol in 1991 at $73, $78, and $79 per gallon of pure alcohol, respectively. In 1991, the actual average tax on a gallon of pure alcohol was approximately $35. This suggests that alcohol taxes could be more than doubled before the "costs" of the increased taxes would begin to exceed their benefits.

Tax Equalization

Many countries, including the United States, have adopted taxation and many other regulatory policies that favor beer and wine over spirits. One justification for these policies is the belief that each type of alcoholic beverage is associated with different physiological effects, and thus has different public health effects. A second justification is that these policies reflect the purchase prices of alcoholic beverages, since alcohol is relatively cheaper to produce in the form of distilled spirits than it is in the form of beer or wine.

Saffer and Chaloupka (1992) provided the first attempt to address the question of whether or not the equalization of alcoholic beverage taxes would be an effective policy. Our estimate suggested that beer taxes should be about 28 percent higher than the taxes on wine and distilled spirits. This is not equalization, but given the difficulties of estimating the optimal tax structure and the complications arising from bottle deposits and sales taxes, our estimates came reasonably close to equalization. Saffer and

Chaloupka (1992) may also be consulted for a detailed discussion of the methods used to produce the above estimate.

Other Tax and Price Strategies

Proposals associated with cigarette taxes provide some guidelines for changes in alcoholic beverage taxes. An example is increased and more uniform State taxation and pricing strategies. Beer taxes, for example, range from a low of 4.5 cents per case of 24 12-ounce cans in Wyoming to $2.28 per case in Georgia. Similar large variations in State taxes on cigarettes in the early 1970's led to the smuggling of cigarettes from low-tax States to high-tax States, either for personal use or for resale.

There is no evidence that the large differences in alcoholic beverage taxes among States have had the same consequences. However, serious problems may arise if States with high alcohol taxes increase them further, while States with low alcohol taxes do not increase them. The resulting increased price differentials might then lead to increased drinking and driving, as drinkers drive into neighboring States to purchase and consume alcohol. A similar phenomenon occurred among the young when differentials in State MLDA's were common (Coate and Grossman 1988; Saffer and Grossman 1987*a*). The problem may be exacerbated by the uneven application of State sales taxes to all alcoholic beverages. This suggests that increases in State alcohol taxes should be relatively large where they are now relatively low, and that sales taxes should be applied evenly to all alcoholic beverages in a State.

As previously noted, the relatively small and infrequent increases in alcoholic beverage taxes have permitted a substantial decline in alcohol prices, after accounting for inflation. One strategy to combat this is to replace the excise taxes on alcoholic beverages with ad valorem taxes, that is, the tax imposed is a fixed percentage of the price. Thus, as the price exclusive of the tax increases, the tax collected increases proportionately. Currently, only Hawaii imposes an ad valorem alcoholic beverage tax, specifically on beer. A related proposal includes indexing the Federal and/or State taxes on alcoholic beverages to the rate of inflation. Each of these proposals would offset the effects of inflation on the value of the tax.

Finally, a proposal included in California's failed proposition 134 was loosely based on the successful proposition 99, which, effective January 1, 1989, raised the California cigarette excise tax by 25 cents per pack. The majority of the increased revenues were dedicated to antismoking education (20 percent) and research (5 percent), environmental and other specified programs (5 percent), and medical care for the poor (the remainder). Proposition 134 was to have used the revenues from a "nickel-a-drink" tax for alcohol-related education, research, treatment, and other programs related to alcohol abuse.

Conclusions

Increases in Federal, State, and local taxes on alcoholic beverages are a potentially effective policy for reducing alcohol consumption, heavy alcohol consumption, and alcohol-related injuries and deaths. These predictions are based on extrapolations from the results of statistical-economic simulation experiments. ■

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Reasons to Increase the Alcohol Beverage Excise Tax

In many Alaska communities a six pack of beer is cheaper than a six pack of Coke. The current alcohol beverage excise tax rate was set in 1983. Inflation has reduced the real tax rate by approximately 30 percent since 1983.

- Nationally, polls consistently show public support for increased excise taxes on alcohol and tobacco, supported by a clear 75 percent majority, according to a Louis Harris poll in 1987.

  Seventy percent of Alaskans surveyed in November 1993, supported an increase in the alcohol tax.

- Higher real prices for beer would reduce the number of young people who drink, national studies indicate.

  Over 70 percent of Alaskan students in grades 10 - 12 report having used alcohol at some time during their lives.

- Nationally, current excise taxes on alcohol cover only about half the lifetime costs that drinkers impose on others through collectively financed health insurance, disability, fines, motor vehicle accidents and criminal justice costs.

  Excise taxes could be considered a "user fee" to partially offset the social, health, public safety, and criminal justice costs associated with alcohol use. The annual expenditure associated with alcohol use and abuse in Alaska state government services, is an estimated $300 million dollars.

- The AMA nationally estimates that up to 40 percent of the people in general hospital beds at any given time are there for illness or injuries in which alcohol was a factor.

  In 1995, the annual expenditure for health care in Alaska was 2.446 billion dollars.

- Increasing alcohol taxes will save lives by reducing consumption, especially among youth. National studies have concluded that higher real prices can reduce the incidence of frequent and heavy drinking, particularly among youth.

  Alaskan youth in grades 7-12 report the use of alcohol at a level comparable to the level reported by youth nationally. However, Alaska's per capita consumption rate is the third highest in the nation.

- Cirrhosis mortality, an indicator of 10 to 20 years of heavy drinking is lower in states that raised distilled spirits taxes compared to states that have not.

  Cirrhosis deaths alone are an inadequate indicator of alcohol problem rates in Alaska because of the small population base and the unusually high accidental death and suicide rate. Alcohol has been linked to approximately 25 percent of all deaths in Alaska and nearly 60 percent of all suicides.

- Taxing alcohol is a traditional method for controlling consumption and for raising revenue in almost every country in the world.

  Prior to the tax increase in 1983 consumption both in total volume and on a per capita basis was steadily increasing. Following the 1983 excise tax increase, total consumption actually decreased for a few years. Since 1990 however, the rate has leveled off, indicating the effect has been offset by inflation.

- One argument commonly used in opposition to an increase in the excise tax is that it regressive and falls on those least able to afford such a tax, the lower and middle classes.

  A counter argument is that these same people are often the most susceptible to alcohol-related injuries and the adverse health consequences of consumption. Unable to pay for the health care they require, these costs are passed on to people who have not contributed to the problem

The source information for the data in this fact sheet is on file at the Department of Health and Social Services, Division on Alcoholism and Drug Abuse and is available upon request.

We can spend millions to educate, counsel, provide "Officer Friendlies", and recreational programs for youth but. . .

When beer is consistantly cheaper . . .

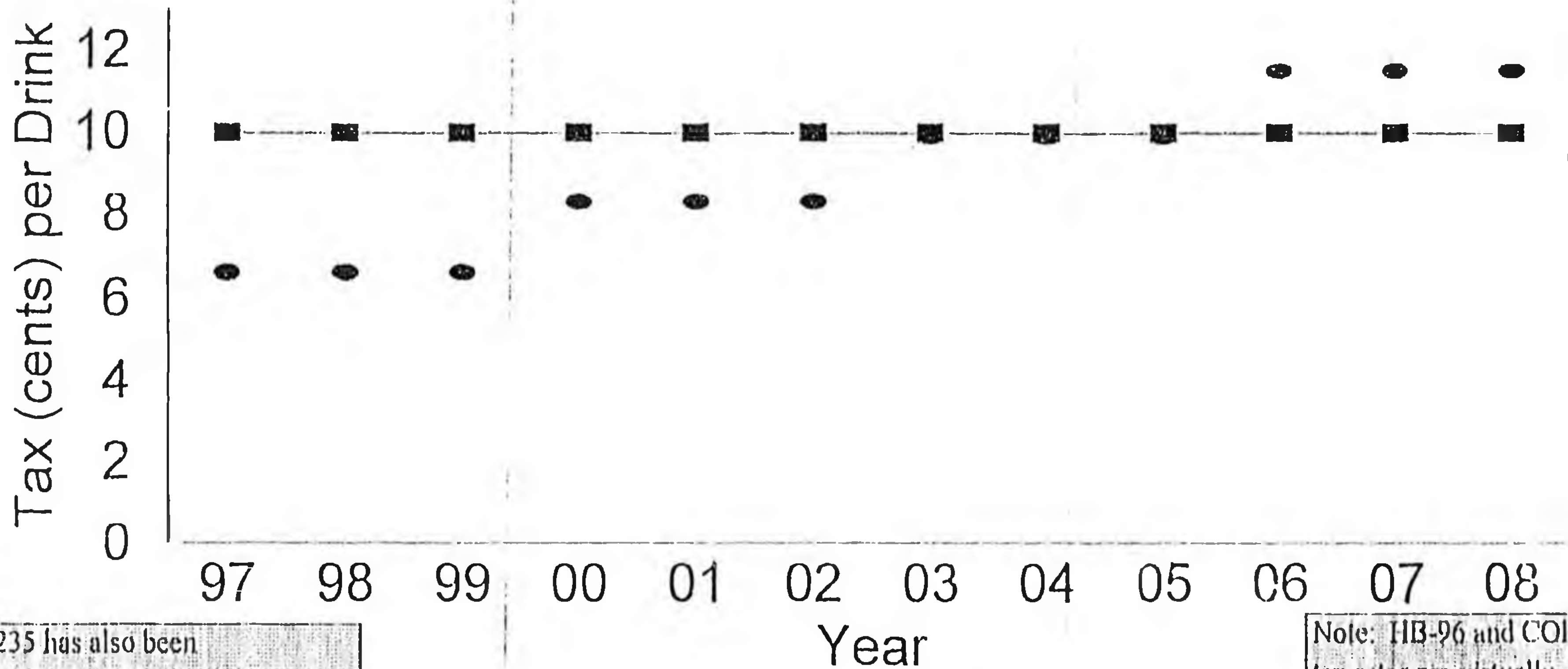
$ 2.45 a six pack at Fred Meyers. . . $ 2.50 at Carr's and K-Mart.
(Juneau, Fred Meyer's - April 9, 1995)

Than Coca~Cola or PEPSI . . . $ 2.59 a six pack
(Juneau Fred Meyer's - April 9, 1995 other location)

What kind of a message do we send to our kids ?
No wonder they don't pay attention !

Comparison of Alcohol Tax Rates

Based on 1oz. Distilled Spirits 12 yrs



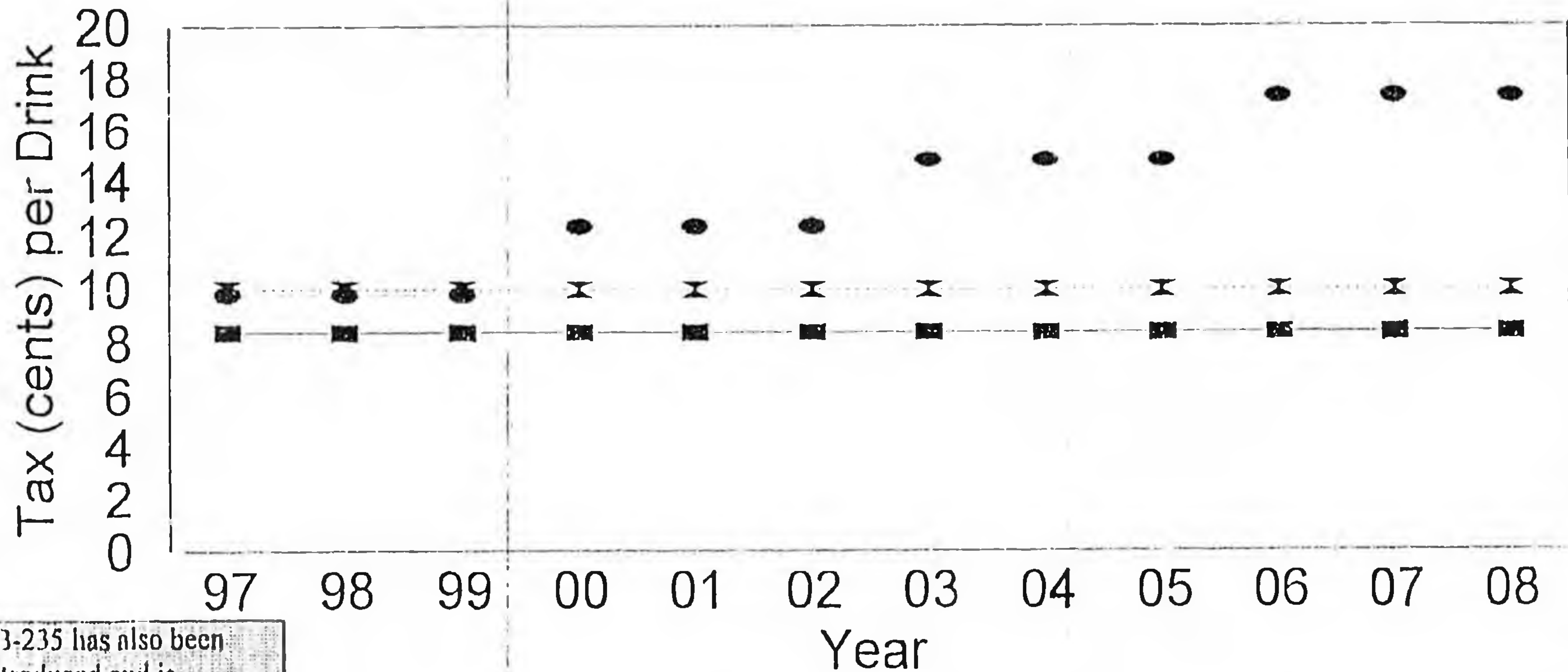
SB-235 has also been introduced and is identical to HB-441

HB-96   HB-441   COPS

Note: HB-96 and COPS tax rates are virtually identical.

Comparison of Alcohol Tax Rates

Based on 5 oz. Wine over 12 years

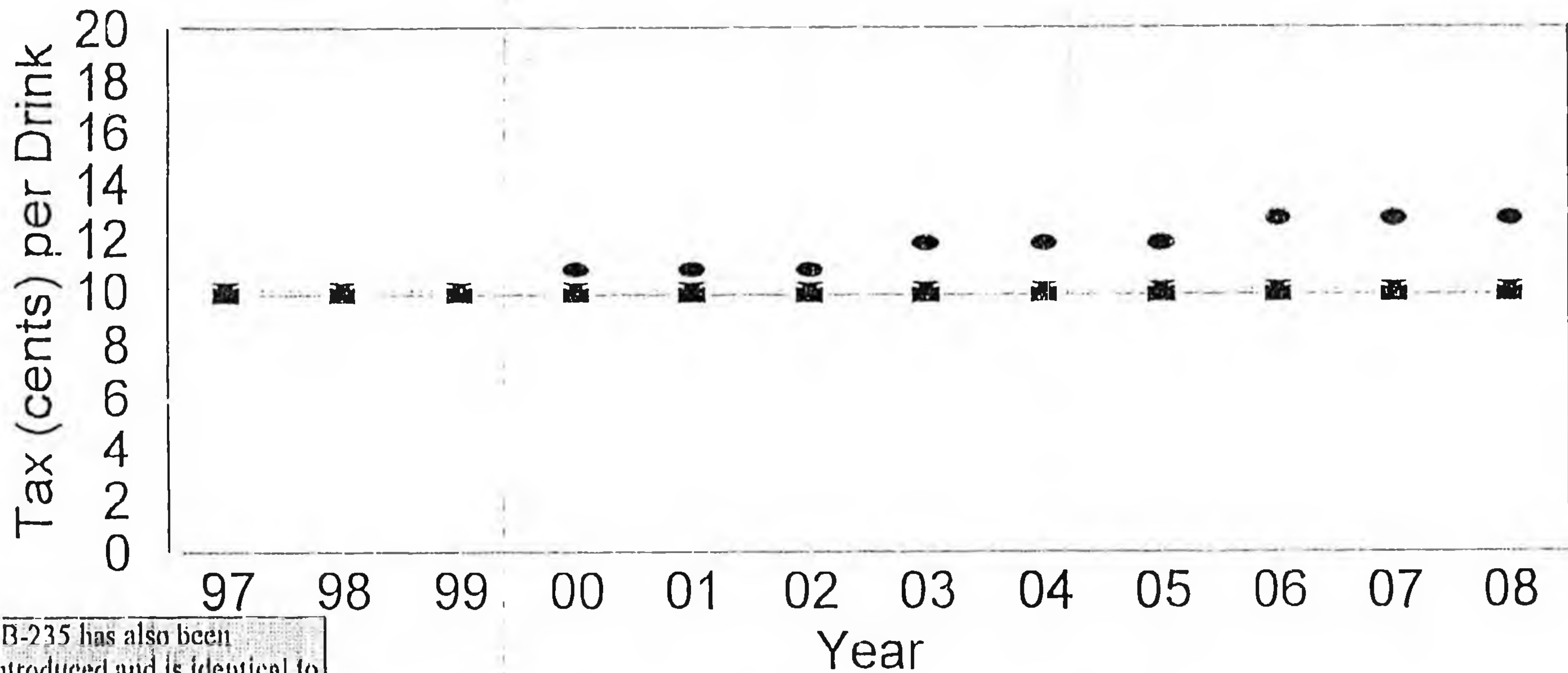


SB-235 has also been introduced and is identical to HB-441

HB-96 HB-441 COPS

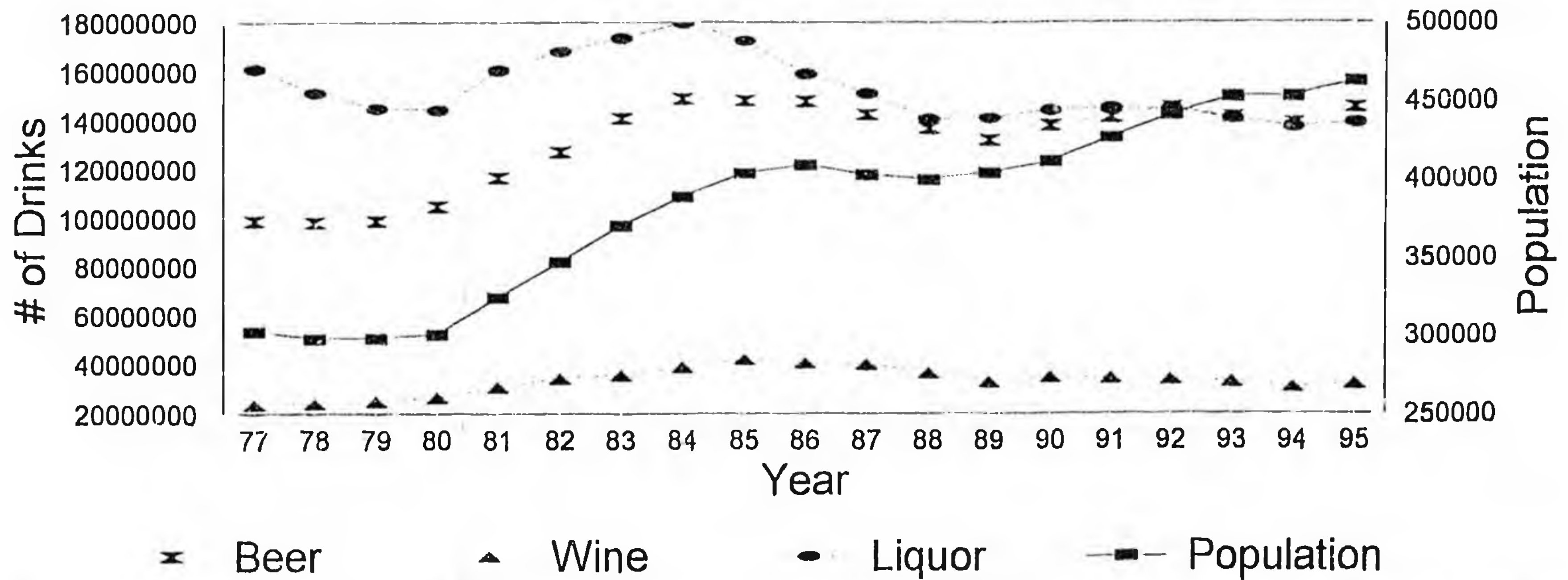
Comparison of Alcohol Tax Rates

Based on 12 oz. Beer over 12 years

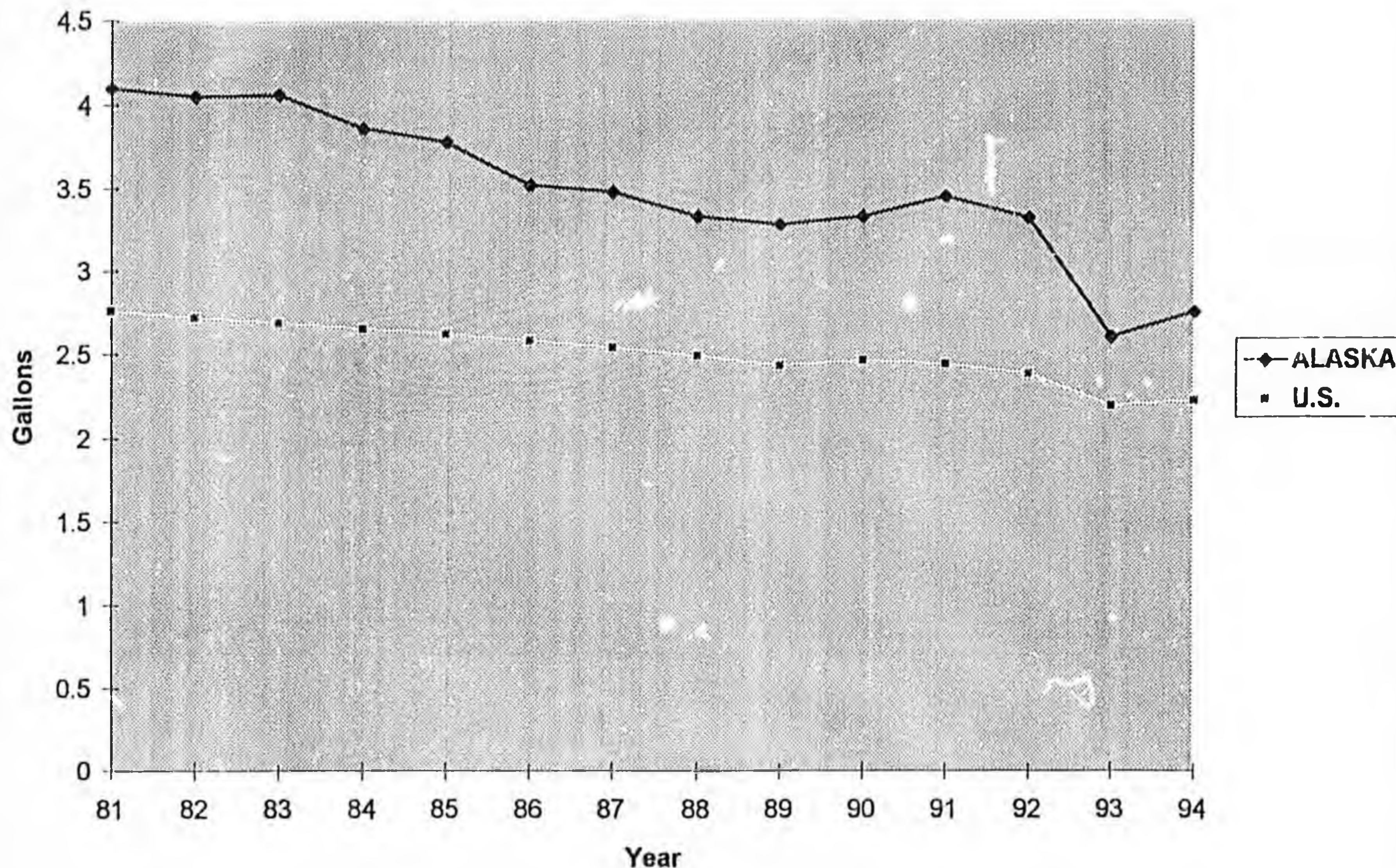


SB-235 has also been introduced and is identical to HB-441.

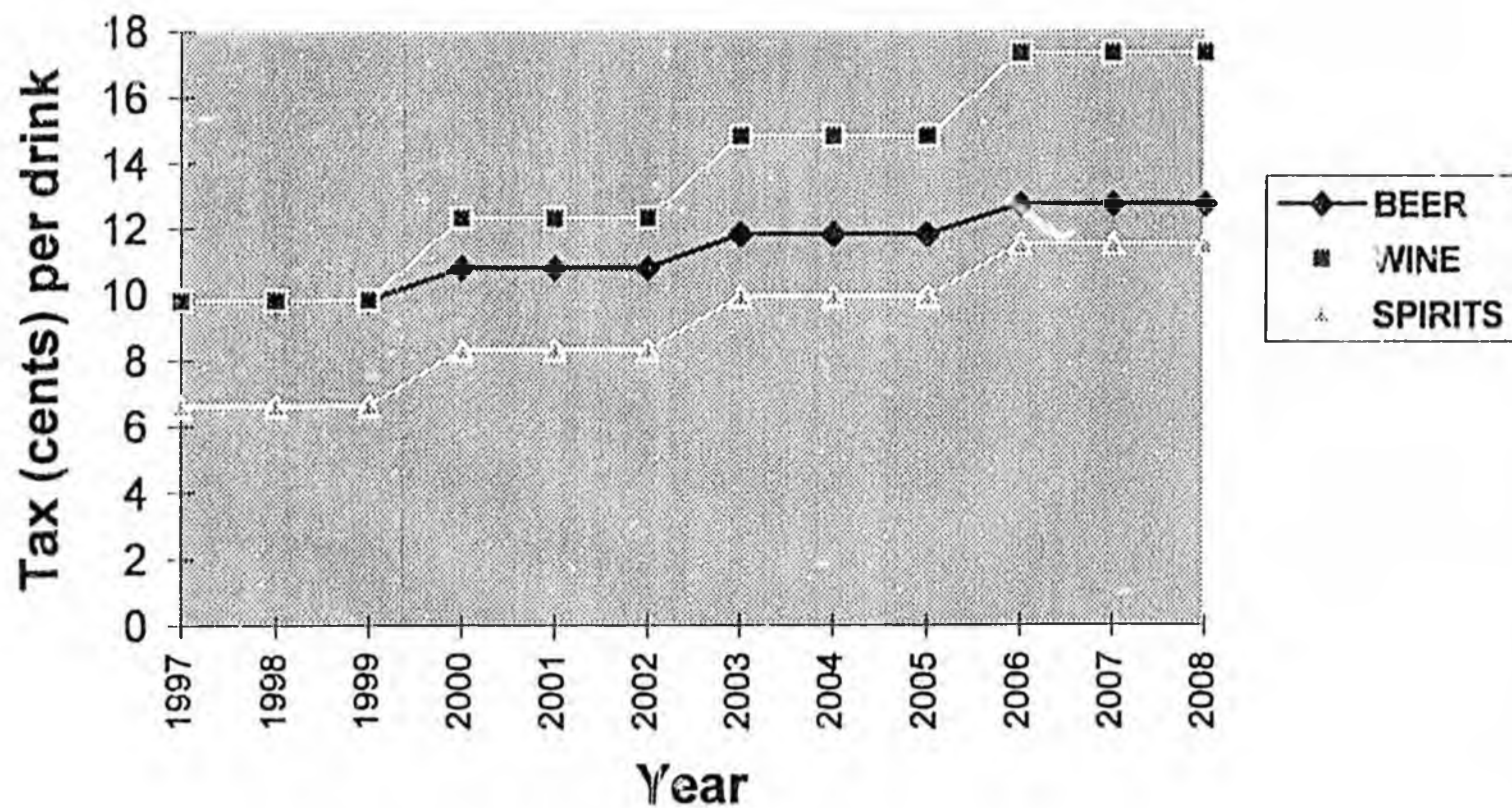
HB-96 HB-441 COPS



Alcohol Consumption vs Population
1977 - 1995
Liquor: 1 Drink = 1 ounce
Beer: 1 Drink = 12 ounces
Wine: 1 Drink = 5 ounces
180000000
160000000
140000000
120000000
100000000
80000000
60000000
40000000
20000000
# of Drinks
500000
450000
400000
350000
300000
250000
Population
77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95
Year
Beer
Wine
Liquor
Population



Source: NIAAA, Surveillance Report #23, 1992; The Bottom Line


HB-441 Projected Tax Rates
Tax (cents) per drink
18
16
14
12
10
8
6
4
2
0
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
Year
BEER
WINE
SPIRITS

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