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INFORMATIONAL PACKET ON ALCOHOLISM INSURANCE

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A. Members of the panel

B. First Draft - Considerations for the inclusion of benefits for alcoholism/drug addiction into Health Insurance Policies.

C. Alcoholism statutes in various state insurance codes.

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D. SB 545 "An Act Relating to Health Insurance" Analysis of SB545 by the Division of Insurance. Correspondence recieved by the Division of Insurance concerning SB 545.

E. Various pieces of legislation proposed in Alaska. All legislation listed below was proposed during the Tenth Alaskan Legislature (January, 1977 through December, 1978.) The majority of the bills listed below were either part of the group of legislation commonly refered to as the "Governor's Alcoholism Package," or part of the group of legislation commonly referred to as the "Citizen's Legislative Bill," which was developed by the Special Senate Committee on Alcholism and Alcohol Related Legislation.

Summary of the legislation known as the "Governor's Alcoholism Package."

Summary of the legislation known as the "Citzen's Legislative Bill."

A brief history of alcoholism legislation during the Tenth Alaska State Legislature.

SB76 "An act providing a method of adjusting certain tax rates."

SB167 "An act relating to the excise tax and licence fees on intoxicating liquors." (Note: Originally, the wording was the same as HB 196.)

SB168	"An act making a special appropriation to the Department of Health and Social Services and to the Department of Education for alcohol-related programs." (Note: Originally, this bill had the same language as HB241.)
SB242	"An act relating to treatment of alcoholism and drug abuse" (Note: The language of this bill and HB340 remained the same.)
SB333	"An act making a special appropriation to the Alaska Public Broadcasting Commission for alcohol and drug abuse programs."
SB479	"An act making a special appropriation to the Department of Health and Social Services or the National Council on Alcoholism, Alaska Region."
SB540	"An act making a special appropriation to the Office of Alcoholism in the Department of Health and Social Services for the prevention and treatment of alcohol abuse and alcoholism."
SB541	"An act relating to alcohol and drug abuse education in public schools."
SB542	"An act adding to the powers and duties of the office of alcoholism."
SB543	"An act relating to alcoholism grants-in-aid."
SB544	"An act relating to standards for alcohol treatment facilities."
SB545	"An act relating to health insurance."
SB546	"An act establishing a tax credit for contributions to alcoholism programs."
SB547	"An act making a special appropriation to the Department of Revenue to increase the number of enforcement personnel employed by the Alcoholic Beverage Control Board.
SB548	"An act relating to waiter and waitress permits."
SB549	"An act relating to the serving of intoxicating liquor."
SB550	"An act relating to administration and enforcement of alcoholic beverage control statutes and regulations."
SB551	"An act relating to the rehabilitation of persons who commit criminal offenses as a result of alcohol problems."
SB552	"An act relating to alcohol."
HB196	"An act relating to the license fees for wholesale sale of intoxicating liquors."
HB232	"An act relating to municipal sales taxes."
HB240	"An act relating to alcoholism beverages."
HB241	"An act making a special appropriation to the Department of Health and Social Services and to the Department of Education for alcohol-related programs."
HB340	"An act relating to treatment of alcoholism and drug abuse."
HB570	"An act making a special appropriation to the Department of Health and Social Services for a feasibility study of an alcoholism treatment facility on Umnak Island."

SCR88 "Directing the Legislative Council to accomplish a substantive revision of the alcoholic beverage laws."

SCR98 "Relating to the underutilization of hospital beds in light of the need for detoxification facilities."

F. Excerpts from "Alcoholism, The Total Treatment Approach."

G. Booklet - "Health Insurance Coverage for Alcoholism: State Legislature and Regulatory Activities." By Dr. Jerome B. Hallan April, 1974.

H. Excerpts from "Second Special Report to the US Congress on Alcohol and Health." June, 1978.

I. Excerpts from "Third Special Report to the US Congress on Alcohol and Health." June, 1978.

J. Article - "Alcoholic Persons Right to Disability Aid Stressed." Mututal Insurance Bulletin June, 1978.

K. Various articles from the "Wisconsin Insurer." May, 1978 & September, 1978.

L. Article - "Mortality from Alcoholism." Metropolitan's Statistical Bulletin. December, 1977.

M. Newsletter - Public Policy Report" - New Jersey Alcoholism Association.

N. Newsletter - "The State Bar of California Reports:" January, 1976.

O. Booklet - "Information for Health Care Providers Concerning Mandated Benefits for the Treatment of Alcoholism, Drug Abuse and Mental and Nervous Disorders." - State of Wisconsin.

P. Article - "Third Party Coverage Cuts Nonalcoholism Care Cost." NIAAA Information and Feature Service. April, 1978.

Q. Excerpt - "Alcohol and Health Chapter XI. Financing Alcoholism Treatment Services." Department of Health, Education and Welfare October, 1978.

R. Booklet - "A Study of Health Insurance Coverage for Alcoholism for California State Employees." By Dr. Harold D. Holder and Dr. Jerome B. Hallan December, 1976.

S. Booklet - "A Report on Health Insurance Coverage of Alcoholism and Drug Abuse Treatment in Alaska." Prepared by Lawn and Associates for Robert L. Cole, Office of Alcoholism and Drug Abuse.

T. Booklet - "An Outline of a Uniform Accounting and Financial Report System for Alcoholism and/or Drug Abuse Treatment Programs in Alaska" Prepared by Lawn and Associates for Robert L. Cole, Office of Alcoholism and Drug Abuse.

U. Booklet - "Report on a Demonstration Project: A Study to Determine Cost Components and Develop Fee Schedules (Including Payment Mechanisms) in the Fairbanks Native Association's Comprehensive Alcoholism Program and Fairbanks Drug Treatment Center." Prepared by Lawn and Associates for Robert L. Cole, Office of Alcoholism and Drug Abuse. Spring, 1978.

INFORMATIONAL PACKET ON ALCOHOLISM INSURANCE

SUPPLEMENT

I. "Accreditation Manual for Alcoholism Programs." Published by the Joint Commission on Accreditation of Hospitals.

II. "A Status Report on Training and Certification for Alcoholism and Drug Abuse Personnel in Alaska." Submitted by Human Services Horizons for Robert L. Cole, Director. Office of Alcoholism and Drug Abuse.

III. "Working Papers: Descriptive Analysis of the Impact of Alcoholism and Alcohol Abuse in Alaska, 1975 (Four Volumes).

Volume I
"The Economic Impact of Alcoholism and Alcohol Abuse in Alaska, 1975.

Volume II
"An Analysis of State Legislation Pertaining to Regulation and Control of Beverage Alcohol and Alcoholism and Alcohol Abuse, Alaska, 1975.

Volume IV
"Social Systems Indicators of Alcoholism and Alcohol Abuse in Alaska, 1975.

Volume V
"Executive Summary: Descriptive Analysis of the Impact of Alcoholism and Alcohol Abuse in Alaska, 1975."

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STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W—ALASKA OFFICE BUILDING

FINANCE DIVISION
POUCH W—STATE CAPITOL

JUNEAU 99801

November Sixth
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MEMORANDUM

TO: Don Koch
Division of Insurance

FROM: Senator Mike Colletta, Chairman
A Study of Third Party Alcoholism Insurance

Don,

This is to remind you that there will be an organizational meeting of the panel to study third-party alcoholism insurance coverage. This meeting will be on Friday, November 17, 1978 at 10:00 am at the Bull Shed Restaurant. The Bull Shed is located at 3230 Seward Highway in Anchorage. The management of the restaurant has requested that all cars be parked to the rear or to the side of the restaurant.

Please find enclosed information concerning health insurance policies. The material has been provided by the Office of Alcoholism. I have also enclosed a listing of all panel members for your convenience. If you have any questions please feel free to contact me or any member of the staff. I would like to thank you for taking the time to participate in this group effort. I am looking forward to meeting you soon.

First Draft

Considerations for the inclusions of benefits for alcoholism / drug addiction into Health Insurance policies.

5/78

EXCERPTS FROM:

"Alcoholism Benefit Study; Project Summary & Overview." 1977.

N.B. Ths is an extensive study, review of present status and recommendations for action, financed by a Federal Grant from HEW-NIAAA, 7/76 thru 6/77.

1. Background. The majority of Blue Cross Plans provide benefits for the treatment of alcoholism, but they are severely limited in that resources focus on the medical and/or organic complications of alcoholism; renal or hepatic failure and gastric pathology etc., and not on the "drinking behavior" itself. The alcoholic has, therefore, acess only to benefits which treat the end result, organic complications, and not to benefits which will address the chronic nature of the disease, repetitive and addictive drinking.

2. Recommendations. Drawing from the conclusions reached in Phase I of the study, which concerned itself with the feasibility of the implementation of benefits for alcoholism the Study's final paragraph states:

"Given the continuing need to develop alcoholism treatment resources and the demonstrated interest and support of all the involved parties - The BCA, the alcoholism field as represented by the Alcoholism Benefit Study Advisory Committee, and the National Institute on Alcoholism and Alcohol Abuse, the Blue Cross Association recommends that continuing effort, further field testing on the model benefits, be performed."

DEFINITION OF ALCOHOLISM

Alcoholism is an illness, characterized by the chronic incapacity of the victim to either control the limits of his alcohol ingestion or to abstain from the use of alcohol, to such an extent that compliance with the customary dietary or social usages of his community are violated to the detriment of his physical, social or economic well-being.

DEFINITIONS OF ALCOHOLISM:

1. Alcoholism is a psychogenic dependence on or a physiological addiction to ethanol (or similar intoxicants), manifested by the inability of the alcoholic consistently to control either the start of drinking or its termination once started.

   Mark Keller, Vol 21 QJSA, 125, 128 (1960)

2. Alcoholism is a chronic illness, psychic or somatic, or psychosomatic, which manifests itself as a disorder of behavior. It is characterized by the repeated drinking of alcoholic beverages, to an extent that exceeds customary dietary use or compligance with the social customs of the community and that interferes with the drinker's health or his social and economic functioning.

   Keller & Efron, "Alcoholism", in ENCYCLOPEDIA AMERICANA 348 (1956)

3. "Alcoholic" means any person who chronically or habitually uses alcoholic beverages to the extent that said person has lost the power of self-control with respect to the use of such beverage, or while chronically and habitually under the influence of alcoholic beverages endangers public morals, health, safety or welfare.

   Defined by statute in the following states:
   Arkansas (1960), Georgia (1968), Indiana (1964)
   Iowa (1965), Kentucky (1959), Michigan (1967)
   Missippi (1956), New York (1968), Rhode Island (1956),
   Tennesee (1968), Texas (1968), W. Virginia (1966)

EXISTING ALCOHOLISM BENEFITS BY STATE:

1. Illnois-

"Provides that no group accident or health insurance which provides in-patient hospital coverage for sicknesses shall exclude the treatment of alcoholism."

2. Kansas-

All group sickness and accident policies providing care in medical facilities, must make available by offer, and if requested, provide treatment in a licensed hospital or facility licensed by the State, not less than 30 days treatment per year, for alcoholism.

3. Connecticut-

Provides coverage for alcoholism in defined and licensed alcoholism treatment centers.

"----------for expenses incurred in connection with the treatment of alcoholism on an out-patient basis."

4. Colorado-

No contract may be issued unless purchases is offered an opportunity to purchase coverage for conditions arising from alcoholism.

a) In State-licensed facility for 45 days of confinement.

b) Out-patient benefits to the extent of $500. per year.

5. Louisiana-

Group health insurance policies must include as an option of choice, benefits for the treatment of alcoholism as rendered or prescribed by a physician, in a licensed hospital or in an appropriate State-licensed facility.

6. Maryland-

Group hospital and medical policies must offer, at additional premium, optinal benefits for expenses incurred in licensed alcoholism treatment facilities.

a) 30 days of in-patient care.

b) 60 out-patient visits.

7. Minnesota-

All health insurance plans must specifically include benefits, on the same basis as other benefits, for the treatment of alcoholism, chemical dependency or drug addiction, in licensed facilities.

a) up to 20% of the total patient day allowed by the policy as in-patient.

b) 130 hours per policy year in out-patient status.

8. Michigan-

Insurers shall offer to include a provision to provide coverage for in-patient and out-patient treatment of alcoholism and drug abuse, in facilities approved by Department of Public Health.

9. Mississippi-

All sickness and accident policies shall include health service beneftis, on the same basis as other benefits, for the care and treatment of alcoholism.

a) Applies only to group policies

b) $1000. per calender year.

10. North Dakota-

All group policies (over 50 persons or 70% of group's eligible persons) must provide benefits of the same type as for other illnesses, for

alcoholism and drug addiction, in licensed hospitals.

a) up to 70 days in-patient care in a calendare year.

b) up to 140 partial hospitalization (out-patient care)

10. South Dakota-

All group accident and sickness policies must include an offer, in writing, for coverage for inpatient care for alcoholism in hospitals and in approved treatment facilities.

a) Up to 30 days care in any 6-month period.

b) Not exceeding 90 days of care during the life of the contract.

11. Oregon-

Requires group health policies to provide coverage for the treatment of alcoholism.

a) Up to $3,000. in any consectutive 24-month period.

12. Tennessee-

All individual, blanket, or group health insurance policies shall provide benefits for psychiatric disorders, mental or nervous conditions, alcoholism or drug addiction.

13. Virginia-

All individual and group health insurnace policies shall provide coverage for mental, emotional and nervous disorders.

a) (These disorders) shal include physiological and psychological dependence on alcohol and drugs.

b) Limited to 30 days treatment in any policy year.

c) In State-licensed facilities.

14. Washington-

Each group disability insurance contract shall provide benefits for the treatment of alcoholism in State-approved facilities.

15. Wisconsin-

Each group disability policy shall provide coverage for alcoholism and drug addiction in approved in-patient or out-patient facilities, under the care of a physician.

a) Up to 30 days confinement in a single calender year.

b) No more than $500 total expenses for out-patient care in andy calendar year.

16. Hawaii-

Alcoholism and drug addiction are illnesses and shall receive benefits as for any other illness.

a) Detoxification or other in-hospital beneftis limited to three admissions per calender year at 7 days per admission for alcoholism, 21 days per admission for other drugs.

17. Nevada-

Provides for the provision of benefits for alcohol and drug abuse.

a) Special provision not available.

DRAFT

Consideration of pertinent concepts in the formulation of Health Insurance contracts to cover alcoholism and/or other drug addiction.

1. Offering coverage as an additional option to the basic plan (Rider).
   Traditionally, persons (or groups) will not elect to buy optional services, and this is particularly so when the option pertains to an illness which is not socially well received.
   Coverage for alcohol/drug addiction should be written as an integral part of the basic policy.

2. Limiting the service-delivery area to a licensed general hospital.
   While detoxification of acute pathology (presence of delerium, acute hepatic dysfunction, etc.) should take place under the direct supervision of a qualified medical doctor in a hospital setting, the greatest majority of alcoholics do not need such heroic measures. Supervision by a R.N. in an appropriate and State-approved setting with emergency equipment available, under supervision of an M.D. to do staff training and act as emergency back-up, has sufficed, in the long experience of hundreds of alcoholism facilities, for all but near-terminal cases. Since it is the chronic and repetitive nature of the disease which needs to be addressed if alcoholism treatment is to be cost-effective, the door to specialized rehabilitation programs, staffed by professionals and trained para professionals, approved and inspected by the State, should be left open.

   (See Section 1, "Excerpts From The Alcoholism Benefit Study")

3. Time and Dollar Limitations on Treatment Afforded under the various plan.
   a) These limitations should be optionally neither so short as to allow insufficient time for effective therapy, nor so long as to promote recidivism and become cost-burdensome.

Movement on the part of the patient from medical detoxification care into longer and extensive therapy directed at the chronicity of the disease -- the repetitive drinking behavior -- should be encouraged by the make-up of the policy itself. There is much evidence to the effect that medical detoxification by itself can do very little to ameliorate the physical, psychological and sociological aspects of this tripartite illness, but that it tends to respond well to counselling and educational therapy in a less expensive rehabilitation setting.

An example of this sort of encouragement might well be that in-hospital detoxification services be afforded underwriting at the level of only 50-75% deductible, unless such services are delivered as an integral part of a rehabilitation program of at least 21 days duration, in which case the services would be underwritten at the 90-100% level.

b) There is evidence, based on the experience of public and private alcoholism rehabilitation programs that have been functioning over twenty years, that there exists a direct positive correlation between the time spent in treatment and the rate of effective disease arrest. While the state of presenting pathology is a strong affect, there is general agreement that there exists an irreducible minimum of time spent in the presentation of specialized therapies. In the case of at least one nationally famous center, the time-frame has moved from 21 days to 40 as experience has mounted.

In the further consideration of time availability for benefit, it has also become evident that relapses, when they occur, nearly always do so within one year of the onset of treatment. From this

experience has sprung the next important concept; that immediately on the onset of a relapse, the patient should have available to him the opportunity to re-institute treatment before the disease has once more progressed to a point where expensive in-hospital bed treatment must be prescribed.

An effective plan, therefore, must never be limited to a single treatment episode in a particular calendar or policy year.

4. The inclusion of benefits for out-patient therapy.

Not all diagnosable cases of alcoholism will have reached the point of physical debilitation that demands either medically supervised detoxification or in-patient treatment. These cases will, however, demand applied therapy which may be provided on an out-patient basis. Effective out-patient therapy for alcoholism must proceed through the same stages as psychological treatment for any other type of psychosocial dysfunction; resistance, transference, and accomodation. All these processes require time. In the opinion of experts in the field, a basic minimum of three out-patient sessions a week for a period of twelve weeks is indicated, or more if adjunctive therapies such as Alcoholics Anonymous are not available.

Aftercare services for clients discharged from formal therapy are considered so important that they have been incorporated as an essential element of treatment by the Joint Committee on the Accreditation of Alcoholism Programs. This service is provided on an out-patient basis, and time which will afford the application of this service must be underwritten as a part of the total rehabilitative effort. A time allowance of two hours per month of agency services for six months is generally considered to be minimal in the experienced opinion of long-standing agencies.

Consideration must be given here to the concept that it may be false economy to encourage out-patient treatment, because it is less expensive, in favor of treatment in an in-facility setting, especially in those cases in which a response to relapse is indicated.

Example:

4 weeks in-patient @ $500	=	$2,000	
12 hours out-patient @ 30	=	360	
		$2,360	Total
80 hours out-patient @ $ 30	=	$2,400	Total

DRAFT

-- SUMMARY --

~~Working~~ On the accepted premise that to accomplish its ultimate purpose (no further demands on the providing system), any insurance policy should avoid temporizing and half-way measures which will result only in the continual and reiterated demand for the re-extension of benefits. An approach to the arrest of alcoholism should be thorough, broad-based, elastic enough to make provision for a variety of levels of presenting pathology, and at the same time should encourage and permit clients to participate in all facets of effective therapy.

In the opinion of the State Office of Alcoholism and Drug Abuse, any health insurance policy offered in Alaska should contain the following basic and minimal clauses:

A. Treatment should be afforded in those cases where alcoholism is a pre-existing condition.

B. Age, sex, or minimal and maximal states of the illness should not be a consideration.

C. The carrier should be permitted to purchase services from special agencies whose primary function is the treatment of alcoholism or other drug addiction.

D. Opinions as to the need of services should emanate from qualified professionals in the treatment field, on the basis of the evidenced presence of accepted symptomatology, not excluding but not limited to Doctors of Medicine.

E. Opportunities for client inclusion into a program for treatment should be authorized at least twice in a policy or calendar year.

F. If medically supervised detoxification benefits are a separate part of the policy, some provision must be built into the contract which will result in it being to the clients' advantage to move in the direction of a more extensive therapeutic program at the conclusion of the physical detoxification process.

G. In-patient programs which supply [redacted] therapeutic process on a daily basis should not be limited to less than 28 days total residence, or 21 days of applied therapy.

H. Out-patient treatment should consist of not less than 78 hours of individual or group sessions if an in-facility treatment regime is not utilized, or 12 hours of out-patient follow-up services at the conclusion of in-patient treatment.

2 hrs/wk for 16 weeks = 48 hours in OP Treatment
2 hrs/mo for 6 months = 12 " Aftercare
18 = Emergency Care
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	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona			
Arkansas			
California			
Colorado	§10-8-301	1-1-75	Grp. must offer 45 days inpatient and $500 outpatient; coinsurance up to 50%. Each day of confinement shall reduce days covered under policy for illness and for minimum mental illness coverage
Connecticut	38-262b Public Act 77-237	5-10-74 10-1-77	Grp. Ks must include coverage for confinement as for any other condition; minimum of 45 days in "treatment facilities"
Delaware	Laws 1977		Insurers must offer a group contract providing coverage for alcoholism on an outpatient basis
Florida			
Georgia			
Hawaii			
Idaho			

	Citation	Effective Date	Comments
Illinois	§979(10)	10-1-72	Group policy with individual conversion for sickness or accident excludes treatment of alcoholism from such coverage. Does not apply to a policy covering specified sicknesses only
Indiana			
Iowa			
Kansas	SB105 40-2,105	7-1-77	Group policies must affirmatively offer reimbursement or indemnity for confinement for treatment of alcoholism limited to not less than 30 days per year
Kentucky			
Louisiana	§215.5	7-1-75	Grp., blanket and franchise policies must offer coverage - no benefits defined
Maine			
Maryland	477L	7-1-76	Grp. Ks of 25 or more lives must offer coverage of licensed alcoholic rehabilitation program for 30 days or partial days per year on 2 for 1 basis
Massachusetts			
Michigan	§3609	7-1-74	Grp. and blanket Ks must offer inpatient and outpatient benefits in approved facility as may be agreed upon by policyholder
Minnesota	62A.149	9-1-76	Grp. Ks must provide inpatient services in hospital or treatment centers, 20% of total days not less than 28 days, and at least 130 hours in nonresidential treatment program
Mississippi	83-9-27 83-9-29 83-9-30	1-1-75	Grp. Ks must provide benefits on same basis as other illness up to $1,000 per year
Missouri			

	Citation	Effective Date	Comments
Montana			
Nebraska			
Nevada	689A.030 689B.030 (HIAA Ins. Nev. No. 1-	Dept. Bul. 75)	Ind. and Grp. Ks must offer up to 10 days inpatient in hospital and up to 30 days in other than hospital; outpatient up to 180 days not to exceed $800
New Hampshire			
New Jersey			
New Mexico	None		
New York			
North Carolina			
North Dakota	26-39-01 Dept. Bul. No. 30	7-1-75	Requires 70 days inpatient; 140 days outpatient; blanket, franchise and group policies over 50 lives and which cover 70% or more of group
Ohio			
Oklahoma			
Oregon	743.557	1-1-76	Grp. Ks must provide not less than $2,500 in any 36 consecutive month period; type of facility may be restricted. Applies to existing Ks upon renewal or expiration of collective bargaining agreement
Pennsylvania	743.411 to 743.417	10-4-77	Individual policies must provide, at the request of the applicant, coverage for expenses for treatment of alcoholism

	Citation	Effective Date	Comments
Rhode Island			
South Carolina			
South Dakota	58-18-7.1 58-18-7.2 58-18-7.3	7-1-77	Must offer in writing benefits up to 30 days in 6 month period not to exceed 90 days policy lifetime - Group only, and other ~~not mass~~ medical accident policies specifically excluded.
Tennessee	56-1167	7-1-74	Must provide alcoholism coverage unless specifically excluded. Benefits not defined
Texas			
Utah			
Vermont			
Virginia	38.1-348.7	7-1-78	Ind. & grp. Ks - optional cov. same as illness; mandates min. benefits of 14 days per year in licensed alcoholism or drug treatment facility, 30 days intermediate care facility, 45 hours out-patient in alcoholism or drug treatment facility, various hourly req. for different facilities
Washington	48.21.160 48.21.170 48.21.180 48.21.190	7-1-74	Group policies must provide alcoholism coverage in licensed treatment centers. Benefits not defined
West Virginia			
Wisconsin	632.89	9-1-74	Grp. Ks must include up to 30 days inpatient; outpatient up to $500
Wyoming			

SUPPLEMENTAL LIST OF STATE ENACTMENTS - ALCOHOLISM CHART

10/28/77

	Citation	Effective Date	Comments
Connecticut	Public Act 77-237 Laws 1977	10-1-77	Insurers must offer grp. contracts providing coverage for alcoholism on an outpatient basis
Illinois	Sec. 979 (10)	10-1-73	Group policy with in-hospital coverage for sicknesses cannot exclude treatment of alcoholism from such coverage. Does not apply to a policy covering specified sicknesses only.
Kansas	S.B. 105	7-1-77	Group policies must affirmatively offer reimbursement or indemnity for confinement for treatment of alcoholism limited to not less than 30 days per year.
Oregon	743.411 to 743.444	10-4-77	Individual policies must provide, at the request of the applicant, coverage for expenses for treatment of alcoholism.

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underwriting the group insurance or supplemental plans. Such investments shall be made as determined by the state treasurer and shall be limited to those securities authorized for investment by the public employees' retirement board pursuant to section 24-51-107, C.R.S. 1973.

Source: L. 65, p. 785, § 15; C.R.S. 1963, § 72-22-15; L. 67, p. 591, § 11; L. 74, p. 300, § 15.

10-8-216. State payments – authority of controller. Beginning July 1, 1974, or in the case of a supplemental plan, beginning on the first of the month specified by the board, the state contributions to group insurance and supplemental plans shall be paid monthly to the board by the controller, who shall make a charge against the accounts of the state departments, agencies, and institutions for this purpose. Such charges shall be the amounts necessary to cover the state contributions for the employees in each state department, agency, and institution enrolled in a group insurance or supplemental plan and shall be made against both general revenue fund accounts and specific cash fund accounts as required.

Source: L. 65, p. 785, § 16; C.R.S. 1963, § 72-22-16; L. 67, p. 591, § 12; L. 74, p. 301, § 16.

10-8-217. Estimate of costs – governor's report. No later than February 15 preceding each ensuing fiscal year, the governor shall transmit his analysis of the fringe benefits survey required under section 24-30-104(5), C.R.S. 1973, in terms of comparative employee benefits received and his estimate of costs for group insurance contributions to the joint budget committee of the general assembly for inclusion as a separate item in the general appropriations bill.

Source: Added, L. 74, p. 301, § 17.

10-8-218. Continuation of previously existing benefits for persons absorbed by the state personnel system. Any other provision of law to the contrary notwithstanding, the board shall continue, as a benefits option, the existing group life and health benefits of any person employed by a state agency if such person has been or will be brought or assimilated into the state personnel system on or after January 1, 1972, until such time as similar benefits offered by the board to state employees pursuant to this part 2 are equivalent in benefit and economic cost to the benefits held by said person.

Source: L. 77, S.B. 482, § 1.

PART 3

REQUIRED HEALTH INSURANCE BENEFITS FOR ALCOHOLISM TREATMENT

10-8-301. Group health insurance benefits for alcoholism. (1) Any other provision of law to the contrary notwithstanding, no hospitalization or medi-

(1) Each contract on a group basis issued by an insurer under this article shall be void in this state unless a policyholder under such contract is offered the opportunity to purchase coverage for benefits for the treatment of and for conditions arising from alcoholism, which benefits are at least equal to the following minimum requirements:

(a) In the case of benefits based upon confinement as an inpatient in an accredited or licensed hospital or in any other public or private facility or portion thereof providing services especially for the treatment of alcoholics, which is licensed by the department of health for those services, such benefits shall be not less than forty-five days in any calendar year.

(b) Each day of confinement as an inpatient shall reduce by one day the total days available for all other illnesses during any one twelve-month benefit period.

(c) Each day of confinement as an inpatient shall reduce by one day the available days provided under section 10-8-116.

(2) Outpatient benefits shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished by:

(a) An accredited or licensed hospital; or

(b) Any public or private facility or portion thereof providing services especially for the treatment of alcoholics, which is licensed by the department of health for those purposes; or

(c) Any mental health facility approved as such by the department of institutions.

(3) (a) Such insurer offering coverage for alcoholism under this part 3 may establish a copayment requirement for such coverage which may or may not differ from the copayment requirement established for any other condition or illness, except that copayment requirements for the treatment of alcoholism shall not exceed a fifty percent copayment requirement.

(b) Such insurer may establish a deductible amount for coverage pertaining to alcoholism, but such deductible amount shall not differ from the deductible amount for any other condition or illness.

(c) In any event, benefits will not be payable unless the patient having the coverage provided under this section shall have completed the full continuum of care, including detoxification and rehabilitation.

(4) The commissioner may exempt from the requirements of this section any policy or type of policy with respect to which he has determined that the prescribed alcoholism benefits are inapplicable or inappropriate.

Source: Added, L. 75, p. 366, § 1.

Revised, 1977

§ 38–262b. Group hospital or medical expense insurance policy coverage for treatment of alcoholism

(a) For purposes of this section:

(1) "Effective treatment" means a program of therapy prescribed by a physician licensed pursuant to the provisions of chapter 370, and certification by such a physician of the establishment for the patient of a comprehensive follow-up program;

(2) "medical complications" means such diseases as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.

(b) Every group hospital or medical expense insurance policy and every group hospital or medical service plan contract providing coverage on an expense incurred basis shall provide coverage for expenses incurred in connection with confinement for treatment of alcoholism or medical complications thereof pursuant to diagnosis or recommendation by a physician licensed pursuant to the provisions of chapter 370.

(c) Confinement for treatment of alcoholism of medical complications thereof in a hospital, other than in a part of a hospital used primarily for such treatment unless otherwise provided for in such contract, shall be recognized to the extent specified in the contract for confinement for any other disease.

(d) Confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, shall be recognized to the extent specified in the contract, but only in connection with effective treatment of alcoholism or medical complications thereof, either for a period of at least forty-five days within any period of twelve consecutive months commencing with admission to such a facility or such part of a hospital or for a period of at least forty-five days within any calendar year.

(e) The provisions of this section shall apply to any group insurance policy and group subscriber contract delivered or issued for delivery in this state on and after May 10, 1974, and to any group insurance policy or group subscriber contract which are thereafter amended to substantially alter or change benefits or coverages. (1974, P.A. 74–162, §§ 1 to 5.)

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the death of the insured employee or group member the dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of dependents' coverage.

(9) No group hospital policy covering miscellaneous hospital expenses issued or delivered in this State shall contain any exception or exclusion from coverage which would preclude the payment of expenses incurred for the processing and administration of blood and its components.

(10) No policy of group accident and health insurance, delivered in this State more than 120 days after the effective day of the section, which provides in-patient hospital coverage for sicknesses shall exclude from such coverage the treatment of alcoholism. This subsection shall not apply to a policy which covers only specified sicknesses.

(11) No policy of group accident and health insurance, which provides benefits for hospital or medical expenses based upon the actual expenses incurred, issued or delivered in this State shall contain any specific exception to coverage which would preclude the payment of actual expenses incurred in the examination and testing of a victim of rape or attempted rape to establish that sexual contact did occur or did not occur, and to establish the presence or absence of venereal disease or infection, and examination and treatment of injuries and trauma sustained by the victim of rape or attempted rape arising out of the rape or attempted rape. This subsection shall not apply to a policy which covers hospital and medical expenses for specified illnesses and injuries only.

(12) No group hospital, medical or surgical expense policy shall contain any provision whereby benefits otherwise payable thereunder are subject to reduction solely on account of the existence of similar benefits provided under other group or group-type accident and sickness insurance policies where such reduction would operate to reduce total benefits payable under those policies below an amount equal to 100% of total allowable expenses provided under these policies. 1937, June 29, Laws 1937, p. 696, § 367; 1941, July 17, Laws 1941, vol. 1, p. 838, § 1; 1947, July 21, Laws 1947, p. 1125, § 1; 1949, Aug. 2, Laws 1949, p. 1030, § 1; 1951, June 29, Laws 1951, p.

ration within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one day period. (L. 1974, ch. 190, § 4; July 1.)

40-2,103. Same; time when provisions required in policies.

The requirements of this act (*) shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of the act (*). (L. 1974, ch. 190, § 5; July 1.)

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* "This act," see, also, 40-2,102, 40-1809, 40-1909, 40-19a10.

40-2,104. Insurance coverage to include reimbursement for services performed by certified psychologist.

Notwithstanding any provision of an individual or group policy or contract of health and accident insurance delivered within the state whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly certified psychologist within the state of Kansas, the insured, or any other person covered by the policy or contract shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or a duly certified psychologist. (L. 1974, ch. 189, § 1; July 1.)

40-2,105. Insurance coverage for reimbursement of services rendered in treatment of alcoholism.

Every insurer, which issues any group policy of accident and sickness, medical or hospital expense insurance which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must make available by affirmative offer and, if requested by the contract holder, provide reimbursement or indemnity under such policy which shall be limited to not less than thirty (30) days per year when such person is confined in either a licensed hospital for the treatment of alcoholism or a facility licensed under the provisions of K.S.A. 1977 Supp. 65-4014 for the treatment of alcoholism. (L. 1977, ch. 161, § 1; July 1.)

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215.5. Group, blanket and franchise health insurance; treatment for alcoholism

Any group, blanket or franchise health insurance policy issued under R.S. 22:215 of this title after July 1, 1975, shall include as an option, to be exercised at the choice of the policyholder, as defined in R.S. 22:215, covered benefits for the treatment of alcoholism rendered or prescribed by a physician licensed pursuant to Chapter 15 of Title 37 of the Louisiana Revised Statutes, received in any licensed hospital or any other public or private facility or portion thereof duly authorized by the appropriate state authority to provide alcoholism treatment and rehabilitation services.[1]

Any insurer who, on July 1, 1975, has group, blanket or franchise health insurance policies in force shall have until July 1, 1976, to convert such existing policies to conform to the provisions of this section. (Added by Acts 1974, No. 252, § 1.)

[1] Acts 1974, No. 252 § 1 enacted the above section as R.S. 22:215.3. It has been redesignated to avoid duplication in numbering on authority of R.S. 24:253.

215.6. Group or blanket health and accident insurance replacement; continuance of benefits

A. Upon the replacement of one carrier by another of any group or blanket health and accident insurance policy for ten or more members issued for delivery or delivered in this state, any limitation on benefits otherwise payable because of preexisting conditions clauses, if any, in the succeeding carrier's plan shall be the lesser of:

(1) The benefits of the new plan determined without application of the preexisting conditions limitation.

(2) The benefits of the prior plan.

B. In a group of fifty or more members the succeeding carrier shall give credit for the satisfaction or partial satisfaction of any deductibles or waiting periods in its plan effected under a prior plan providing similar benefits. In the case of deductible

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(b) The individual converted policies must provide benefits as required by the Commissioner. The Commissioner may establish different requirements and different levels of benefits for various types or categories of coverage and for varying types of group policies. In establishing minimum requirements, the Commissioner may establish exclusions and benefit limitations which he deems appropriate. The Commissioner may exempt certain types of group policies, and certain types of coverage under such policies, from the requirements of this section, where, in his discretion he deems such exemption appropriate. The Commissioner may establish conditions under which the conversion privilege shall not be operative. Such conditions may include, but need not be limited to, replacement of a terminated coverage by similar group coverage or by health programs sponsored by any government or by the group policyholder.

(c) The Commissioner shall establish notification requirements for the insurer to the person whose coverage is being terminated of his right of conversion, and requirements regarding the timely election of the conversion privilege. The requirements for notification shall include, but need not be limited to, a provision in any certificates furnished persons covered under group and blanket health insurance policies setting forth the conditions applicable to election of the conversion privilege.

(d) After January 1, 1978 the provisions of this section shall apply to all group policies delivered or renewed in the State, upon the effective date or renewal anniversary date, whichever is later, of the policy.

(Added 1976, ch. 274; amended 1977, ch. 526.)

§ 447L. Benefits for expenses of alcoholic rehabilitation treat-[redacted] programs

(a) After July 1, 1976, every insurer which proposes to issue a group hospital policy or a group major medical policy in Maryland shall offer the prospective group policyholder at an appropriate additional premium the option of providing benefits for expenses arising from any alcoholic rehabilitation

treatment program licensed by the Department of Health and Mental Hygiene, Division of Licensing and Enforcement or approved by the Department of Health and Mental Hygiene, Division of Alcoholism Control.

(b) Benefits shall provide the minimum requirements specified by the Department of Health and Mental Hygiene, Division of Alcoholism Control for not less than 30 days or partial days of in-patient care in any period of 12 consecutive months. For purposes of this section, two out-patient visits shall be considered as equivalent to one day's care.

(c) For purposes of this section, any proposed change in benefits provided by an existing group hospital or group major medical policy shall be considered a proposal to issue a policy under subsection (a).

(d) The provisions of this section shall apply only if an initial enrollment of at least 25 certificate holders under the new or expanded group policy can reasonably be expected.

(Added 1976, ch. 432.)

§ 477M. Benefits for costs of psychiatric care through partial hospitalization

(a) *Option to be offered prospective group policyholders.*—After January 1, 1977, every insurer which proposes to issue a group hospital policy in Maryland shall offer the prospective group policyholder at an appropriate premium adjustment, if any, the option of providing benefits for the cost of psychiatric care through partial hospitalization.

(b) *Meaning of "partial hospitalization".*—As used in this section, partial hospitalization means a psychiatric service offered in a hospital or in a psychiatric day care treatment center or in a community mental health facility providing medically directed intensive or intermediate short-term psychiatric treatment for a period of less than 24 hours but more than 4 hours in a day for any individual patient.

(c) *Minimum period.*—Benefits shall provide for psychiatric care for a minimum of 30 partial hospitalization treatment days during any period of 12 consecutive months.

(d) *Changes in existing group policy.*—For purposes of this

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(2) No such group policy may be issued or delivered in this state unless a copy of the form shall have been filed with the commissioner and approved by him.

(3) Such policies shall also be subject to section 3474 (filing of risk classifications and rates). P.A.1956, No. 218, § 3606, Eff. Jan. 1, 1957.

§ 500.3608 Same; required provisions

Sec. 3608. Every policy of group disability insurance shall contain:

(1) A provision that the policy, application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured, shall constitute the entire contract between the parties, and that all statements made by the employer, or the executive officer or trustee, or by the individual employees or members, shall, in the absence of fraud, be deemed representations and not warranties, and that the statements shall not be used in defense of a claim under the policy, unless they are contained in a written application.

(2) A provision that the insurer will issue to the employer, or to the executive officer or trustee of the association, for delivery to the employee or member, who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled to and to whom payable.

(3) A provision that to the group or class thereof originally insured shall be added from time to time all new employees of the employer, or members of the association eligible to, and applying for insurance in the group or class. P.A.1956, No. 218, § 3608, Eff. Jan. 1, 1957, as amended P.A.1974, No. 50, § 1, Eff. July 1, 1974.

§ 500.3609 Coverage for alcoholism and drug abuse treatment

Sec. 3609. Any insurer who delivers, issues for delivery, or renews in this state a policy of group disability insurance shall offer to include in such policy a provision that the insurer will provide coverage for such inpatient and outpatient treatment of alcoholism and drug abuse as may be agreed upon between the insured employer or other insured organization

and the insurer to be provided in a facility approved by the department of public health for hospitalization or treatment of alcoholism and drug abuse. Such coverage shall be subject to the provisions of sections 3406 to 3466[1] of this act. P.A.1956, No. 218, § 3609, added by P.A.1974, No. 50, § 1, Eff. July 1, 1974.

[1] Sections 500.3406, 500.3466.

§ 500.3610 Required provisions, group disability policies

Sec. 3610. Every policy of group disability insurance shall contain the applicable provisions required in sections 3406 through 3466.[1] P.A.1956, No. 218, § 3610, added by P.A.1974, No. 225, § 1, Eff. Nov. 1, 1974.

[1] Sections 500.3406 to 500.3466.

§ 500.3611 Newly born children

Sec. 3611. (1) All group disability insurance policies providing coverage on an expense incurred basis which provide coverage for a family member of the insured shall, as to that family member's coverage, also provide that the disability insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

(2) The coverage for children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium shall be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond the 31-day period. P.A.1956, No. 218, § 3611, added by P.A.1975, No. 20, § 1, Imd. Eff. April 3, 1975.

§ 500.3620 Family expense insurance

Sec. 3620. (1) **Definition.** Family expense insurance is that form of accident and health or hospitalization, medical, surgical and sick-care insurance which is written under 1 policy issued to the head of a family who may be either spouse, and insuring such head and 1 or more dependents, and may

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§ 62A.148 Group insurance; provision of benefits for disabled employees

No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. If the employee is required to pay all or any part of the premium for the extension of coverage, payment shall be made to the employer, by the employee. Added Laws 1973, c. 340, § 2.

§ 62A.149 Benefits for alcoholics and drug dependents

Subdivision 1. No policy or plan of insurance regulated under chapter 62A, or subscriber contract offered by a nonprofit health service plan corporation regulated under chapter 62C shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of insurance unless the policy, plan or contract specifically includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of alcoholism, chemical dependency or drug addiction in

(1) a licensed hospital,

(2) a residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine,

(3) a non-residential treatment program approved or licensed by the state of Minnesota.

Provided, however, that the restrictions and requirements of this subdivision shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy.

Subd. 2. Coverage under subdivision 1, clauses (1) and (2), shall be for at least 20 percent of the total patient days allowed by the policy and in no event shall coverage be for less than 28 days in each 12 month benefit year. Coverage under subdivision 1, clause (3), shall be for at least 130 hours of treatment in a 12 month benefit year. Laws 1973, c. 585, §§ 1, 2; amended Laws 1976, c. 262, § 1.

MISSISSIPPI

§ 83-9-27. Alcoholism care and treatment—coverage.

Notwithstanding any provision of any policy of accident or sickness insurance as defined by section 83-9-1, issued on or after January 1, 1975, whenever such policy provides for the reimbursement for loss resulting from sickness, or from bodily injury by accidental means, or both, said reimbursement shall include health service benefits to any insured or any person covered thereunder, on the same basis as other benefits, for care and treatment of alcoholism.

For purposes of sections 83-9-27 through 83-9-31, alcoholism is defined as the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

SOURCES: Laws, 1974, ch. 522 § 1, eff from and after January 1, 1975.

Cross references—

As to commitment of alcoholics for treatment, see §§ 41-31-1 et seq.

As to alcoholism, alcohol abuse prevention, control and treatment, see §§ 41-30-1 et seq.

ALR Annotations—

Clause in life, accident, or health policy excluding or limiting liability in case of insured's use of intoxicants or narcotics. 13 ALR2d 987.

§ 83-9-29. Alcoholism care and treatment—application of law.

The provisions of sections 83-9-27 through 83-9-31 shall apply only to group policies or group plans of health affording coverage from sickness, or bodily injury by accidental means, or both, or nonprofit health plans corporations regulated by the Mississippi Insurance Commission issued or renewed after January 1, 1975.

The provisions of sections 83-9-27 through 83-9-31 shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy.

SOURCES: Laws, 1974, ch. 522 § 2, eff from and after January 1, 1975.

§ 83-9-31. Alcoholism care and treatment—limitation of coverage.

The coverage required under section 83-9-27 shall not exceed one thousand dollars ($1,000.00) during any calendar

Added, 1974

NEVADA

689A.010 Short title. This chapter may be cited as the Uniform Health Policy Provision Law.
(Added to NRS by 1971, 1751)

689A.020 Scope of chapter. Nothing in this chapter applies to or affects:

1. Any policy of liability or workmen's compensation insurance with or without supplementary expense coverage therein.
2. Any group or blanket policy, except as to NRS 689A.380 (definitions of terms).
3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or as to

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant become totally and permanently disabled, as defined by the contract or supplemental contract.

4. Reinsurance.

(Added to NRS by 1971, 1751)

689A.030 Scope, format of policy. No policy of health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

1. The entire money and other considerations therefor shall be expressed therein;
2. The time when the insurance takes effect and terminates shall be expressed therein;
3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, dependent children, from the time of birth as provided in NRS 689A.043, or any children under a specified age which shall not exceed 19 years except as provided in NRS 689A.043, and any other person dependent upon the policyholder;
4. The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points (the "text" shall include all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions);

5. The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in NRS 689A.050 to 689A.200, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

6. Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

7. The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

8. The policy shall provide benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007.

9. The policy shall provide, at the option of the applicant, benefits for expenses incurred for the treatment of alcohol and drug abuse as provided in NRS 689A.047.

(Added to NRS by 1971, 1752; A 1973, 546; 1975, 446, 1108, 1848)

689A.040 Required provisions: Captions; omissions; substitutions.

1. Except as provided in subsections 2 and 3, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in NRS 689A.050 to 689A.170, inclusive, in the words in which the same appear, except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

2. Each policy, delivered or issued for delivery in this state after November 1, 1973, shall contain a provision, if applicable, setting forth the provisions of NRS 689A.045.

3. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall

689B.010 Scope of chapter; short title.

1. This chapter may be cited as the Group or Blanket Health Insurance Law.

2. This chapter applies only to group health insurance contracts and to blanket health insurance contracts as provided for in this chapter.

(Added to NRS by 1971, 1767)

689B.020 "Group health insurance" defined; eligible groups and benefits.

1. "Group health insurance" is hereby declared to be that form of health insurance covering groups of two or more persons, formed for a purpose other than obtaining insurance.

2. Any group health policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, dental or surgical services, home health care or health supportive services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

3. The commissioner may, in his discretion require the form of each certificate proposed to be delivered in this state under a group health policy not made under the laws of this state to be filed with him by the insurer for informational purposes only.

(Added to NRS by 1971, 1767; A 1971, 1954; 1975, 447)

689B.025 Uniform billing, claims forms. Every insurer under a group health insurance contract or a blanket health insurance contract and every state agency, for its records shall accept from:

1. A hospital the Uniform Billing and Claims Forms established by the American Hospital Association in lieu of its individual billing and claims forms.

2. An individual who is licensed to practice one of the health professions regulated by Title 54 of NRS such uniform health insurance claims forms as the commissioner shall prescribe, except in those cases where the commissioner has excused uniform reporting.

(Added to NRS by 1975, 897)

689B.030 Required provisions in group policies. Each such group health insurance policy shall contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by

the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

2. A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family unit.

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

4. A provision for benefits for expense arising from home health care or health supportive services if such care or service was prescribed by a physician and would have been covered by the policy if performed in a health and care facility as defined in NRS 449.007.

5. A provision for benefits, at the option of the applicant, payable for expenses incurred for the treatment of alcohol and drug abuse, as provided in NRS 689B.037.

(Added to NRS by 1971, 1767; A 1975, 448, 1850)

689B.032 Required provision concerning coverage relating to complications of pregnancy.

1. No group health or blanket health policy may be delivered or issued for delivery in this state if it contains any exclusion, reduction or other limitation of coverage relating to complications of pregnancy, unless the provision applies generally to all benefits payable under the policy.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires hospital confinement for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. A policy subject to the provisions of this chapter which is delivered or issued for delivery on or after July 1, 1977, has the legal effect of including the coverage required by this section, and any provision of the policy which is in conflict with this section is void.

(Added to NRS by 1977, 415)

689B.033 Required provision concerning coverage for newly-born children.

1. All group health insurance policies providing coverage on an expense-incurred basis and all employee welfare plans providing

NORTH DAKOTA

Chapter 26-39

MENTAL ILLNESS AND ADDICTION INSURANCE COVERAGE

Sec.

26-39-01 Definitions.
26-39-02 Insurance companies to comply with chapter.
26-39-03 Types of coverage required.
26-39-04 Types of benefits required.
26-39-05 Other policies.

§ 26-39-01. Definitions

As used in this chapter, unless the context or subject matter otherwise requires:

1. "Licensed treatment facility" means any hospital, as defined in subsection 29 of section 52-01-01 and the state department of health rules and regulations pursuant thereto or as licensed under section 23-17.1-01, offering treatment for the prevention or cure of mental illness, alcoholism, drug addiction, or other related illness.

2. "Partial hospitalization" means that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment.

Source: S.L. 1975, ch. 263, § 1.

§ 26-39-02. Insurance companies to comply with chapter

No insurance company, nonprofit hospital service corporation, or nonprofit medical service corporation authorized to do business within this state shall deliver, issue, execute, or renew any policy of health insurance on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by such policy and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for such coverage unless such policy shall conform to the requirements of this chapter.

Source: S.L. 1975, ch. 263, § 2.

Added, 1975

§ 26-39-03. Types of coverage required

Any policy described in section 26-39-02 shall provide benefits, of the same type offered under such policy for other illnesses, for health services to any person covered under such policy, for the diagnosis, evaluation, and treatment of mental illness, alcoholism, drug addiction, or other related illness, in a licensed hospital.

Source: S.L. 1975, ch. 263, § 3.

§ 26-39-04. Types of benefits required

The benefits described in section 26-39-03 may be provided for inpatient treatment and treatment by partial hospitalization:

1. In the case of benefits provided for inpatient treatment, such benefits shall be provided for a minimum of seventy days of service in any calendar year.

2. In the case of benefits provided for partial hospitalization, such benefits shall be provided for a minimum of one hundred forty days of service in any calendar year.

3. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits shall be payable, each day of inpatient treatment shall be equivalent to two days of treatment by partial hospitalization.

Source: S.L. 1975, ch. 263, § 4.

§ 26-39-05. Other policies

The provisions of this chapter shall not be construed to prevent any insurance company or nonprofit hospital or medical service corporation from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this chapter, where such policy or contract is not subject to such provisions.

Source: S.L. 1975, ch. 263, § 5.

Added, 1975

option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

[1967 c.359 §428]

743.411 Entire contract; changes. A health insurance policy shall contain a provision as follows: "ENTIRE CONTRACT; CHANGES: This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

743.412 Coverage for alcoholism treatment; conditions; limits. A health insurance policy providing coverage for hospital or medical expenses not limited to expenses from accidents or specified sicknesses shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The applicant shall be informed of his option to request this coverage.

(2) The inclusion of the coverage may be made subject to the insurer's usual underwriting requirements.

(3) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(4) The policy may limit hospital expense coverage to treatment provided by:

(a) A health care facility licensed under ORS 441.015 to 441.087, 441.525 to 441.595, 441.810 to 441.820, 441.990, 442.300, 442.320, 442.330, 442.340 to 442.350 and 442.400 to 442.450 or accredited by the Joint Commission on Accreditation of Hospitals; or

(b) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health Division under ORS 430.260.

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than $3,000 in any 24-consecutive month period.

[1977 c.632 §2]

743.414 Time limit on certain defenses; incontestability. (1) A health insurance policy shall contain a provision as follows: "TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of that period."

(2) The policy provision set forth in subsection (1) of this section shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, or to limit the application of ORS 743.450 to 743.462 in the event of misstatement with respect to age or occupation or other insurance.

(3) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the provision set forth in subsection (1) of this section the following provision, from which the clause in parentheses may be omitted at the insurer's option: "INCONTESTABLE: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

(4) The policy shall contain a provision as follows, which shall be a separate paragraph under the same caption as, and

OREGON

743.549 Restriction on reduction of benefits provisions in group and blanket health policies. No group or blanket health insurance policy providing hospital, medical or surgical expense benefits, and which contains a provision for the reduction of benefits otherwise payable thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to 100 percent of total allowable expenses.

[1973 c.143 s.2]

743.552 Guidelines for application of ORS 743.549. The commissioner shall by rule establish guidelines for the application of ORS 743.549, including:

(1) The procedures by which persons insured under such policies are to be made aware of the existence of such a provision;

(2) The benefits which may be subject to such a provision;

(3) The effect of such a provision on the benefits provided;

(4) Establishment of the order of benefit determination; and

(5) Reasonable claim administration procedures to expedite claim payments under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision.

[1973 c.143 s.3]

743.555 Application of ORS 743.549 and 743.552. ORS 743.549 and 743.552 shall apply to any group or blanket health insurance policy containing a provision described in ORS 743.549 which is issued more than 90 days after June 26, 1973. Policies which are in existence 90 days after June 26, 1973, shall be brought into compliance on the next anniversary date of the applicable collectively bargained contract, if any, whichever date is latest.

[1973 c.143 s.4]

743.557 Group health insurance coverage for alcoholism treatment. A group health insurance policy providing cover-

age for hospital or medical expenses shall provide coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(2) The policy may limit hospital expense coverage to treatment provided by:

(a) A health care facility licensed under ORS 441.015 to 441.087, 441.525 to 441.595, 441.810 to 441.820, 441.990, 442.300, 442.320, 442.330, 442.340 to 442.350 and 442.400 to 442.450 or accredited by the Joint Commission on Accreditation of Hospitals; or

(b) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health Division under ORS 430.260.

(3) Except as permitted by subsection (1) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than $3,000 in any 24-consecutive month period.

[1975 c.689 §2; 1977 c.632 §3]

743.558 Group health insurance coverage for mental or nervous conditions. Every insurer offering group health insurance benefits shall offer benefits for expense arising from mental or nervous conditions that meet the following requirements:

(1) In the case of benefits based upon confinement as an inpatient in a hospital, the period of confinement for which benefits are payable shall be at least 30 days in any calendar year.

(2) In the case of major medical expense coverage, benefits, after the applicable deductible, shall be at a 50 percent rate for covered expenses incurred by the insured while other than an inpatient in a hospital, and benefits shall be available for such expenses during any calendar year up to a maximum of $500.

[1973 c.613 §2]

SOUTH DAKOTA

payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

Source: SL 1966, ch. 111, ch. 26, § 1(6).

§ 58-18-7.1. Coverage for inpatient treatment of alcoholism to be offered in group policies

Any insurer which delivers or issues for delivery in this state group accident and sickness insurance policies which provide coverage on an expense incurred basis shall offer, in writing, to include in such group policies or contracts issued or renewed on or after July 1, 1977, coverage for the inpatient treatment of alcoholism in a licensed hospitals or residential primary treatment facilities approved by the state of South Dakota which are carrying out an approved program pursuant to diagnosis and recommendation of a doctor of medicine.

Source: SL 1975, ch. 314, § 1; 1976, ch. 314, § 1; 1977, ch. 411, § 1.

§ 58-18-7.2. Benefits provided under alcoholism coverage—Maximum treatment periods permitted

The alcoholism coverage to be offered in writing shall provide benefits on the same basis as benefits provided for the treatment of other sicknesses covered under the group policy; provided, however, that the coverage by the insurance carrier need not exceed thirty days' care in any six-month period, and further provided that the total days' care per recipient need not exceed ninety days during the life of the contract.

Source: SL 1975, ch. 314, § 2; 1977, ch. 411, § 2.

§ 58-18-7.3. Policies not within alcoholism coverage requirement

Sections 58-18-7.1. and 58-18-7.2 shall not apply to group

major-medical insurance policies or accident only, or limited or specified disease policies.

Source: SL 1975, ch. 314, § 3.

§ 58-18-8. Statements by applicant—Representations not warranties—Requirements as to writing in order to avoid insurance or reduce benefits

Each such group health insurance policy shall contain in substance a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

Source: SL 1966, ch. 111, ch. 26, § 2(1).

§ 58-18-9. Summary statement of coverage for delivery to member of insured group

Each such group health insurance policy shall contain in substance a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group, a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family unit.

Source: SL 1966, ch. 111, ch. 26, § 2(2).

§ 58-18-10. Additions to group originally insured

Each such group health insurance policy shall contain in substance a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

Source: SL 1966, ch. 111, ch. 26, § 2(3).

[redacted] TENNESSEE

The provisions of this section shall apply to all such policies, plans and contracts issued, renewed or reinstated on and after July 1, 1974, and to all other policies, plans and contracts otherwise in existence on July 1, 1974, whenever there be a premium or rate change thereunder. [Acts 1974 (Adj. S.), ch. 151, §§ 1, 2.]

56-1167. Health insurance—Coverage of mental illness.

All other provisions of the laws of the state of Tennessee notwithstanding, any individual, franchise, blanket or group policy of insurance issued pursuant to title 56, which provides hospital expense and surgical expense insurance and which is entered into, delivered, issued for delivery, or renewed (excepting individual insurance policy renewal) by agreement or otherwise, commencing on July 1, 1974, shall provide benefits for expense of residents of the state of Tennessee covered under any such policy or plan, arising from psychiatric disorders, mental or nervous conditions (as described and defined in the Diagnostic Standard Manual of the American Psychiatric Association), alcoholism, drug dependence (both defined as mental illness in § 33-302 (*f*)), or the medical complication of mental illness or mental retardation, unless the policy or plan of insurance specifically excludes or reduces the above benefits. [Acts 1974 (Adj. S.), ch. 482, § 1.]

56-1168. Accident and sickness—Denial of coverage for mental illness for lack of surgical facilities prohibited.

Any provision of the law to the contrary notwithstanding, no policy of accident and sickness insurance may be entered into or renewed on or after July 1, 1974, if such policy by way of exclusion, definition, or otherwise denies coverage to an insured undergoing care and treatment in a facility for the care and treatment of mentally ill or mentally retarded persons, based upon the fact that the facility does not have organized facilities for operative surgery, if, in fact, the facility in question has, at the time a claim arises, a bona fide arrangement, by contract or otherwise, with an accredited hospital to perform such surgical procedures as may be required by the facility for mentally ill or retarded persons. [Acts 1974 (Adj. S.), ch. 625, § 1.]

VIRGINIA

services shall be construed to include a dentist performing such services within the scope of his professional license. (1968, c. 292.)

§ 38.1-348.6. Coverage of newborn children required

All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, as to such family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one day period. The requirements of this section shall apply to all insurance policies and subscriber contracts delivered and issued for delivery, reissued, renewed or extended in this State on and after November one, nineteen hundred seventy-six. An insurance policy written before November one, nineteen hundred seventy-six shall be deemed to be reissued or renewed if the provisions of that policy or contract allow the insurer to change the terms of the policy or contract or adjust the premiums charged, and if a change or adjustment is made on or after November one, nineteen hundred seventy-six. (1975, c. 281; 1976, c. 342.)

§ 38.1-348.7. Coverages for mental, emotional or nervous disorders

A. All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and

individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, in the case of benefits based upon treatment as an inpatient in a mental hospital or a general hospital, provide coverage for mental, emotional or nervous disorders, with limits that are not more restrictive than for any other illness except that such benefits may be limited to thirty days of active treatment in any policy year. The requirements of this section shall apply to all insurance policies and subscriber contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment is made.

B. Every insurer which proposes to issue a group hospital policy or a group major medical policy in this State and every nonprofit hospital and medical service plan corporation which proposes to issue hospital, medical or major medical service plan contracts which provide coverage for the insured or the subscriber shall, in the case of outpatient benefits, make available additional benefits as specified herein for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for such policy or contract to select any alternative level of benefits as may be offered by the insurer or service plan corporation. Outpatient benefits shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that the coinsurance factor need not exceed fifty per centum of the coinsurance factor applicable for physical illness generally, whichever is greater, and the maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to not less than one thousand dollars.

This subsection B shall apply to policies or contracts delivered or issued for delivery in this State on or after November one, nineteen hundred seventy-seven; but shall not apply to blanket, short-term travel, accident only, limited or specified disease,

individual conversion policies, or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under State or federal governmental plans.

As used in this section, the following terms shall have the meanings indicated below.

(1) *"Outpatient benefits"* means only those payable for (i) charges made by a hospital for the necessary care and treatment of mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, (ii) charges for services rendered or prescribed by a physician or a psychologist duly licensed to practice in Virginia for the necessary care and treatment for mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, or (iii) charges made by a mental health treatment center, as defined herein, for the necessary care and treatment of a covered person provided in such treatment center.

(2) *"Mental health treatment center"* means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician or a psychologist duly licensed to practice in Virginia and which facility is also: (i) licensed by the State, or (ii) funded or eligible for funding under federal or State law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

C. *"Mental, emotional or nervous disorders"* as used in this section, shall include physiological and psychological dependence upon alcohol and drugs; provided, however, that in instances where the optional coverage made available pursuant to § 38.1-348.8 B is accepted by or on behalf of the insured or subscriber and included in a policy or contract "mental, emotional or nervous disorders" shall not include coverge for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs. (1976, c. 355; 1977, cc. 603, 606; 1978, c. 349.)

§ 38.1-348.8. Coverages for alcohol and drug dependence

A. As used in this section:

1. *"Treatment"* includes diagnostic evaluation, medical, psychiatric and psychological care, counseling and rehabilitation for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs which is determined to be necessary by and is provided by a certified alcoholism counselor, certified drug counselor, professional counselor, psychologist, or social worker licensed or certified pursuant to chapter 28 (§ 54-923 et seq.) of Title 54, or by a licensed physician.

2. *"Alcoholism or drug addiction facility"* means a facility in which is provided a State-approved program for the treatment of alcoholism or drug addiction and which is (i) a facility licensed by the State Board o' Health pursuant to chapter 16 of Title 32 (§ 32-297 et seq.) or by the State Mental Health and Mental Retardation Board pursuant to chapter 8 (§ 37.1-179 et seq.) or chapter 11 (§ 37.1-203 et seq.) of Title 37.1; (ii) an office or clinic of a licensed physician o:' clinical psychologist; (iii) a State agency or institution or (iv) a facility accredited by the Joint Commission on Accreditation of Hospitals.

3. *"Intermediate care facility"* means a duly licensed, residential public or private alcoholism or drug addiction facility which is not a hospital and which is operated primarily for the purpose of providing a continuous, structured twenty-four-hour-a-day State-approved program of inpatient treatment and care for inpatient alcoholics or drug addicts.

B. No group accident and sickness insurance policy providing coverage on an expense incurred basis and no group service or indemnity type contract issued by a nonprofit corporation which provides coverage of a family member of the insured or the subscriber, shall be delivered or issued for delivery in this State on or after July one, nineteen hundred seventy-eight, unless coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs as hereinafter provided was made available as an option. Such coverage made available as

quently than annually after the two year period following the child's attainment of the limiting age. (1977 1st ex.s. c 80 § 32; 1969 ex.s. c 128 § 4.)

48.21.155 Coverage of dependent children to include newborn infants and congenital anomalies from moment of birth. Any group disability insurance contract except blanket disability insurance contract, providing hospital and medical expenses and health care services, renewed, delivered or issued for delivery in this state more than one hundred twenty days after February 16, 1974, which provides coverage for the dependent children of persons in the insured group, shall provide coverage for newborn infant children of persons in the insured group from and after the moment of birth. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth. (1974 1st ex.s. c 139 § 2.)

48.21.160 Alcoholism treatment benefits—Legislative declaration. The legislature recognizes that alcoholism is a disease and, as such, warrants the same attention from the health care industry as other similarly serious diseases warrant: the legislature further recognizes that only very infrequently do health insurance contracts and contracts for health care services include provisions providing benefits for the treatment of alcoholism. In order to assist the many citizens of this state who suffer from the disease of alcoholism, and who are presently effectively precluded from obtaining any medical assistance under the terms of their health insurance contract or health care service contract, the legislature hereby declares that provisions providing benefits for the treatment of alcoholism shall be included in new contracts and that *this 1974 act is necessary for the protection of the public health and safety. (1974 1st ex.s. c 119 § 1.)

*Reviser's note: "this 1974 act" (1974 1st ex.s. c 119) consists of RCW 48.21.160, 48.21.170, 48.21.180, 48.21.190 and 48.44.240.

48.21.170 Alcoholism treatment benefits—Provisions of contracts issued or renewed July 1, 1974-January 1, 1975. Each group disability insurance contract which is issued, or renewed, on or after July 1, 1974 and before January 1, 1975

and which insures for hospital or medical care shall contain provisions providing benefits for the treatment of alcoholism rendered to the insured by alcoholism treatment facilities approved under RCW 70.96.092 and for the treatment of alcoholism rendered to the insured by an alcoholic treatment facility which is an "approved treatment facility" under RCW 70.96A.020(2). (1974 1st ex.s. c 119 § 2.)

48.21.180 Alchoholism treatment benefits—Provisions of contracts issued or renewed after January 1, 1975. Each group disability insurance contract which is issued, or renewed, on or after January 1, 1975 and which insures for hospital or medical care shall contain provisions providing benefits for the treatment of alcoholism rendered to the insured by an alcoholic treatment facility which is an "approved treatment facility" under RCW 70.96A.020(2). (1974 1st ex.s. c 119 § 3.)

48.21.190 Alcoholism treatment benefits—RCW 48.21.160—48.21.190, 48.44.240 inapplicable, when. RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to the renewal of a contract in force prior to the pertinent date provided for such contract under RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended where there exists a right of renewal on the part of the insured or subscriber without any change in any provision of the contract: *Provided further*, That RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to contracts which provide only accident coverage, nor to any contract written as supplemental coverage to any federal or state programs of health care including, but not limited to, Title XVIII health insurance for the aged (commonly referred to as Medicare, Parts A and B), and amendments thereto. (1975 1st ex.s. c 266 § 10; 1974 ex.s. c 119 § 5.)

48.21.200 Reduction or refusal of benefits on basis of other existing coverages. (1) No group disability insurance policy which provides benefits for hospital, medical, or surgical expenses shall be delivered or issued for delivery in this state after September 8, 1975 which contains any provision whereby

State of Wisconsin \ DEPARTMENT OF HEALTH & SOCIAL SERVICES

DIVISION OF COMMUNITY SERVICES
1 WEST WILSON STREET
MADISON, WISCONSIN 53702

October 6, 1977

TO: Directors, State Alcohol Authorities
Directors, Single State Drug Abuse Agencies

FROM: Larry W. Monson, ACSW, Director
Bureau of Alcohol and Other Drug Abuse

Re: INFORMATIONAL BULLETIN ON WISCONSIN INSURANCE COVERAGE FOR ALCOHOL AND OTHER DRUG ABUSE

Attached is an informational bulletin prepared by our Insurance Commissioner's Office for distribution to health care providers in our State, regarding insurance coverage for alcohol and other drug abuse. We also have attached referenced sections of our State Statutes as noted on the last page of this brochure.

I though you might be interested in our insurance coverage for alcohol and other drug abuse, especially with the increased emphasis on collections via all sources of Third Party payments to generate program revenue.

If you have any questions or desire further information, please contact our Acting Chief of Program Operations and Management as follows:

Mr. Clifford Bertagnoli
Acting Chief, Program Operation and Management
Bureau of Alcohol and Other Drug Abuse
Room 523, 1 West Wilson Street
Madison, WI 53702
(608) 266-0907.

LWMbrs

cc Carl Akins, Executive Director, NASDAPC
Riley Regan, Chairperson, CSTAA
Gus Hewlett, ADPA
William Butynski, Chairperson, ADPA
Joel Egertson, NIAAA
Louise Meister, NIDA

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Office of Alcoholism L

TITLE XLI.

Insurance Code.

CHAPTER 600

GENERAL PROVISIONS

600.01 Scope of application of code.
600.02 Interpretive rules
600.03 Definitions, usages and synonyms.
600.12 Construction.
600.13 Orders relaxing restrictions.

600.01 Scope of application of code. (1) GENERAL. (a) The insurance code restricts otherwise legitimate business activity and what the code does not prohibit is authorized unless contrary to other provisions of the law of this state.

(b) Unless otherwise expressly provided, this code does not apply to:

1. Reinsurance.

2. Death and disability benefits provided by an organization the principal purpose of which is not to provide such benefits but charitable, educational, social or religious objectives not related thereto, if the organization does not incur a legal obligation to pay a specified amount.

3. Group or blanket insurance covering risks in this state if:

a. The policyholder exists primarily for purposes other than to procure insurance;

b. The policyholder is not a Wisconsin corporation or other resident and does not have its principal office in Wisconsin;

c. No more than 25% of the certificate holders or insureds are resident in this state;

d. On request of the commissioner, the insurer files with the commissioner a copy of the policy and a copy of each form of certificate; and

e. The insurer agrees to pay taxes on the Wisconsin portion of the business on the same basis it would do if authorized to do business in this state, and provides the commissioner with such security as the commissioner deems necessary for the payment of such taxes.

4. Group or blanket insurance covering risks mainly outside this state if:

a. The policyholder exists primarily for purposes other than to procure insurance;

b. The policyholder is not a Wisconsin corporation or other resident and does not have its principal office in Wisconsin; and

c. Any Wisconsin residents insured under the policy are covered because their principal place of employment is outside the state.

5. Other business specified in rules promulgated by the commissioner if the transaction of such business in this state does not require regulation for the protection of the interests of Wisconsin insureds or public or for which it would be impracticable to require compliance with this code, when necessary expenses and efforts are compared with the possible benefits.

6. Transactions independently procured through negotiations under s. 618.42, except as they are subject to taxation under s. 618.43.

(2) EXCEPTIONS. After a hearing, the commissioner may order an insurer to transfer the Wisconsin portion of the business under sub. (1) (b) 3 or 4 to an authorized insurer if it is written by an unauthorized one, or may subject any insurance under sub. (1) (b) to this code, if he finds that the foregoing conditions are not satisfied or that any circumstances require that the insurer be authorized to do business in this state or that the transactions be subject to this code in order to provide adequate protection to Wisconsin insureds and public. Coverage of a resident of this state is the doing of an insurance

(2) PROOF OF INCAPACITY. The insurer may require that proof of the incapacity and dependency be furnished by the person insured under the policy within 31 days of the date the child attains the limiting age, and at any time thereafter except that the insurer may not require proof more frequently than annually after the 2-year period immediately following attainment of the limiting age by the child.

History: 1975 c. 375.

632.89 Required coverage of alcoholism and other diseases. (1) DEFINITIONS. In this section:

(a) "Outpatient treatment facility" means a facility licensed or approved by the department of health and social services whose outpatient services meet the standards established in s. 51.42 (12) and which provides those services, except inpatient services, enumerated in s. 51.42 (5) (b) to (d) for the prevention and amelioration of mental disabilities, including but not limited to mental and nervous disorders, alcoholism and drug abuse.

(b) "Hospital" is a facility described in s. 140.24 (1) (a) and (c) which is licensed under s. 140.26 or is an approved public or private treatment facility for the treatment of alcoholics as defined in s. 51.45 (2) (b) and (c).

(c) "Physician" has the meaning designated in s. 990.01 (28).

(d) "Outpatient services" means services, medications, equipment and supplies performed or furnished by or under the supervision of or on referral from a physician at a hospital or outpatient treatment facility to a patient who is not a bed patient of the hospital or outpatient treatment facility.

(2) REQUIRED COVERAGE FOR ALL INSURERS UNDER CHAPTERS 611 AND 613. (a) *Scope.* Each group disability policy, joint contract or contract providing hospital treatment coverage shall include coverage for:

1. Inpatient hospital treatment of mental and nervous disorders, alcoholism and drug abuse.

(b) *Exclusions in coverage.* Except as provided in par. (c), coverages under pars. (a) and (d) may not be subject to exclusions or limitations which are not generally applicable to other conditions covered under the policy or contract.

(c) *Minimum confinement.* Coverages under par. (a) 1 may not provide less than 30 days' confinement in any calendar year.

(d) *Outpatient treatment.* Every contract or joint contract issued by an insurer subject to this section providing coverage for outpatient treatment shall provide coverage for outpatient services for mental and nervous disorders, alcoholism and drug abuse including but not limited to partial hospitalization services, prescribed drugs and collateral interviews with patients' families, relating to diagnosed alcoholism, drug abuse, or mental and nervous disorders of the patient, in an amount not less than the first $500 in any calendar year for any alcoholism or drug abuse services, or for outpatient services provided by or under contract for a board established under s. 51.42, and $500 for any other outpatient services for mental and nervous disorders. No contract or joint contract written in combination with major medical coverage shall be required to provide coverage under this paragraph for more than $500 for any combination of disabilities required to be covered under this paragraph. The department of health and social services may by rule promulgated under ch. 227 adjust this amount at 2-year intervals to reflect changes in the cost of medical care.

(3) ADDITIONAL REQUIRED COVERAGE FOR CORPORATIONS SUBJECT TO CH. 613. Any corporation subject to ch. 613 is subject to sub. (2) and in addition its group disability policies, joint contracts or contracts which provide for hospital treatment or outpatient treatment shall provide:

(a) Outpatient hospital treatment of alcoholism;

(b) Outpatient and home dialysis treatment for kidney disease and kidney transplantation expenses; and

(c) Protection for both recipient and donor of any transplant organs, as provided in s. 49.48 (3) (b).

(4) AMOUNT OF PROTECTION FOR ORGANIZATIONS SUBJECT TO SUB. (3). Coverage under sub. (3) (b) and (c), combined with coverage under s. 632.78 (2), shall not be less than $30,000 annually.

(5) MEDICARE EXCLUSION. No insurer or other organization subject to this section is required to duplicate coverage available under the federal medicare program.

(6) RULES. The department of health and social services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under this section and s. 632.78 (2), which shall not be inconsistent with or less stringent than applicable federal standards.

History: 1975 c. 223, 224, 375.

632.90 Tuberculosis coverage. (1) No policy of disability insurance, whether under subch. II of ch. 40 or otherwise, may include hospital or medical expense coverage unless it contains a provision for a minimum 90 days' continuous coverage of costs for tuberculosis charges, fees or maintenance under ch. 50, including both inpatient care and outpatient dispensary charges or fees. This section applies

Original sponsor: Rules Committee by Request

Offered: 4/18/78
Referred: Finance

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 545

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health insurance."

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

* Section 1. AS 21.89 is amended by adding a new section to read:

Sec. 21.89.050. ALCOHOLISM UNDER HEALTH INSURANCE. All policies, contracts or prepaid plans for individual or group health insurance with the exception of Medicare Supplement issued or delivered in the state on or after the effective date of this Act shall contain provisions providing benefits for the treatment of alcoholism. This coverage may be waived in writing by a group policyholder on or before the effective date of the policy.

FORM B

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Commerce & Economic Development		SB 545

DEPARTMENT POSITION

Not opposed in principal, provided significant amendments are made.

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Insurance	4/3/78	H. Phillip Hubbard	

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)

A whole series of bills concerning alcoholism.

(2) a. ORGANIZATIONAL SUPPORT FOR BILL

Uncertain

(2) b. ORGANIZATIONAL OPPOSITION TO BILL

Uncertain

(3) PROGRAM EFFECTS OF BILL

None

(4) FISCAL IMPACT: ☒ NONE ☐ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

See Attached.

(6) COMMENTS:

See Attached.

The thrust of the bill is to require that insurance companies providing indemnity against medical expense and health care contractors, such as Blue Cross or HMO's and other prepaid health programs, provide coverage for medical treatment of alcoholism to the same extent it would provide medical treatment for any other disease.

The Division of Insurance does not basically oppose the concept, but, as drafted, SB 545 presents substantial problems of interpretation when approving policies.

A primary concern would be the coverage for pre-existing conditions. Currently, under the terms of most insurance policies, medical coverage is either limited or not provided for pre-existing medical conditions. Particularly in group policies, which are renewed annually, it is unlikely that anyone would become an alcoholic within the short period of time of an annual policy. Therefore, alcoholism will almost always be a pre-existing condition, and, thus, not covered under the current health insurance coverages. Yet, this is not the result which, I am sure, is intended by the drafters of the section.

Secondly, there is a wide variety of treatment for alcoholism ranging from simply "drying out" the alcoholic so that he is removed from his state of inebriation, but not really cured of his alcoholism, to carefully pre-planned programs of medical and psychological treatment to cure the alcoholic of his desire for drink.

The latter, of course, is what is intended by the drafters to be covered under the health insurance policies, but it is not clear whether it is intended that "drying out" should also be covered. The Division of Insurance could not sanction any insurance policy covering the "drying out" process, since it does not tend toward rehabilitation, but only making "first aid" changes in the individual without making any effort to address the underlying problem.

Finally, the question of cost has to be considered. With respect to group programs it may be the intent of the Legislature to establish, as a matter of public policy, that group sponsors incur the cost of providing additional coverage for alcoholic rehabilitation, but to the extent that there is contribution to the cost of medical insurance by the employee or member of the group, it is imposing this burden on a large segment of society for the benefit of the few who would have the opportunity to take advantage of the coverage. The division would not particularly oppose this aspect of the bill so long as it is clearly understood by the Legislature that it would have this impact.

If it is desired that the legislation have such an economic impact, then it must consider whether it is going to permit, or prohibit, waivers of alcoholic coverage by individual members of the group.

The division believes that the bill will need substantial redrafting before it would accomplish the desired results, but having some understanding of the results that are anticipated, the Division of Insurance believes that the fundamental objective of the bill is worthy of support.

RLB/mh/2/4

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO · NEW YORK · WASHINGTON

LESLIE P. HENRY, *President*

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March 29, 1976

+13547

RECEIVED
DIV. OF TRADE
APR 14 2 55 PM '76
ALASKA DEPT. OF COMMERCE & ECONOMIC DEVELOPMENT

The Honorable Richard L. Block
Director of Insurance
State of Alaska
Pouch "D"
Juneau, Alaska 99811

Re: Alaska H. B. 190 - Alcoholism and Drug Addiction Coverage

Dear Director Block:

I appreciate very much receiving your letter of March 5, 1976 concerning H. B. 792.

There is another bill now in the Alaska legislature that I am very much concerned about. H. B. 190 would require all group and blanket disability insurance policies that provide benefits for hospital expenses due to an illness or injury also to include coverage for the treatment of alcoholism or drug addiction as an illness, would further require that coverage be furnished for treatment in certain facilities other than general hospitals.

To begin with I would like to say that we generally oppose legislation mandating particular health insurance coverages. We don't think that a legislature should decide for insurers and their policyholders what insurance coverage should be included in health insurance policies, for a number of reasons including the following:

1. Health insurance laws have not historically mandated particular coverages. Once they begin to do so, there is no logical place to stop, until absolutely every health care cost must be covered. Most people cannot afford to pay for coverage for all such costs.

2. The mandated coverages are not the ones most needed by most people. People should first have adequate coverage for hospital, medical, and surgical expenses for injuries and sicknesses in general, before they should think of buying coverages for particular conditions or for particular types of services. Since budgets of individuals and employers are limited, only a certain amount of money is reasonably available for health insurance.

To the extent the legislature mandates coverages for particular conditions or services, it forces the policyholder to reduce the amount of money available for more needed general coverages. The legislature cannot possibly know what coverages a particular individual's or employer's money should be spent for.

3. Most bills that would mandate particular coverages seek to require a coverage that is already available from insurers. If people have not chosen to buy an available coverage, there must be some good reason that they have not. In such cases, the legislature would, in effect, be saying: even though policyholders choose not to buy the particular coverage, the legislature knows better what is good for them and will force them to do what they choose not to do themselves. Where coverage is not available, it is normally because the risk is not an insurable one or is not insurable at a reasonable price.

4. Mandating particular coverages in employer-employee group policies interferes with the collective bargaining process.

5. Bills that would mandate a particular coverage are often drafted in a way that ignores necessary fundamentals of insurance and prevents an insurer from designing the coverage properly. Different coverages may very well need to be designed differently if they are to operate properly and avoid costly abuses.

All of the above comments apply to H. B. 190.

Group insurance coverage is already available to provide benefits for the treatment of alcoholism and drug addiction. Those group policyholders which want such coverage, and can afford it, can secure it from a substantial number of insurance companies. H. B. 190 could be interpreted as requiring the same coverage for these two conditions as is provided for other illnesses. That would be wrong, because these conditions require different treatment from illnesses in general, and coverage specifically for alcoholism or drug addiction must be designed differently to meet special requirements.

Alcoholism is a peculiar thing. No one knows what causes it. There is no cure for it. There is no known medical treatment that is very successful. The only known treatment with any consistent success is what is done by Alcoholics Anonymous, and what Alcoholics Anonymous does is not coverable under a health insurance policy. The only known way to prevent the symptoms of alcoholism from recurring is for the individual to develop enough willpower so that he never takes another drink.

All medical and psychological treatment for alcoholism should at the current status of our medical knowledge, be considered as experimental. Likewise insurance coverages for any such treatment must be regarded as experimental. Insurers should be left free by the legislature to do the necessary experimenting.

Much of what I have just said about the treatment of alcoholism also applies to the treatment of drug addiction. The only known cure is for the individual to develop enough willpower to stop taking drugs. Treatment should be regarded as experimental. Insurance companies should likewise be left free to experiment with coverages for the treatment of drug addiction.

The cost of coverage for the treatment of alcoholism and drug addiction can be substantial. In connection with an almost identical Alaska bill (S. B. 35 of the 1973 session) which would only have mandated coverage for the treatment of alcoholism, Aetna Life and Casualty Company, in its letter of March 21, 1973 to Director O'Shea, estimated that for a typical group of 150 members, the mandated alcoholism coverage would increase the premium rate on the order of 9 to 14%. Adding drug addiction coverage would of course make that figure larger. H. B. 190 contains a number of defects. I will list the more important ones that occur to me.

1. It should not apply to blanket insurance. Blanket insurance is usually accident only coverage. It would seem unwise for the legislators to turn accident only policies into policies which have to cover two types of sicknesses. Those blanket insurance policies which provide coverage for both injuries and sicknesses are mostly policies issued to schools to cover school children or university students. They are generally tailor made for the particular type of institution and the medical facilities that that institution has. Those policies should not be altered by a legislative requirement that is general in nature and is not tailored to the particular institution and its facilities.

2. The bill would also apply to group accident only policies or to group policies that are designed to cover only a specified disease or a few specified diseases (e.g. a cancer policy or a dread disease policy). Such policies should not by legislation be turned into something they were never designed to be.

3. The reference to any "other licensed treatment facility" is most troublesome. Before we can provide coverage for care or treatment in a given facility we have to know what that facility is and what it does. We should not be asked to extend coverages to any facility just because it is licensed. Some states do not have standards for licensing of alcoholism or drug addiction treatment facilities, so that the reference in the bill to state would not

give us the controls needed in trying to provide coverage for treatment in such institutions.

4. The bill does not appear to give us the freedom we need to design benefits specifically tailored to the available types of treatment for alcoholism and drug addiction and to the facilities in which that treatment is given.

5. The bill could be interpreted as applying to previously issued policies, which may be unconstitutional as impairing the obligation of contract, and which would interfere with existing collective bargaining agreements.

6. The bill does not allow sufficient lead time to prepare and secure approval of the necessary policy forms.

The employer-employee programs dealing with alcoholism, that have experienced some degree of success, are programs that involve much more than just health insurance coverage. Generally they consist of an employee education program, a medical staff that becomes involved in early detection and in following up after formal treatment ends, an arrangement with a hospital or other facility which has a specific program for the treatment of alcoholism, and an arrangement to work with Alcoholics Anonymous. Only larger employers can afford such a costly program. The legislature should not force smaller and medium sized employers to pay for an elaborate program, nor for just the insurance portion of a program which, to be successful, requires much more.

We hope that you will join us in trying to convince the legislature that it should not adopt H. B. 190.

Sincerely,

Charles D. Kuhnen/RT

Charles D. Kuhnen
Counsel

CDK:rt

HEALTH INSURANCE ASSOCIATION OF AMERICA

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April 11, 1978

RECEIVED
DIV. OF INSURANCE
APR 14 2 54 PM '78
ALASKA DEPT. OF
COMMERCE & ECONOMIC
DEVELOPMENT

Honorable Richard L. Block
Director of Insurance
State of Alaska
Pouch "D"
Juneau, Alaska 99811

Re: Alaska S. B. 545 - Alcoholism Coverage (Hearing Scheduled for April 17, 1978)

Dear Director Block:

We hope that your legislature will this year as it has in the past, resist efforts to pass a law which would mandate the inclusion of alcoholism coverage in disability (health) insurance policies.

Senate Bill 545 would require group and individual "health" insurance policies to provide that alcoholism is an illness, and to include benefits for the treatment of alcoholism that are not less than those "for any other illness". In the case of an individual health insurance policy, the alcoholism coverage could be "waived" in writing by the policyholder on or before the effective date of the policy.

My letter to you of March 29, 1976 on H. B. 190 (a copy is attached to this letter) indicates why we oppose mandating particular health insurance coverages, why alcoholism coverage in particular should not be mandated, and what the additional cost to policyholders for alcoholism coverage has been estimated to be (9% to 14% increase in premiums for group insurance).

If the State really wants to do something to help alcoholics, tampering with insurance company experiments to provide effective alcoholism coverage is not the route to take. What the State should do is appropriate some money to: (1) encourage alcoholics and their families to use Alcoholics Anonymous and Alanon, and (2) inform employers of the advantages of having a well-designed program for early detection, treatment, and follow-up as to

employees and family members who are, or are becoming alcoholics. If the latter included assistance for small employers in the form of money or services, so much the better.

Glowing reports of highly successful medical treatment of alcoholism for the employees of an employer are also highly suspect if the employer does not have a well-rounded program of early detection, etc., and if Alcoholics Anonymous is not involved. Those that I have checked do not have credible statistics. Likewise, reports of extremely low costs for insurance coverage probably indicate a program that is used so little that it should be classified as having little effect, e.g. the California program of two years ago for State employees and their dependents.

The following additional comments apply to S.B. 545.

(1) Insurance benefits for the treatment of alcoholism should not be the same as for physical sicknesses. They should be different because the kinds of treatment are different. They should be small enough to encourage the patient to try to help himself. Some of the experts in alcoholism treatment have warned us not to make the insurance benefits too high.

(2) To require insurance policies to contain a provision that says alcoholism is an illness would be a waste of words and money. I have never seen a policy which says this, so companies would have to revise their policy forms - even those which already cover alcoholism. We agree that alcoholism is a type of sickness. To say so in the policy won't change anything. Almost all policies do not cover some sicknesses and some injuries.

(3) In Alaska the correct statutory term for health insurance is "disability insurance", which includes all types of health insurance, e.g. accidental death, loss of time, hospital expense, dental expense, specified disease (such as policies covering only cancer expense), etc. See AS 21.12.050 (disability insurance defined), AS 21.51 (disability insurance policies). "Health" insurance is not distinguished from accident insurance either in your laws or in industry usage. Therefore, S.B. 545 as written either has no proper statutory meaning or it includes types of policies which should not provide alcoholism expense coverage, e.g. accident only policies, loss of time policies, cancer policies, dental policies, etc.

(4) The bill appears to try to apply to Blue Cross-Blue Shield ("prepaid plans"), but cannot do so without using the proper statutory language (see AS 21.87) and without amending AS 21.87 (see AS 21.87.030). The bill should apply to the competitors of health insurers if it is to apply to health insurers.

(5) The words "issued or delivered" on line 11 are incorrect. The correct wording would be "delivered or issued for delivery". See, e.g. AS 21.51.020.

(6) The idea of coverage being "waived" is awkward. An applicant for a policy indicates what coverage he wants on an application form. Would there have to be a separate document called a "waiver", or would all application forms have to be redrafted to contain "waiver" language? Why is the individual given the right to "waive" coverage at any time "on or before the effective date of the policy"?

(7) The bill does not allow any lead time for insurers to prepare and secure approval of policy forms, or to change their procedures in regard to the coverages affected by the bill.

Some 18 states have some kind of law concerning health insurance coverage for alcoholism. Most affect only group insurance. Some don't specify any particular benefits, but those that do normally have a rather limited benefit. These laws differ from one another, which is wasteful in cost and provides more than enough experimentation. Enclosed is a list of states with such laws, which list the Alaska legislative staff asked for and received from us.

Properly designed alcoholism coverage is readily available in group health insurance from a large number of companies. There is no need to require the companies that don't know how to write this coverage to do so anyway. And it is undesirable to require all groups to purchase this coverage whether they want it or not.

As to individual health insurance policies, I do not have an HIAA survey on what companies are writing in the way of alcoholism coverage. From talking to some companies, I have the impression that most companies cover alcoholism treatment in a general hospital. A few companies are experimenting with out-of-hospital alcoholism treatment coverage under individual policies. I think

it would be unwise to require any company to cover what it is not now willing, ready, and able to cover. Companies may be so wary of the risks involved that the requirement becomes counterproductive.

Sincerely,

Charles D. Kuhnen
Counsel

CDK:rt
Enclosure

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361 3000

April 17, 1978

Senator Glenn Hackney, Chairman
Senate Health, Education & Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

I would like to take this opportunity to commend the actions of the committee which studied the alcoholism problems in Alaska and drafted this package of legislation to answer those problems. Blue Cross of Washington and Alaska is particularly interested in one bill in that package, Senate Bill 545. Blue Cross supports the intent of this bill.

The intent, as I understand it, in this legislation is to provide the best benefits available for as many Alaskans as possible for the treatment of alcoholism. To reach that goal you need contracts which provide coverage which is affordable. Otherwise groups will not buy insurance either because it contains benefits the group does not want or the cost is to high.

Two major issues, the level of benefits provided and the cost of the coverage, are the items of negotiation between the insurer and the purchaser. To legislate away those items of negotiation will result in instances where no coverage will be afforded to some groups because the employer either will not buy the standardized coverage or cannot afford to buy it.

This is particularly true when you are dealing with alcoholism coverage. An estimate of the costs of coverage which you would mandate are not readily available because we have no experience on which to determine rates. We do not have the data which would enable us to project rates for increased coverage. We only know that alcoholism treatment is one of the most expensive components in our package. And increasing alcoholism treatment will increase cost by a percentage we cannot predict.

In Senate Bill 545, you mandate that the benefit for alcoholism may not be less than for any other illness.

At the present time, there are approximately 280 group contracts for Blue Cross coverage in Alaska. While those contracts are all similar, they do vary in individual provisions. Those contracts do not treat all illnesses in an identical fashion. To specify that alcoholism treatment "may not be less than for any other illness" is not a definitive explanation for our

purposes, since benefits for specific illnesses may vary from contract to contract.

The therapeutic treatment of the physical effects of alcoholism is now covered in all contracts unless a purchaser specifically deletes coverage for alcoholism. And that does happen. Some purchasers represent groups characterized by membership in a church where there is a religious prohibition on the use of alcohol. Those purchasers want the right to waive that coverage. It is one of the items which is negotiated between the insurer and the purchaser.

In most contracts there is an additional benefit which pays for a limited amount of treatment in an approved alcoholism facility. Let me explain the difference. The Alaskan who is admitted for treatment at Providence Hospital or at Valley Hospital will have complete coverage. The same is true if he is referred to and treated at Shadel Hospital, Riverton Hospital or Alcenas in the State of Washington. In all of those instances the person is a patient at a contracting hospital and is receiving medical care. Other programs are offered which go beyond medical care. These are programs which provide treatment for the mental aspects of alcoholism. Blue Cross pays for this treatment in the same manner as the treatment of any other mental illness.

Blue Cross insures the subscriber for the costs of medical and dental care. The group policyholder has the ability to purchase varying benefit packages. That becomes a major factor in both employee relations and business expenses. It is a factor which must be retained.

Since it is the intent of this Legislature to provide additional opportunities for treatment of alcoholism, I urge you to seriously consider this revised language.

> Section 1. AS 21.89 is amended by adding a new section to read:
> Sec. 21.89.050. ALCOHOLISM UNDER HEALTH INSURANCE. All policies, contracts or prepaid plans for individual or group health insurance with the exception of Medicare Supplement issued or delivered in the state on or after the effective date of this Act shall contain provisions providing benefits for the treatment of alcoholism. This coverage may be waived in writing by a group policyholder on or before the effective date of the policy.

This langauge will mandate that every employer include a benefit for alcoholism treatment. It provides an option for waiver of entire groups. It does not include a waiver on individual policies, which was included in your original bill. Blue Cross has very specific business reasons for asking you to make that change. If every non-group subscriber could opt to delete alcoholism coverage, the costs of administering the program would increase. We estimate that the administrative cost would nearly equal the coverage cost for alcoholism benefits now offered. The option

would not save the subscriber money. The option would, however, increase the likelihood of error in payment. If you want complete coverage of all contracts, then no language of waiver should be included. While this will be a factor in a few marketing instances, Blue Cross will not be opposed if, in the interests of maximum coverage, you decide to delete the waiver provisions.

If the Alaskan statutes require the provision of benefits, there will be increased availability of treatment. And yet you will have preserved the right of the employee and employee groups to bargain for benefits. You will have preserved the right of an employer to structure benefits offered to the costs allowable in his business.

Any other course can result in costs for health care insurance which cannot be met. When that happens, more and more persons or groups "go bare", with no coverage. And the final result is that more persons become the responsibility of the state under Medicaid.

I urge your support of the Blue Cross language.

Thank you.

Sincerely,

John H. Gaumer
Director, Government Relations

JHG:kg

cc: Bill Sumner
Patrick Rodey
Edward C. Willis
W. E. Bradley

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OF COUNSEL
M. E. MONAGLE

April 18, 1978

RECEIVED
STATE OF ALASKA

APR 18 1978

DEPARTMENT OF COMMERCE
& ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE

The Honorable Richard L. Block
Director, Division of Insurance
Department of Commerce and
Economic Development
Pouch D
Juneau, Alaska 99811

Re: S. B. 545

Dear Director Block:

Enclosed is a draft of language which the American Council of Life Insurance plans to propose as a substitute for the present language of HB 545. We believe that it is much more accurate in form and predictable in effect than the present language, but would accomplish the intended objections of the bill. I would be glad to discuss it with you at your convenience.

Very truly yours,

M. T. Thomas

cc: Robert Cole
Office of Alcoholism
& Drug Abuse

SUBSTITUTE LANGUAGE FOR ALASKA S.B. 545

Section 1. The purpose of this Act is to encourage consumers to avail themselves, of basic levels of beneifits under disability insurance policies and subscriber's contracts for the care and treatment of alcoholism, and to preserve the rights of the consumer to select such coverage according to his medical-economic needs.

Section 2. AS 21.89 is amended by adding a new section to read:

Sec. 21.89.050. AVAILABILITY OF COVERAGE FOR ALCOHOLISM. (a) Insurers and nonprofit hospital or medical service corporations transacting disability insurance in this State shall make available under hospital and major medical expense incurred insurance policies and under hospital and medical subscriber's contracts the level of benefits specified herein for the necessary care and treatment of alcoholism, subject to the right of the applicant for the group or individual policy or contract to reject the coverage or to select any alternative level of benefits as may be offered by the insurer or service corporation.

(1) Under basic hospital policies or contracts, inpatient hospital benefits consisting of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that benefits may be limited to not less than 30 days per confinement as defined in the policy or contract.

(2) Under major medical policies or contracts, inpatient hospital benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles and coinsurance factors that are not less favorable than for physical illness generally, except that:

(i) Inpatient hospital benefits may be limited to not less than 30 days per confinement as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days of confinement, the durational limits, dollar limtis, deductibles and coinsurance factors applicable thereto need not be the same as applicable to physical illness generally.

(ii) As to outpatient benefits, the coinsurance factor may not exceed 50% or the coinsurance factor applicable for physical illness generally, whichever is greater, and the maximum benefit for alcoholism in the aggregate during any applicable benefit period may be limited to not less than $500.

(iii) Maximum lifetime benefit limits may be no less than an amount equal to the lesser of $5,000 or 12-1/2% of the lifetime policy limit.

(b) For purposes of this section, the following terms shall have the meanings indicated below.

(1) "Inpatient hospital benefits" means only those payable for charges made by a hospital, as defined in the policy or contract, for the necessary care and treatment of alcoholism furnished to a covered person while confined as a hospital inpatient; and with respect to major medical policies or contracts, also includes those payable for charges made by a physician, as defined in the policy or contract, for the necessary care and treatment of alcoholism furnished to a covered person while confined as a hospital inpatient.

(2) "Outpatient benefits" means only those payable for 1) charges made by a hospital for the necessary care and treatment of alcoholism furnished to a covered person while not confined as a hospital inpatient, and 2) charges for services rendered or prescribed by a physician for the necessary care and treatment for alcoholism furnished to a covered person while not confined as a hospital inpatient.

Section 3. AS 21.87.340 is amended by adding a new paragraph to read:

(17) AS 21.89.050

Section 4. APPLICABILITY. This Act shall apply to policies or contracts delivered or issued for delivery in this State more than 180 days after the effective date of this Act; but shall not apply to blanket, short term travel, accident only, limited or specified disease, individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under State or Federal governmental plans.

A BRIEF HISTORY OF MAJOR ALCOHOLISM LEGISLATION PROPOSED DURING THE TENTH ALASKA STATE LEGISLATURE

During the first session of the Tenth Alaska State Legislature, early in 1977, Governor Hammond developed legislation dealing with the problem of alcoholism in the State of Alaska. When portions of this proposed legislation, which later became known as the "Governor's Alcohol Package," reached the Senate side of the Legislature, several Senators felt that some questions should be answered before they took any action. The Senate Special Committee on Alcoholism and Alcohol Related Legislation was formed, and Senator Mike Colletta was appointed chairman of this committee. The other committee members were Senators Ziegler, Ray, Hackney and Ferguson. Representative Lethin was appointed as House liaison member. During the life of this special committee, 36 hearings were held in 31 communities. During the hearings four areas were consistantly labled as major problems and were discussed by the participants of the meetings. These were: Prevention and Education, Alternatives to Drinking/Treatment, Local Options and Enforcement. After the first round of hearings the committee solicited specific comments from over 2500 people. From the testimony at those hearings and the written comments the committee received, thirteen bills were developed and proposed to the Legislature during the second session. Below I have listed the bills in the Governor's package and the bills developed through the Special Committee. I have also listed what the status of each of those bills were at the end of the second session, Tenth Alaska State Legislature.

SB76 "An act providing a method of adjusting certain tax rates." (Died in (S) State Affairs Committee.)

HB196 "An act relating to the excise tax on, and licence fees for, sale of intoxicating liquors." (Died in (H) Finance Committee.)

HB232 "An act relating to Municiple Sales tax." (Died in (H) Community and Regional Affairs Committee.)

HB240 "An act relating to Alcoholic Beverages." (Died in (H) Judiciary Committee.)

SB167 [HCSCSSB167amH] "An act relating to the excise tax on and license fees for sale of intoxicating liquors." (Died in (H) Rules Committee.)

HB340 "An act relating to the treatment of alcoholism and drug abuse." (Died in (H) Health, Education and Social Services Committee.)

SB540 "An act making a special appropriation to the office of alcoholism in the Department of Health and Social Services for the prevention and treatment of alcoholism and alcohol abuse. (Died in (S) Finance Committee.)

SB541 [SB541am] "An act relating to alcohol and drug abuse education in public schools." (Signed into law; July 22, 1978)

SB542 [CSSB542amH] "An act adding to the powers and duties of the office of alcoholism." (Signed into law; July 22, 1978)

SB543 [CSSB543amH] "An act relating to alcoholism grants-in-aid." (Signed into law; July 22, 1978)

SB544 [CSSB544am] "An act relating to standards for alcoholism treatment facilites." (Signed into law; July 22, 1978)

SB545 "An act relating to health insurance." (Died in (S) Finance Committee.)

SB546 [SB546amH] "An act establishing a tax credit for contributions to alcoholism programs." (Failed on the (H) floor.)

SB547 [SB547am] "An act making a special appropriation to the Department of Revenue to increase the number of enforcement personnel employed by the ABC Board." (Signed into law, July 22, 1978 - Governor reduced appropriation by $50,000.)

SB548 [CSSB548am] "An act relating to waiter and waitress permits." (Failed on the (S) floor.)

SB549 "An act relating to the serving of intoxicating liquor." (Died in (S) Health, Education and Social Services Committee.)

SB550 "An act relating to administration and enforcement of Alcoholic Beverage Control statutes and regulations. (Died in (S) Commerce Committee.)

SB551 "An act relating to the rehabilitation of persons who commit criminal offences as a result of alcohol problems. (Died in (S) Health, Education, and Social Services Committee.)

SB552 [FCCSHCSSB552] "An act relating to alcohol." (Signed into law, July 22, 1978.)

Key to Bill Titles

SB	Senate Bill
HB	House Bill
CS	Committee Substitute
HCS	House Committee Substitute
SCS	Senate Committee Substitute
FCCS	Free Conference Committee Substitute
am	Amended on the floor of the House of origin
amH	Amended on the floor of the House of Representatives
amS	Amended on the floor of the Senate

Below is an example of how the bill title symbols are read.
[CSSB542amH] Committee Substitute for Senate Bill 542 as amended on the floor of the House.

SUMMARY OF THE GOVERNOR'S

ALCOHOL BILLS

SB 76 — Adjusting tax rates. ((S) State Affairs, then C&RA, then Fin.)
Status date: 1/25/77

Directs the Commissioner of Revenue to adjust the alcohol taxes to bring them in line with changes in the consumer price index for the previous year. The legislature had the right to disapprove the changes by a Resolution of the majority of each house.

CS HB 196 — Excise tax and license fees on sale of Alcohol. ((H) Fin. & HCS CS SB 167 Ret. (H) Rules)
Status date: 4/19/77 & 5/28/77

A conservative estimate is that alcohol abuse cost the state over $17 million last year. Alcohol excise taxes generated only $7 million. This bill attempts to make up the difference.

General Wholesale License Holders:

* may not sell to a consumer.
* may sell liquor in the original package and wine in bulk quantities of not less than 5 gallons to license holders.
* Internal revenue strip stamps shall be on all liquor packages requiring them.
* A general wholesale license shall be required for each distributing point.
* The general wholesale license fee schedule is based upon the total amount of business transacted during any year. The minimum fee is $500 up to $50,000 with fee increases adjusted upward to reflect greater volume of business.

Malt beverage and wine license holders fall under the same constraints as holders of general wholesale license holders. There is a $100 minimum fee up to the first $10,000 of business transacted with fee escalations for greater volume of business.

Studies have said that a price rise far higher than this would be necessary to significantly reduce alcohol sales.

Retail License Holders:

* may sell liquors in original packages and wine in bulk.
* Internal revenue stamps strips shall be on packages of liquor requiring them.

* Consumption of liquor on premises prohibited.

* Sales are limited to less than 20 wine gallons to any one person in any sale.

* The license fee is raised from $600 to $1,000.

For retail liquor stores whose gross sales do not exceed $20,000 per year the fee is $300.

HB 232 — Municipal sales tax; alcohol. ((H) C&RA, then Fin.)
Status date: 2/18/77

Municipalities:

* may regulate by ordinance barter, sale and possession of alcohol.

* When a community votes to become "dry" they may by ordinance make sale of alcohol a misdemeanor.

* Municipal taxes may include only property taxes on liquor inventories and sales taxes.

Boroughs:

* may levy and collect a higher sales tax on liquor than other commodities.

This is aimed at encouraging local treatment and compensating local governments for their alcohol-caused expenses.

HB 240 — Alcoholic beverages; licenses. ((H) Jud, then Fin & SB 183 (S) C&RA, then Fin.)
Status date: 2/21/77 & 3/17/78

These two bills are identical.

The Director of the ABC Board who is appointed by the Governor is no longer subject to confirmation by the legislature.

* Shall enforce regulations adopted by the board.

* Although the Director is not a member of the board, he may cast a tie-breaking vote.

* The Director shall issue all licenses under Title 4.

Voters have the option of completely restricting sale of alcohol and banning shipment of mail or telephone ordered alcohol.

Dry Communities: Should a town vote itself dry (no type of liquor store) or if a town has already voted dry, the following things will happen:

* Communities which limit liquor sales should not have to pay the penalty of lost sales tax revenue. Communities which are presumed dry should have the benefit of more effective alcohol law enforcement. Therefore, the state will pay each voted dry community $10 per resident.

* In order to reduce bootlegging, no person in a dry community will be allowed to possess more than the equivalent of a case of fifths of liquor and 4.5 gallons of wine and beer.

* Sale in violations of local option (bootlegging) will be punished as a felony with a maximum sentence of six years and a fine of $30,000 (up from one year and $5,000) It is thought that the present penalties are so low as to be an acceptable cost of doing business to bootleggers some of whom make up to $100,000 a year.

* As a further deterrent to bootleggers using automobiles, aircraft or boats, the state may seize a vehicle used in bootlegging activities. Upon conviction of the offender the court may order the conveyance transferred to the community where the offence took place, or to the state. Owners of common carriers having no knowledge of the illegal transaction and mortgage or lein holders will be protected.

HCS CS SB 167 Excise tax and license fees on sale of alcohol. (Ret. (H) Rules)
Status date: 5/28/77

This bill is the same as HB 196 but also provides that all malt beverages (1% or more by volume) wines and hard or distilled liquors are subject to the following taxes:

1) malt beverages - 25 cents a gallon or fraction of a gallon.

2) wines or other liquor of less than 14% (lowered from 21%) - the tax rate is raised 40 cents (from 60 cents to a dollar) per gallon or fraction of a gallon.

3) liquors of more than 21% increases $1 (from $4 to $5)

4) wine or liquor of 14% but not more than 21% is taxed at $1.35 a gallon or fraction of a gallon.

Beverage Dispensary License Holders:

* may sell alcoholic beverages for consumption on the premises only.

* The fee is raised from $500 to $750 for unincorporated communities, and in incorporated communities with a population up to 1,500 (as determined at the time the application is filed). In all unincorporated communities and incorporated communities with a population up to 1,500 (as determined at the time the application is filed) the fee is raised from $1,000 to $1,500.

* Each applicant shall file a $2,500 bond to assure ownership, financial responsibility and compliance to liquor laws.

Restaurant License Holders:

* may sell beer and wine with meals furnished in good faith. The fee is raised from $300 to $500.

Roadhouse Licenses: - may be issued to owners which allow the sale of wine and beer for premises serving food. The alcohol may be consumed on the premises only. The roadhouse may not be located less than 18 miles from corporate city limits.

In-flight Catering Licenses: - authorize the issuance of licenses to permit sale of alcohol along with meals. Holders may not sell to a consumer and must purchase from a licensed wholesaler. The fee for this license is $600.

Unlimited Community Liquor Licenses: - would allow communities to run their own liquor store. The advantages are that under community management, the store may limit sales, and control sale hours to minimize abuses of alcohol and binge drinking. The profits may be used by the community for any purpose including local treatment and alcohol caused costs.

Limited Community Liquor License: Issuance of these licenses preclude issuance of private liquor licenses. This license allows the community to run a liquor store which would only be allowed to sell a limited amount of alcohol (2.4 wine gallons to any one person in a given day). This alcohol must be ordered two weeks in advance.

Public Notice: When a liquor license is applied for or renewed, notice must be posted rather than advertised as was previously done, unless the ABC Board determines that advertised notices are in the public interest. Announcements of proposed issuance, renewal or transfer of licenses must be bilingual when necessary.

* Technical provisions are included in the bill for protest of local governing bodies and areas outside municipalities.

* Transfer of ownership of licenses is contingent on a determination by the ABC Board that debts and taxes are paid or that satisfactory security is given.

Local Option Elections: Upon petition of 35% of the voters, or action by the governing body, an election will be held which will allow the voters to choose the following alcohol options:

1) Going "dry" ad prohibition of bootlegging.

2) Community Liquor License.

3) Unlimited Community Liquor License.

Advertising Ban: Holders of liquor licenses may not advertise alcohol in any newspaper, magazine or on any cable or broadcast television or radio station.

Solicitation: It would become illegal for men as well as women to solicit the purchase of alcoholic beverages at licensed establishments.

Violations: Upon conviction of a licensee for a violation, notification and record of conviction shall be sent to the appropriate municipality which may suspend the license for first and second violations and on the third violation, the Board but not a council or assembly may revoke the license and declare the bond forfeited.

HB 340 Alcohol and drug abuse treatment. ((H) HESS, then Jud & SB 242 (S) HESS, then Fin.)
Status date: 3/11/77

These bills are identical. They combine the Alcohol and Drug Abuse offices with a combined budget. Grantees in the field will remain seperate.

* Advisory boards will be combined from current nine member

boards into a single nine member board.

* The office of Alcoholism's current ambiguous "approval" authority over treatment facilities will be changed to a specific licensing authority.

* Involuntary committments to treatment facilities will be simplified by allowing the court to commit directly to a licensed facility rather than to the office of alcoholism.

SUMMARY OF BILLS INTRODUCED BY THE RULES COMMITTEE BY REQUEST OF THE SPECIAL COMMITTEE ON ALCOHOLISM AND ALCOHOL RELATED LEGISLATION:

SB 540 "An Act making a special appropriation to the office of Alcoholism in the Department of Health and Social Services for the prevention and treatment of alcohol abuse and alcoholism; and providing for an effective date." (S HESS then Fin 3/17/78)

This bill appropriates $8,200,000 to the office of alcoholism for planning, coordinating, regulating, monitoring, and evaluating the statewide alcoholism program and to provide training and technical assistance to local programs.

SB 541 "An Act relating to health education in public schools." (S HESS then Fin 3/17/78)

Section 1 requires the inclusion of alcohol and drug abuse education in the health education programs already required in the public schools.

Section 2 is a statement of legislative intent that the public school systems implement programs of alcohol and drug abuse education.

SB 542 "An Act adding to the powers and duties of the office of Alcoholism." (S HESS then Fin 3/17/78)

Section 1 empowers the office to award grants and directs that grants and contracts awarded by the office shall be, whenever possible, for at least two years.

Section 2 requires the office to establish standards for training paraprofessional alcoholism workers.

Section 3 requires the department to identify facilities and services available through community organization for the treatment of alcoholics, including identification and utilization for detoxification of under utilized hospital beds.

Section 4 requires the office to develop and implement a training program for government employees whose duties bring them into contact with alcoholics.

Section 5 establishes within the office a revolving loan fund for temperate social activities. It also provides for the administration of the fund.

SB 543 "An Act relating to alcoholism grants-in-aid." (S HESS then Fin 3/17/78)

Section 1 provides that grants-in-aid may be awarded by the Department of Health and Social Services only on the basis of community need and only after the consideration of proposed grants by the Advisory Board on Alcoholism.

Section 2 provides that the grants shall only be for that portion of a program which the department determines the community is incapable of bearing.

Section 3 requires (1) grantees to submit an approved plan for the expenditure of the grant monies, to provide for receipt of advice and comment from local advisory boards, and to establish goals in terms of percentage reduction of alcoholics; (2) the department to monitor the implementation of the plans of the grantees; (3) as a prerequisite to award of a grant, that municipal officials must actively enforce the law relating to manufacture and sale of alcohol beverages; and (4) the department to develop management training programs for grantees and uniform accounting systems to be utilized by the grantees.

Section 4 removes the issuance of licenses to facilities receiving grants-in-aid from the department's regulation making power under the grant program.

Section 5 amends the definition of "approved public treatment facility" to include those treatment agencies operating through a grant awarded under AS 47.30.475 (grants-in-aid).

SB 544 "An Act relating to standards for alcohol treatment facilities." (S HESS then Fin 3/17/78)

Section 1 is a statement of legislative intent that standards that are more responsive to existing needs and conditions be developed for alcohol treatment facilities in rural communities.

Section 2 requires that the office of alcoholism establish separate standards for communities with populations of 5,000 or more and communities with populations of less than 5,000.

SB 545 "An Act relating to health insurance." (S HESS then Fin 3/17/78)

This bill requires that all policies for health insurance issued or delivered in the state must define alcoholism as an illness and provide benefits for treatment in the same amounts as provided for any other illness.

SB 546 "An Act establishing a tax credit for contributions to alcoholism programs." (S HESS then Fin 3/17/78)

This bill provides for a tax credit of not more than $50 per year for contributions made to a state or municipally approved alcoholism program.

SB 547 "An Act making a special appropriation to the Department of Revenue to increase the number of enforcement personnel employed by the Alcohol Beverage Control Board; and providing for an effective date." (S HESS then Fin 3/17/78)

This bill appropriates $200,000 to the Alcoholic Beverage Control Board to pay for the employment of additional enforcement personnel.

SB 548 "An Act relating to waiter and waitress permits." (S L&M 3/17/78)

Section 1 requires an employee of a holder of a beverage dispensary license and who serves alcoholic beverages to hold a permit. The applicant is required to undergo eigth hours of instruction in state law and policy relating to alcohol before a permit can be issued.

Section 2 adds the holding of a valid permit issued under Section 1 to the qualifications for being a waiter or waitress in an establishment operating under a beverage dispensary license.

SB 549 "An Act relating to the serving of intoxicating liquor." (S HESS 3/17/78

This bill would prohibit the serving of more than one drink at one time to a patronof licensed premises.

SB 550 "An Act relating to administration and enforcement of alcoholic beverage control statutes and regulations." (S HESS then Jud 3/17/78)

Section 1 requires the Alcoholic Beverage Control Board to hold public hearings on al' new licenses, renewals, reissuances, and transfers upon the filing of a protest. It also designates agents and assistants employed by the board for enforcement purposes as "peace officers."

Section 2 provides procedures for the protest of the transfer, renewal, or issuance of a new license for establishments within a city or unified municipality.

Section 3 provides procedures for the protest of the transfer, renewal, issuance, or reissuance of a new license for establishments outside a city or unified municipality. It gives residents standing to protest such establishments if they live within five miles of its location. The board may, in its discretion, hold a hearing on the protest, unless at least 35 per cent of the residents of the area participate in the protest. In that case, a special election must be held on the issuance, reissuance, renewal, or transfer of the license.

(continued on next page)

SB 550 (Cont.) Section 4 permits 20 per cent of the residents outside a city, unified municipality, or established village, but within five miles of the licensed presmises within a city or unified municipality, to require the board to refuse issuance, reissuance, renewal, or transfer of a license unless the board finds no legal grounds for refusal, or that there will be no substantial harm to the health, safety or welfare of the residents.

Section 5 provides for automatic renewal of licenses unless a protest has been filed or the licensee convicted of an offense under AS 04.15.100.

Section 6 provides that upon conviction the Board shall suspend the license for first (from 10 to 45 consecutive days) and second (from 30 to 90 consecutive days) violations and shall revoke the license and declare the bond forfeit for the third violation.

SB 551 "An Act relating to the rehabilitation of persons who commit criminal offenses as a result of alcohol problems." (S Jud 3/17/78)

Section 1 provides that upon conviction of an offense that was the result of or caused by the offender's alcohol problem, he must be sentenced to an alcohol education or rehabilitation program in addition to any other punishment imposed by the court. It also allows the court to be provided with information obtained during prior alcohol treatment.

Section 2 provides an exception to the rule of confidentiality applying to information obtained during a aperson's participation in an alcohol treatment program. This is in order to provide the information to the sentencing court under Section 1.

SB 552 "An Act relating to alcohol." (S SA then Fin 3/17/78)

Section 1 is a legislative finding that the crime of driving while under the influence of intoxicating liquor or drugs arises as a result of misinformation about alcohol and drugs or their chronic abuse, and that participation in an information and rehabilitation program is effective in preventing occurrences of that offense.

Section 2 requires mandatory particpation in an alcohol education or rehabilitation program upon the conviction for the offense of driving while under the influence of intoxicating liquor or drugs.

Section 3 requires that information compiled during a person's participation in a program as required under Section 2 be provided to the sentencing court in any subsequent conviction.

Section 4 provides an exception to the confidentiality requirement applying to information gained during the participation of a person in an alcohol treatment program. This is required to implement Section 3.

Introduced: 1/25/77
Referred: State Affairs, Community & Regional Affairs and Finance

IN THE SENATE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

SENATE BILL NO. 76

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act providing a method of adjusting certain tax rates."

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

* Section 1. AS 43.40 is amended by adding a new section to read:

Sec. 43.40.015. ADJUSTMENT OF TAX RATES. (a) The commissioner of revenue shall adjust the tax rates provided for in sec. 10 of this chapter in accordance with changes in the Consumer Price Index for Anchorage, Alaska, published by the Bureau of Labor Statistics, United States Department of Labor. The Consumer Price Index for October 1976 is considered the initial Consumer Price Index.

(b) In making the adjustments under (a) of this section, the commissioner shall comply with the following procedure:

(1) after November 30 and before December 31 of each year the commissioner shall calculate the change in the October Consumer Price Index for the current year from the October Consumer Price Index for the previous year;

(2) the commissioner shall then

(A) compute the percentage increase or decrease for that period; and

(B) adjust the tax rates set out in sec. 10 of this chapter by the same percentage increase or decrease, rounded to the nearest half cent;

(3) no later than the 10th day of each regular session of the legislature, the commissioner shall submit the adjusted tax rates

to the legislature; if not disapproved by the legislature by a resolution concurred in by a majority of the members of each house within 45 days after submission, or by the end of the session, whichever occurs first, the new rates become law; and

(4) the commissioner shall promptly post the adjusted tax rates and notify the taxpayers of them.

(c) The adjusted tax rates become effective on July 1 of the year in which they become law.

(d) If adjusted tax rates submitted to the legislature under (b) of this section are disapproved by the legislature, the commissioner may, within 15 days after the disapproval, submit a revised set of adjusted tax rates. These rates become law if not disapproved within 30 days or by the end of the session, whichever occurs first, and become effective July 1. The commissioner shall promptly post these rates and notify the taxpayers of them.

* Sec. 2. AS 43.50 is amended by adding a new section to read:

Sec. 43.50.095. ADJUSTMENT OF TAX RATES. (a) The commissioner of revenue shall adjust the tax rates provided for in secs. 90 and 190 of this chapter in accordance with changes in the Consumer Price Index for Anchorage, Alaska, published by the Bureau of Labor Statistics, United States Department of Labor. The Consumer Price Index for October 1976 is considered the initial Consumer Price Index.

(b) In making the adjustments under (a) of this section, the commissioner shall comply with the following procedure:

(1) after November 30 and before December 31 of each year the commissioner shall calculate the change in the October Consumer Price Index for the current year from the October Consumer Price Index for the previous year;

(2) the commissioner shall then

(A) compute the percentage increase or decrease for that period; and

(B) adjust the tax rates set out in secs. 90 and 190 of this chapter by the same percentage increase or decrease, rounded to the nearest quarter mill;

(3) no later than the 10th day of each regular session of the legislature, the commissioner shall submit the adjusted tax rates to the legislature; if not disapproved by the legislature by a resolution concurred in by a majority of the members of each house within 45 days after submission, or by the end of the session, whichever occurs first, the new rates become law; and

(4) the commissioner shall promptly post the adjusted tax rates and notify the taxpayers of them.

(c) The adjusted tax rates become effective on July 1 of the year in which they become law.

(d) If adjusted tax rates submitted to the legislature under (b) of this section are disapproved by the legislature, the commissioner may, within 15 days after the disapproval, submit a revised set of adjusted tax rates. These rates become law if not disapproved within 30 days or by the end of the session, whichever occurs first, and become effective July 1. The commissioner shall promptly post these rates and notify the taxpayers of them.

* Sec. 3. AS 43.60 is amended by adding a new section to read:

Sec. 43.60.015. ADJUSTMENT OF TAX RATES. (a) The commissioner of revenue shall adjust the tax rates provided for in sec. 10 of this chapter in accordance with changes in the Consumer Price Index for Anchorage, Alaska, published by the Bureau of Labor Statistics, United States Department of Labor. The Consumer Price Index for the month of October 1976 is considered the initial Consumer Price Index.

(b) In making the adjustments under (a) of this section, the commissioner shall comply with the following procedure:

(1) after November 30 and before December 31 of each year the commissioner shall calculate the change in the October Consumer Price Index for the current year from the October Consumer Price Index for the previous year;

(2) the commissioner shall then

(A) compute the percentage increase or decrease for that period; and

(B) adjust the tax rates set out in sec. 10 of this chapter by the same percentage increase or decrease, rounded to the nearest one-tenth of a dollar;

(3) no later than the 10th day of each regular session of the legislature, the commissioner shall submit the adjusted tax rates to the legislature; if not disapproved by the legislature by a resolution concurred in by a majority of the members of each house within 45 days after submission, or by the end of the session, whichever occurs first, the new rates become law; and

(4) the commissioner shall promptly post the adjusted tax rates and notify the taxpayers of them.

(c) The adjusted tax rates become effective on July 1 of the year in which they become law.

(d) If adjusted tax rates submitted to the legislature under (b) of this section are disapproved by the legislature, the commissioner may, within 15 days after the disapproval, submit a revised set of adjusted tax rates. These rates become law if not disapproved within 30 days or by the end of the session, whichever occurs first, and become effective July 1. The commissioner shall promptly post these rates and notify the taxpayers of them.

Original sponsor: Rules Committee by request of the Governor

Offered: 5/9/77
Referred: Rules

IN THE SENATE BY THE FINANCE COMMITTEE

HOUSE CS FOR CS FOR SENATE BILL NO. 167

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the excise tax on and license fees for sale of intoxicating liquors; and providing for an effective date."

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

* Section 1. AS 43.60.010(a) is amended to read:

(a) Every brewer, distiller, bottler, jobber, retailer, wholesaler, or manufacturer who sells intoxicating liquors in the state or who consigns shipments of intoxicating liquors into the state, whether or not the liquors are brewed, distilled, bottled, or manufactured in the state, shall pay on all malt beverages (alcoholic content of one per cent or more by volume), wines, and hard or distilled liquors, the following taxes: (1) malt beverages at the rate of 25 cents a gallon or fraction of a gallon; (2) wine or other liquor of <u>less than 14</u> [21] per cent alcohol by volume [OR LESS,] at the rate of <u>$1</u> [60 CENTS] a gallon or fraction of a gallon; [AND] (3) other liquors having a content of more than 21 per cent alcohol by volume at the rate of <u>$5</u> [$4.00] a gallon<u>; and (4) wine or other liquor of at least 14 per cent alcohol by volume but not more than 21 per cent alcohol by volume at the rate of $1.35 a gallon or fraction of a gallon</u>.

* Sec. 2. AS 04.10.110 is amended to read:

Sec. 04.10.110. WHOLESALE LICENSE. (a) The holder of a general wholesale license may sell intoxicating liquors in the original package, and wine in bulk, in quantities of not less than five wine gallons to holders of licenses. The holder of a general wholesale license may

not sell to a consumer. Liquor requiring internal revenue strip stamps shall have the stamps intact on the package. A general wholesale license shall be required for each distributing point. The general wholesale license fee schedule is based upon the total amount of business transacted during any year and is $500 as a minimum license fee, to accompany the application, and in payment of the fee for the first $50,000 of business transacted, and, in addition thereto, on the business transacted during any year,

above $50,000 and not over $75,000	a fee of $250
above $75,000 and not over $100,000	a fee of $500
above $100,000 and not over $125,000	a fee of $750
above $125,000 and not over $150,000	a fee of $1000
above $150,000 and not over $175,000	a fee of $1250
above $175,000 and not over $200,000	a fee of $1500
above $200,000 and not over $250,000	a fee of $2000
above $250,000 and not over $300,000	a fee of $2500
above $300,000 and not over $350,000	a fee of $3000
above $350,000 and not over $400,000	a fee of $3500
above $400,000 and not	

over $500,000	a fee of $4500
above $500,000	<u>one per cent of the business transacted</u>
	[A FEE OF $5000]

(b) The holder of a wholesale malt beverage and wine license may sell malt beverages and wine in the original packages and malt beverages and wine in bulk in quantities of not less than five wine gallons to holders of licenses. The holder of a wholesale malt beverage and wine license may not sell to a consumer. The malt beverages and wine license fee schedule is based on the total amount of business transacted in any year and is $100 as a minimum license fee, to accompany the application, and in payment of the fee for the first $10,000 of business transacted, and, in addition, on the business transacted during any year,

above $10,000 and not over $25,000	a fee of $150
above $25,000 and not over $50,000	a fee of $500
above $50,000 and not over $75,000	a fee of $750
above $75,000 and not over $100,000	a fee of $1000
above $100,000 and not over $150,000	a fee of $1500
above $150,000 and not over $200,000	a fee of $2000
above $200,000 and not over $300,000	a fee of $3000
above $300,000 and not over $400,000	a fee of $4000

above $400,000 — <u>one per cent of the business transacted</u>

[A FEE OF $5000]

* Sec. 3. AS 04.10.040(a) is amended to read:

(a) The holder of a beverage dispensary license may sell for cash or serve on the premises beer, wine and hard liquors for consumption on the premises only. The beverage dispensary license fee is <u>$750</u> [$500] in all unincorporated communities and incorporated cities having a population not exceeding 1,500 persons and <u>$1,500</u> [$1,000] in all unincorporated communities and incorporated cities having a population in excess of 1,500 persons. The population shall be determined at the time of filing the application. Each applicant for a beverage dispensary license shall file with the application a cash bond or a surety bond executed by a surety company approved by the board. The condition of the bond or undertaking shall be that the applicant or applicants are the sole owners of the business to be licensed, and that no other person is financially interested directly or indirectly, and that the applicant or applicants will conduct the business in accordance with the applicable laws pertaining to intoxicating liquor in the state. The bond shall be in the penal sum of $2,500. Upon revocation of the license, the bond may be forfeited and the amount deposited into the general fund of the state.

* Sec. 4. AS 04.10.050 is amended to read:

Sec. 04.10.050. RESTAURANT LICENSE. The holder of a restaurant license may sell beer and wine in a restaurant with meals furnished in good faith to patrons. The restaurant license fee is <u>$500</u> [$300].

* Sec. 5. AS 04.10.060 is amended to read:

Sec. 04.10.060. ROADHOUSE LICENSE. The holder of a roadhouse license whose licensed premises are located not less than 18 miles

from the corporate limits of a city and who serves food to the traveling public, may sell beer and wine for consumption on the premises only. The roadhouse license fee is $250 [$150].

* Sec. 6. AS 04.10.100 is amended to read:

Sec. 04.10.100. RETAIL LICENSE. The holder of a retail license may sell for cash in his establishment intoxicating liquors in the original packages and wine in bulk. All liquor requiring internal revenue strip stamps shall have the stamps intact upon the packages. The consumption of intoxicating liquor on premises licensed under this provision is prohibited. Sales under a retail license are limited to less than 20 wine gallons to any one person in any one sale. The retail license fee is $1,000 [$600], but the retail license fee for a retail liquor store having gross sales from the sale of intoxicating liquors not exceeding $20,000 in any calendar year is $300.

* Sec. 7. This Act takes effect July 1, 1977.

Original sponsor: Rules Committee by request of the Governor

Offered: 5/5/77
Referred: Rules

IN THE SENATE BY THE FINANCE COMMITTEE

CS FOR SENATE BILL NO. 168

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services and to the Department of Education for alcohol-related programs; and providing for an effective date."

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

* Section 1. The sum of $804,500 is appropriated from the general fund to the Department of Health and Social Services for the fiscal year ending June 30, 1978, to be allocated as follows:

Medical alcohol detoxification services	$100,000
Operation of 30-day residential intensive treatment facility for alcohol affected persons	600,000
Training of personnel for service in alcohol treatment and counseling programs at various locations	104,500

* Sec. 2. The sum of $416,000 is appropriated from the general fund to the Department of Education for the fiscal year ending June 30, 1978, to be allocated as follows:

Alaska Public Broadcasting Commission public information and education regarding alcohol abuse	$350,000
School curriculum development and implementation relating to alcohol abuse	66,000

DO NOT PASS IN 77/78

Introduced: 3/11/77
Referred: Health, Education & Social Services and Finance

IN THE SENATE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

SENATE BILL NO. 242

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to treatment of alcoholism and drug abuse; and providing for an effective date."

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

* Section 1. AS 47.37 is amended to read:

CHAPTER 37. [UNIFORM] ALCOHOLISM AND DRUG ABUSE [INTOXICATION TREATMENT ACT].

ARTICLE 1. TREATMENT.

* Sec. 2. AS 47.37.010 is amended to read:

Sec. 47.37.010. DECLARATION OF POLICY. It is the policy of the state that alcoholics, [AND] intoxicated persons, drug addicts and drug abusers should not be criminally prosecuted for their consumption of alcoholic beverages or drugs but [AND THAT THEY] should be afforded a continuum of treatment so they may lead normal lives as productive members of society.

* Sec. 3. AS 47.37.020 is amended to read:

Sec. 47.37.020. OFFICE OF ALCOHOLISM AND DRUG ABUSE. An office of alcoholism and drug abuse is established in the department. The office shall be headed by a coordinator appointed by the commissioner. The coordinator shall be a qualified professional who has training and experience in the organization and administration of treatment services for persons with alcoholism-drug [MEDICAL-SOCIAL] problems. The coordinator is in the classified service.

* Sec. 4. AS 47.37.030 is amended to read:

Sec. 47.37.030. POWERS OF OFFICE. The office may

(1) plan, establish, and maintain prevention, training, treatment and rehabilitation programs as appropriate;

(2) make contracts necessary or incidental to the performance of its duties and the execution of its powers, including contracts with public and private agencies, organizations, and individuals, to pay them for services rendered or furnished to alcoholics, [OR] intoxicated persons, or other drug addicted or drug abusing persons;

(3) solicit and accept for use a gift of money or property or a grant of money, services, or property from the federal government, the state, or a political subdivision of it or a private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for a grant;

(4) review and comment on, and administer or supervise the administration of the provisions relating to alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, of any state plan submitted for federal funding under federal health, welfare, [OR] treatment, traffic safety, and criminal justice legislation;

(5) coordinate its activities and cooperate with alcoholism and drug abuse programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies for the treatment of alcoholics, [AND] intoxicated persons, drug addicts, or drug abusers and for the common advancement of alcoholism and drug abuse programs in this and other states;

(6) keep records and engage in research and the gathering of relevant statistics; have access to records used by other agencies of the state government except as prohibited by law;

(7) do other acts necessary to implement the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest in it, and construct, lease, or otherwise provide treatment facilities for alcoholics, [AND] intoxicated persons, drug addicts and drug abusers; however, the office shall encourage local initiative, involvement and financial participation under grants-in-aid whenever possible in preference to the construction or operation of facilities directly by the office.

* Sec. 5. AS 47.37.040 is amended to read:

Sec. 47.37.040. DUTIES OF OFFICE. The office shall

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and drug abuse and treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and drug abuse and treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers;

(3) cooperate with the division of corrections in establishing and conducting programs to provide treatment for alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers in or on parole from penal institutions;

(4) cooperate with the Department of Education, school boards, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and drug abuse and treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, and preparing curriculum materials for use at all levels of

school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol and other drugs;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers which includes the dissemination of information concerning the nature and effects of alcohol and other drugs;

(7) organize and implement a coordinated manpower training and education program [FOSTER TRAINING PROGRAMS] for all persons engaged in occupations which provide treatment or other related services to [OF] alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers;

(8) sponsor and encourage research into the causes and nature of alcoholism, alcohol abuse, drug addiction and drug abuse, [AND] treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, and serve as a source [CLEARINGHOUSE] for information relating to alcoholism and drug abuse;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the commissioner, the regional health systems agencies, the state health coordinating council, and the governor in the preparation of an annual [A] comprehensive plan for the prevention, treatment, and control of alcohol and drug abuse [TREATMENT OF ALCOHOLICS AND INTOXICATED PERSONS];

(11) review all state health, welfare, criminal justice, traffic safety and treatment plans to be submitted for federal funding, and advise the commissioner on provisions to be included relating to alcohol and drug abuse [ALCOHOLISM AND INTOXICATED PERSONS];

(12) encourage [ASSIST IN] the development and maintenance of 'troubled employees' [, AND COOPERATE WITH, ALCOHOL EDUCATION AND TREATMENT] programs in Alaska [FOR EMPLOYEES OF STATE AND LOCAL GOVERNMENTS AND BUSINESSES AND INDUSTRIES IN THE STATE];

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcohol or drug abusers [ALCOHOLICS], to encourage alcohol or drug abusing persons [ALCOHOLICS] to voluntarily undergo treatment;

(14) cooperate with the Department of Public Safety and the Department of Highways in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated or under the influence of drugs;

(15) monitor the admissions of [ENCOURAGE] hospitals and other appropriate health facilities in compliance with federal law which requires that the office ensure that they [TO] admit without discrimination alcoholics and intoxicated persons and [TO] provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism and certain other forms of drug abuse and addiction as [A] covered illnesses [ILLNESS];

(17) submit to the legislature an annual report covering the activities of the office.

* Sec. 6. AS 47.37.050 is amended to read:

Sec. 47.37.050. INTERDEPARTMENTAL COORDINATING COMMITTEE. (a) An interdepartmental coordinating committee is created, composed of

the coordinator, [AND] the commissioners of health and social services, revenue, education, [HIGHWAYS, LABOR AND] public safety, community and regional affairs, the directors of traffic safety and the Criminal Justice Planning Agency and representatives from the Department of Law, the Division of Planning and Policy Development, the Division of Budget and Management, and the Alaska Court System. The committee shall meet at least quarterly [TWICE ANNUALLY] at the call of the commissioner of health and social services who is its chairman. The committee shall supervise the development and implementation of an annual interdepartmental state plan for the prevention, treatment and control of alcohol and drug abuse [PROVIDE FOR THE COORDINATION AND EXCHANGE OF INFORMATION ON ALL PROGRAMS RELATING TO ALCOHOLISM], and act as a permanent liaison among state departments engaged in activities affecting alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers. The annual interdepartmental plan for the prevention, treatment, and control of alcohol and drug abuse shall reflect consideration of related plans and plan requirements of other agencies with similar goals. [THE COMMITTEE SHALL ASSIST THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES AND THE COORDINATOR IN FORMULATING A COMPREHENSIVE PLAN FOR PREVENTION OF ALCOHOLISM AND FOR TREATMENT OF ALCOHOLICS AND INTOXICATED PERSONS.]

(b) In exercising its coordinating functions, the committee shall assure that the appropriate state agencies

(1) provide all necessary medical, social, treatment, and educational services for alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers and for the prevention and control of both alcohol and drug abuse [OF ALCOHOLISM], without unnecessary duplication of services;

(2) cooperate in the planning and implementation of integrated

systems of enforcement, adjudication, treatment, and rehabilitation appropriate to the humane and professional provision of services to [USE OF FACILITIES AND IN THE TREATMENT OF] alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers;

(3) adopt approaches for the prevention, [OF ALCOHOLISM AND THE] treatment, and control of alcohol [ALCOHOLICS] and drug abuse [INTOXICATED PERSONS] consistent with the policy of this chapter.

* Sec. 7. AS 47.37.060 is amended to read:

Sec. 47.37.060. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There is established in the Department of Health and Social Services an advisory board on alcoholism and drug abuse. This advisory board shall function as a committee of the state health coordinating council, and three representatives of it shall serve as an advisory subcommittee of the interdepartmental coordinating committee.

* Sec. 8. AS 47.37.070 is amended to read:

Sec. 47.37.070. COMPOSITION. The advisory board on alcoholism and drug abuse consists of nine members appointed by the governor.

* Sec. 9. AS 47.37.080 is amended to read:

Sec. 47.37.080. QUALIFICATIONS OF BOARD MEMBERS. Of the nine members

(1) two shall be persons who are licensed to practice medicine in the state [, ONE OF WHOM SHALL BE CERTIFIED IN PSYCHIATRY BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY OR ELIGIBLE FOR THAT CERTIFICATION, EXCEPT THAT IF A PSYCHIATRIST IS NOT AVAILABLE A CLINICAL PSYCHOLOGIST MAY BE APPOINTED];

(2) one shall be a practicing attorney who has been admitted to the practice of law by the state supreme court;

(3) four [TWO] shall be persons who have evidenced an interest in the problems of alcoholism or drug abuse and who have

knowledge of the social problems encountered in the rehabilitation of alcoholics or drug abusers;

(4) two [ONE] shall be persons chosen from the following professions:

(A) education;

(B) nursing;

(C) pharmacy;

(D) social work [A PUBLIC HEALTH NURSE];

(5) three shall also represent the board of directors of each of the three regional health systems agencies created under P.L. 93-641 [ONE SHALL BE A REPRESENTATIVE OF THE LIQUOR INDUSTRY];

[(6) ONE SHALL BE FROM THE PUBLIC AT LARGE;]

[(7) ONE SHALL BE A SOCIAL WORKER].

* Sec. 10. AS 47.37.090 is amended to read:

Sec. 47.37.090. TERM OF OFFICE. (a) The members of the board initially appointed under sec. 80(1)[(a)] of this chapter serve terms of three [FOUR] years.

(b) The member initially appointed under sec. 80(2)[(b)] of this chapter serves a term of three years.

(c) Two members [THE MEMBER] initially appointed under sec. 80(3)[(c)] of this chapter serve terms [SERVES A TERM] of one year and the other two serve terms of two years [TWO YEARS].

(d) The members initially appointed under sec. 80(4)[(d) - (h)] of this chapter serve terms of two [FOUR] years. Subsequent terms for all board members are three [FOUR] years.

(e) A vacancy occurring in the membership of the board shall be filled by an appointment by [OF] the governor for the unexpired portion of the vacated term.

(f) Board members serve at the pleasure of the governor.

* Sec. 11. AS 47.37.100 is amended to read:

Sec. 47.37.100. COMPENSATION, PER DIEM, OR EXPENSES. Members of the advisory board on alcoholism and drug abuse are not entitled to a salary, but are entitled to per diem, reimbursement for travel and other expenses authorized by law for other boards.

* Sec. 12. AS 47.37.110 is amended to read:

Sec. 47.37.110. DUTIES. The board shall act in an advisory capacity to the commissioner and the interdepartmental coordinating committee in the following matters:

(1) special problems affecting mental health which alcoholism and drug abuse may present;

(2) educational and research activities conducted by the office in respect to the problems presented by alcoholism and drug abuse;

(3) social problems which affect rehabilitation of alcoholics and drug abusers;

(4) legal processes which affect the treatment and rehabilitation of alcoholics and drug abusers;

(5) a program of public relations concerning the problem of alcoholism and drug abuse conducted by a department of the state government or by any organized group [AN ORGANIZED GROUP WHOSE PURPOSE IS THE REHABILITATION OF ALCOHOLICS].

* Sec. 13. AS 47.37.120 is amended to read:

Sec. 47.37.120. ALCOHOLISM AND DRUG ABUSE PROGRAM COORDINATOR. The alcoholism and drug abuse program coordinator shall carry out the development and implementation of a comprehensive program dealing with the prevention, treatment, and control of, research on and education concerning alcohol and drug [ALCOHOLIC] problems as they affect the state.

* Sec. 14. AS 47.37.130 is amended to read:

Sec. 47.37.130. COMPREHENSIVE PROGRAM FOR TREATMENT; REGIONAL PROGRAMS [FACILITIES]. (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers. The [SUBJECT TO THE APPROVAL OF THE COMMISSIONER, THE] coordinator shall [MAY] divide the state into [APPROPRIATE] regions that conform to the health service areas established by the secretary of the Department of Health, Education and Welfare under P.L. 93-641 to plan and implement [TO CONDUCT] the program and establish standards for the development of the program on the regional level. In establishing the programs [REGIONS], consideration shall be given to the city, [AND] borough, and Native corporation boundaries [LINES] and population concentrations and, when feasible, programs shall be established with maximum local community and Native corporation involvement.

(b) The program of the office shall include

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and follow-up treatment.

(c) The office shall provide adequate and appropriate treatment for alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers admitted under secs. 160 - 190 of this chapter within the limits of available state and federal funds.

(d) The office shall maintain, supervise and control all facilities operated by it subject to the regulations of the department. The administrator of each facility operated by the department shall make an annual report of its activities to the coordinator in the form and

manner the coordinator specifies.

(e) The [IF POSSIBLE, THE] office shall coordinate the activities of the program with all appropriate public and private resources.

(f) The office shall issue an annual license to a public or private treatment facility which meets the appropriate standards established under sec. 140(a) of this chapter. No treatment facility may be operated in the state without a license, and no facility may receive state funds under a contract or a grant-in-aid unless it is licensed as a public treatment facility. [THE COORDINATOR SHALL PREPARE, PUBLISH, AND DISTRIBUTE ANNUALLY A LIST OF ALL APPROVED PUBLIC AND PRIVATE TREATMENT FACILITIES.]

(g) The office may contract for the use of any facility as an approved public treatment facility if the coordinator, subject to the regulations of the department, considers this an effective and economical course to follow.

* Sec. 15. AS 47.37.140 is amended to read:

Sec. 47.37.140. PUBLIC AND PRIVATE TREATMENT FACILITIES. (a) The office shall establish standards in regulations adopted by the department for facilities before their licensure [APPROVAL] as public or private treatment facilities, and fix the fees to be charged for the required inspections of those facilities. The standards for private facilities may [SHALL] concern only the health conditions to be met and standards of treatment to be afforded patients, but standards for public facilities may include additional criteria to assure responsible processing of state contract and grant-in-aid funds.

(b) The office shall inspect, on a regular basis, licensed [APPROVED] public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The office shall prepare, maintain, publish and distribute annually a list of licensed [APPROVED] public and private treatment facilities.

(d) Each licensed [APPROVED] public or [AND] private treatment facility shall file with the office on request, data, statistics, schedules, and information which the office reasonably requires under (a) of this section. If a licensed [AN APPROVED] public or private treatment facility, [THAT] without good cause, fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns of them, its license shall be suspended or revoked [REMOVED FROM THE LIST OF APPROVED TREATMENT FACILITIES].

(e) The coordinator, after holding a hearing under the provisions of the Administrative Procedure Act (AS 44.62), may suspend, revoke, limit, restrict, or refuse to grant a license [AN APPROVAL] for a treatment facility, for failure to meet the [ITS] standards established by the department.

(f) Upon petition of the office and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the office authorizing him to enter and inspect at reasonable times, and examine the books and accounts of any licensed [AN APPROVED] public or private alcoholism, drug addiction, or drug abuse treatment facility refusing to consent to inspection or examination by the office or which the office has reasonable cause to believe is operating in violation of this chapter.

* Sec. 16. AS 47.37.150 is amended to read:

Sec. 47.37.150. ACCEPTANCE FOR TREATMENT. The department [COORDINATOR] shall adopt [PROMULGATE] regulations for the admission of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective

treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers. In establishing the regulations, the department [COORDINATOR] shall be guided by the following standards:

(1) if possible a patient shall be treated on a voluntary rather than an involuntary basis;

(2) a patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment;

(3) a person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment;

(4) an individualized treatment plan shall be prepared and maintained on a current basis for each patient;

(5) provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will utilize other appropriate treatment and facilities.

* Sec. 17. AS 47.37.160 is amended to read:

Sec. 47.37.160. VOLUNTARY TREATMENT OF ALCOHOLICS AND DRUG ADDICTS. (a) An alcoholic, drug addict, or drug abuser may voluntarily apply for treatment directly to a licensed [AN APPROVED] public or private treatment facility.

(b) Subject to regulations adopted [PROMULGATED] by the department [COORDINATOR], the administrator in charge of a licensed [AN APPROVED] public or private treatment facility may determine who shall be admitted for treatment. If a person is refused admission to a licensed [AN APPROVED] public or private treatment facility, the administrator shall [, IF POSSIBLE,] refer the person to another licensed [APPROVED] public or private treatment facility.

(c) When a patient receiving inpatient care leaves a licensed

[AN APPROVED] public or private treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic or drug addict who requires help, the facility administrator [OFFICE] shall arrange for assistance in obtaining supportive services and residential facilities.

(d) Except for diagnosis and referral, alcoholism treatment programs shall be separate and distinct from treatment programs for drug addicts. There may be integrated inpatient programs for the treatment of alcoholics and cross-addicted persons, and there may be integrated prevention programs for all forms of substance abuse. No person addicted to an opium derivative may be treated except at a licensed drug addiction treatment center. All federal and state laws and regulations relating to requirements for methadone maintenance for persons addicted to an opium derivative shall be strictly adhered to by all drug addiction treatment facilities operated or funded by the office.

* Sec. 18. AS 47.37.170(a) is amended to read:

(a) An intoxicated person may come voluntarily to a licensed [AN APPROVED] public or private alcoholism 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 his home, a licensed [AN APPROVED] public treatment facility, a licensed [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.

* Sec. 19. AS 47.37.170(b) is amended to read:

(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 a licensed [AN APPROVED] public treatment facility, a licensed [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.

* Sec. 20. AS 47.37.170(c) is amended to read:

(c) A person who voluntarily appears or is brought to a licensed [AN APPROVED] public or private treatment facility shall be examined by a licensed physician within 24 hours [AS SOON AS POSSIBLE]. After the examination, he may be admitted as a patient or referred to another health facility. The licensed [APPROVED] public or private treatment facility which refers him shall arrange for his transportation.

* Sec. 21. AS 47.37.170(d) is amended to read:

(d) No person who, after medical examination, is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may be detained at a facility after he is no longer incapacitated by alcohol. No person may be detained at a facility if he remains incapacitated by alcohol for more than 72 [48] hours after admission as a patient, unless he is committed under secs. [SEC.] 180 or 190 of this chapter.

A person may consent to remain in the facility as long as the physician or administrator in charge considers it appropriate.

* Sec. 22. AS 47.37.170(e) is amended to read:

(e) A person who is not admitted to a licensed [AN APPROVED] public or private treatment facility, is not referred to another health facility, and has no funds, may be taken to his home, if any. If he has no home, the licensed [APPROVED] public or private treatment facility shall assist him in obtaining shelter.

* Sec. 23. AS 47.37.170(f) is amended to read:

(f) If a patient is admitted to a licensed [AN APPROVED] public or private treatment facility, his 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, his request shall be granted.

* Sec. 24. AS 47.37.170(g) is amended to read:

(g) Peace officers or members of the emergency service patrol who comply with this section are acting in the course of their official duty and are not criminally or civilly liable for that compliance [IT].

* Sec. 25. AS 47.37.170(h) is amended to read:

(h) If the physician or administrator in charge of a licensed [THE APPROVED] public or private treatment facility determines it is for the patient's benefit, he shall initiate either an emergency commitment procedure under sec. 180 of this chapter or an involuntary commitment proceeding under sec. 190 of this chapter, whichever is appropriate in his professional judgment [AN ATTEMPT SHALL BE MADE TO ENCOURAGE THE PATIENT TO SUBMIT TO FURTHER DIAGNOSIS AND APPROPRIATE VOLUNTARY TREATMENT].

* Sec. 26. AS 47.37.180 is amended to read:

Sec. 47.37.180. EMERGENCY DETENTION AND COMMITMENT. (a) An intoxicated person who [(1)] has threatened, attempted to inflict, or inflicted physical harm on another may be charged under an appropriate criminal statute, taken into custody, and transported to a state or municipal detention facility. A person who [OR IS LIKELY TO INFLICT PHYSICAL HARM ON ANOTHER UNLESS COMMITTED, OR (2)] is incapacitated by alcohol, may be committed to a licensed [AN APPROVED] public or private alcoholism treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the licensed [APPROVED] public or private alcoholism treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate supporting the need for emergency treatment and stating that the physician has examined the person sought to be committed within two days before the certificate's date.

(c) Upon approval of the application by the administrator in charge of the facility, the person may be brought to the facility by a peace officer, a health officer, a member of the emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under (e) of this section. [HOWEVER, NO PERSON MAY BE DETAINED UNDER THIS SECTION FOR MORE THAN 48 HOURS UNLESS A DISTRICT OR SUPERIOR COURT JUDGE HAS REVIEWED AND APPROVED THE COMMITMENT APPLICA-

TION.]

(d) The administrator in charge of a licensed [AN APPROVED] public or private treatment facility may refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of his medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in a treatment facility for more than five days. If a petition for involuntary commitment under sec. 190 of this chapter has been filed within the five days and the administrator in charge of a licensed [AN APPROVED] public or private treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's [PERSONS'] right to legal counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult with legal counsel.

* Sec. 27. AS 47.37.190(a) is amended to read:

(a) After a hearing initiated by petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of a licensed [AN APPROVED] public or private treatment facility, a person may be committed to the custody of an appropriate licensed private or public alcoholism treatment agency [THE OFFICE] by the superior court. The petition shall allege that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages, or [AND THAT HE (1) HAS THREATENED, ATTEMPTED TO INFLICT, OR INFLICTED

PHYSICAL HARM ON ANOTHER AND] that unless committed is likely to inflict physical harm on <u>himself or</u> another,[;] or [(2)] is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to need for treatment. The petition shall 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 shall be alleged in the petition. The certificate shall set out the physician's findings in support of the allegations of the petition.

* Sec. 28. AS 47.37.190(b) is amended to read:

(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 <u>licensed</u> [APPROVED] public <u>or private</u> treatment facility in which the committed person has been committed for emergency care, and any other person the court considers appropriate. A copy of the petition and certificate shall be delivered to each person notified.

* Sec. 29. AS 47.37.200(a) is amended to read:

(a) At the hearing required under sec. 190(b) of this chapter, the court or the jury, if requested under sec. 190(c) of this chapter, 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 his presence is likely to be injurious to him, in which case the court shall appoint a guardian

ad litem to represent him throughout the proceeding. The court may examine the person in open court, or if advisable, examine him out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to request examination by a court-appointed licensed physician. If he 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 him to a licensed public or private treatment facility in which he is being held under sec. 170 of this chapter [THE OFFICE] for a period of not more than five days for purposes of a diagnostic examination.

* Sec. 30. AS 47.37.200(b) is amended to read:

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the licensed public or private treatment facility [OFFICE], 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 licensed facility [OFFICE]. No court may order the commitment of a person except to a licensed public or private treatment facility which [UNLESS IT DETERMINES THAT THE OFFICE] is able to provide adequate and appropriate treatment for him.

* Sec. 31. AS 47.37.200(c) is amended to read:

(c) A person committed under secs. 190 - 200 of this chapter shall remain in the custody of the licensed facility [OFFICE] for treatment for a period of up to 30 days. At the end of the 30-day period, he shall be discharged automatically unless the facility administrator or physician [OFFICE], before the expiration of the period, obtains a court order for his recommitment upon the grounds set out in sec. 190(a) of this chapter for a further period of up to

90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on <u>himself or</u> another, the <u>facility administrator or physician</u> [OFFICE] shall apply for recommitment if after examination it is determined that the likelihood still exists.

* Sec. 32. AS 47.37.200(d) is amended to read:

(d) A person recommitted under (c) of this section who has not been discharged by the <u>facility</u> [OFFICE] before the end of the 90-day period shall be discharged at the expiration of that period unless the <u>facility administrator or physician</u> [OFFICE], before expiration of the period, obtains a court order on the grounds set out in sec. 190(a) of this chapter for recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on <u>himself or</u> another, the <u>facility administrator or physician</u> [OFFICE] shall apply for recommitment if after examination it is determined that the likelihood still exists. No more than two recommitment orders may be permitted under (c) and (d) of this section.

* Sec. 33. AS 47.37.200(f) is amended to read:

(f) The <u>licensed public or private treatment facility</u> [OFFICE] shall provide adequate and appropriate treatment for a person in its custody. The <u>licensed facility</u> [OFFICE] may transfer a person in its custody [FROM ONE APPROVED PUBLIC TREATMENT FACILITY] to another <u>licensed facility</u> if the transfer is medically advisable.

* Sec. 34. AS 47.37.200(g) is repealed and re-enacted to read:

(g) A person committed to the custody of a licensed public or private treatment facility for treatment shall, if he is an alcoholic committed on the grounds that he is likely to inflict physical harm on himself or another, be discharged at any time before the end of the period for which he has been committed if either of the following

conditions is met:

(1) he no longer demonstrates the likelihood that he will inflict physical harm on himself or another; or

(2) treatment is no longer adequate or appropriate.

* Sec. 35. AS 47.37.210 is amended to read:

Sec. 47.37.210. RECORDS OF ALCOHOLICS, [AND] INTOXICATED PERSONS, DRUG ADDICTS, AND DRUG ABUSERS. (a) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(b) Notwithstanding (a) of this section, the coordinator may make available information from patient's records for purposes of research into the causes and treatment of alcoholism, drug addiction or drug abuse. No information may disclose a patient's name.

* Sec. 36. AS 47.37.220 is amended to read:

Sec. 47.37.220. VISITATION AND COMMUNICATION OF PATIENTS. (a) Patients in any licensed [APPROVED] treatment facility under this chapter shall be granted reasonable opportunities for adequate consultation with counsel, and for continuing contact with family and friends including the use of telephone facilities, consistent with an effective treatment program.

(b) No mail or other communication to or from a patient in a licensed [ANY APPROVED] treatment facility may be intercepted, read, or censored.

* Sec. 37. AS 47.37.240(a) is amended to read:

(a) A patient in a licensed [AN APPROVED] treatment facility, or the person obligated to provide for the cost of treatment of a person committed under this chapter, is liable to the office or the licensed treatment facility which provided the treatment, whichever is appropriate, for the cost of maintenance and treatment of the patient in

accordance with rates established by the coordinator.

* Sec. 38. AS 47.37.270(2) is amended to read:

(2) "licensed [APPROVED] private treatment facility" means a private agency which does not receive grants-in-aid from the office, but meets the limited [MEETING THE] standards prescribed in sec. 140(a) of this chapter for private facilities and licensed under sec. 130(f) of this chapter [AND APPROVED UNDER SEC. 140(c) OF THIS CHAPTER];

* Sec. 39. AS 47.37.270(3) is amended to read:

(3) "licensed [APPROVED] public treatment facility" means a treatment agency operating under the supervision [DIRECTION AND CONTROL] of the office and [OR] providing treatment under this chapter through a grant from or contract with the office, [UNDER SEC. 130(g) OF THIS CHAPTER AND] meeting all of the standards prescribed in sec. 140(a) of this chapter, and licensed [APPROVED] under sec. 130(f) . [140(c)] of this chapter;

* Sec. 40. AS 47.37.270(5) is amended to read:

(5) "coordinator" means the coordinator of the office of alcoholism and drug abuse;

* Sec. 41. AS 47.37.270(11) is amended to read:

(11) "office" means the office of alcoholism and drug abuse within the Department of Health and Social Services;

* Sec. 42. AS 47.37.270(12) is amended to read:

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling; [.]

* Sec. 43. AS 47.37.270 is amended by adding new paragraphs to read:

(13) "drug addict" means a person addicted to opium derivatives;

(14) "drug abuser" means a person who is addicted to or misuses barbiturates, amphetamines, tranquillizers, and similar drugs which are not opium derivatives, to the detriment of his health and social well-being;

(15) "cross-addicted person" means a person who is alcoholic and simultaneously addicted to barbiturates, amphetamines, tranquillizers, and similar drugs which are not opium derivatives;

(16) "troubled employees" means workers whose performance has been affected by the use of alcohol or other drugs.

* Sec. 44. AS 47.37 is amended by adding new sections to read:

ARTICLE 2. GRANTS-IN-AID.

Sec. 47.37.300. POWERS AND DUTIES OF DEPARTMENT. The department shall:

(1) administer a community grant-in-aid program for alcoholism and drug abuse;

(2) submit an annual report concerning the grant-in-aid program within 10 days after the convening of the legislature in each regular session.

Sec. 47.37.310. GRANT-IN-AID PROGRAM. (a) A profit-making corporation, a non-profit corporation, a city or borough government, or other political subdivision of the state, or combination of these, is eligible for grant-in-aid funds under this section. Applications shall be sent to the department.

(b) The department shall award grants under this section with the advice of the advisory board on alcoholism and drug abuse, in the interest of providing or developing a comprehensive program of prevention, treatment, and rehabilitation for alcoholics, intoxicated persons,

drug addicts, and drug abusers. Separate budgets shall be appropriated for alcoholism and drug addiction treatment and rehabilitation programs. Grants will be awarded on a competitive basis. In considering applications for grants the department shall, if all other factors are equal, give preference to applicants in political subdivisions which devote local government revenues generated by the sale of intoxicating liquor to the treatment of alcoholism. The department shall consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program.

(c) Grants shall be awarded in a ratio of 75 per cent state money to 25 per cent community money except that in communities designated as poverty areas the ratio is 90 per cent state money to 10 per cent community money, for the purposes of providing staff and limited improvement or renovation of facilities for detoxification or intermediate care. The office may require up to a 50 per cent community match for the purchase or new construction of facilities. No grant for improving, renovating, purchasing or constructing may exceed $50,000 except when there is a lack of applicants for available money and then only with the approval of the advisory board on alcoholism and drug abuse. The department is not required to award all money available under this program, or the full percentages specified in this subsection, when another source of money is available, or could reasonably be made available to the applicant.

(d) Money used by the applicant to qualify for state money may be from any other source than the state. The cost of developing an application is not reimbursable from the grant. All community match contributions to grants shall be in the form of cash.

(e) No program is eligible for funding under this section

unless it conforms to the standards adopted by the office under the provisions of sec. 140(a) of this chapter, or in the case of a new program, the office determines that the program will be able to conform to those standards within a period of time to be specified in the initial grant agreement.

(f) In order for programs to be eligible for funding under this section they must be able to demonstrate successful collection of patient fees for services at a rate and proportion to be established by the office.

Sec. 47.37.320. GRANT-IN-AID PROGRAM REGULATIONS. The department shall adopt regulations necessary to implement sec. 310 of this chapter. The regulations shall provide for the method of application, the time for consideration of the applications, the processing of applications, the type of record keeping, the requirements for reporting the progress and statistics regarding the program, the notification of the applicant as to the action taken on the application, and the issuance of licenses for facilities receiving grants-in-aid under sec. 310 of this chapter. The department shall also establish the necessary forms of application and may adopt other regulations considered necessary to meet the requirements of health and safety and the orderly administration of the grant-in-aid program.

Sec. 47.37.330. JUDICIAL NOTICE. The superior courts of this state may take judicial notice of the fact that an alcoholic or drug addict is suffering from an illness and is in need of proper medical, advisory, or rehabilitative treatment.

Sec. 47.37.340. DEFINITIONS. In secs. 300 - 350 of this chapter, "poverty area" means an area in which 15 per cent or more of the population, based on the 1970 census data, is under 125 per cent of the Community Services Administration poverty guidelines.

* Sec. 45. AS 44.29.100 - 44.29.150 and AS 47.30.470 - 47.30.500 are repealed.

* Sec. 46. This Act takes effect July 1, 1977.

VETOED BY THE GOVERNOR

Introduced: 4/22/77
Referred: Health Education and Social Services and Finance

IN THE SENATE BY FERGUSON

SENATE BILL NO. 333

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Alaska Public Broadcasting Commission for alcohol and drug abuse programs; and providing for an effective date."

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

* Section 1. The sum of $1,500,000 is appropriated from the general fund to the Alaska Public Broadcasting Commission for alcohol and drug abuse programs, to be allocated as follows:

(1)	Petersburg	$ 30,000
(2)	Kotzebue	100,000
(3)	Barrow	100,000
(4)	Dillingham	100,000
(5)	Bethel	100,000
(6)	Anchorage FM	15,000
(7)	KTOO, Juneau	15,000
(8)	Wrangell	30,000
(9)	KAKM	60,000
(10)	Kodiak	30,000
(11)	Selawick mini TV	15,000
(12)	15 mini TV's	200,000
(13)	Galena Radio Station	300,000
(14)	Unalakleet Radio Station	300,000
(15)	"Alaskan Review"	40,000
(16)	Alaska Public Broadcasting Commission.	65,000

* Sec. 2. This Act takes effect July 1, 1977.

PASSED 7/7/78 (FY 78 SUPPL.)

Introduced: 2/9/78
Referred: Health, Education & Social Services and Finance

IN THE SENATE BY CROFT

SENATE BILL NO. 479

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services for the National Council on Alcoholism, Alaska Region; and providing for an effective date."

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

* Section 1. The sum of $50,000 is appropriated from the general fund to the Department of Health and Social Services to be paid as a lump sum grant to the National Council on Alcoholism-Alaska Region, Inc. for the purpose of alcoholism prevention and education.

* Sec. 2. The unexpended and unobligated portion of this appropriation lapses into the general fund June 30, 1979.

* Sec. 3. This Act takes effect immediately in accordance with AS 01.10.-070(c).

Introduced: 3/17/78
Referred: Health, Education & Social Services and Finance

IN THE SENATE

BY THE RULES COMMITTEE
BY REQUEST

SENATE BILL NO. 540

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the office of alcoholism in the Department of Health and Social Services for the prevention and treatment of alcohol abuse and alcoholism; and providing for an effective date."

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

* Section 1. The sum of $8,200,000 is appropriated from the general fund to the office of alcoholism in the Department of Health and Social Services for the planning, coordination, regulation, monitoring, and evaluation of statewide alcoholism efforts and for providing training and technical assistance to local programs engaged in the prevention, treatment, and control of alcohol abuse and alcoholism in the state.

* Sec. 2. This Act takes effect July 1, 1978.

LATEST VERSION PASSED

Introduced: 3/17/78
Referred: Health, Education & Social Services and Finance

IN THE SENATE

BY THE RULES COMMITTEE
BY REQUEST

SENATE BILL NO. 541 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to alcohol and drug abuse education in public schools."

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

* Section 1. AS 14.30.360(a) is amended to read:

(a) Each district in the state public school system shall be encouraged to initiate and conduct a program in health education for kindergarten through grade 12. The program should include instruction in physical health <u>including alcohol and drug abuse education</u>, dental health, family health, environmental health, and appropriate use of health services.

* Sec. 2. It is the intent of the legislature that public school systems implement a program of alcohol and drug abuse education in coordination with other health education programs.

Original sponsor: Rules Committee by request

PASSED 7/7/78

Offered: 5/31/78

IN THE SENATE BY THE RULES COMMITTEE

CS FOR SENATE BILL NO. 542 am H

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act adding to the powers and duties of the office of alcoholism."

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

* Section 1. AS 47.37.030(2) is amended to read:

(2) make contracts and award grants necessary or incidental to the performance of its duties and the execution of its powers, including contracts with and grants to public and private agencies, organizations, and individuals, to pay them for services rendered or furnished to alcoholics or intoxicated persons; to the maximum extent possible, contracts and grants shall be for a period of two years;

* Sec. 2. AS 47.37.040(7) is amended to read:

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons and establish standards for training paraprofessional alcoholism workers;

* Sec. 3. AS 47.30.470(4) is amended to read:

(4) identify, and utilize whatever facilities and services are available or can be made available through community organization for carrying out the purposes of this section, including identification and utilization for detoxification of under utilized hospital beds;

* Sec. 4. AS 47.37.040 is amended by adding new paragraphs to read:

(18) develop and implement a training program on alcoholism for employees of state and municipal governments, and private institutions;

(19) develop curriculum materials on drug and alcohol abuse

for use in grades kindergarten through 12, as well as a course of instruction for teachers to be charged with presenting the curriculum.

Original sponsor: Rules Committee by request

PASSED 77/78

Offered: 4/25/78
Referred: Finance

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 543 am H

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to alcoholism grants-in-aid."

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

* Section 1. AS 47.30.475(b) is amended to read:

(b) Money available under this section shall be awarded by the department to applicants on the basis of community need, but only if the award is consistent with the annual implementation plan developed under sec. 1513(b)(2) of P.L. 93-641 by the health systems agency for the health system area in which the applicant is located and the state health plan developed by the Statewide Health Coordinating Council under sec. 1524(c)(2)(A) of P.L. 93-641, and only after consideration of comment and advice of the Advisory Board on Alcoholism [THE DEPARTMENT SHALL AWARD GRANTS UNDER THIS SECTION WITH THE ADVICE OF THE ADVISORY BOARD ON ALCOHOLISM, IN THE INTEREST OF PROVIDING OR DEVELOPING A COMPREHENSIVE PROGRAM OF ALCOHOLIC REHABILITATION AND PREVENTION. GRANTS WILL BE AWARDED ON A COMPETITIVE BASIS]. In awarding grants, the [THE] department shall further consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program of alcoholic rehabilitation and prevention.

* Sec. 2. AS 47.30.475 is amended by adding new subsections to read:

(c) No grant may be awarded under this section unless the application includes a plan which provides for

(1) the expenditure of grant money for education and other preventative measures, or the treatment of alcoholics;

(2) the reception of advice and comment from a local advisory board, or, if a local advisory board cannot be formed because the area is sparsely populated, from the governing bodies of private nonprofit health organizations, regarding the design, implementation, and evaluation of the plan and action to be taken;

(3) goals, expressed in quantifiable terms that express the intended impact of the assistance provided under the plan upon the number of individuals needing or utilizing such assistance;

(4) coordination with the goals and objectives of the health systems plan developed by the health systems agencies under sec. 1513-(b)(2) of P.L. 93-641.

(f) The department shall monitor the implementation of the plan required under (e) of this section, and shall terminate payment of grant money if the plan is not implemented or approval of the program as a public or private treatment program under AS 47.37.140 is not granted within one year of the award of the grant, or is suspended, revoked, limited or restricted. Modification of the plan required by (e) of this section must be approved by the department before implementation of the modification.

(g) The department shall provide management training for persons administering a program receiving grant money under this section.

(h) If the department determines, after the award of a grant under (e) of this section, that the community is capable of bearing a greater portion of the cost of a program than originally determined, the department may

(1) reduce the award by that portion of the cost of a program which the department subsequently determined the community could bear; or

(2) terminate payment of the grant entirely.

* Sec. 3. AS 47.30.477 is amended to read:

Sec. 47.30.477. GRANT-IN-AID PROGRAM REGULATIONS. The department shall adopt regulations implementing sec. 475 of this chapter. The regulations shall provide for the method of application, the time for consideration of applications, the processing of applications, the type of record keeping, the requirements for reporting the progress and statistics regarding the program, and the notification of the applicant as to the action taken on the application [, AND THE ISSUANCE OF LICENSES FOR FACILITIES RECEIVING GRANTS-IN-AID UNDER SEC. 475 OF THIS CHAPTER]. The department shall also establish the necessary forms of application and may adopt other regulations considered necessary to meet the requirements of health and safety and the orderly administration of the grant-in-aid program. Such regulations shall include reporting requirements which will permit an evaluation of the success of the program.

* Sec. 4. AS 47.37.270(3) is amended to read:

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under sec. 130(g) of this chapter or through a grant awarded under AS 47.30.475, and meeting the standards prescribed in sec. 140(a) of this chapter and approved under sec. 140(c) of this chapter;

Original sponsor: Rules Committee by request

PASSED 7/7/78

Offered: 4/19/78
Referred: Finance

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 544 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to standards for alcohol treatment facilities."

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

* Section 1. Recognizing the standards for rural alcohol treatment facilities currently employed by the Department of Health and Social Services are not entirely appropriate, it is the intent of the legislature that standards more responsive to rural needs and conditions be adopted.

* Sec. 2. AS 47.37.140(a) is repealed and re-enacted to read:

(a) The office shall establish standards for facilities; these standards may vary in their requirements and stringency according to the population, price level, remoteness, access to transportation, and availability of ancillary services of the area to be served; and shall fix the fees to be charged for the required inspections of those facilities. Every facility shall meet the applicable standards before it is approved as a public or private treatment facility. The standards shall be enacted in a manner that will provide protection of the health, safety and well-being of clients of the affected programs and protection for the affected programs from exposure to malpractice and liability actions.

Introduced: 3/17/78
Referred: Health, Education & Social Services and Finance

IN THE SENATE

BY THE RULES COMMITTEE
BY REQUEST

SENATE BILL NO. 545

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health insurance."

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

* Section 1. AS 21.89 is amended by adding a new section to read:

Sec. 21.89.050. ALCOHOLISM UNDER HEALTH INSURANCE. All policies, contracts or prepaid plans for individual or group health insurance issued or delivered in the state on or after the effective date of this Act shall provide that alcoholism is an illness and that benefits for treatment of alcoholism may not be less than for any other illness, except that this coverage may be waived in writing by the policyholder of an individual health insurance policy on or before the effective date of the policy.

Introduced: 3/17/78
Referred: Health, Education & Social Services and Finance

IN THE SENATE

BY THE RULES COMMITTEE BY REQUEST

SENATE BILL NO. 546

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing a tax credit for contributions to alcoholism programs; and providing for an effective date."

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

* Section 1. AS 43.20.031 is amended by adding a new subsection to read:

(i) An individual is entitled to a tax credit not to exceed $50 for the amount of contributions made during the tax year to a state or municipally approved alcoholism program.

* Sec. 2. This Act takes effect January 1, 1979 and applies to tax years beginning on or after January 1, 1978.

REDUCED TO $50,000 BY THE GOVERNOR

Introduced: 3/17/78
Referred: Health, Education & Social Services and Finance

IN THE SENATE BY THE RULES COMMITTEE BY REQUEST

SENATE BILL NO. 547 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Revenue to increase the number of enforcement personnel employed by the Alcoholic Beverage Control Board; and providing for an effective date."

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

* Section 1. The sum of $200,000 is appropriated from the general fund to the Department of Revenue, Alcoholic Beverage Control Board, to pay expenses of employment of additional field enforcement personnel.

* Sec. 2. The unexpended and unobligated portion of this appropriation lapses into the general fund June 30, 1979.

* Sec. 3. This Act takes effect immediately in accordance with AS 01.10.-070(c).

Original sponsor: Rules Committee by request

Offered: 5/15/78
Referred: Rules

IN THE SENATE

BY THE LABOR AND MANAGEMENT COMMITTEE

CS FOR SENATE BILL NO. 548 am(failed S)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to waiter and waitress permits."

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

* Section 1. AS 04.15 is amended by adding new sections to read:

Sec. 04.15.115. PERMIT REQUIRED. No person may serve, sell or barter, offer for sale or barter, possess for sale or barter, traffic in, exchange for goods, take orders for, give, furnish or deliver, nor permit the giving, selling, bartering or drinking of intoxicating liquor on licensed premises excluding premises licensed as a bottling works, brewery, wholesaler, distillery or winery unless authorized by a permit issued under sec. 120 of this chapter.

Sec. 04.15.120. ISSUANCE OF PERMITS. A permit shall be granted to a person after successful completion of instruction on state law, regulations, and policy regarding alcohol, developed by and conducted by the board, and compliance with such other requirements as the board may prescribe by regulation. The board shall provide for temporary permits.

* Sec. 2. AS 04.05.040(10) is amended to read:

(10) providing for the issuance, renewal, reissuance, revocation and suspension of licenses and permits <u>including permits required under sec. 115 of this chapter</u>;

* Sec. 3. AS 04.10.040(b) is amended to read:

(b) A <u>person who holds a permit issued under AS 04.15.120 and is</u> [CITIZEN OF THE UNITED STATES,] over the age of 19 years and of good moral character, may be regularly employed as a waiter or waitress in an establishment operating under a beverage dispensary license. The duties

of waiters and waitresses employed in such an establishment [THEREIN] shall be confined to taking orders and serving beverages, alcoholic or otherwise, and food. Waiters and waitresses employed under this section may not solicit or encourage the purchase of beverages, alcoholic or otherwise, by the patron of the premises, whether the beverage is for the patron or for another. No waiter or waitress may accept any beverage, alcoholic or otherwise, purchased for him or her by a patron of the establishment.

* Sec. 4. AS 04.15.100(b) is amended to read:

(b) Upon conviction of a licensee or a holder of a permit for a violation under (a) of this section, or for violation of a municipal ordinance adopted by a municipality in conformity with sec. 70 of this chapter, the judge having jurisdiction shall send a notification of conviction together with a certified copy of the record of conviction to the board. The board may, upon the direction of a majority of its members, thereupon suspend the license or permit as hereinafter provided for the first and second violations and upon a third violation may revoke the license or permit and declare any [THE] bond required under this chapter forfeited. For the purpose of this section, the terms "second violation" and "third violation" include only those violations which occur within five years of the first violation, but are not limited to repeated violations of the same statutory provision or municipal ordinance.

(1) First violation. The license of the premises involved may be suspended for not less than 10 nor more than 45 days;

(2) Second violation. The license of the premises involved may be suspended for a period of not less than 30 days nor more than 90 days.

Introduced: 3/17/78
Referred: Health, Education & Social Services

IN THE SENATE

BY THE RULES COMMITTEE
BY REQUEST

SENATE BILL NO. 549

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the serving of intoxicating liquor."

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

* Section 1. AS 04.15 is amended by adding a new section to read:

Sec. 04.15.105. PROHIBITED SERVICE. (a) No person, firm, company, or corporation holding a license permitting the sale of intoxicating liquor for consumption on licensed premises, or an employee of the firm, company, or corporation, may serve patrons more than one drink simultaneously nor serve intoxicating liquor to a patron already in the possession of intoxicating liquor served on the premises, regardless of whether payment for the intoxicating liquor is made by the patron or by another.

(b) For the purposes of this section, "drink" means a single serving containing an intoxicating liquor for consumption on licensed premises, served in a single container.

Introduced: 3/17/78
Referred: Commerce and Finance

IN THE SENATE BY THE RULES COMMITTEE BY REQUEST

SENATE BILL NO. 550

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to administration and enforcement of alcoholic beverage control statutes and regulations."

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

* Section 1. AS 04.05.030(c) and (d) are amended to read:

(c) The board shall [MAY] hold public hearings on applications for new licenses and on applications for license renewals, reissuances or transfers when any applications are protested in the manner provided in AS 04.10.270 - 04.10.300, and require an applicant to answer any pertinent questions.

(d) The board may appoint agents, assistants, clerks and stenographic employees as it considers necessary in giving effect to this title. Agents and assistants employed by the board to enforce the provisions of this title are "peace officers" within the meaning of the term as defined in AS 01.10.060.

* Sec. 2. AS 04.10.270 is repealed and re-enacted to read:

Sec. 04.10.270. PROTEST IN CITIES AND UNIFIED MUNICIPALITIES. (a) An application for a transfer, renewal, or new license coming from within a city or a unified municipality shall be transmitted directly to the board and need not bear a recommendation of the governing body of the municipality. Upon receipt of an application under this section, the director shall immediately transmit written notice of receipt of the transfer, renewal, or new license application to the governing body of the city or unified municipality.

(b) The governing body of the city or unified municipality shall

have 30 days from receipt of the director's written notice to protest approval of the transfer, renewal or issuance of a new license. Not less than 10 nor more than 20 days before expiration of the period allowed for protest, the governing body shall provide opportunity at a regular or special meeting for the receipt of public comments with respect to a license application.

(c) The license application shall be protested by the governing body of the municipality

(1) for licensed premises within a city, if not less than 10 per cent of the residents of the city petition the council to object to the license application; or

(2) for licensed premises within a unified municipality, if not less than 10 per cent of the residents of a service area of the unified municipality within which the premises for which application is submitted is located or, if the unified municipality has no service areas, if not less than 10 per cent of the residents of the unified municipality petition the assembly to object to the license application.

(d) The license application may be protested by the governing body of the municipality for any other valid reason.

(e) Upon receipt of a protest under (c) or (d) of this section, the board may not take final action on the application until it has provided for a hearing on the protest in accordance with the requirements of the Administrative Procedure Act (AS 44.62).

* Sec. 3. AS 04.10.300(a) and (b) are amended to read:

Sec. 04.10.300. PROTEST IN AREAS OUTSIDE <u>CITIES AND UNIFIED</u> MUNICIPALITIES. (a) An adult resident in an area outside a <u>city or unified</u> municipality who desires to protest the issuance, reissuance, renewal or transfer of a license for an establishment that is outside <u>the city or the unified</u> [A] municipality and within <u>five</u> [TWO] miles of

his permanent place of abode or within the established village in which his permanent place of abode is located shall serve upon the applicant and the director [BOARD] a written statement of the reasons for his protest. Upon the receipt of the protest, the director, after consulting with members of the board, may give notice and schedule [HOLD] a board hearing in the area in which the protestant resides, at which all persons interested may be heard.

(b) If the protest is made in writing to the board by at least 35 per cent of the adult residents having a permanent place of abode within the established village where the licensed premises is situated or is to be situated and within five [TWO] miles of the established village, a special election conducted by the Department of Community and Regional Affairs held within the protest area [VILLAGE] is mandatory. If at the election the majority of the adult residents having a permanent place of abode within the established village and within five [TWO] miles of the established village object to issuance, reissuance, renewal or transfer, the board may not issue, reissue, renew or transfer any licenses in, or within five [TWO] miles of, the established village.

* Sec. 4. AS 04.15.300(c) is repealed and re-enacted to read:

(c) If the licensed premises is situated or is to be situated outside a city or unified municipality or established village and at the hearing more than 20 per cent of the adult residents having a permanent place of abode within five miles of the premises but outside the city or unified municipality or established village object to issuance, reissuance, renewal or transfer, the board shall refuse to issue, reissue, renew or transfer the license unless, in the opinion of the board, no grounds for refusal exist by law and no substantial harm will occur to the health, safety or general welfare of the residents. A decision of the board under this subsection shall be accompanied by a statement of

the findings of the board and the reasons supporting the decision of the majority of the board.

* Sec. 5. AS 04.10.350(a) is repealed and re-enacted to read:

(a) A license issued under this chapter is renewable automatically if the fee is paid in accordance with secs. 40 - 149 of this chapter. However, a license may not be automatically renewed if

(1) protest to renewal has been made in accordance with secs. 270 - 300 of this chapter; or

(2) the licensee has been convicted under AS 04.15.100.

* Sec. 6. AS 04.15.100(b) is amended to read:

(b) Upon conviction of a licensee for a violation under (a) of this section, or for violation of a municipal ordinance adopted by a municipality in conformity with sec. 70 of this chapter, the judge having jurisdiction shall send a notification of conviction together with a certified copy of the record of conviction to the board. The board shall [MAY, UPON THE DIRECTION OF A MAJORITY OF ITS MEMBERS, THEREUPON] suspend the license as [HEREINAFTER] provided in this subsection for the first and second violations and upon a third violation shall [MAY] revoke the license and declare the bond forfeited. For the purpose of this section, the terms "second violation" and "third violation" include only those violations which occur within five years of the first violation, but are not limited to repeated violations of the same statutory provision or municipal ordinance.

(1) First violation. The license of the premises involved shall [MAY] be suspended for not less than 10 consecutive days nor more than 45 consecutive days;

(2) Second violation. The license of the premises involved shall [MAY] be suspended for a period of not less than 30 consecutive days nor more than 90 consecutive days.

DIED IN COMMITTEE

Introduced: 3/17/78
Referred: Health, Education & Social Services and Judiciary

IN THE SENATE BY THE RULES COMMITTEE BY REQUEST

SENATE BILL NO. 551

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the rehabilitation of persons who commit criminal offenses as a result of alcohol problems; and providing for an effective date."

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

* Section 1. AS 12.55 is amended by adding a new section to read:

Sec. 12.55.072. ALCOHOL-RELATED OFFENSES. (a) When a court finds that the commission of an offense was the result of or caused by alcohol problems suffered by the person committing the offense, upon conviction for that offense and in addition to any other punishment adjudged by the court, the person convicted shall be sentenced to undertake for a term specified by the court that program of alcohol education or rehabilitation which the court, after consideration of any information compiled under (b) of this section, finds appropriate.

(b) Except as prohibited by federal law or regulation, every provider of treatment programs to which persons are ordered under (a) of this section shall supply the Alaska court system with the information regarding the condition and treatment of those persons as the supreme court may require by rule. Information compiled under this subsection is confidential and may only be used by a court in sentencing a person convicted under (a) of this section, or by an officer of the court in preparing a presentence report for the use of the court in sentencing a person convicted under (a) of this section.

(c) The imposition or execution of a sentence to a term of alcohol education or rehabilitation required to be imposed under this section

may not be suspended and probation or parole may not be granted until the term of rehabilitation or education has been completed. AS 12.55.-080 and 12.55.085 are inapplicable to the extent that they are inconsistent with this subsection.

* Sec. 2. AS 47.37.210(a) is amended to read:

(a) Except as required by AS 12.55.072(b), the [THE] registration and other records of treatment facilities shall remain confidential and are priviledged to the patient.

* Sec. 3. This Act is inapplicable to criminal proceedings initiated before January 1, 1979.

* Sec. 4. This Act takes effect January 1, 1979.

Sec 992 and SB 545

Introduced: 3/17/78
Referred: Judiciary

IN THE SENATE

BY THE RULES COMMITTEE
BY REQUEST

SENATE BILL NO. 552

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to alcohol."

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

* Section 1. The legislature finds that violations of AS 28.35.030 arise from misinformation about drugs or alcohol or the chronic abuse of drugs and alcohol, and further finds that participation in alcohol and drug information and rehabilitation programs is effacious in preventing a recurrence of violations of AS 28.35.030.

* Sec. 2. AS 28.35.030 is amended to read:

Sec. 28.35.030. DRIVING WHILE UNDER THE INFLUENCE OF INTOXICATING LIQUOR OR DRUGS. (a) A person who, while under the influence of intoxicating liquor, depressant, hallucinogenic or stimulant drugs or narcotic drugs as defined in AS 17.10.230(13) and AS 17.12.150(3) operates or drives an automobile, motorcycle or other motor vehicle in the state, upon conviction, is punishable by a fine of not more than $1,000, or by imprisonment for not more than one year, or by both. Upon a second conviction within five years after a first conviction under this section, the court shall impose a minimum sentence of imprisonment of not less than three days. Upon a subsequent conviction within five years after a second conviction under this section, the court shall impose a mimimum sentence of imprisonment of not less than 10 days. The execution of sentence may not be suspended nor may probation or parole be granted until the minimum imprisonment provided in this section has been served, nor may imposition of sentence be suspended, except upon the condition that the defendant be imprisoned for no less than the

minimum period provided in this section, nor may the punishment provided for in this section be reduced under AS 11.05.150. In addition, his operator's license shall be revoked in accordance with AS 28.15.210(c). In addition, a person convicted under this statute shall undertake, for a term specified by the court, that program of alcohol education or rehabilitation which the court, after consideration of any information compiled under (b) of this section, finds appropriate.

* Sec. 3. AS 28.35.030 is amended by adding a new subsection to read:

(b) Except as prohibited by federal law or regulation, every provider of treatment programs to which persons are ordered under (a) of this section shall supply the Alaska court system with the information regarding the condition and treatment of those persons as the supreme court may require by rule. Information compiled under this subsection is confidential and may only be used by a court in sentencing a person convicted under (a) of this section, or by an officer of the court in preparing a presentence report for the use of the court in sentencing a person convicted under (a) of this section.

* Sec. 4. AS 47.37.210(a) is amended to read:

(a) Except as required by AS 28.35.030(b), the [THE] registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

Original sponsor: Rules Committee by request of the Governor

Offered: 4/19/77
Referred: Finance

IN THE HOUSE BY THE COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 196

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the license fees for wholesale sale of intoxicating liquors; and providing for an effective date."

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

* Section 1. AS 04.10.110 is amended to read:

Sec. 04.10.110. WHOLESALE LICENSE. (a) The holder of a general wholesale license may sell intoxicating liquors in the original package, and wine in bulk, in quantities of not less than five wine gallons to holders of licenses. The holder of a general wholesale license may not sell to a consumer. Liquor requiring internal revenue strip stamps shall have the stamps intact on the package. A general wholesale license shall be required for each distributing point. The general wholesale license fee schedule is based upon the total amount of business transacted during any year and is $500 as a minimum license fee, to accompany the application, and in payment of the fee for the first $50,000 of business transacted, and, in addition thereto, on the business transacted during any year,

above $50,000 and not over $75,000	a fee of $250
above $75,000 and not over $100,000	a fee of $500
above $100,000 and not over $125,000	a fee of $750
above $125,000 and not	

over $150,000	a fee of $1000
above $150,000 and not over $175,000	a fee of $1250
above $175,000 and not over $200,000	a fee of $1500
above $200,000 and not over $250,000	a fee of $2000
above $250,000 and not over $300,000	a fee of $2500
above $300,000 and not over $350,000	a fee of $3000
above $350,000 and not over $400,000	a fee of $3500
above $400,000 and not over $500,000	a fee of $4500
above $500,000	1 per cent of the business transacted [A FEE OF $5000]

(b) The holder of a wholesale malt beverage and wine license may sell malt beverages and wine in the original packages and malt beverages and wine in bulk in quantities of not less than five wine gallons to holders of licenses. The holder of a wholesale malt beverage and wine license may not sell to a consumer. The malt beverages and wine license fee schedule is based on the total amount of business transacted in any year and is $100 as a minimum license fee, to accompany the application, and in payment of the fee for the first $10,000 of business transacted, and, in addition, on the business transacted during any year,

above $10,000 and not over $25,000	a fee of $150

above $25,000 and not over $50,000	a fee of $500
above $50,000 and not over $75,000	a fee of $750
above $75,000 and not over $100,000	a fee of $1000
above $100,000 and not over $150,000	a fee of $1500
above $150,000 and not over $200,000	a fee of $2000
above $200,000 and not over $300,000	a fee of $3000
above $300,000 and not over $400,000	a fee of $4000
above $400,000	1 per cent of the business transacted [A FEE OF $5000]

* Sec. 2. This Act takes effect July 1, 1977.

Introduced: 2/18/77
Referred: Community & Regional Affairs and Finance

IN THE HOUSE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

HOUSE BILL NO. 232

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to municipal sales taxes."

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

* Section 1. AS 04.15.070(a) is amended to read:

(a) A municipality may by ordinance provide [RULES AND] regulations governing the barter, sale and possession of intoxicating liquor within the municipality necessary to the orderly conduct of the business of selling intoxicating liquor. When, under a local option election, the city clerk finds the majority of the voters are against the sale of intoxicating liquor, the municipality, by ordinance, may make the sale of intoxicating liquor within the municipality a misdemeanor whether the sale is made pursuant to license or otherwise. The ordinance may not be inconsistent with this title or the rules and regulations promulgated under this title. No municipality may impose taxes other than property taxes on liquor inventories and sales taxes on liquor sales [WHEN THESE TAXES ARE LEVIED ON OTHER PROPERTY AND SALES WITHIN THE MUNICIPALITY].

* Sec. 2. AS 29.53.415(a) is amended to read:

(a) A borough may levy and collect a sales tax not exceeding three per cent on sales or rents, and on services made within the borough, except that a higher rate may be imposed on the sales of intoxicating liquor. The sales tax may apply to any or all of these sources. Exemptions may be granted by ordinance. Nothing in this subsection prohibits the levy of a sales tax on a single class of commodity, or the levy of a higher rate of tax on one class of com-

modity than on another.

Introduced: 2/21/77
Referred: Judiciary and Finance

IN THE HOUSE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

HOUSE BILL NO. 240

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to alcoholic beverages; and providing for an effective date."

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

* Section 1. AS 04.05.010(b) is amended to read:

(b) The governor shall appoint a director [, SUBJECT TO CONFIRMATION BY THE LEGISLATURE,] who is the executive officer of the board. The director shall enforce this title and the [RULES AND] regulations adopted [PROMULGATED] by the board. The director is not a member of the board but may cast a tie-breaking vote. He shall issue all licenses provided for under this title.

* Sec. 2. AS 04.10.020(m) is amended to read:

(m) unlimited community liquor license; [.]

* Sec. 3. AS 04.10.020 is amended by adding new subsections to read:

(p) limited community liquor license;

(q) in-flight catering license.

* Sec. 4. AS 04.10.100 is amended to read:

Sec. 04.10.100. RETAIL LICENSE. The holder of a retail license may sell for cash in his establishment intoxicating liquor in the original packages and wine in bulk. He may not sell intoxicating liquor which has been ordered by mail or telephone from (1) an incorporated city, organized borough, unified municipality or election precinct which has prohibited the sale of intoxicating liquor if the governing body by resolution or the precinct voters by election have expressed opposition to mail and telephone orders and notified the

board; (2) an incorporated city, organized borough, or unified municipality which has been issued a limited community liquor license; or (3) an incorporated city, organized borough, or unified municipality which has no licensed premises and has not authorized the sale of intoxicating liquor if its governing body has expressed by resolution its opposition to mail and telephone orders and notified the board. The board shall regularly furnish retail license holders with a current list of these municipalities and precincts. All liquor requiring internal revenue strip stamps shall have the stamps intact upon the packages. The consumption of intoxicating liquor on premises licensed under this provision is prohibited. Sales under a retail license are limited to less than 20 wine gallons to any one person in any one sale. The retail license fee is $600, but the retail license fee for a retail liquor store having gross sales from the sale of intoxicating liquors not exceeding $20,000 in any calendar year is $300.

* Sec. 5. AS 04.10 is amended by adding a new section to read:

Sec. 04.10.135. IN-FLIGHT CATERING LICENSE. The holder of an in-flight catering license may sell intoxicating liquors in the original package and wine in bulk with prepared meals catered to certificated domestic and international air carriers. The holder of an in-flight catering license may not sell to a consumer and must purchase intoxicating liquor, wine, and beer from a wholesaler licensed under sec. 110 of this chapter. The in-flight catering license fee is $600.

* Sec. 6. AS 04.10.139 is amended to read:

Sec. 04.10.139. COMMUNITY LIQUOR LICENSES. (a) The holder of an unlimited [A] community liquor license must be an incorporated city, unified municipality, or organized borough in which the majority of voters has authorized unlimited community sale of intoxicating liquor by a local-option election under secs. 430 or 433 of this

chapter [A FIRST OR SECOND CLASS CITY]. [A CITY WHICH HAS WITHIN ITS MUNICIPAL BOUNDARIES A LIQUOR LICENSE COMING UNDER SEC. 20(a) OR (g) OF THIS CHAPTER AND ISSUED TO A PRIVATE PERSON WITHIN THE CITY BEFORE JUNE 1, 1970 IS NOT ELIGIBLE FOR A COMMUNITY LIQUOR LICENSE, EXCEPT THAT A CITY HAVING HELD A LIQUOR LICENSE THROUGH A LOCAL CORPORATION OR OTHERWISE BEFORE JUNE 1, 1970 IS ELIGIBLE FOR THE LICENSE.] Unlimited community [COMMUNITY] liquor licenses issued under this subsection [SECTION] are restricted to the types of licenses authorized under sec. 20(a) and (g) of this chapter. [THIS SECTION DOES NOT CHANGE THE PROVISIONS OF SEC. 430 OF THIS CHAPTER PROVIDING FOR LOCAL OPTION ELECTIONS.]

* Sec. 7. AS 04.10.139 is amended by adding new subsections to read:

(b) The holder of a limited community liquor license must be an incorporated city, unified municipality, or organized borough in which the majority of voters has authorized limited community sale of intoxicating liquor by a local-option election under secs. 430 or 433 of this chapter. It may conduct only retail sales of intoxicating liquor as provided by sec. 100 of this chapter for a license under sec. 20(g), except that sales shall be limited to no more than 2.4 wine gallons to any one person in any one day, and sales may be made only by advance orders placed at least two weeks before delivery.

(c) Upon the issuance of a limited or unlimited community liquor license the board may not issue or renew a privately held liquor license as long as the community liquor license is in effect. All existing privately held liquor licenses will remain in effect for three months after the local-option election or until the current period of licensure expires, whichever is later. No fees may be imposed for this extension of existing licenses beyond their normal expiration date.

(d) A community liquor license remains in effect for the period specified in sec. 320 of this chapter. Subject to local-option election results, a community liquor license may be renewed.

(e) A community liquor license issued before the effective date of this Act is considered an unlimited community liquor license. If a majority of the voters at an election in an incorporated city, unified municipality, or organized borough holding an unlimited community liquor license approves application for a limited community liquor license, or reject both classes of community liquor license, it may not be reissued by the board after it has expired. A new community liquor license may be issued following voter approval at a new election under secs. 430 or 433 of this chapter.

* Sec. 8. AS 04.10.200 is repealed and re-enacted to read:

Sec. 04.10.200. PUBLIC NOTICE. (a) Notice shall be given by the applicant for a new license or for the renewal, reissuance, or transfer of an existing license by posting at the premises for a period of at least 10 days a true copy of the application. If the application is for a location in the unorganized borough, the applicant shall, in addition to posting at the premises, post notice at the nearest post office.

(b) When it determines that the public interest requires, the board shall require the applicant to cause announcements to be made to inform the public of the proposed issuance, renewal, or transfer of licenses in newspapers and on radio or television stations beginning not later than 10 days after the application is filed. Announcements must be bilingual when necessary, and the board may direct or require that the announcement be published or delivered in a language other than English that serves to inform the public.

* Sec. 9. AS 04.10.270 is amended to read:

Sec. 04.10.270. [HEARING ON] PROTEST OF LOCAL GOVERNING BODY. An application for a transfer, renewal or new license [COMING FROM] within a municipality shall be transmitted directly to the board and need not bear a recommendation of the governing body of the municipality. Upon receipt of [DECIDING TO APPROVE] an application, the board shall transmit a copy of the application to the city council [WRITTEN NOTICE OF ITS INTENT TO APPROVE THE TRANSFER, RENEWAL OR NEW LICENSE REQUESTED TO THE CITY GOVERNING BODY], if the application is for premises within an incorporated city, or to the borough assembly, if the application is for premises within the area of an organized borough outside the boundaries of an incorporated city. If the [LOCAL] governing body wishes to protest the application [APPROVAL], it shall furnish the board with a notice of protest within 30 days after [OF] receipt of the copy of the application provided by the board [NOTICE OF INTENT TO APPROVE THE APPLICATION]. Upon receipt of the [A] protest by the local governing body, the board may not take final action on the application until it has provided for a hearing on the protest in accordance with the administrative adjudication provisions [REQUIREMENTS] of the Administrative Procedure Act (AS 44.62).

* Sec. 10. AS 04.10.300 is repealed and re-enacted to read:

Sec. 04.10.300. PROTEST IN AREAS OUTSIDE MUNICIPALITIES. An adult resident of the unorganized borough outside incorporated cities who resides within a 10-mile radius of an establishment may protest the issuance of a new license or the renewal or transfer of an existing license within that area. Within 30 days after a copy of an application is first posted, an adult resident may protest by delivering or mailing to the applicant and the board a written statement of the reasons for his protest. In considering the application, the board shall consider

every protest duly received. The board may give notice and hold a hearing within the area at which all persons residing there may be heard. The board may, if in its opinion the public interest would be served by the refusal, refuse to issue, renew, or transfer the license.

* Sec. 11. AS 04.10.330(b) is amended to read:

(b) Application for the transfer of ownership of an existing license shall be accompanied by a statement, under oath, executed by the transferor in which he lists all debts and the amounts which he owes to a creditor of the business and the taxes due. The board shall promptly inform each creditor of the application and of the amount owed that creditor. <u>The board shall determine those debts and taxes which must be paid or for which satisfactory security must be given before an application for transfer may be approved.</u> The board <u>may</u> [SHALL] not approve the application for transfer unless all of the debts and taxes <u>which it determines must be paid</u> are <u>in fact</u> paid, or the transferor gives security for the payment of them satisfactory to the creditor or taxing authority prior to approval of the application.

* Sec. 12. AS 04.10.350(c)(4)(A) is amended to read:

(A) upon application filed during the <u>30-day</u> [SIX-MONTH] period beginning with February 28;

* Sec. 13. AS 04.10.430 is repealed and re-enacted to read:

Sec. 04.10.430. ELECTION IN INCORPORATED CITIES OR UNIFIED MUNICIPALITIES. (a) Whenever 35 per cent of the total number of voters at the last general municipal election held in an incorporated city or unified municipality petition the governing body to do so, the governing body shall conduct an election on the following questions:

(1) Do you favor allowing the sale of intoxicating liquor within this municipality? YES [ ] NO [ ]

(2) If the results of this election show a majority

in favor of the sale of intoxicating liquor would you favor having private licenses or only a community license? PRIVATE [ ] COMMUNITY [ ]

(3) If the results of this election show a majority in favor of a community license, would you favor an unlimited community license or limited community license? LIMITED [ ] UNLIMITED [ ]

(4) If the results of this election show a majority against the sale of intoxicating liquor, would you also favor prohibiting purchases of intoxicating liquor by mail or telephone order from other areas by residents of this municipality? YES [ ] NO [ ]

(b) The election shall be conducted in accordance with standard election procedures in the city or unified municipality not later than 60 days after receipt of a proper petition. The regular election officials for the city or unified municipality shall canvass the ballots and certify the election results to the board. The board shall proceed as follows:

(1) if a majority of the votes cast on question 1 is against the sale of intoxicating liquor in the city or unified municipality, the board shall reject all applications for a new license or to transfer or renew a license for an establishment within the city or unified municipality or within five miles of it;

(2) if a majority of the votes cast on question 1 favors the sale of intoxicating liquor in the city or unified municipality, the board may issue, renew, or transfer licenses within the city or unified municipality or within five miles of it solely on the basis of the election results on questions (2) and (3).

(c) If, at an election under (a) of this section, a majority is

against the sale of intoxicating liquor but is not against mail or telephone orders, question 4 alone may be presented to the voters at a subsequent date, upon following the procedures set out in (a) of this section.

(d) If, following an election resulting in a prohibition against or a limitation upon the sale of intoxicating liquor in the municipality, a majority of the voters at a subsequent election conducted for the purpose and in accordance with (a) of this section favor a change from the then existing status of the sale of intoxicating liquor, the board may issue licenses solely on the basis of the election results on questions 2 and 3, and, if no restrictions are adopted, may, upon application, issue the number and type of license to the same or other premises within the municipality as were in existence at the time of the last election at which a majority of the voters favored prohibiting or restricting the sale of intoxicating liquor. Those applicants who were licensees and whose licenses were not reissued by reason of the last election conducted under the provisions of this section have a preference over other applicants.

(e) No new license for the sale of intoxicating liquor may be issued under this title for an establishment in an incorporated city or unified municipality in which, on the effective date of this Act, there are no licensed premises, unless an election under this section is first conducted.

* Sec. 14. AS 04.10 is amended by adding new sections to read:

Sec. 04.10.433. ELECTION IN ORGANIZED BOROUGHS. (a) Whenever 35 per cent of the total number of voters at the last general municipal election held in an organized borough outside incorporated cities within that borough petition the governing body to do so, the governing body shall conduct an election on the following questions:

(1) Do you favor allowing the sale of intoxicating liquor within this borough outside incorporated cities? YES [ ] NO [ ]

(2) If the results of this election show a majority in favor of the sale of intoxicating liquor, would you favor having private licenses or only a community license? PRIVATE [ ] COMMUNITY [ ]

(3) If the results of this election show a majority in favor of a community license, would you favor an unlimited community license or a limited community license? LIMITED [ ] UNLIMITED [ ]

(4) If the results of this election show a majority against the sale of intoxicating liquor, would you also favor prohibiting purchases of intoxicating liquor by mail or telephone order from other areas by residents of this borough outside incorporated cities? YES [ ] NO [ ]

(b) The election shall be conducted in accordance with standard election procedures in the borough not later than 60 days after receipt of a proper petition. The regular election officials for the borough shall canvass the ballots and certify the election results to the board. The board shall proceed as follows:

(1) if a majority of the votes cast on question 1 is against the sale of intoxicating liquor in the borough outside incorporated cities, the board shall reject all applications for a new license or to transfer or renew a license for an establishment within that area, or within five miles of it outside the borough;

(2) if a majority of the votes cast on question 1 favors the sale of intoxicating liquor in the borough outside incorporated

cities, the board may issue, renew, or transfer licenses within that area or within five miles of it outside the borough solely on the basis of the election results on questions (2) and (3).

(c) The provisions of this section apply to an organized borough on an areawide basis if 35 per cent of the voters at the last general election in the borough, with proportionate representation of incorporated cities within the borough and of the area outside those cities, petition the governing body of the borough under this section.

(d) If, at an election under (a) of this section, a majority is against the sale of intoxicating liquor but is not against mail or telephone orders, question 4 may be presented alone to the voters at a subsequent date, upon following the procedures set out in (a) of this section.

(e) If, following an election resulting in a prohibition against or a limitation upon the sale of intoxicating liquor within an organized borough outside incorporated cities, a majority of the voters at a subsequent election conducted for the purpose and in accordance with (a) of this section favor a change from the then existing status of the sale of intoxicating liquor within that area, the board may issue licenses solely on the basis of the election results on questions 2 and 3, and, if no restrictions are adopted, may, upon application, issue the number and type of license to the same or other premises within that area as were in existence at the time of the last election at which a majority of the voters favored prohibiting or restricting the sale of intoxicating liquor. Those applicants who were licensees and whose licenses were not reissued by reason of the last election conducted under the provisions of this section have a preference over other applicants.

(f) No new license for the sale of intoxicating liquor may be

issued under this title for an establishment in an organized borough outside an incorporated city in which area, on the effective date of this Act, there are no licensed premises unless an election under this section is first conducted.

Sec. 04.10.436. ELECTION IN THE UNORGANIZED BOROUGH. (a) Whenever 35 per cent of the total number of voters at the last general election within an election precinct of the unorganized borough outside incorporated cities petition the lieutenant governor to do so, he shall conduct a special election within the election precinct on the following questions:

(1) Do you favor allowing the sale of intoxicating liquor within this election precinct?	YES [ ]	NO [ ]
(2) If the results of this election show a majority against the sale of intoxicating liquor, would you also favor prohibiting purchases of intoxicating liquor by mail or telephone order from other areas by residents of this election precinct?	YES [ ]	NO [ ]

(b) The lieutenant governor shall conduct the election substantially in accordance with the provisions of the Alaska Election Code (AS 15.05 - 15.60), except that the election shall be conducted not later than 60 days after the receipt of a proper petition. The lieutenant governor shall canvass the ballots and certify the election results to the board. If a majority of the votes is against the sale of intoxicating liquor in the precinct, the board shall reject all applications for new licenses or to transfer or renew licenses for establishments within the precinct.

(c) If, at an election under (a) of this section, a majority is against the sale of intoxicating liquor but is not against mail or

telephone orders, question 2 may be presented alone to the voters at a subsequent date, upon following the procedures set out in (a) of this section.

(d) If, following an election resulting in a prohibition against the sale of intoxicating liquor in the precinct, a majority of the voters at a subsequent election conducted for the purpose and in accordance with (a) of this section favor the sale of intoxicating liquor within the precinct, the board may issue the number and type of license to the same or other premises within the precinct as were in existence at the time of the last election at which a majority of the voters prohibited the sale of intoxicating liquor. Those applicants who were licensees and whose licenses were not reissued by reason of the last election conducted under the provisions of this section have a preference over other applicants.

(e) No new license for the sale of intoxicating liquor may be issued under this title for an establishment in a precinct in the unorganized borough outside incorporated cities in which precinct, on the effective date of this Act, there are no licensed premises unless an election under this section is first conducted.

Sec. 04.10.439. COMPENSATION FOR LOST REVENUE. (a) A municipality with a population of fewer than 12,000 which has prohibited the sale of intoxicating liquor is eligible for and may apply to the Department of Community and Regional Affairs for payment to compensate the municipality for any revenue which it may have lost or foregone as a result of prohibiting the sale of intoxicating liquor. The municipality is eligible for payment of $10 per resident for Fiscal Year 1978. The commissioner of community and regional affairs shall adjust the payment rate for future fiscal years in accordance with changes in the Consumer Price Index for Anchorage, Alaska, published by the

Bureau of Labor Statistics, United States Department of Labor. The Consumer Price Index for October 1976 is considered the initial Consumer Price Index. No payment may be made for any fiscal year preceding Fiscal Year 1978.

(b) In making the adjustments under (a) of this section, the commissioner of community and regional affairs shall comply with the following procedure:

(1) before December 31 of each year, the commissioner shall calculate the change in the October Consumer Price Index for the current year from the October Consumer Price Index for the previous year;

(2) the commissioner shall then

(A) compute the percentage increase or decrease for that period; and

(B) adjust the payment rate by the same percentage increase or decrease, rounded to the nearest tenth of a dollar.

(c) The determination of the Department of Community and Regional Affairs on the adjustment to be made, if any, is final and not subject to judicial review.

(d) In this section, "municipality" means an incorporated city, organized borough, and municipality unified under AS 29.68.240 - 29.68.440.

* Sec. 15. AS 04.15 is amended by adding a new section to read:

Sec. 04.15.015. RESTRICTION ON ADVERTISING. No holder of a license issued by the board, with the exception of those authorized by AS 04.10.080, 04.10.090, and 04.10.120, may advertise intoxicating liquor in any newspaper or magazine, or on any broadcasting station or community cable system, in the State of Alaska. As used in this section, "newspaper" includes shopping news and local television

program guides carrying advertisements for various businesses.

* Sec. 16. AS 04.15.090 is amended to read:

Sec. 04.15.090. PROHIBITION WITH RESPECT TO CERTAIN PERSONS [FEMALES] IN CONNECTION WITH THE SALE OF BEVERAGES UPON LICENSED PREMISES. (a) No [FEMALE] person employed in any capacity or for any purpose by the holder of a license for a beverage dispensary establishment, club, roadhouse, restaurant, or common carrier dispensary, or by the operator or manager thereof may solicit or encourage the purchase of any beverage, alcoholic or otherwise, by patrons of the licensed premises for consumption by the patrons or by the [FEMALE] person; nor may the [FEMALE] person accept a beverage, alcoholic or otherwise, purchased by a patron of the establishment.

(b) No [FEMALE] person, whether an employee or patron of a licensed beverage dispensary establishment, club, roadhouse, restaurant, or common carrier dispensary may remain about the premises of the establishment and solicit any beverage, alcoholic or otherwise, from a patron of the establishment, whether the beverage is for that person [HERSELF], the patron, or another.

(c) No holder of a license for a beverage dispensary establishment, club, roadhouse, restaurant, or common carrier dispensary, or an operator or manager thereof may permit a [FEMALE] person employed by him, in any capacity or for any purpose, to solicit or encourage the purchase of any beverage, alcoholic or otherwise, by patrons of the licensed premises for consumption by the patron or by the [FEMALE] person; nor may the holder, operator, or manager permit an [A FEMALE] employee to accept any beverage, alcoholic or otherwise, purchased or offered by a patron of the licensed premises.

(d) No holder of a license for a beverage dispensary establishment, club, roadhouse, restaurant, or common carrier dispensary, or an

operator or manager thereof may permit any [FEMALE] person to remain about the premises of the establishment and solicit any beverage, alcoholic or otherwise, from a patron of the licensed premises, whether the said beverage be for that person [HERSELF], the patron, or another.

(e) A holder of a license for a beverage dispensary establishment, club, roadhouse, restaurant, or common carrier dispensary, or the operator or manager thereof, or an [A FEMALE] employee thereof who violates this section is guilty of a misdemeanor.

(f) A [FEMALE] person, not an employee of any licensed premises described in this section, who violates (b) of this section is guilty of a misdemeanor.

* Sec. 17. AS 04.15.100(b) is amended to read:

(b) Upon conviction of a licensee for a violation under (a) of this section, or for violation of a municipal ordinance adopted by a municipality in conformity with sec. 70 of this chapter, the judge having jurisdiction shall send a notification of conviction together with a certified copy of the record of conviction to the board and to the city or unified municipality, if any, in which the licensed establishment is located or to the organized borough, if the licensed establishment is located outside a city in an organized borough. The board, council, or assembly may, upon the direction of a majority of its members, thereupon suspend the license as hereinafter provided for the first and second violations and upon a third violation, the board, but not a council or assembly, may revoke the license and declare the bond forfeited. For the purpose of this section, the terms "second violation" and "third violation" include only those violations which occur within five years of the first violation, but are not limited to repeated violations of the same statutory provision or municipal

ordinance.

(1) First Violation. The license of the premises involved may be suspended for not less than 10 nor more than 45 days;

(2) Second Violation. The license of the premises involved may be suspended for a period of not less than 30 days nor more than 90 days.

* Sec. 18. AS 04.15 is amended by adding new sections to read:

Sec. 04.15.105. POSSESSION OF ALCOHOLIC BEVERAGES FOR COMMERCIAL PURPOSES. No person may, for commercial purposes and without a license, possess or bring into the state intoxicating liquor in excess of 20 wine gallons. A person who violates this section is guilty of a misdemeanor and, upon conviction, is punishable in accordance with sec. 100 of this chapter.

Sec. 04.15.107. POSSESSION IN VIOLATION OF LOCAL OPTION. (a) No person may possess more than 2.4 wine gallons of intoxicating liquor other than beer and wine, and 4.5 wine gallons of beer and wine, in a municipality or election precinct which has prohibited the sale of intoxicating liquor or a municipality which holds a limited community liquor license unless he has obtained a permit from the board for possession for special occasions. The board may issue a permit that allows a person to possess up to 20 wine gallons of intoxicating liquor in a municipality or election district which has prohibited the sale of intoxicating liquor or a municipality which holds a limited community license, for a restricted period of time so that it may be served to a large group of persons at a wedding or similar special occasion. A person who violates this section is guilty of a misdemeanor and, upon conviction, is punishable in accordance with sec. 100 of this chapter.

(b) In this section, "municipality" means an incorporated city,

organized borough, or municipality unified under AS 29.68.240 - 29.68.440.

* Sec. 19. AS 04.15.110 is amended to read:

Sec. 04.15.110. SALE IN VIOLATION OF LOCAL OPTION. Notwithstanding any other provision of this chapter, a person who unlawfully sells or offers for sale an intoxicating liquor in an area where the local option election has made these activities illegal is, upon conviction, guilty of a <u>felony</u> [MISDEMEANOR] and punishable by imprisonment for a period not to exceed <u>six years</u> [ONE YEAR], or a fine not to exceed <u>$30,000</u> [$5,000], or by both.

* Sec. 20. AS 04.15 is amended by adding new sections to read:

Sec. 04.15.120. SEIZURE OF CONVEYANCE. A conveyance used, or intended for use, to transport or in any manner to facilitate the transportation, sale, receipt, possession or concealment of an alcoholic beverage sold in an area where a local option election has made its sale or offering for sale illegal may be seized when the seizure is incident to an arrest or a search under a search warrant.

Sec. 04.15.130. FORFEITURE AND SALE OF CONVEYANCE. Upon conviction of the offender or upon judgment of the court having jurisdiction that a conveyance was used or intended for use to transport or in any manner to facilitate the transportation, sale, receipt, possession or concealment of an alcoholic beverage illegally sold in an area described in sec. 120, it is forfeited and shall be disposed of to the community in the local-option area most directly affected by the sale of the intoxicating liquor or to the state, as directed by the court. If the conveyance is sold for the benefit of the state, the proceeds of the sale shall be transmitted to the proper state officer for deposit in the general fund. If not ordered disposed of by the court, any seized conveyance shall be returned after completion of the case

and payment of the fine, if any.

Sec. 04.15.140. LIMITATIONS ON SEIZURE AND FORFEITURE. (a) No conveyance used as a common carrier in the transaction of business as a common carrier is forfeited under sec. 130 of this chapter unless the owner or other person legally in charge of the conveyance consented to or knew of the illegal conduct.

(b) No conveyance is forfeited under sec. 130 of this chapter because of conduct of a person, other than the owner, having unlawful possession of it.

Sec. 04.15.150. APPEARANCE BY PERSON HAVING INTEREST IN CONVEYANCE. A person holding a lien, mortgage, or conditional sales contract on a conveyance seized under sec. 120 of this chapter may appear before the court in the proceeding involving the forfeiture to petition for remittance or mitigation of the forfeiture. The court shall remit or mitigate the forfeiture if it finds that the petitioner has an interest in the conveyance which he acquired in good faith and without knowledge or reason to believe that the conveyance was being used or would be used in the transportation of an illegally sold alcoholic beverage.

Sec. 04.15.160. DEFINITIONS. In secs. 120 - 160 of this chapter

(1) "conveyance" means a vessel, motor vehicle, trailer, aircraft or other means, except animals, of transporting goods or people;

(2) "illegally sold alcoholic beverage" means any intoxicating liquor as defined in AS 04.20.010 which is sold in the manner described in AS 04.15.110.

* Sec. 21. AS 04.10.310 and 04.10.440 are repealed.

* Sec. 22. This Act takes effect immediately in accordance with AS 01.-10.070(c).

FISCAL NOTE PULLED BY HOUSE FINANCE 7/78

Introduced: 2/21/77
Referred: Finance

IN THE HOUSE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

HOUSE BILL NO. 241

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services and to the Department of Education for alcohol-related programs; and providing for an effective date."

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

* Section 1. The sum of $1,521,600 is appropriated from the general fund to the Department of Health and Social Services for Fiscal Year 1978, allocated as follows:

Medical Alcohol Detoxification Services	$100,000
Non-Medical Alcohol Detoxification Facility Acquisition Grants	367,100
Operation of 30-Day Residential Intensive Treatment Facility for Alcohol Affected Persons	600,000
Public Information and Education Regarding Alcohol Abuse	350,000
Training of Personnel For Service in Alcohol Treatment and Counseling Programs at Various Locations	104,500

* Sec. 2. The sum of $66,000 is appropriated from the general fund to the Department of Education for Fiscal Year 1978, for the purpose of development and implementation of an alcohol education curriculum for use in the state's schools.

* Sec. 3. This Act takes effect July 1, 1977.

DIED IN HOUSE H&SS COMMITTEE

Introduced: 3/11/77
Referred: Health, Education & Social Services and Judiciary

IN THE HOUSE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

HOUSE BILL NO. 340

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to treatment of alcoholism and drug abuse; and providing for an effective date."

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

* Section 1. AS 47.37 is amended to read:

CHAPTER 37. [UNIFORM] ALCOHOLISM AND DRUG ABUSE [INTOXICATION TREATMENT ACT].

ARTICLE 1. TREATMENT.

* Sec. 2. AS 47.37.010 is amended to read:

Sec. 47.37.010. DECLARATION OF POLICY. It is the policy of the state that alcoholics, [AND] intoxicated persons, drug addicts and drug abusers should not be criminally prosecuted for their consumption of alcoholic beverages or drugs but [AND THAT THEY] should be afforded a continuum of treatment so they may lead normal lives as productive members of society.

* Sec. 3. AS 47.37.020 is amended to read:

Sec. 47.37.020. OFFICE OF ALCOHOLISM AND DRUG ABUSE. An office of alcoholism and drug abuse is established in the department. The office shall be headed by a coordinator appointed by the commissioner. The coordinator shall be a qualified professional who has training and experience in the organization and administration of treatment services for persons with alcoholism-drug [MEDICAL-SOCIAL] problems. The coordinator is in the classified service.

* Sec. 4. AS 47.37.030 is amended to read:

Sec. 47.37.030. POWERS OF OFFICE. The office may

(1) plan, establish, and maintain prevention, training, treatment and rehabilitation programs as appropriate;

(2) make contracts necessary or incidental to the performance of its duties and the execution of its powers, including contracts with public and private agencies, organizations, and individuals, to pay them for services rendered or furnished to alcoholics, [OR] intoxicated persons, or other drug addicted or drug abusing persons;

(3) solicit and accept for use a gift of money or property or a grant of money, services, or property from the federal government, the state, or a political subdivision of it or a private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for a grant;

(4) review and comment on, and administer or supervise the administration of the provisions relating to alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, of any state plan submitted for federal funding under federal health, welfare, [OR] treatment, traffic safety, and criminal justice legislation;

(5) coordinate its activities and cooperate with alcoholism and drug abuse programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies for the treatment of alcoholics, [AND] intoxicated persons, drug addicts, or drug abusers and for the common advancement of alcoholism and drug abuse programs in this and other states;

(6) keep records and engage in research and the gathering of relevant statistics; have access to records used by other agencies of the state government except as prohibited by law;

(7) do other acts necessary to implement the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest in it, and construct, lease, or otherwise provide treatment facilities for alcoholics, [AND] intoxicated persons, drug addicts and drug abusers; however, the office shall encourage local initiative, involvement and financial participation under grants-in-aid whenever possible in preference to the construction or operation of facilities directly by the office.

* Sec. 5. AS 47.37.040 is amended to read:

Sec. 47.37.040. DUTIES OF OFFICE. The office shall

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and drug abuse and treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and drug abuse and treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers;

(3) cooperate with the division of corrections in establishing and conducting programs to provide treatment for alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers in or on parole from penal institutions;

(4) cooperate with the Department of Education, school boards, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and drug abuse and treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, and preparing curriculum materials for use at all levels of

school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol and other drugs;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers which includes the dissemination of information concerning the nature and effects of alcohol and other drugs;

(7) organize and implement a coordinated manpower training and education program [FOSTER TRAINING PROGRAMS] for all persons engaged in occupations which provide treatment or other related services to [OF] alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers;

(8) sponsor and encourage research into the causes and nature of alcoholism, alcohol abuse, drug addiction and drug abuse, [AND] treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, and serve as a source [CLEARINGHOUSE] for information relating to alcoholism and drug abuse;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the commissioner, the regional health systems agencies, the state health coordinating council, and the governor in the preparation of an annual [A] comprehensive plan for the prevention, treatment, and control of alcohol and drug abuse [TREATMENT OF ALCOHOLICS AND INTOXICATED PERSONS];

(11) review all state health, welfare, criminal justice, traffic safety and treatment plans to be submitted for federal funding, and advise the commissioner on provisions to be included relating to alcohol and drug abuse [ALCOHOLISM AND INTOXICATED PERSONS];

(12) encourage [ASSIST IN] the development and maintenance of 'troubled employees' [, AND COOPERATE WITH, ALCOHOL EDUCATION AND TREATMENT] programs in Alaska [FOR EMPLOYEES OF STATE AND LOCAL GOVERNMENTS AND BUSINESSES AND INDUSTRIES IN THE STATE];

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcohol or drug abusers [ALCOHOLICS], to encourage alcohol or drug abusing persons [ALCOHOLICS] to voluntarily undergo treatment;

(14) cooperate with the Department of Public Safety and the Department of Highways in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated or under the influence of drugs;

(15) monitor the admissions of [ENCOURAGE] hospitals and other appropriate health facilities in compliance with federal law which requires that the office ensure that they [TO] admit without discrimination alcoholics and intoxicated persons and [TO] provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism and certain other forms of drug abuse and addiction as [A] covered illnesses [ILLNESS];

(17) submit to the legislature an annual report covering the activities of the office.

* Sec. 6. AS 47.37.050 is amended to read:

Sec. 47.37.050. INTERDEPARTMENTAL COORDINATING COMMITTEE. (a) An interdepartmental coordinating committee is created, composed of

the coordinator, [AND] the commissioners of health and social services, revenue, education, [HIGHWAYS, LABOR AND] public safety, community and regional affairs, the directors of traffic safety and the Criminal Justice Planning Agency and representatives from the Department of Law, the Division of Planning and Policy Development, the Division of Budget and Management, and the Alaska Court System. The committee shall meet at least quarterly [TWICE ANNUALLY] at the call of the commissioner of health and social services who is its chairman. The committee shall supervise the development and implementation of an annual interdepartmental state plan for the prevention, treatment and control of alcohol and drug abuse [PROVIDE FOR THE COORDINATION AND EXCHANGE OF INFORMATION ON ALL PROGRAMS RELATING TO ALCOHOLISM], and act as a permanent liaison among state departments engaged in activities affecting alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers. The annual interdepartmental plan for the prevention, treatment, and control of alcohol and drug abuse shall reflect consideration of related plans and plan requirements of other agencies with similar goals. [THE COMMITTEE SHALL ASSIST THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES AND THE COORDINATOR IN FORMULATING A COMPREHENSIVE PLAN FOR PREVENTION OF ALCOHOLISM AND FOR TREATMENT OF ALCOHOLICS AND INTOXICATED PERSONS.]

(b) In exercising its coordinating functions, the committee shall assure that the appropriate state agencies

(1) provide all necessary medical, social, treatment, and educational services for alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers and for the prevention and control of both alcohol and drug abuse [OF ALCOHOLISM] without unnecessary duplication of services;

(2) cooperate in the planning and implementation of integrated

systems of enforcement, adjudication, treatment, and rehabilitation appropriate to the humane and professional provision of services to [USE OF FACILITIES AND IN THE TREATMENT OF] alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers;

(3) adopt approaches for the prevention, [OF ALCOHOLISM AND THE] treatment, and control of alcohol [ALCOHOLICS] and drug abuse [INTOXICATED PERSONS] consistent with the policy of this chapter.

* Sec. 7. AS 47.37.060 is amended to read:

Sec. 47.37.060. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There is established in the Department of Health and Social Services an advisory board on alcoholism and drug abuse. This advisory board shall function as a committee of the state health coordinating council, and three representatives of it shall serve as an advisory subcommittee of the interdepartmental coordinating committee.

* Sec. 8. AS 47.37.070 is amended to read:

Sec. 47.37.070. COMPOSITION. The advisory board on alcoholism and drug abuse consists of nine members appointed by the governor.

* Sec. 9. AS 47.37.080 is amended to read:

Sec. 47.37.080. QUALIFICATIONS OF BOARD MEMBERS. Of the nine members

(1) two shall be persons who are licensed to practice medicine in the state [, ONE OF WHOM SHALL BE CERTIFIED IN PSYCHIATRY BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY OR ELIGIBLE FOR THAT CERTIFICATION, EXCEPT THAT IF A PSYCHIATRIST IS NOT AVAILABLE A CLINICAL PSYCHOLOGIST MAY BE APPOINTED];

(2) one shall be a practicing attorney who has been admitted to the practice of law by the state supreme court;

(3) four [TWO] shall be persons who have evidenced an interest in the problems of alcoholism or drug abuse and who have

knowledge of the social problems encountered in the rehabilitation of alcoholics or drug abusers;

(4) two [ONE] shall be persons chosen from the following professions:

(A) education;

(B) nursing;

(C) pharmacy;

(D) social work [A PUBLIC HEALTH NURSE];

(5) three shall also represent the board of directors of each of the three regional health systems agencies created under P.L. 93-641 [ONE SHALL BE A REPRESENTATIVE OF THE LIQUOR INDUSTRY];

[(6) ONE SHALL BE FROM THE PUBLIC AT LARGE;]

[(7) ONE SHALL BE A SOCIAL WORKER].

* Sec. 10. AS 47.37.090 is amended to read:

Sec. 47.37.090. TERM OF OFFICE. (a) The members of the board initially appointed under sec. 80(1)[(a)] of this chapter serve terms of three [FOUR] years.

(b) The member initially appointed under sec. 80(2)[(b)] of this chapter serves a term of three years.

(c) Two members [THE MEMBER] initially appointed under sec. 80(3)[(c)] of this chapter serve terms [SERVES A TERM] of one year and the other two serve terms of two years [TWO YEARS].

(d) The members initially appointed under sec. 80(4)[(d) - (h)] of this chapter serve terms of two [FOUR] years. Subsequent terms for all board members are three [FOUR] years.

(e) A vacancy occurring in the membership of the board shall be filled by an appointment by [OF] the governor for the unexpired portion of the vacated term.

(f) Board members serve at the pleasure of the governor.

* Sec. 11. AS 47.37.100 is amended to read:

Sec. 47.37.100. COMPENSATION, PER DIEM, OR EXPENSES. Members of the advisory board on alcoholism and drug abuse are not entitled to a salary, but are entitled to per diem, reimbursement for travel and other expenses authorized by law for other boards.

* Sec. 12. AS 47.37.110 is amended to read:

Sec. 47.37.110. DUTIES. The board shall act in an advisory capacity to the commissioner and the interdepartmental coordinating committee in the following matters:

(1) special problems affecting mental health which alcoholism and drug abuse may present;

(2) educational and research activities conducted by the office in respect to the problems presented by alcoholism and drug abuse;

(3) social problems which affect rehabilitation of alcoholics and drug abusers;

(4) legal processes which affect the treatment and rehabilitation of alcoholics and drug abusers;

(5) a program of public relations concerning the problem of alcoholism and drug abuse conducted by a department of the state government or by any organized group [AN ORGANIZED GROUP WHOSE PURPOSE IS THE REHABILITATION OF ALCOHOLICS].

* Sec. 13. AS 47.37.120 is amended to read:

Sec. 47.37.120. ALCOHOLISM AND DRUG ABUSE PROGRAM COORDINATOR. The alcoholism and drug abuse program coordinator shall carry out the development and implementation of a comprehensive program dealing with the prevention, treatment, and control of, research on and education concerning alcohol and drug [ALCOHOLIC] problems as they affect the state.

* Sec. 14. AS 47.37.130 is amended to read:

Sec. 47.37.130. COMPREHENSIVE PROGRAM FOR TREATMENT; REGIONAL PROGRAMS [FACILITIES]. (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers. The [SUBJECT TO THE APPROVAL OF THE COMMISSIONER, THE] coordinator shall [MAY] divide the state into [APPROPRIATE] regions that conform to the health service areas established by the secretary of the Department of Health, Education and Welfare under P.L. 93-641 to plan and implement [TO CONDUCT] the program and establish standards for the development of the program on the regional level. In establishing the programs [REGIONS], consideration shall be given to the city, [AND] borough, and Native corporation boundaries [LINES] and population concentrations and, when feasible, programs shall be established with maximum local community and Native corporation involvement.

(b) The program of the office shall include

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and follow-up treatment.

(c) The office shall provide adequate and appropriate treatment for alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers admitted under secs. 160 - 190 of this chapter within the limits of available state and federal funds.

(d) The office shall maintain, supervise and control all facilities operated by it subject to the regulations of the department. The administrator of each facility operated by the department shall make an annual report of its activities to the coordinator in the form and

manner the coordinator specifies.

(e) The [IF POSSIBLE, THE] office shall coordinate the activities of the program with all appropriate public and private resources.

(f) The office shall issue an annual license to a public or private treatment facility which meets the appropriate standards established under sec. 140(a) of this chapter. No treatment facility may be operated in the state without a license, and no facility may receive state funds under a contract or a grant-in-aid unless it is licensed as a public treatment facility. [THE COORDINATOR SHALL PREPARE, PUBLISH, AND DISTRIBUTE ANNUALLY A LIST OF ALL APPROVED PUBLIC AND PRIVATE TREATMENT FACILITIES.]

(g) The office may contract for the use of any facility as an approved public treatment facility if the coordinator, subject to the regulations of the department, considers this an effective and economical course to follow.

* Sec. 15. AS 47.37.140 is amended to read:

Sec. 47.37.140. PUBLIC AND PRIVATE TREATMENT FACILITIES. (a) The office shall establish standards in regulations adopted by the department for facilities before their licensure [APPROVAL] as public or private treatment facilities, and fix the fees to be charged for the required inspections of those facilities. The standards for private facilities may [SHALL] concern only the health conditions to be met and standards of treatment to be afforded patients, but standards for public facilities may include additional criteria to assure responsible processing of state contract and grant-in-aid funds.

(b) The office shall inspect, on a regular basis, licensed [APPROVED] public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The office shall prepare, maintain, publish and distribute annually a list of licensed [APPROVED] public and private treatment facilities.

(d) Each licensed [APPROVED] public or [AND] private treatment facility shall file with the office on request, data, statistics, schedules, and information which the office reasonably requires under (a) of this section. If a licensed [AN APPROVED] public or private treatment facility, [THAT] without good cause, fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns of them, its license shall be suspended or revoked [REMOVED FROM THE LIST OF APPROVED TREATMENT FACILITIES].

(e) The coordinator, after holding a hearing under the provisions of the Administrative Procedure Act (AS 44.62), may suspend, revoke, limit, restrict, or refuse to grant a license [AN APPROVAL] for a treatment facility, for failure to meet the [ITS] standards established by the department.

(f) Upon petition of the office and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the office authorizing him to enter and inspect at reasonable times, and examine the books and accounts of any licensed [AN APPROVED] public or private alcoholism, drug addiction, or drug abuse treatment facility refusing to consent to inspection or examination by the office or which the office has reasonable cause to believe is operating in violation of this chapter.

* Sec. 16. AS 47.37.150 is amended to read:

Sec. 47.37.150. ACCEPTANCE FOR TREATMENT. The department [COORDINATOR] shall adopt [PROMULGATE] regulations for the admission of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective

treatment of alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers. In establishing the regulations, the department [COORDINATOR] shall be guided by the following standards:

(1) if possible a patient shall be treated on a voluntary rather than an involuntary basis;

(2) a patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment;

(3) a person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment;

(4) an individualized treatment plan shall be prepared and maintained on a current basis for each patient;

(5) provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will utilize other appropriate treatment and facilities.

* Sec. 17. AS 47.37.160 is amended to read:

Sec. 47.37.160. VOLUNTARY TREATMENT OF ALCOHOLICS AND DRUG ADDICTS. (a) An alcoholic, drug addict, or drug abuser may voluntarily apply for treatment directly to a licensed [AN APPROVED] public or private treatment facility.

(b) Subject to regulations adopted [PROMULGATED] by the department [COORDINATOR], the administrator in charge of a licensed [AN APPROVED] public or private treatment facility may determine who shall be admitted for treatment. If a person is refused admission to a licensed [AN APPROVED] public or private treatment facility, the administrator shall [, IF POSSIBLE,] refer the person to another licensed [APPROVED] public or private treatment facility.

(c) When a patient receiving inpatient care leaves a licensed

[AN APPROVED] public or private treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic or drug addict who requires help, the facility administrator [OFFICE] shall arrange for assistance in obtaining supportive services and residential facilities.

(d) Except for diagnosis and referral, alcoholism treatment programs shall be separate and distinct from treatment programs for drug addicts. There may be integrated inpatient programs for the treatment of alcoholics and cross-addicted persons, and there may be integrated prevention programs for all forms of substance abuse. No person addicted to an opium derivative may be treated except at a licensed drug addiction treatment center. All federal and state laws and regulations relating to requirements for methadone maintenance for persons addicted to an opium derivative shall be strictly adhered to by all drug addiction treatment facilities operated or funded by the office.

* Sec. 18. AS 47.37.170(a) is amended to read:

(a) An intoxicated person may come voluntarily to a licensed [AN APPROVED] public or private alcoholism 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 his home, a licensed [AN APPROVED] public treatment facility, a licensed [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.

* Sec. 19. AS 47.37.170(b) is amended to read:

(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 a licensed [AN APPROVED] public treatment facility, a licensed [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.

* Sec. 20. AS 47.37.170(c) is amended to read:

(c) A person who voluntarily appears or is brought to a licensed [AN APPROVED] public or private treatment facility shall be examined by a licensed physician within 24 hours [AS SOON AS POSSIBLE]. After the examination, he may be admitted as a patient or referred to another health facility. The licensed [APPROVED] public or private treatment facility which refers him shall arrange for his transportation.

* Sec. 21. AS 47.37.170(d) is amended to read:

(d) No person who, after medical examination, is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may be detained at a facility after he is no longer incapacitated by alcohol. No person may be detained at a facility if he remains incapacitated by alcohol for more than 72 [48] hours after admission as a patient, unless he is committed under secs. [SEC.] 180 or 190 of this chapter.

A person may consent to remain in the facility as long as the physician or administrator in charge considers it appropriate.

* Sec. 22. AS 47.37.170(e) is amended to read:

(e) A person who is not admitted to a licensed [AN APPROVED] public or private treatment facility, is not referred to another health facility, and has no funds, may be taken to his home, if any. If he has no home, the licensed [APPROVED] public or private treatment facility shall assist him in obtaining shelter.

* Sec. 23. AS 47.37.170(f) is amended to read:

(f) If a patient is admitted to a licensed [AN APPROVED] public or private treatment facility, his 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, his request shall be granted.

* Sec. 24. AS 47.37.170(g) is amended to read:

(g) Peace officers or members of the emergency service patrol who comply with this section are acting in the course of their official duty and are not criminally or civilly liable for that compliance [IT].

* Sec. 25. AS 47.37.170(h) is amended to read:

(h) If the physician or administrator in charge of a licensed [THE APPROVED] public or private treatment facility determines it is for the patient's benefit, he shall initiate either an emergency commitment procedure under sec. 180 of this chapter or an involuntary commitment proceeding under sec. 190 of this chapter, whichever is appropriate in his professional judgment [AN ATTEMPT SHALL BE MADE TO ENCOURAGE THE PATIENT TO SUBMIT TO FURTHER DIAGNOSIS AND APPROPRIATE VOLUNTARY TREATMENT].

* Sec. 26. AS 47.37.180 is amended to read:

Sec. 47.37.180. EMERGENCY DETENTION AND COMMITMENT. (a) An intoxicated person who [(1)] has threatened, attempted to inflict, or inflicted physical harm on another may be charged under an appropriate criminal statute, taken into custody, and transported to a state or municipal detention facility. A person who [OR IS LIKELY TO INFLICT PHYSICAL HARM ON ANOTHER UNLESS COMMITTED, OR (2)] is incapacitated by alcohol, may be committed to a licensed [AN APPROVED] public or private alcoholism treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the licensed [APPROVED] public or private alcoholism treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate supporting the need for emergency treatment and stating that the physician has examined the person sought to be committed within two days before the certificate's date.

(c) Upon approval of the application by the administrator in charge of the facility, the person may be brought to the facility by a peace officer, a health officer, a member of the emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under (e) of this section. [HOWEVER, NO PERSON MAY BE DETAINED UNDER THIS SECTION FOR MORE THAN 48 HOURS UNLESS A DISTRICT OR SUPERIOR COURT JUDGE HAS REVIEWED AND APPROVED THE COMMITMENT APPLICA-

TION.]

(d) The administrator in charge of a licensed [AN APPROVED] public or private treatment facility may refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of his medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in a treatment facility for more than five days. If a petition for involuntary commitment under sec. 190 of this chapter has been filed within the five days and the administrator in charge of a licensed [AN APPROVED] public or private treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's [PERSONS'] right to legal counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult with legal counsel.

* Sec. 27. AS 47.37.190(a) is amended to read:

(a) After a hearing initiated by petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of a licensed [AN APPROVED] public or private treatment facility, a person may be committed to the custody of an appropriate licensed private or public alcoholism treatment agency [THE OFFICE] by the superior court. The petition shall allege that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages, or [AND THAT HE (1) HAS THREATENED, ATTEMPTED TO INFLICT, OR INFLICTED

PHYSICAL HARM ON ANOTHER AND] that unless committed is likely to inflict physical harm on <u>himself or</u> another,[;] or [(2)] is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to need for treatment. The petition shall 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 shall be alleged in the petition. The certificate shall set out the physician's findings in support of the allegations of the petition.

* Sec. 28. AS 47.37.190(b) is amended to read:

(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 <u>licensed</u> [APPROVED] public <u>or private</u> treatment facility in which the committed person has been committed for emergency care, and any other person the court considers appropriate. A copy of the petition and certificate shall be delivered to each person notified.

* Sec. 29. AS 47.37.200(a) is amended to read:

(a) At the hearing required under sec. 190(b) of this chapter, the court or the jury, if requested under sec. 190(c) of this chapter, 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 his presence is likely to be injurious to him, in which case the court shall appoint a guardian

ad litem to represent him throughout the proceeding. The court may examine the person in open court, or if advisable, examine him out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to request examination by a court-appointed licensed physician. If he 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 him to a licensed public or private treatment facility in which he is being held under sec. 170 of this chapter [THE OFFICE] for a period of not more than five days for purposes of a diagnostic examination.

* Sec. 30. AS 47.37.200(b) is amended to read:

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the licensed public or private treatment facility [OFFICE], 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 licensed facility [OFFICE]. No court may order the commitment of a person except to a licensed public or private treatment facility which [UNLESS IT DETERMINES THAT THE OFFICE] is able to provide adequate and appropriate treatment for him.

* Sec. 31. AS 47.37.200(c) is amended to read:

(c) A person committed under secs. 190 - 200 of this chapter shall remain in the custody of the licensed facility [OFFICE] for treatment for a period of up to 30 days. At the end of the 30-day period, he shall be discharged automatically unless the facility administrator or physician [OFFICE], before the expiration of the period, obtains a court order for his recommitment upon the grounds set out in sec. 190(a) of this chapter for a further period of up to

90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on himself or another, the facility administrator or physician [OFFICE] shall apply for recommitment if after examination it is determined that the likelihood still exists.

* Sec. 32. AS 47.37.200(d) is amended to read:

(d) A person recommitted under (c) of this section who has not been discharged by the facility [OFFICE] before the end of the 90-day period shall be discharged at the expiration of that period unless the facility administrator or physician [OFFICE], before expiration of the period, obtains a court order on the grounds set out in sec. 190(a) of this chapter for recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on himself or another, the facility administrator or physician [OFFICE] shall apply for recommitment if after examination it is determined that the likelihood still exists. No more than two recommitment orders may be permitted under (c) and (d) of this section.

* Sec. 33. AS 47.37.200(f) is amended to read:

(f) The licensed public or private treatment facility [OFFICE] shall provide adequate and appropriate treatment for a person in its custody. The licensed facility [OFFICE] may transfer a person in its custody [FROM ONE APPROVED PUBLIC TREATMENT FACILITY] to another licensed facility if the transfer is medically advisable.

* Sec. 34. AS 47.37.200(g) is repealed and re-enacted to read:

(g) A person committed to the custody of a licensed public or private treatment facility for treatment shall, if he is an alcoholic committed on the grounds that he is likely to inflict physical harm on himself or another, be discharged at any time before the end of the period for which he has been committed if either of the following

conditions is met:

(1) he no longer demonstrates the likelihood that he will inflict physical harm on himself or another; or

(2) treatment is no longer adequate or appropriate.

* Sec. 35. AS 47.37.210 is amended to read:

Sec. 47.37.210. RECORDS OF ALCOHOLICS, [AND] INTOXICATED PERSONS, DRUG ADDICTS, AND DRUG ABUSERS. (a) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(b) Notwithstanding (a) of this section, the coordinator may make available information from patient's records for purposes of research into the causes and treatment of alcoholism, drug addiction or drug abuse. No information may disclose a patient's name.

* Sec. 36. AS 47.37.220 is amended to read:

Sec. 47.37.220. VISITATION AND COMMUNICATION OF PATIENTS. (a) Patients in any licensed [APPROVED] treatment facility under this chapter shall be granted reasonable opportunities for adequate consultation with counsel, and for continuing contact with family and friends including the use of telephone facilities, consistent with an effective treatment program.

(b) No mail or other communication to or from a patient in a licensed [ANY APPROVED] treatment facility may be intercepted, read, or censored.

* Sec. 37. AS 47.37.240(a) is amended to read:

(a) A patient in a licensed [AN APPROVED] treatment facility, or the person obligated to provide for the cost of treatment of a person committed under this chapter, is liable to the office or the licensed treatment facility which provided the treatment, whichever is appropriate, for the cost of maintenance and treatment of the patient in

accordance with rates established by the coordinator.

* Sec. 38. AS 47.37.270(2) is amended to read:

(2) "licensed [APPROVED] private treatment facility" means a private agency which does not receive grants-in-aid from the office, but meets the limited [MEETING THE] standards prescribed in sec. 140(a) of this chapter for private facilities and licensed under sec. 130(f) of this chapter [AND APPROVED UNDER SEC. 140(c) OF THIS CHAPTER];

* Sec. 39. AS 47.37.270(3) is amended to read:

(3) "licensed [APPROVED] public treatment facility" means a treatment agency operating under the supervision [DIRECTION AND CONTROL] of the office and [OR] providing treatment under this chapter through a grant from or contract with the office, [UNDER SEC. 130(g) OF THIS CHAPTER AND] meeting all of the standards prescribed in sec. 140(a) of this chapter, and licensed [APPROVED] under sec. 130(f) [140(c)] of this chapter;

* Sec. 40. AS 47.37.270(5) is amended to read:

(5) "coordinator" means the coordinator of the office of alcoholism and drug abuse;

* Sec. 41. AS 47.37.270(11) is amended to read:

(11) "office" means the office of alcoholism and drug abuse within the Department of Health and Social Services;

* Sec. 42. AS 47.37.270(12) is amended to read:

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics, [AND] intoxicated persons, drug addicts, and drug abusers, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling; [.]

* Sec. 43. AS 47.37.270 is amended by adding new paragraphs to read:

(13) "drug addict" means a person addicted to opium derivatives;

(14) "drug abuser" means a person who is addicted to or misuses barbiturates, amphetamines, tranquillizers, and similar drugs which are not opium derivatives, to the detriment of his health and social well-being;

(15) "cross-addicted person" means a person who is alcoholic and simultaneously addi ted to barbiturates, amphetamines, tranquillizers, and similar drugs which are not opium derivatives;

(16) "troubled employees" means workers whose performance has been affected by the use of alcohol or other drugs.

* Sec. 44. AS 47.37 is amended by adding new sections to read:

ARTICLE 2. GRANTS-IN-AID.

Sec. 47.37.300. POWERS AND DUTIES OF DEPARTMENT. The department shall:

(1) administer a community grant-in-aid program for alcoholism and drug abuse;

(2) submit an annual report concerning the grant-in-aid program within 10 days after the convening of the legislature in each regular session.

Sec. 47.37.310. GRANT-IN-AID PROGRAM. (a) A profit-making corporation, a non-profit corporation, a city or borough government, or other political subdivision of the state, or combination of these, is eligible for grant-in-aid funds under this section. Applications shall be sent to the department.

(b) The department shall award grants under this section with the advice of the advisory board on alcoholism and drug abuse, in the interest of providing or developing a comprehensive program of prevention, treatment, and rehabilitation for alcoholics, intoxicated persons,

drug addicts, and drug abusers. Separate budgets shall be appropriated for alcoholism and drug addiction treatment and rehabilitation programs. Grants will be awarded on a competitive basis. In considering applications for grants the department shall, if all other factors are equal, give preference to applicants in political subdivisions which devote local government revenues generated by the sale of intoxicating liquor to the treatment of alcoholism. The department shall consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program.

(c) Grants shall be awarded in a ratio of 75 per cent state money to 25 per cent community money except that in communities designated as poverty areas the ratio is 90 per cent state money to 10 per cent community money, for the purposes of providing staff and limited improvement or renovation of facilities for detoxification or intermediate care. The office may require up to a 50 per cent community match for the purchase or new construction of facilities. No grant for improving, renovating, purchasing or constructing may exceed $50,000 except when there is a lack of applicants for available money and then only with the approval of the advisory board on alcoholism and drug abuse. The department is not required to award all money available under this program, or the full percentages specified in this subsection, when another source of money is available, or could reasonably be made available to the applicant.

(d) Money used by the applicant to qualify for state money may be from any other source than the state. The cost of developing an application is not reimbursable from the grant. All community match contributions to grants shall be in the form of cash.

(e) No program is eligible for funding under this section

unless it conforms to the standards adopted by the office under the provisions of sec. 140(a) of this chapter, or in the case of a new program, the office determines that the program will be able to conform to those standards within a period of time to be specified in the initial grant agreement.

(f) In order for programs to be eligible for funding under this section they must be able to demonstrate successful collection of patient fees for services at a rate and proportion to be established by the office.

Sec. 47.37.320. GRANT-IN-AID PROGRAM REGULATIONS. The department shall adopt regulations necessary to implement sec. 310 of this chapter. The regulations shall provide for the method of application, the time for consideration of the applications, the processing of applications, the type of record keeping, the requirements for reporting the progress and statistics regarding the program, the notification of the applicant as to the action taken on the application, and the issuance of licenses for facilities receiving grants-in-aid under sec. 310 of this chapter. The department shall also establish the necessary forms of application and may adopt other regulations considered necessary to meet the requirements of health and safety and the orderly administration of the grant-in-aid program.

Sec. 47.37.330. JUDICIAL NOTICE. The superior courts of this state may take judicial notice of the fact that an alcoholic or drug addict is suffering from an illness and is in need of proper medical, advisory, or rehabilitative treatment.

Sec. 47.37.340. DEFINITIONS. In secs. 300 - 350 of this chapter, "poverty area" means an area in which 15 per cent or more of the population, based on the 1970 census data, is under 125 per cent of the Community Services Administration poverty guidelines.

* Sec. 45. AS 44.29.100 - 44.29.150 and AS 47.30.470 - 47.30.500 are repealed.

* Sec. 46. This Act takes effect July 1, 1977.

DIED IN COMMITTEE

Introduced: 1/9/78
Referred: Health, Education & Social Services and Finance

IN THE HOUSE BY OSTERBACK

HOUSE BILL NO. 570

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services for a feasibility study of an alcoholism treatment facility on Umnak Island; and providing for an effective date."

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

* Section 1. The sum of $150,000 is appropriated from the general fund to the Department of Health and Social Services for the purpose of conducting a feasibility study of an alcoholism treatment facility on Umnak Island.

* Sec. 2. The unexpended and unobligated portion of this appropriation lapses into the general fund June 30, 1979.

* Sec. 3. This Act takes effect July 1, 1978.

INTERIM "CODE REVISION COMMITTEE" IS NOW WORKING ON THIS

Introduced: 3/13/78
Referred: State Affairs

IN THE SENATE

BY THE RULES COMMITTEE
BY REQUEST

SENATE CONCURRENT RESOLUTION NO. 88

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

Directing the Legislative Council to accomplish a substantive revision of the alcoholic beverage laws.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

The legislature has determined that the laws of the state found in Title 4, Alaska Statutes, and relating to the sale and dispensing of alcoholic beverages, are in serious disarray. This disarray is the result of patchwork amending over several decades and as a result the laws are very difficult to administer effectively and defy constructive amendment on a piecemeal basis. This small but important body of law is overdue for a substantive revision. A revision project would involve a thorough review of the policies involved and a comprehensive rearrangement and rewording of the laws to make effective administration possible and to facilitate legislative amendment in the future.

The Senate Special Committee on the Revision of Title 4 of the Alaska Statutes (Alcoholic Beverages) will expire with other special committees at the end of the regular session, but the legislature finds that the subject matter before it will require interim attention between adjournment and the convening of the next legislature.

BE IT RESOLVED by the Alaska State Legislature that under provisions of AS 24.20.090 and Uniform Rule 48(c) the Legislative Council is directed to establish a joint interim committee of the council to continue the special committee's work and accomplish a substantive revision of Title 4, Alaska Statutes (Alcoholic Beverages) during the 1978 interim.

Introduced: 3/13/78
Referred: State Affairs

IN THE SENATE

BY THE RULES COMMITTEE
BY REQUEST

SENATE CONCURRENT RESOLUTION NO. 88 am H

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

Directing the Legislative Council to carry out certain studies.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

The legislature has determined that the laws of the state found in Title 4, Alaska Statutes, and relating to the sale and dispensing of alcoholic beverages, are in serious disarray. This disarray is the result of patchwork amending over several decades and as a result the laws are very difficult to administer effectively and defy constructive amendment on a piecemeal basis. This small but important body of law is overdue for a substantive revision. A revision project would involve a thorough review of the policies involved and a comprehensive rearrangement and rewording of the laws to make effective administration possible and to facilitate legislative amendment in the future.

The Senate Special Committee on the Revision of Title 4 of the Alaska Statutes (Alcoholic Beverages) will expire with other special committees at the end of the regular session, but the legislature finds that the subject matter before it will require interim attention between adjournment and the convening of the next legislature.

BE IT RESOLVED by the Alaska State Legislature that under provisions of AS 24.20.090 and Uniform Rule 48(c) the Legislative Council is directed to establish a joint interim committee of the council to continue the special committee's work and accomplish a substantive revision of Title 4, Alaska Statutes (Alcoholic Beverages) during the 1978 interim; and

WHEREAS the State Personnel Act (AS 39.25) of the State of Alaska represents a considerable and vital body of law which has not undergone

substantive revision and is consequently vastly out of step with personnel developments of the last decade; and

WHEREAS the advent of collective bargaining and the tremendous growth in the number of state government employees require refinement of the personnel system; and

WHEREAS investigations by the Legislative Audit Division and the Office of the Ombudsman have revealed major deficiencies in the present personnel system; and

WHEREAS it is impossible during the course of a legislative session to devote the necessary time required to study and refine the Personnel Act;

BE IT RESOLVED by the Alaska State Legislature that the Legislative Council, in cooperation with the Director of Personnel, is authorized to form a "blue ribbon" commission to study and refine the State Personnel Act and to investigate the feasibility of decentralizing the hiring of employees and a method for regularizing the hiring of specialists who, because of higher comparable salaries in the private sector for the skills involved, must be paid at levels in excess of the salary schedule, and to submit to the First Session of the Eleventh Legislature a proposed revision of the State Personnel Act based on the commission's recommendations; and be it

FURTHER RESOLVED that the membership of the commission should be representative of all persons and groups vitally concerned with the personnel system; and be it

FURTHER RESOLVED that the Legislative Council is authorized to contract with a competent person or firm knowledgeable in the varying aspects of personnel administration to oversee and direct the work of the commission.

Introduced: 4/7/78
Referred: Health, Education &
Social Services

IN THE SENATE BY THE STATE AFFAIRS COMMITTEE

SENATE CONCURRENT RESOLUTION NO. 98

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

Relating to the underutilization of hospital beds in light of the need for detoxification facilities.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS alcoholics undergoing detoxification often need the care available in medical facilities, particularly in the first three to five days when complications such as delirium tremens and heart problems are likely to arise; and

WHEREAS alcoholics in need of such care are often refused admission to medical facilities, in spite of occupancy rates for these facilities which typically vary between 20 and 85 per cent; and

WHEREAS such underutilization of beds is not only wasteful but downright inefficient, due to the fact that the costs of care of alcoholism may often be recovered from the Veterans Administration, private health plans, and a number of other sources of payment; and

WHEREAS full utilization of hospital beds will reduce the amount of state dollars needed to build detoxification centers; and

WHEREAS a refusal to admit a person needing detoxification to a health facility often consigns the person to detoxification in a state or municipal detention facility;

BE IT RESOLVED that the Alaska State Legislature urges medical facilities receiving federal funds to admit for care persons in need of detoxification.

COPIES of this resolution shall be sent to the appropriate authorities in the Department of Health and Social Services for distribution to medical facilities throughout the state.

Alcoholism
The Total Treatment Approach
Third Principle

MESSAGE TO THE CONGRESS*

"The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment. Even with the present limited state of our knowledge, much can be done to reduce the untold suffering and uncounted waste caused by this affliction. I have instructed the Secretary of Health, Education and Welfare to:

Appoint an advisory committee on alcoholism.

Establish in the Public Health Service a center for research on the cause, prevention, control and treatment of alcoholism.

Develop an educational program in order to foster public understanding based on scientific fact.

Work with public and private agencies on the State and local level, to include this disease in a comprehensive health program."

LYNDON B. JOHNSON

*Delivered as part of the President's Annual Health and Education Message to the Congress of the United States of America on March 1, 1965.

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for involuntary patients or patients with other illnesses such as psychosis, diabetes, etc. Certain treatment modalities, like Alcoholics Anonymous, may be effective in most of the above settings. Other treatment modalities, like individual insight therapy, may be effective in only certain treatment settings.

[redacted]

TYPES OF DRINKERS

It is important to not fall into the trap of regarding all users of alcoholic beverages as alcoholics. Although eighty million Americans drink alcohol, only six million are alcoholics. It is true that there are wide variations in drinking patterns, and a general classification of these patterns is useful. A classification of drinkers in the United States is as follows:

1. *Total abstainers*—those who use no alcohol under any conditions.
2. *Moderate or social drinkers*—persons who drink on social occasions or with meals, but rarely to excess. They conduct themselves well while drinking and do not suffer any serious consequences because of their drinking. This includes also people who drink as part of the observance of religious occasions.
3. *Sporadic excessive drinkers*—people who develop a habit of drinking excessively on certain occasions, such as New Year's Eve and other holidays, on pay-check weekends or on other occasions for celebrating. Also into this category falls the teenager who develops a pattern of getting drunk with the gang. These people may well suffer consequences of their drinking, such as auto accidents, fights, hangovers, etc., while intoxicated, but otherwise show no signs of progressive social or physical deterioration related to drinking.
4. *Heavy social drinkers*—persons who habitually drink heavily mostly on social occasions with frequent or regular episodes of intoxication to the point of obvious muscle incoordination and intoxicated behavior. This drinking does not seriously handicap the individual in his life adjustment. Many of these people ultimately become alcoholics, but by no means all of them.
5. *Alcoholic drinkers*—people who have developed a disease called alcoholism.

CLASSIFICATION OF ALCOHOLICS

One of the most penetrating classifications of alcoholics was originated by E. M. Jellinek.[14] He divided alcoholics into four major and several minor categories. The four major classifications are as follows:

Alpha Alcoholism

Alpha alcoholism represents a purely psychological continued dependence upon the effect of alcohol to relieve bodily or emotional pain. An alcoholic suffering from this kind of dependence violates the rules of society, for example drinking at unacceptable places and times, in excessive amounts and showing unacceptable behavior while drinking. This dependence is not characterized, though, by loss of control or inability to abstain from drinking; nor are there any signs of a progressive process. The relief of bodily pain or emotional disturbances implies an underlying illness, but this species of alcoholism cannot be regarded as an illness in and of itself, according to Dr. Jellinek. This is similar to what other authors call symptomatic alcoholism.

Beta Alcoholism

Beta alcoholism is that species of alcoholism in which such alcoholic complications as polyneuropathy, gastritis and cirrhosis of the liver may occur without either physical or psychological dependence upon alcohol. The incentive to a heavy drinking pattern which leads to such serious complications may be the custom of certain social groups in conjunction with poor nutritional habits. Beta alcoholism is neither a disease *per se* nor a symptom, although the excessive drinking may result in a number of medical illnesses as well as other serious nutritional diseases.

Gamma Alcoholism

Gamma alcoholism is that species of alcoholism characterized by acquired increased tissue tolerance to alcohol; adaptive cell metabolism; withdrawal symptoms and "craving," i.e., physical dependence; and loss of control over the use of alcohol. There is a definite progression from psychological to physical dependence and a marked deterioration of behavior. Under certain conditions a person with alpha or beta alcoholism may develop into a person with gamma alcoholism. This species produces the most serious kind of damage and is prevalent in the United States. This type of alcoholism constitutes a disease in and of itself.

Delta Alcoholism

Delta alcoholism shows the same characteristics as gamma alcoholism except that, instead of a loss of ability to control the use of alcohol, there is inability to abstain from drinking. Thus the ability to control the amount of intake on any given occasion remains. But if this type of alcoholic stops

drinking for even a day or two, he experiences a rapid onset of withdrawal symptoms, such as tremors and delirium tremens. This type of alcoholic is the most prevalent type in France, where cultural values provide a strong incentive to high alcohol intake, mostly of wine. This species of alcoholism is also a disease in and of itself.

A more recent classification system[13] separates alcoholics into two main types, addictive and nonaddictive. This classification applies particularly to American alcoholics, and is quite useful clinically.

The *addictive alcoholic** represents a large portion of alcoholics in the United States. These people are psychologically and physically dependent on the drug alcohol. The psychologic dependence is a chronic condition, and is the phenomenon which causes these alcoholics to resume drinking after a long period of sobriety. The physical dependence is the phenomenon which causes these alcoholics to continue to drink excessively once they have started drinking again, and to undergo a withdrawal syndrome after a prolonged drinking bout. This type of alcoholic manifests a loss of control over the use of alcohol, and is the type of alcoholic particularly prevalent in Alcoholics Anonymous. As such alcoholics continue to drink, they undergo progressive intermittent deterioration in their social and economic relations and in their physical and emotional health.

The nonaddictive alcoholic† group is also quite large[14]—how large we do not know. It is similar to the addictive alcoholic group, except that no physical dependence on alcohol is present, and consequently loss of control over the use of alcohol and withdrawal upon cessation of drinking are not features. These people are psychologically dependent on alcohol. After a long period of time, some members of this group do develop physical dependence on alcohol. Many seem to remain only psychologically dependent on alcohol, and never develop a true physical dependence or addiction to the drug. These people also undergo progressive intermittent deterioration in their social and economic relations and in their physical and emotional health. But the progress of the deterioration is more subtle, and the rate more slow. Alcoholics in this group are often still married, on the job, and do not appear chronically ill. They are the hardest to diagnose, but often respond well to the proper treatment.

This separtion of alcoholics into addictive and nonaddictive types appears to have definite clinical value. For example, the author of the present paper noted, during a study involving compulsory treatment of alcoholic prisoners at a Federal penitentiary in Texas,[5] that there appeared to be a difference in these two groups in their response to treatment. The addictive alcoholics were much more responsive to the treatment techniques used

*Also called "drug dependence, alcohol, psychological and physical type."
†Also called "drug dependence, alcohol, psychological type."

than were the nonaddictive alcoholics. Alcoholics Anonymous appears to be made up primarily of addictive alcoholics, indicating that the approach to recovery which this group practices may be more helpful to the addictive than the nonaddictive alcoholic. Nonaddictive alcoholics may possibly be better helped by psychologically oriented treatment such as is available in many state alcoholism programs and private psychiatric hospitals.

PSYCHIATRIC DIAGNOSIS

Many studies and scientific papers, too numerous to review here, have described a variety of psychiatric diagnostic schemes for patients with pathologic drinking behavior. Authors vary greatly in their diagnostic schemes, depending largely on their theoretical orientations regarding the "cause" of alcoholism and probably less on the natural bias inherent in any small sample of patients. At one extreme, some authors make the primary diagnosis of alcoholism, but always regard it as the secondary result of some other primary or "underlying" psychopathology. At the other extreme, some authors give a primary diagnosis of alcoholism in persons exhibiting a more or less clearly defined syndrome of symptoms, occasionally adding another primary diagnosis of some other severe psychologic illness, such as schizophrenia or manic-depressive illness. Still others prefer to routinely describe their alcoholic patients with a series of diagnoses such as follows: diagnosis of any existing psychotic or neurotic disorder; diagnosis of any existing personality disorder; diagnosis of any existing drug dependency, i.e., "drug dependence, alcohol, addictive (psychological and physical) type," drug dependence, alcohol, nonaddictive (psychological) type," "drug dependence, barbiturate, addictive (psychological and physical) type," etc. The author feels this latter system to be the most desirable, generally. The words in parenthesis, "psychological" or "psychological and physical," are optional, being included only for additional clarification if necessary. Needless to say, many other diagnostic schemes do exist.

Several recent studies will be briefly cited below to illustrate the variations in diagnosis reported on groups of alcoholic patients:

1. Robert Willerstein[11] divided the 178 alcoholic patients he studied at the Winter Veterans Administration Hospital in Topeka into three main groups: a) psychotic or psychotic-like character problems (44 patients); b) "character-disorder" character problems (97 patients); and c) neurotic character problems (36 patients). Apparently he regarded the basic pathology in these alcoholics as a character problem which may or may not be associated with a neurotic or psychotic disorder. It was the basic character disorder, with or without a neurotic or psychotic disorder, which he believed secondarily gave rise to the alcoholism syndrome. Forty of the forty-four psychotic and psychotic-like diagnoses were schizophrenic,

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also more tendency toward neurotic disorders. It appeared to the author that these conditions may or may not have preceded alcoholism. Most patients of the middle and upper classes at the time of treatment also displayed other significant psychopathology in addition to alcoholism—primarily of the personality-disorder type. But the symptoms of personality disorder tended to diminish greatly in most alcoholics as their length of sobriety increased. These observations are in need of a definitive study. It is eminently clear that much more research is needed in the area of diagnosis and alcoholism.

THE ETIOLOGY OF ALCOHOLISM

All of the factors involved in causing a person to develop alcoholism are not yet known. However, a number of theories of etiology are prevalent, and each has factual observations to partially substantiate it. These theories fall into three main categories, i.e., biologic, psychologic and sociocultural.

Biologic Theories

Inherited peculiarities of body biology have been indicted as the cause of alcoholism by many. E. M. Jellinek, one of the most distinguished workers in the field of alcoholism, compiled a number of studies dealing with rates of alcoholism in families.[14] He found that an overall average of 52 per cent of alcoholics had at least one alcoholic parent. Conversely, the expectancy rate of alcoholism in the children of families where at least one parent is an alcoholic is between 20 and 30 per cent. In contrast, the expectancy rate of alcoholism in the general population is only between 2 and 3 per cent. This might mean that a tendency to develop alcoholism is inherited.

Two additional personal observations have always struck me as very interesting. First, many of my alcoholic patients have stated that they literally lost control of the use of alcohol with their first experience with alcohol as a youngster. As one alcoholic told me, "The first time I remember drinking was when I was 14, down in my Daddy's wine cellar. I drank until I got so drunk and sick that I vomited." Many never touched a drink again until years later; and when they did, they again drank to the point of drunkenness and have continued to do so since. One might postulate that these people have a high degree of genetic biological determinancy for addiction to alcohol.

The second observation stems from a group of my patients who are overly dependent, immature, emotionally unstable, come from broken or unhappy homes, and in general have most of the characteristics frequently thought to be the basis of alcoholism by those who adhere to psychologic factors as the cause. Several of these people have told me how they actually set out to become alcoholics during a very unhappy period in their lives. They

hoped that once they became alcoholics, they "wouldn't care about anything anymore," including their troubles. They reported drinking heavily over many months, and finally decided the whole experiment was a failure; they didn't get much of a lift out of drinking and were tired of the hangover effects of alcohol, so they quit without any trouble. Some of them stated they take occasional social drinks now and have no desire to drink heavily. One might postulate that these people have a very low degree of genetic biologic determinancy to become addicted to alcohol—"they just don't have what it takes."

Exactly how would such a genetic biologic factor work? One of the well-known workers in the alcoholism field, R. J. Williams,[10] postulates that alcoholism may be caused by an inherited metabolic pattern which results in nutritional deficiences, such as deficiency of glutamine. Consequently, a craving for another nutrient, alcohol, arises. In certain cases, glutamine has been given to alcoholics, and they have subsequently been reported to lose their taste for alcohol. However, no specific metabolic deficiency has ever been demonstrated, and glutamine has not been widely reported to be effective in treating alcoholics.

Does the alcoholic suffer from some other type of metabolic abnormality such as endocrine imbalance, which biologically predisposes him to become addicted to alcohol, as J. J. Smith postulates?[11] Again, no conclusive evidence of this has yet come to light. Could the alcoholic genetically inherit an emotional makeup which predisposes him to alcoholism? This is a fascinating idea, but no convincing evidence has ever been uncovered. Others who hold to a biologic etiology of alcoholism state that if the biologic factor were not inherited, it may well be acquired. Through repeated bouts of heavy drinking, a person may develop an unusual sensitivity to alcohol—that is, he may actually become allergic to alcohol, as many members of Alcoholics Anonymous believe. Again, no such allergy has ever been demonstrated.

An interesting study was done by M. Freile Fleetwood,[12] who measured three chemical substances in the blood of alcoholics as against non-alcoholic controls. One of these substances appeared mostly when a person was anxious (norepinephrine), another when he was tense (acetylcholine), and a third substance (unidentified) when he was resentful. He then administered alcohol to the alcoholics and the non-alcoholic controls and remeasured the substances. The only striking difference between the alcoholics and non-alcoholics was that alcohol caused a great reduction in the "resentment substances" in the blood of alcoholics. This would lend some further substance to the idea that there is a real chemical difference between alcoholics and non-alcoholics.

In summary, many people who work extensively in treating alcoholics are drawn to the conclusion that some "X" factor in their biology must be

present which makes it impossible for them to be social drinkers. This factor, however, has as yet never been elucidated.

Psychologic Theories

Other workers in the field of alcoholism feel that since no biologic peculiarities of alcoholics have been proven in spite of prolonged attempts to do so, the most likely cause of alcoholism lies in the psychologic area. This area can be divided into two parts: (a) studies of the family backgrounds of family alcoholics and (b) studies of alcoholics' personality characteristics.

Familial Background of Alcoholics

The family backgrounds of seventy-seven alcoholics were studied by Howard Clinebell,[31] who carefully interviewed the alcoholics themselves regarding their home lives as children. He found that 57 per cent of the alcoholics came from homes which could be regarded as severely inadequate. The four major parental characteristics in these homes were authoritarianism, success-worship, moralism and overt rejection. The first three of these characteristics are, in part, also subtle forms of rejection.

Robins[32] *et al.* did a thirty-year follow-up study on 502 children who had been seen in a child-guidance clinic, and compared this group to matched controls who had never been treated in a clinic. She found that a significantly larger percentage of the ex-child-guidance clinic patients developed alcoholism as compared to the matched controls. Antecedent factors evident in the childhood histories of the clinic patients found to be significantly related to alcoholism in later life were very low family social status, parental inadequacy (particularly antisocial behavior on the part of fathers) and serious antisocial behavior of the patients themselves.

Amark[33] found a high rate of criminal behavior and alcoholism in the brothers of alcoholics, and some evidence that the fathers also had a high rate of criminal activities. This would lend support to the theory that the antisocial family gives rise to alcoholism in the children.

Manfred Bleuler[34] studied the family backgrounds of fifty well-to-do American alcoholics who were hospitalized at the Payne Whitney Clinic. He found that, even in this upper-class group, 38 per cent had "grossly unfavorable home environments" as children, and 58 per cent had long-standing contact with alcoholics before the age of twenty.

The theme that runs through all of these studies is the strong tendency toward an unusual amount of psychopathology in the families of alcoholics. One would seem rather safe in saying that the family background of an alcoholic provides at least part of the seedbed in which alcoholism grows.

Personality Characteristics of Alcoholics

Multiple studies have been done on the psychologic characteristics of al-

coholics themselves. Since most of these studies have been done after the person has developed alcoholism, only inferences can be made as to his personality before he became an alcoholic. Many people, such as Karl Menninger and Robert Knight, have written about the "alcoholic personality," and have depicted it as a rather clear-cut entity. However, after a multitude of psychologic studies by many workers there appears to be no specific or easily definable alcoholic personality upon which alcoholism is extremely likely to develop. There are, though, certain characteristics[21] that do appear to be quite common in a majority of alcoholics, and various combinations of these characteristics may well have formed the seedbed in which alcoholism grew. These characteristics are as follows: a) angry over-dependency; b) inability to express emotions adequately; c) high level of anxiety in interpersonal relations; d) emotional immaturity; e) ambivalence toward authority; f) low frustration tolerance; g) gradiosity; h) low self-esteem; i) feelings of isolation; j) perfectionism; k) guilt; l) compulsiveness; m) sex-role confusion.

Angry over-dependency is actually one of the most common and most basic characteristics of many alcoholics. In simple terms, many alcoholics do not grow up emotionally, but remain overly dependent on one or the other parent, such as is normal for a youngster up until the age of thirteen or fourteen. This failure to mature emotionally is associated with rejection by one or both parents. This rejection can take the form of either overt neglect or overprotection and overdomination by the parents. These parental attitudes cause a literal arresting of emotional growth at the early adolescent age-level. As an adult, the future alcoholic remains overly dependent. He is painfully aware of his excessive needs for attention, affection, praise, and being pampered and "babied." As a result, he is chronically angry that these excessive demands are never fully met, because his spouse or any other adult is unable to satisfy such excessive dependency needs.

Inability to express emotions adequately is common in alcoholics, and is also rather prominent in people suffering from depression. Alcoholics are in general very sensitive people. Consequently, they tend to build up feelings of anger at even minor rejections or frustrations. In addition, they find it very hard to deal adequately with this great wealth of angry feelings. They often find it very difficult to "talk out" their feelings, and therefore either hold them inside or explosively let them out in an argument or fight. They initially begin using alcohol in moderately heavy amounts to aid them in releasing these emotions or disguising them with feelings of euphoria. Often they end up in arguments, fights, extra-marital love affairs, etc. As it becomes obvious to the alcoholic that this type of release of emotional conflict is not very satisfactory either, he will begin drinking alcohol in

tremely large amounts to deaden his emotions altogether. This is commonly called "drinking to oblivion." One of the main aims of therapy is to help the alcoholic learn to express his feelings verbally.

Alcohol's ability to reduce a *high level of anxiety in interpersonal* relations has caused Dr. Jellinek to dub alcohol "a social lubricant." Many alcoholics, early in their disease, use alcohol as a drug for calming anxious and insecure feelings which arise at social gatherings. As their disease progresses, they seem to become even less able to relate to people, and therefore become even more dependent on alcohol to "get in the mood to relax and have fun." As will be further explained later, alcoholics often feel they are not worthy of being loved or cared about; therefore they feel insecure and out of place in a social gathering. Thus, as their inability to deal with people effectively becomes more pronounced, they need increasing amounts of alcohol to blot out this increasingly unpleasant reality. It has been my personal experience, in a follow-up study of alcoholics treated in a military hospital,[21] that the ones who have attained the longest period of sobriety are usually the ones who have noted most improvement in ability to get along with their friends. Conversely, the ones who have been able to maintain little sobriety also note little improvement in ability to get along with their friends.

Emotional immaturity includes being excessively moody, demanding that one's desires be met promptly, having a violent temper, expressing one's emotions through acts rather than words and being self-centered. Certainly, many alcoholics can be described thusly. It is not certain, though, whether these alcoholics had always been this way or whether they became this way only after their disease of alcoholism had become established.

Ambivalence toward authority, as emphasized by Giorgio Lolli, is an extremely prevalent symptom of alcoholics. A constant struggle goes on in many alcoholics between the need to be dependent and subservient and the need to be dominant and mighty. The common example is the alcoholic who married a domineering wife because of his need to be dependent on someone, and, upon getting drunk, beats her up to prove he is really the dominant one.

Low frustration tolerance is part of emotional immaturity, and is a common attribute of children, as well as alcoholics. It is this limited ability to stand frustration that often causes the alcoholic to resume drinking.

Grandiosity is present in the alcoholic when he is sober as well as when he is drinking. Everyone knows of the alcoholic sitting in a bar who boasts to his drinking chums of the fantastic business deal he is about to close tomorrow. And when the alcoholic sobers up the next morning, he manifests the opposite side of the same coin. He states to his wife: "I'm the worst

person in the world; I've failed in everything I've ever done." To be all that bad is no small accomplishment, either. Grandiosity is a defense against feelings of guilt which obsess the alcoholic.

Low self-esteem is one of the important traits that helps alcoholics continue to drink. "When I drink, I feel like a champ, a king; and the next morning, I realize what a crumb I am," as one alcoholic expressed it to me. This being the case, what a great temptation it is to have "just one more drink" to feel good again. Feelings of low self-esteem often stem from being emotionally neglected as a child. The alcoholic often feels he has never really been loved as he should have been, and probably is not really worth loving.

Feelings of isolation are the natural outgrowth of his inability to get along with people. As the alcoholic continues drinking, his behavior and conversation becomes less acceptable to those about him, and, consequently, his family and friends begin isolating him from their social circle.

Perfectionism and compulsiveness are components of grandiosity. All three of these symptoms are largely an outgrowth of intense feelings of guilt, feelings of being unloved and unlovable. The alcoholic must prove that he is better than his fellowman so that he will not have to feel so guilty about his failures whenever he is sober. Therefore, he must do things better than most people, and consequently becomes compulsive and perfectionistic.

One of the biggest conflicts present in many alcoholics revolves around *sex-role confusion*—their manliness, womanliness or lack thereof. Over and over again in therapy, alcoholics expand on the theme that alcohol makes them feel like the real he-man or she-woman they always wanted to be. Along with this he-manliness goes sexual promiscuity (Don Juan syndrome), fighting, boasting, etc. This sex-role confusion usually seems associated with an immaturity of sexual emotional development, rather than being of a homosexual nature. In other words, the alcoholic often regards his wife as a mama who provides a home for him or primarily as a sexual partner rather than a mature, complex woman with attributes and needs of a characteristic feminine type.

At this point it should be reiterated that the above characteristics are common in alcoholics, but do not occur in all of them. Also, many of these attributes are seen in people with other types of emotional disorders.

One final, pertinent study regarding the psychologic etiology of alcoholism is the McCord research.[1] This is one of the few longitudinal studies which has actually evaluated alcoholics both during childhood years and later, when they have become overt alcoholics. The McCords studied a group of 253 adults who had been intensively studied in 1935 while children in the Cambridge-Somerville Youth Study Center, which was established for the prevention of juvenile delinquency. They found that twenty-nine

of their group ultimately turned out to be alcoholics, which is far above the expectancy rates in the general population. The characteristics of the alcoholics in childhood, compared to a group of non-alcoholic controls, showed that alcoholics tended to be outwardly more self-confident, undisturbed by abnormal fears, indifferent toward other siblings and disapproving of their mothers. It was hypothesized by the McCords that these children were really defending against strong dependency needs which were never satisfied; and when they became adults they were unable to keep up the facade. As a result, they turned to alcoholism.

Sociocultural Theories

The final avenue for trying to gain insight into the etiology of alcoholism is to compare various social and cultral groups as to the incidence of alcoholism to see what factors seem to be correlated to high incidence of the disease. Although many sociocultural factors relating to the drinking of alcohol and alcoholism will be discussed in a later chapter by D. J. Pittman, two observations will be cited at this point.

First, alcoholism tends to be extremely common among certain ethnic groups, such as the Irish and the French. This fact does not appear to be explained simply by observing that most Irishmen and Frenchmen have tasted of spirits at some time in their lives. In a recent study of the Jewish culture,[11] it was reported that 91 per cent of the group had first tasted alcoholic beverages while they were between the ages of five and seven. Yet alcoholism is very rare among the Jews. Thus, some other factor besides mere exposure to alcohol must determine whether or not a person becomes an alcoholic.

Second, there appears to be a definite relationship between culturally accepted drinking patterns and the incidence of alcoholism in a given ethnic group. The more the average person in a society drinks, the greater is the incidence of alcoholism in that society. But this is by no means strictly true. For instance, Frenchmen consume about twice as much absolute alcohol per person as do Italians.[8] Yet France has five times more alcoholics than does Italy. The apparent reason for this discrepancy is that Italians drink mostly wine and mostly with their meals. Frenchmen drink more distilled spirits and frequently without meals. Thus, the simultaneous intake of food with alcohol seems to partially protect Italians against the disease. If this assumption is true, it is obvious that both cultural and physiological factors affect the rate of alcoholism in these two countries.

In summary, it is a fairly sound truism to assume that human beings in general try to adjust to their environments successfully. People who ultimately become alcoholics discovered at some point in their life what a definite aid alcohol appeared to be in helping them adjust successfully to

their lives. Alcohol is a drug with many appealing properties. It relieves anxiety and tension. It is an anesthetic which can relieve physical and emotional pain. It helps release inhibitions. It can be made into a tasty and readily available beverage.

It is no wonder, then, that people who find themselves in a chronically stressful situation which can be "temporarily relieved" by drinking alcohol gradually begin depending on alcohol as a source of relief. Whether the chronically uncomfortable situation stems from the individual's own psychological problems, whether it comes from chronic environmental stresses, such as a unhappy marriage or extremely frustrating job, or whether it comes from chronic physical pain or poor health, alcohol offers temporary relief for all these conditions. Unfortunately though, alcohol is an addicting drug; and, as its use is repeated over the months and years, the drinker gradually develops alcoholism.

NATURAL HISTORY OF THE DISEASE OF ALCOHOLISM

The final area to discuss in understanding the disease of alcoholism is its natural history, i.e., the course the illness usually takes if untreated. This disease very predictably progresses through four distinct phases, as originally described by E. M. Jellinek.[11]

Phase I: The Pre-alcoholic Phase

This phase lasts from six months to ten or more years, and has two main features:

1. The future alcoholic attempts to alleviate everyday tensions of life by drinking. This type of drinker is not regarded by any close friends or acquaintances as a problem drinker. He has begun to use alcohol as a drug to treat his "nerves," relax, gain a general sense of well-being, etc., rather than a beverage consumed at a social occasion or with a meal, but he experiences no progressive social or physical deterioration.
2. He begins drinking progressively larger amounts of alcohol to gain the same effect that less alcohol used to give, and he begins drinking on more frequent occasions.

Phase II: The Early Alcoholic Phase (Non-addictive Alcoholism)*

The drinker imperceptibly slips from the non-alcoholic Phase I to the alcoholic Phase II. As he firmly establishes himself as an early alcoholic, he will exhibit at least several, if not all, of the following five characteristics:

1. *Blackouts* may occur. These are brief periods of amnesia which occur during or immediately following a drinking episode. Although the drinker may appear to be moderately alert and behaving normally while drinkin-

*Drug dependence, alcohol, psychological type.

upon sobering up he will not remember the events which took place during the previous drinking episode. He begins worrying that he may have done something foolish during the blackout period, and therefore tries to avoid talking about it. These blackouts become more and more frequent. Many alcoholics do not develop blackouts until later years, and still others never experience blackouts.

2. He begins *sneaking drinks.* This takes several forms. He may start having a few extra drinks at a party, gulping the first few drinks, drinking it "on the rocks," having a few drinks before the party begins and a "nightcap" afterward, etc. In later stages, he may actually hide a bottle and sneak drinks from it when no one is looking.

3. He develops a *preoccupation with alcohol.* He becomes worried that he won't get enough at a party, so he will bring his own bottle. His key consideration regarding any activity is whether there will be a plentful supply of alcohol or not.

4. He becomes plagued by *feelings of guilt* about his drinking behavior. He realizes his drinking has become abnormal; and, as a defense, he becomes overtly angry when approached on the subject.

5. He consequently *avoids reference to alcohol* in conversation, particularly when sober. He tries desperately to deny that he has any problem with alcohol, and therefore he certainly does not need to feel guilty about continuing to drink.

The person at this phase is called by many of his associates a "heavy drinker," but is not yet considered an alcoholic by them. But the person himself and his immediate family realize things are getting out of control. He experiences fleeting insight into the fact that he is becoming sick and needs help, but he tends to rationalize this away. This phase lasts from six months to five years for those alcoholics who ultimately become addictive alcoholics. Other alcoholics apparently stay in this stage indefinitely and never become addictive alcoholics.

Thus, Phase II can also be called the nonaddictive phase, as the alcoholic has become psychologically dependent on alcohol, but has not become physically dependent. He can still control, with great effort, his drinking on any given occasion, if he sets out to. But his drinking pattern is one of drinking too much, too often, resulting in all the previously mentioned symptoms of this phase, i.e., he begins developing new problems associated with drinking in the areas of his family, job, friends and health.

During Phase II the alcoholic exhibits a greatly exaggerated usage of four main mechanisms of defense which he had formerly used less. These defenses or "alibi systems" serve to relieve his anxiety, blot out unpleasant reality and continue his sick drinking behavior. They are the following:

1. *Denial.* This is the most basic of the alcoholic's defense mechanisms.

It is precisely his inability to face unpleasant reality which in the beginning leads him to use alcohol to excess. And as his illness becomes progressively more severe, so must his denial become progressively stronger. An example of the alcoholic's denial is evident in the oft-quoted phrase, "I can take it or leave it alone." It is painfully apparent to everyone else but the alcoholic that this statement is nothing more than an attempt at blanket denial of his great drinking problem.

2. *Rationalization.* When faced with reality, simple denial of the existence of a drinking problem is difficult to maintain. Therefore, the process of rationalization, i.e., twisting the illogical until it appears logical, is a handy device. An example is the following: "It was a sunny, hot day; and when I finished mowing the yard, I went to the icebox for a drink. When I saw that ice-cold beer there, I knew that was the best thing I could take to quench my thirst." The obvious question one must ask is: "Wasn't there any icewater or sodapop or milk or something else that would quench your thirst?"

3. *Projection.* Another overworked mechanism of defense when fra[illegible] denial tends to break down is to project the guilt for drinking from the [illegible]coholic to another person, usually a family member or an employer. "If my wife would just quit nagging me about drinking too much, I wouldn't do it anymore." Question: "Is there some unpleasant change that takes place in your personality when you drink that causes your wife to complain?"

4. *Fragmentation.* This is an extremely useful and overworked mechanism of defense in which the alcoholic fragments reality into small bits which he then focuses on as if they were the whole. This helps him blot out unpleasant reality. For example, a newly admitted patient on an alcoholism ward was asked the question: "How much do you drink a day on an average?" His answer: "Some days I don't drink anything!" This is an excellent example of the alcoholic's fragmenting his behavior into brief periods of time, and then focusing only on those periods of time when he was not drinking at all. He then tries to pretend that this brief sober period is an accurate sample of his general living pattern, i.e., sober. One of the important aims of treatment is to help the patient integrate all parts of his behavior, pleasant and unpleasant, and make them readily accessible to his conscious thought processes.

Phase III: The Crucial Phase (Addictive Alcoholism)*

The most prominent characteristic of this phase is development of loss of control over the use of alcohol; i.e., if the alcoholic takes one drink, he will continue to the point of drunkenness. It is during this phase that everyone

*Drug dependence, alcohol, psychological and physical type.

who has any repeated contact with the alcoholic becomes painfully aware of the seriousness of this person's problems. It is called the *crucial phase*, because the alcoholic stands in great danger of losing everything he holds near and dear to him (his family, his job, his friends, his health) unless he succeeds in arresting his illness.

Additional prominent characteristics of the alcoholic in this phase are the following:

1. He exhibits *grandiose behavior;* i.e., he begins telling extravagant stories of fantasied great accomplishments in his life in order to cover up for his great feelings of failure and low self-esteem.

2. He exhibits *marked aggressive behavior* as he convinces himself that all his troubles are due to his wife, his friends or his debtors.

3. He may well have periods of *total abstinence to prove* to himself he can "take it or leave it alone." Social drinkers do not need to prove to themselves that they do not have a drinking problem, and consequently will not find it necessary to undergo a prolonged period of self-enforced sobriety.

4. He will *change* his *drinking pattern* to prove to himself that he has no drinking problem. For instance, he resolves never to drink before dinner, because only alcoholics drink earlier in the day than that. Or he will change from drinking bourbon to drinking scotch, because scotch gives less of a hangover, or to beer, because he earnestly believes one can't become alcoholic on beer, or to vodka, because it isn't supposed to smell on his breath, etc.

5: He will *change his associates* as he convinces himself they are responsible for his problem. Thus, he ends up divorcing his spouse and cutting off old friendships.

6. If the alcoholic stops drinking suddenly, he will go through a *withdrawal syndrome* consisting of the "shakes," delirium tremens or alcoholic hallucinosis.

Thus, Phase III fulfills the criteria of a true addiction, i.e., craving for a drug, development of tolerance to the drug and a withdrawal syn drome upon sudden cessation of the drug. The symptom of loss of control over the use of alcohol appears to be a symptom of this physical dependence on alcohol.

Phase IV: The Chronic Phase

By the time the patient's addiction has reached this chronic phase, he finds himself going on prolonged, unplanned drinking sprees which last for many days. These are called, in the alcoholic vernacular, "benders." Formerly the addict has been able to reserve his heavy drinking periods for the weekends; but with the onset of this unplanned heavy drinking, lasting throughout his waking hours, he finds himself confronted with grave social condemnation from all segments of society except the lower social-class al-

coholic with whom he drinks. His health also suffers rapid deterioration due to the fact his diet is made up mostly of alcoholic beverages rather than nutritious foods.

He undergoes marked *ethical deterioration*, and will, possibly for the first time in his life, engage in stealing, writing worthless checks, and inflicting severe injuries on himself and/or others. Some female alcohol addicts begin engaging in prostitution.

His thinking becomes chronically impaired in such a manner that, even if he has been withdrawn from alcohol and been sober for several weeks, he will still be unable to assess himself and the world about him accurately. He can think on only a superficial level, and thus finds it difficult to realize the severely deteriorated state he has come to, or to make sound plans for rehabilitating himself in the future. This blunting of intellect constitutes a *mild chronic brain syndrome* which may not clear up for many months. In some cases it never disappears. Chronic alcoholic psychosis also occurs in a small percentage of these addicts.

Commonly noticed at this time is a *loss of alcohol tolerance*. It now takes much less alcohol to arrive at a severely intoxicated state. He also *begins drinking any type of alcohol* or alcohol substitute which is available, including shaving lotion, rubbing alcohol, Sterno, cough medicine, barbiturates, certain tranquilizers, etc. The severe medical complications of alcoholism become manifest including cirrhosis of the liver, brain damage, esophageal varices, etc.

One final important observation must be made about the natural history of alcoholism. The predictable downhill progression can, in a large percentage of cases, be arrested at any stage, usually with the aid of some therapy modality.* Occasionally, alcoholics do "quit on their own," but, for many, special therapy is necessary. The goal of therapy is abstinence from all alcohol use and social and psychological reintegration. Reports in recent years have indicated that some alcohol addicts can return to social drinking. This must be an uncommon phenomena in light of the experience of most workers in this field.

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*Although numerous references will be made in this book to the effectiveness of rehabilitation efforts with alcoholics, the reader's specific attention is called to the follow-up study reviewed in the chapter by James H. Williams.

SEVERITY OF INTOXICATION IN RELATION TO CONCENTRATION OF ALCOHOL IN THE BLOOD

To gauge the degree of intoxication by the symptoms alone is unsatisfactory, and even physicians fail to agree when using such a basis. But the great mass of evidence on the correlation of driving impairment with blood alcohol levels affords better criteria to estimate the severity of intoxication. Formerly the value of 150 mg of alcohol per 100 ml of blood was taken as the lower limit for dangerous driving in the United States. But many years have passed since the standard of 150 mg per 100 ml, was set, and it is now thought to be too high. The additional information which led to this conclusion was obtained by the actual operation of a car or a "dummy" automobile and also by laboratory tests. Some subjects showed driving impairment with alcohol levels as low as 50 mg per 100 ml. All were impaired when the blood alcohol levels reached 100 mg per 100 ml. In 1960, therefore, the House of Delegates of the American Medical Association recommended that the zone of dangerous driving should begin at an alcohol level of 100 mg per 100 ml of blood as indicated in Figure 2-1. Persons with concentrations of less than 50 mg per 100 ml are not to be regarded as under the influence of alcohol. But those with concentration between 50 mg per 100 ml and 100 mg per 100 ml should be judged according to the circumstances, including the results of physical examination as indicated in Figure 2-1, which also depicts the volumes of whiskey or beer necessary to produce the values of 50 mg per 100 ml and 100 mg per 100 ml respectively in a person weighing 150 lb (68 kg). Most individuals are unmistakably inebriated at levels of 200 mg per 100 ml. All drinkers are intoxicated with a level of 350 mg per 100 ml, and the intoxication is severe at 450 mg per 100 ml. Levels of 350 to 450 mg per 100 ml have caused death, while those above 550 mg per 100 ml are usually fatal in untreated individuals.

Though the level of blood alcohol is a determining factor in estimating the degree of intoxication, blood analyses do not always afford the method of choice to obtain this information because of problems in obtaining and analyzing blood samples. In New York State, for example, the services of a licensed physician are demanded in the collection of the blood sample. It is therefore advantageous that we may rely on samples of urine, saliva, and breath to estimate alcohol concentrations. The blood values can then be calculated because of an equivalence between the concentration of alcohol in blood with that of urine, saliva, and breath as indicated below.

Urine: blood	1.25:1
Saliva: blood	1.12:1
Blood: alveolar air	2,100:1

These figures mean, for instance, that, when alveolar air is in equilibrium with the blood with respect to alcohol, 2,100 ml of alveolar air will contain

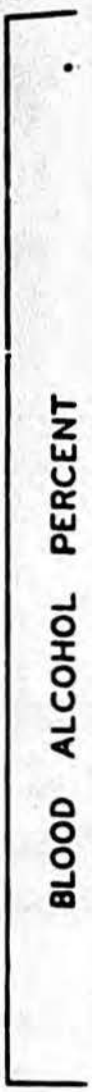


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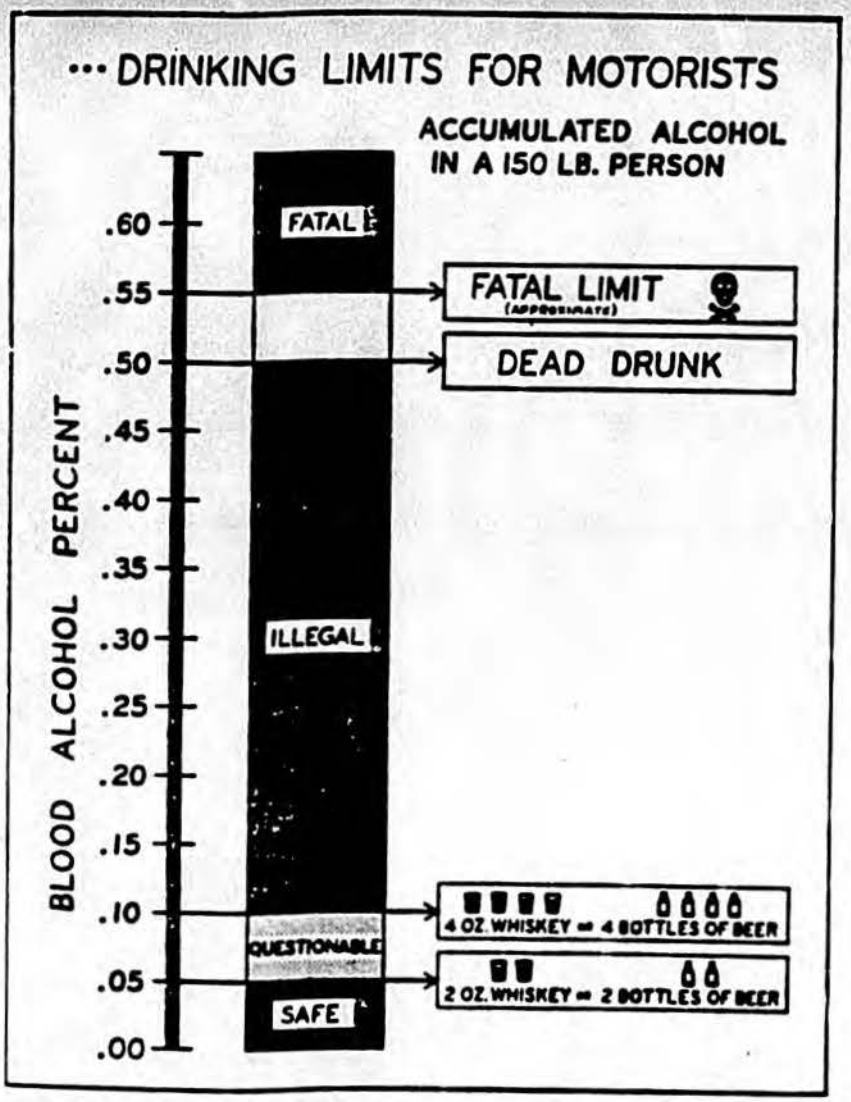


FIGURE 2-1. This figure is adapted from R. N. Harger and H. R. Hulpieu, and is reproduced with their permission from *Alcoholism*, edited by G. N. Thompson and published by Charles C Thomas, Publisher, Springfield, Illinois, 1956, Chapter 2.

as many milligrams of alcohol as does 1 ml of blood. On comparing these sources of alcohol it must be emphasized that analysis of the alcohol in the breath possesses many practical advantages, not only over those of urine and saliva but also of blood. The collection of the air samples requires less cooperation on the part of the subject, and the actual determination for alcohol can be made most rapidly on the air sample. Most important, the

The toxic symptoms and signs induced by disulfiram and citrated calcium carbamide are largely due to interferences with removal of acetaldehyde, which accumulates as its combustion is inhibited. Normally Stage 1, from alcohol to acetaldehyde, is the slowest phase of alcohol oxidation. With these drugs, however, Stage 2, from acetaldehyde to acetyl CoA, becomes even slower. As a result, acetaldehyde is retained in the body and produces the toxic changes described above.

A real advantage afforded by these drugs is that the patient has to make a decision not to drink alcohol only once a day instead of many times. In general, disulfiram has greater effectiveness and is correspondingly less safe than citrated calcium carbamide. If the patient takes a drink of alcohol, the symptoms are much more severe with disulfiram, which therefore serves as a greater deterrent than citrated calcium carbamide. In any event, the patient's willingness to take either of the drugs is a sign that he is strongly motivated in his desire for relief from his disease.

SUMMARY

[redacted] Alcohol is chiefly a brain depressant and seems to act from above downward. The clinical picture of acute alcoholic intoxication reveals a progressive march starting in cortical functions and gradually descending the brainstem to the medulla oblongata. Thus the most complex faculties of judgment, memory, learning, self-criticism, and environmental awareness are among the first to be impaired. Similarly, the release of lower brain centers from cortical control is evident in the excitement characteristic of one phase of alcoholic intoxication. The mechanism involved in this progressive march of symptoms is complex, and two different explanations are offered, probably each one being partly correct. As discussed in the text, not all areas of the brain are equally susceptible to alcohol; some parts of the cerebral cortex, for example, are more sensitive than a subcortical area, the reticular formation. On the other hand, the reticular formation succumbs earlier to the effects of alcohol than other cortical areas.

Alcoholic beverages can induce a mild degree of depression of cortical functions, a depression that serves as a relief from the cares of the day and secures relaxation before dinner. A drink before bedtime may break a vicious cycle, so that one need not take his troubles to bed. Similarly, alcohol facilitates interpersonal relationships and performs many other valuable services. On the other hand, when alcohol is not taken as temporary relief, but is habitually used instead of more appropriate methods to resolve difficulties at work or at home, the drinker invites future addiction. Similarly, alcohol employed to allay inner conflicts, as in an individual with a

schizophrenic personality, may serve to complicate further the pathologic picture. In this event, first functional and then structural changes take place in the body as alcohol assumes the role of a necessary foodstuff and the patient becomes an addict.

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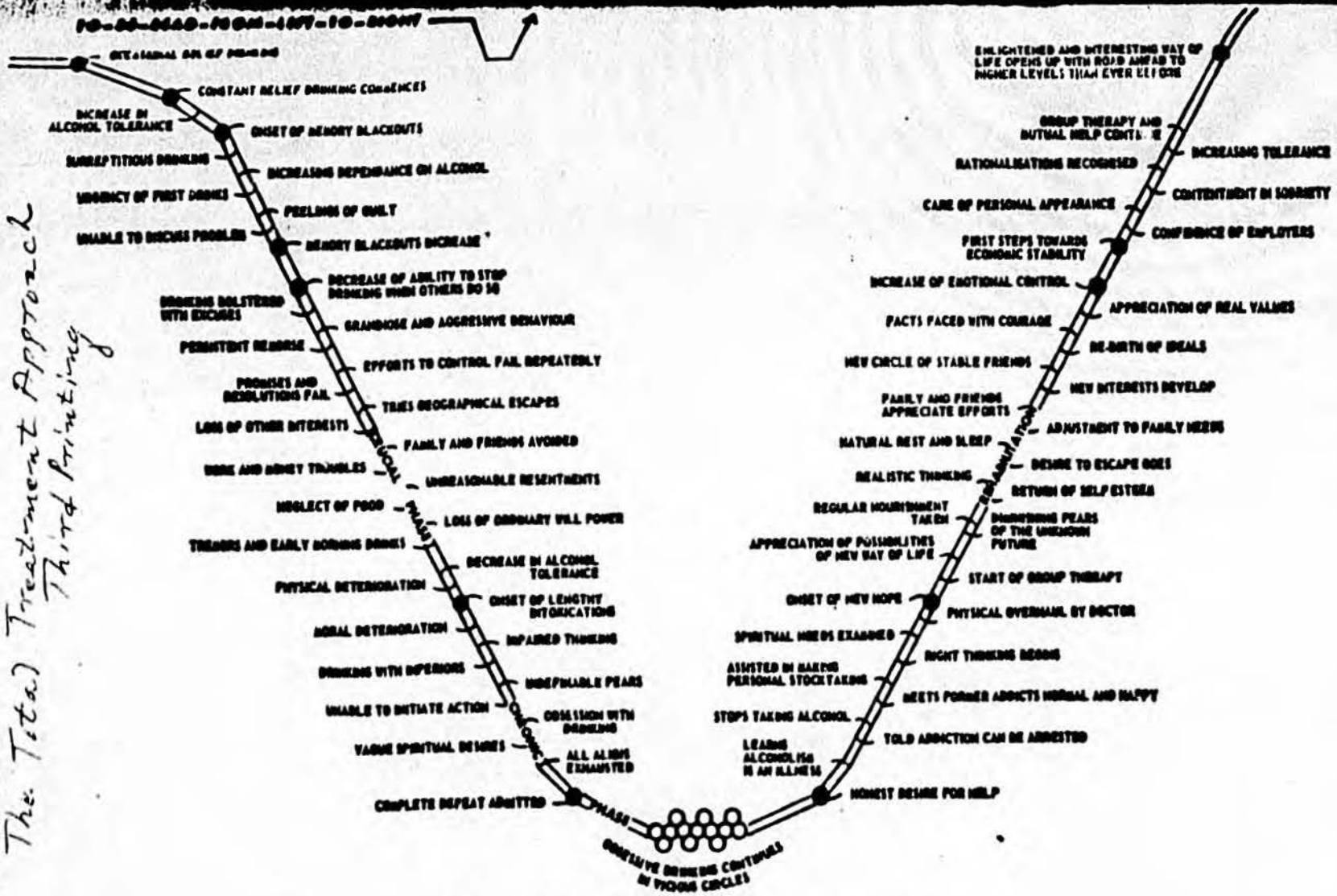
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A CHART OF ALCOHOL ADDICTION AND RECOVERY

*Reprinted by special permission of the author of this chart, Dr. M. M. Glatt.

Alcoholism
The Total Treatment Approach
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CHAPTER 16

SOCIAL CASEWORK WITH THE ALCOHOLIC AND HIS FAMILY*

LAURA ESTHER ROOT

VARIOUS TYPES of therapy have been used in the treatment of alcoholics, including Alcoholics Anonymous, chemotherapy with various tranquilizers, antidepressants and disulfiram, and group therapy to name a few. Some have been more successful than others. The most successful approaches appear to be centered around Alcoholics Anonymous and group therapy, inasmuch as more alcoholics maintain their sobriety through these types of treatment than others. Individual counseling and family group therapy are also useful in helping the alcoholic and his family to maintain his sobriety.

Social workers in their practice could be of invaluable help in this field of treatment where there are too few facilities and too few professionals willing to invest themselves in working with the alcoholic. Social workers need to be concerned about the lack of treatment available to this large segment of our population, 10 per cent of whom are alcohol-dependent, and 5 per cent of whom are alcoholic.[1]

Alcoholism has been moving from an area of moral stigma into the field of scientific investigation. With this change a body of objective information has come concerning alcohol, alcoholics, and alcoholism. Research in treatment techniques, in drug therapy, in types of treatment facilities, and the like have uncovered much factual knowledge where previously only myth existed. As yet no definitive studies have been done to isolate a specific variable as the cause of the disease, nor is there any known cure. Social workers then, are confronted with a disease whose etiology remains unknown, whose number of victims is increasing at the rate of some 200,000 annually, as well as the fact that treatment facilities and personnel have lagged far behind the current need.

What can social workers do? They can accept the challenge now in the

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field of alcoholism as did the early professionals with the then-unpopular problems and invest themselves in treatment of alcoholics.

It must be noted that, as a profession, Social work has not been overly enthusiastic in seeing the alcoholic client. Although this is not as popular a field as community organization, group work, settlement-house work, welfare and medical/psychiatric social work, still there have been a few social work leaders, such as Margaret Cork, Jean Sapir, Catherine Peltenberg, Margaret Bailey, and Gladys Price, who have pioneered and made outstanding contributions in the field of alcoholism.

The few social workers who have had some contacts with alcoholics are generally those in hospitals, welfare agencies, and probation and parole offices. Some settlement-house workers and a few workers in family agencies have also had contacts with alcoholics. Social workers are being presented with a challenge to help alcoholics, and in so doing help to roll back the "curtain of ignorance," moral condemnation, and lack of acceptance of alcoholics which is found rooted in community attitudes throughout the country. The "revolving-door" alcoholic and the tuberculus alcoholic are rarely seen by social workers for any length of time. Now is the appropriate time to accept this challenge and do something about it. Many other professions have said that social workers are threatened by working with alcoholics, since alcoholics force them to question their traditional case methods. This is not always the truth. It is my feeling that if we had followed one of our earlier pioneers, Mary Richmond, we would have long ago been working with alcoholics, since she early identified this type of patient as of appropriate concern for social workers. Social workers have much to give to this field, but first they must have a knowledge of the disease of alcoholism.

Attitudes of Social Workers

One of the barriers which has kept social workers from entering this field has been their own attitudes about alcoholism. This is documented in the Bailey and Fuchs study, "Alcoholism and Social Work," in which they observe that social worker's attitudes have often negatively affected their work with alcoholics.[2] It is necessary, then, for social workers to modify their views, as well as incorporate current knowledge about alcoholism into their practice. The importance of their own attitudes toward alcoholics has a tremendous effect on their ability to work with these people. Most alcoholics are extremely sensitive people who have low self-esteem, which usually accompanies this progressive disease and generally makes them search for rejection. Indeed, they may overtly try to provoke a professional into rejecting them, since they are anticipating moral condemnation. Many times they are in fact rejected; otherwise, a great many

of the 6,500,000 alcoholics in the United States today would be seeing professionals in the many social-work agencies in existence.

Learning begins when one commences to understand the chronicity of the disease of alcoholism and what this entails. Many social workers will say that they understand the concept of chronicity in diseases because of their work with the tuberculus patient, or heart patient, or diabetic patient. They may feel that, because of their experience as medical social workers or as welfare workers, these are types of patients which they understand very well. They can accept and deal with the relapses which occur with these chronic types of patients. Generally they are very supportive and accepting, explaining to the patient and their families that the patient has overdone himself and that he probably was not as cautious as he should have been in following his diet and prescribed routine of medical care. They interpret, both to the patient and the family, this *matter of chronicity.*

However, the attitude which many professional social workers hold towards alcoholics is quite different. When an alcoholic is returned to a treatment facility with a relapse, or comes into the office with evidence of imbibing, if the social worker automatically thinks, "Oh, not again," I question whether this is an objective or moralistic attitude. Therefore it is extremely important for the *social worker* to accept the fact that alcoholism is a chronic *disease,* which can be arrested by proper treatment before the worker can hope to deal successfully with the alcoholic patient. If social workers refine their casework methods and utilize them in their relationships with alcoholics, they will be able to handle the relapses which occur in this chronic illness and use them constructively in their total treatment goal.

COUNSELING THE ALCOHOLIC

Social workers are noted for their ability to communicate to patients. One of the techniques of their profession is an ability and skill in interviewing and communicating. However, in working with alcoholics, their communication must be at a different level. Many clinicians fail in the treatment of alcoholics because they are unable to, and/or fail to, communicate. Learning to interact with alcoholics is something that comes with time. As one learns about the disease, one begins to understand and accept the chronicity factor; and one eventually realizes the impact of the disease upon the individual in his total milieu. It is most important that the therapist understand the patient's drinking problem and how his life with this progressive addiction to alcohol affects him as an individual. He is not "an alcoholic personality," but changes do occur in personality traits with the onset of the chronic phase of the disease. The more one learns, the more one understands, accepts, and gains insight and knowledge

in learning to communicate with alcoholics. Ultimately, one learns to speak "his language."

The Intake Interview

One of the most important skills of the social worker is an ability to help people when they come to the agency with a problem and to make them feel comfortable during the "intake interview." This is an interview in which the patient or client presents a problem, and the social worker, with her training, helps him express his need without being too traumatic to the patient. However, if the "social worker regards the intake interview as a study or exploratory process and the applicant conceives of it as a help-getting experience,"[3] difficulties will ensue before the agency's service is extended to a client who needs help. Conception, as well as expectations, of the roles of the social worker and client are not the same. A method of interpretation and communication is necessary if the goal of service is to be achieved in most agencies. The intake situation is even more confused if the social worker has a poor attitude toward alcoholics, as well as a lack of knowledge of the disease, while the alcoholic not only has an inability to acknowledge his disease, but greater difficulty in asking for help. One can begin to see the barriers which have been erected between social workers and alcoholics and have prevented a needed service from developing.

It is difficult, at best, for many people to request help. But for an alcoholic patient to acknowledge that he needs help with his drinking problem is almost an impossible task, for often he cannot accept the fact that he is indeed an alcoholic. To come to an agency or a clinic and request help requires a great deal of courage for alcoholics, because in so doing they are admitting that something is "wrong." This is extremely threatening to them, and many have to get drunk in order to seek help.

In the "intake interview" the social worker focuses upon the alcohol problem by obtaining a complete drinking history. This should be done in a frank and open discussion with the individual. If one obtains a comprehensive drinking history, he will have a very adequate social history of the individual, since drinking cuts across all areas of the alcoholic's life. The following information should be included in the drinking history:

1. Age at first drink; what beverage was it; did parents drink, or were they abstinent?
2. If parents drank, what were their drinking patterns? Did they keep liquor in the home?
   Did they make wine or beer at home?
3. If parents drank, what type of drinkers were they? social? Did one or both parents have a problem?

4. How old was the patient when he or she:
   a) Was first intoxicated?
   b) Had his first blackout (a brief period of amnesia while drinking)?
   c) Took his first morning drink?
   d) Had increase in frequency of blackouts?
   e) Lost control of his drinking?
   f) Started to protect his liquor supply?
   g) Started daytime drinking?
   h) Began going on binges?
   i) Began drinking alone?
   j) Had his first hallucination or delirium tremens?
   k) Thought for the first time he was going to die?
5. How many jobs has he had in the last three or four years?
6. What job did he hold the longest?
7. How many times has he been arrested for intoxification and/or alcohol-related offenses?
8. Has he left his family, or have they left him?
9. If he is still with his family, do they have their meals together?
10. Does he have shared activities with the family?
11. Who makes the decisions at home?
12. Does his wife work? If so, how long has she worked?
13. How long ago did she start calling in to cover for him on his job or with his friends?
14. Has he lost any property as a result of his drinking?
15. Has he taken any personal articles of his own, his family's, or articles from his home to sell when he needed a drink and did not have cash?
16. How many bar bills, liquor stores, and friends does he owe money to, and for how long?

These and other similar types of questions will provide information concerning the impact of the drinking problem upon the individual patient and his total milieu. If the interviewer obtains a complete and detailed drinking history, it will provide a basic social history of the patient. An all-inclusive drinking history is a must in making a treatment plan for the patient.

In most private family agencies, the clients are more apt to be middle-class alcoholics who are in the earlier phase of alcoholism, rather than in the later chronic phase when addiction has occurred. The earlier phase is the optimal time for intrusion for treatment. The therapist's approach to this patient would have to be different than it would be with one who is "downed" by the chronicity of his disease, as is the "revolving-door" alcoholic, who may have been arrested some two hundred times or more and who has served half or two-thirds of his lifetime in jail on the "installment plan."

Motivation for Help

Let us next consider the motivations which bring patients to our offices in our regular practice and the manner in which we evaluate his motivation for seeking help. We wish to know why he has come; and if he has come of his own volition; or if he has been forced to do so because of whatever is occurring in himself or within his family. Does some type of illness, problem, etc., bring him in for help? The motivation of an alcoholic to come seeking help is usually the force of his illness. He might, however, come as a result of pressure from a family member, employer, or friend; but, whatever the reason, we must first deal with the feelings which have been aroused. We must work also with any other barriers which might be present, such as a morbidity of personality. We need to identify these factors. For an alcoholic to come of his own volition for an initial contact is the optimum for long-rang goals in treatment. If, however, he comes as a result of force, this injects a resistance factor into the situation which usually acts as a deterrent to his ultimate goal of sobriety.

Sometimes it is not only hard to acknowledge, but also difficult to accept, the fact that we are unable to help a client. If the agency does not handle the type of problem the client presents, we usually say that "we are sorry, but we cannot help you," and we generally try to make a referral to some other agency which would be able to provide the necessary service. It is somewhat different with an alcoholic when he comes to an agency, as we must evaluate whether or not he has come because of pressure. If he comes "with a gun at his back," and we accept him without acknowledging this, we will be erecting a barrier which will interfere with his sobriety as previously indicated. It is quite conceivable that the patient may not yet be ready for help. If this is true, we must help him to identify this, explaining to him that we will be glad to help him when he is ready.

There have been several articles written on "motivation" of the alcoholic and on the concept of motivating the alcoholic. The Pittman-Sterne article in the *Quarterly Journal of Studies on Alcoholism*[4] points out that when too much stress is placed upon motivation it may mask the disinterest of the professionals or their desire not to be involved with this different type of patient. Many social workers have permitted themselves to accept a common myth that alcoholics cannot be helped unless they seek help themselves. In my clinical practice I find this not true. More important, I feel that when we use this excuse we are hiding behind it. We might do well to examine our own motives for using this objection. Do we really want to work with alcoholics? I submit that we must not accept the myth which insists that alcoholics must request help before they can accept treatment effectively. I think that it is a challenge for us to help to motivate alcoholics sooner, and to help their families, as well, to understand and to

learn to live with the alcoholic member, so that they, in turn, can support him to seek help at an earlier period.

Additional Important Information

After we have a drinking history and have ascertained why the patient has sought help, we should then further evaluate the alcoholic to see if he considers himself an alcoholic, or if it is his family or his employer who does so. Second, we need to know if he has ever had treatment; if he has had sobriety we also want to know what type of sobriety it is, as well as the duration of the period he maintained it. There are several types of sobriety, and it is important for us to know which type the patient has experienced before he came to us for treatment. The chronic addictive alcoholic generally stays sober longer if he has achieved sobriety which he himself sought. Alcoholism is a selfish disease, and the sobriety which must be achieved by an arrested alcoholic is sobriety for himself, to the exclusion of anyone or anything else. In other words, his sobriety has top priority above any other factor or person in his scheme of life. For, if he is not sober, he can achieve little in terms of work, family, or the community.

There are, as I indicated, several types of sobriety. There is what I choose to call "reluctant sobriety," during which kind the patient remains sober, not because he wants to, but because of the pressure from either his family, employer, or friends. When a patient is attempting to maintain his sobriety without investing himself to the fullest extent, he is a patient who will probably relapse within a short period of time. Conversely, I call the other type of sobriety "peaceful or happy sobriety," and yet this is actually a misnomer, because in the beginning or earlier stages of sobriety, it is not at all peaceful. Let us say rather, for the alcoholic who has decided to stay sober, wishes to work at it, invests himself in maintaining his sobriety, this could then be considered a more tranquil sobriety in comparison to "reluctant sobriety." Still, one must be aware that, in the beginning, no sobriety is tranquil; it is a fight for the alcoholic every minute of every hour of every day in the beginning to keep from drinking. We must understand, therefore, how imperative it is for social workers to be aware of any sobriety which the patient might have achieved prior to his coming to the agency.

At the same time that we obtain a drinking history, as indicated previously, the various data that are needed for a complete diagnostic background history of the patient can be obtained. It is at this time that we must be sure to have a complete diagnostic workup done on the patient, including medical, neurological, psychiatric, and sociocultural evaluations. It is best to know what the positive attributes of these patients are, rather

than just the negative ones. It seems that many professional people, when evaluating a client or a patient, tend to stress what he has not done, rather than what he has done. An evaluation should be made of the positive ego strengths which the patient has, rather than emphasizing the negative ego deficits, in making an effective treatment plan for the alcoholic.

Initial Therapeutic Suggestions

In my clinical experience with alcoholics I have found that if you focus first upon their reason for drinking, you fail. Therefore it is better generally to request that all ingestion of ethyl alcohol be stopped at the beginning of treatment, rather than later on. If there are any underlying emotional problems, and indeed there are with some alcoholics, it is best for these to wait until the patient has begun to achieve some measure of control over his alcohol intake. It has been my experience that should you reverse this procedure and attempt to find out why the patient drinks, to search out what problems or reasons he had for drinking before he became chronically addicted, it is usual for the patient to continue drinking and for some to increase their ingestion. Therefore I think it is imperative that in casework with alcoholics you must first help them to stop drinking. Should you wish to approach them from an analytical standpoint thereafter, you can still do so. But equate the drinking with acting out, and have them stop any ingestion of alcohol first.

In my clinical experience, when I attempted to ease tension by first helping the patient resolve his conflicts, I found that the addiction remained. When I speak of addiction here, I am referring to the physical addiction to alcohol which is found in the chronically addicted alcoholic. This means that there is a physical compulsivity to drink, with an inability to control alcohol ingestion once the alcoholic begins drinking. Many social workers have failed in working with alcoholics because they have concentrated on the underlying problem, while the drinking has increased in its intensity.

Social workers in working with alcoholics, need to give educational information to them about alcoholism. This is somewhat unique in our field, but it is imperative that the alcoholic patient or client be given as much factual knowledge about his disease as possible. With each session you may be somewhat didactic for a part of the time by conveying knowledge about the disease to the clients or patients. This helps the individual gain some insight and understanding of his chronic illness. Florence Hollis has said: "Insight is a technique of social work whereby the client is made to see himself and his problem."[9] Imparting of information is a good way to begin the insight process.

Furthermore, we may need to modify the environment so that the alco-

holic may achieve a new design for living without alcohol. The technique of modification and manipulation of the environment to help the client is one of the most basic techniques of social work. For an alcoholic to change his life completely, in terms of a new design for living without alcohol, is a tremendous task. To do this he must have continued positive support from his therapist. Social workers are specially trained in using supportive techniques. They "help the client to help himself."

Common Problems of Treatment

One of the things which will aid social workers in their work with alcoholics is an understanding of some of the characteristics of alcoholic behavior. The alcoholic will test his therapist by coming late or missing his appointment. If psychologically difficult areas have been brought up in treatment he may start to "nibble" (ingest a few drinks). He may even suggest that he has done this to "get enough courage to come to the office for another visit." On such an occasion the social worker has to make it clear that if the patient continues to show up for visits under the influence of alcohol, the visits will have to stop. At the same time skill will have to be used to make the patient understand that this is not rejection, but rather is a necessary requirement for successful treatment.

Social workers are skilled in using either a diagnostic or functional approach, or a combination of both in building relationships with clients within which they are able to work. Some workers feel that the diagnostic approach is the most appropriate, while others feel that the functional is the only right method. In terms of working with the alcoholic, it is appropriate to use both diagnostic and functional approaches. Accurate diagnosis and realistic assessment of current problems and assets are both necessities for success with the alcoholic client.

Alcoholics, particularly those who are in the chronic addicted phase, have learned to employ to a pathological extent some of the defense mechanisms which have been used to excess in other types of clients with which social workers are familiar. The major defenses are projection, rationalization, denial, and manipulation. The alcoholic, however, uses these for one purpose, i.e., to reinforce his drinking patterns. The therapist must help him to understand and be aware of his pathologic defenses, identifying with the client why he uses these specific defenses and his purpose in doing so.

Some time ago, when I was conducting a group session with alcoholics, one of the patients was speaking about his problem, rationalizing his reasons for drinking. His rationale was that he drank when he was happy, and that as years went on he continued to drink while he was happy, but eventually he became an uncontrolled drinker. I stopped him at this point and

asked him, "Who do you think you are kidding?" The patient stopped short and responded, "Well, I guess I'm not kidding anyone but myself." A discussion ensued among other patients which reinforced this point. The individual patient began in that session to gain some insight into his problem, and from that day on he began to make progress in his treatment. This happened four years ago. The other day the patient stopped by my office, and he remarked that throughout his years of sobriety, every now and then, when he is rationalizing about some other things in life, he recalls my comment, "Who do you think you are kidding?" and he said that he always replies, "Really, only myself."

Long-Term Treatment Plans

In addition to the manipulation of environment, the patient must be helped to plan a new design for living. One of the most difficult things for the alcoholic is just staying sober for an hour at a time for the first year. Trying to get through life "dry" utilizes all his effort and energy, which leaves him without anything to invest in other areas. Playing the role of a father, of a husband, of an employee, is a tremendous demand upon an individual for strengths he does not have. When helping an alcoholic to try to find a new way of life, one must give support and help in planning the things which will assist him in making new constructive life goals. Also, plans must be devised for him to spend his free time constructively.

The alcoholic is always concerned about the time when he is not working which used to be devoted to drinking: What should he do with it now that he is drinking no longer? He wants things to do. He must be helped to set up realistic goals. For example, he should be helped to assume his rightful role within his family milieu if he is fortunate enough to be returning to live with his family. If he is working, he must be helped with his employment situation and attitude to see that he performs adequately on the job. He will need continued support and encouragement. He must also be assisted in trying to rebuild his life in the community so that it is meaningful to him and his family. Furthermore, a suggestion that he join Alcoholics Anonymous and attend several meetings a week is usually quite helpful. The fact to keep uppermost in mind is that this patient must invest so much of himself just to maintain his sobriety alone that he is frequently incapable of making the right decisions. During the initial months of sobriety he cannot be left alone to become lost in the many tasks which make up his daily life. Supportive therapy by the social worker is imperative during this period of treatment.

It is quite feasible that some social workers will feel that working this closely with alcoholics will increase their dependency to the degree they

will never be able "to cut the ties that bind." This is not true! At an appropriate time, treatment can be discontinued and remain only on a "when-necessary" basis. I have done this repeatedly with alcoholics with whom I have worked, and have encountered no great difficulties.

As treatment continues, plans must eventually be made "to cut the umbilical treatment cord." As the length of sobriety increases, clients begin to pick up the threads of their lives and weave them back into a meaningful fabric. Appointments are spread further and further apart, so that, instead of seeing the patient once or twice each week, gradually he is seen once a month, and ultimately is told to come back any time in the future he feels the need. This is a new design for living which helps him to manage his life realistically. As the alcoholic learns to live with his sobriety, he gains strengths and a greater feeling of independence.

The patient and his family need to understand that not all problems disappear when the alcohol ingestion is stopped. Rather, there are often many more problems, sometimes of a deeper nature than those which were present while he was drinking. One cannot work with the alcoholic in a vacuum. Total family therapy is a necessary part of his treatment. At times the social worker may not see any member of the client's family or may see a family member in a separate individual session. But to work effectively with the alcoholic, a different type of approach must be used. Family group counseling is often a necessity, as well as alcoholic group therapy. This family group therapy often should include the entire family, i.e., spouse, children, and even parents who may be living in the same household.

COUNSELING THE FAMILIES OF ALCOHOLICS

What is the family's role in the treatment of the alcoholic? Many people have written about various types of families of alcoholics; they have given them a number of labels. Some have been called "sick families," "maladjusted families," "neurotic families," etc. However, in my experience I prefer to see them as *disorganized families* in which the disruption of the family milieu occurs with the progression of the alcoholic member's disease. The dynamic interaction between the family members breaks down because of the chronic addiction of the alcoholic spouse. It has been said that most families wait at least nine years from the time the spouse first begins to have difficulty with drinking until they seek some type of help. During this period a process of disorganization is occurring as the problem increases, together with the fact that the family must also handle the stigma which society places upon the disease of alcoholism.

Initial Evaluation and Planning

In working with the family of an alcoholic, one must see the non-alcoholic spouse and the children as well. Of course, it is taken as a given

fact that the very young children will not be seen, but it is my belief that children as young as nine or ten years of age should be included in the family evaluation. One of the best evaluation techniques is a home visit by the social worker. This provides a diagnostic evaluation of the family in a familiar setting. It should be scheduled at a time when all the family members will be present, especially the alcoholic spouse. The worker is then able to evaluate the family dynamics—the interaction which is occurring within the family milieu in their usual setting, not in an artificial office setting. After the initial home visit and evaluation, there is no reason why subsequent meetings could not be held in the worker's office, agency, or facility.

Following the evaluation at the home level, in which an attempt is made to find out about the family dynamics, the stability of its interpersonal relationships, its psychosocial functioning, the roles of family members and their places in the community, an important question must be asked, to: "When am I going to start to work with this family, and how frequently will I see them?" It is generally good practice not to see the family too soon (before the alcoholic is ready), since timing is an important aspect of work with alcoholics. The reason for this is as follows: If the family of the alcoholic has become involved in treatment before the alcoholic has been able to feel comfortable with his therapist, he will be threatened by the family's comments and accusations during the treatment session. This is not to say that one should never see the family initially for an evaluation, just as was done for the patient. It is wiser, however, to bring the family in at a later point in time if possible. Ultimately, sessions should be held with all the family members present, both the alcoholic spouse and the non-alcoholic spouse, together with the children. If necessary, the non-alcoholic spouse can be seen on an individual basis as well as in the family group therapy session.

In trying to evaluate what is occurring within the family milieu, the social worker must ask the family members how they view the problem of the alcohol ingestion by the client. Do they see this only as an annoyance, or are they partly satisfied with his behavior when drinking and only wish to get him to cut down on his intake? If this is the case, then it is certain that the family has little or no knowledge about the disease of alcoholism, and that when they try to help, they will, in many instances, create more difficulties for the alcoholic member, which in turn often lead him to a greater ingestion of alcohol.

It is imperative for the social worker to impart factual knowledge about this disease to the family. Furthermore, the family must be aware that when the individual stops drinking, it does not mean that everything is fine, that there are no longer any problems, or that all crises are over.

They must understand the nature of the disease, its implications, and the fact that crises will occur and can in fact be anticipated to occur more frequently following the stopping of ingestion of alcohol. Furthermore, the family must not see the cessation of drinking alcohol as a "cure" to all of its problems.

Effect on the Children

It is most important in working with alcoholics to evaluate the interaction between the family members and to find out how the various members view each other's roles in relation to this problem. In general, children tend to see the father in the role of "someone" who is in the background; this is the case when the father is the alcoholic, with the mother assuming the authoritarian or "head-of-the-house" role. Many times she is forced to be the father, the breadwinner, the arbitrator, and so on for the family. If the children are going through puberty and adolescence during this period, this in itself makes for a great deal of difficulty in their adjustment to life, and must be considered as well. Children are most affected by this disease and its impact upon the role of the mother, as well as that of the father, since invariably the mother's role becomes stronger as the father's weakens; frequently he becomes as another child in the family. I recall one patient who, when he was trying to work toward sobriety, and had been sober for some time, was sitting at his dinner table when his older boy asked his mother for the keys to the car for that night. Father was extremely insulted and said, "How dare you ask your mother and why shouldn't you ask me?" and he proceeded to scold his son for disrespect, since he, the father, was head of the household, etc. The boy left the table in tears, and the mother later on commented to her husband, "Won't you realize that this is one of the infrequent times that you have been at the dinner table sober and aware of what is going on."

It is important for families, especially the children, to understand what is occurring during this time of treatment. The children need to be aware that there are going to be times when the parent will be extremely irritable and upset because of his difficulty in maintaining his sobriety. This is where interpretation to the family, support, and encouragement can be very beneficial, not only to them but to the alcoholic member of the family. They, in turn, are able to give him the necessary support and encouragement which he needs to stay sober. He must have this understanding and support of his family along with the support and understanding of the social worker, his employer, and the community.

Planning Long-Term Goals

One of the most important factors families must learn is the "setting of goals" during this period of sobriety. Sometimes families have been in

such stages of distress and discomfort during these years that when the alcoholic member has stopped drinking and has returned to work, family members tend to set too high a goal for themselves and the alcoholic member. This is self-defeating to the alcoholic. Families must know that only realistic goals can be planned in terms of what can be expected and achieved by someone who has this illness and is striving for his sobriety. Many times, in working with the family, we have to let them know that the alcoholic wishes to obtain things for them, desires a better home, better furniture, or whatever the economic needs might be, but he isn't capable of this as yet. Things must be taken slowly, for if the goals are set too high they become overwhelming to the point that a relapse occurs. When this happens the family generally will revert back to their old way of handling the alcoholic member when he was drinking—"rejection." It is important, then, for family members to be aware of all the many factors which must be considered while the alcoholic is being treated. They must be aware that when the alcohol ingestion is stopped it sometimes takes a year or longer for "alcoholic thinking" to disappear. This simply means that the patient was used to handling things in a rigid and extremist manner while he was drinking, that there was a certain compulsiveness about everything he did, that he was impulsive and tended to rush into things. This is a learned pattern of behavior which occurred with his progressive addiction to alcohol. These behavior patterns tend to continue after sobriety occurs. Family members must learn to understand and handle this alcoholic thinking, being realistic in their approach to its gradual diminution over a long period of time.

CONCLUSION

Social [redacted] if they are willing to accept the challenge to use their skills and techniques in working with them and their families. It is my belief that our traditional casework methods are appropriate to use in working with the alcoholics in our population. Caseworkers in private or public agencies, in hospital settings, or elsewhere will all encounter alcoholics or members of their family who need help.

Some of the traditional methods, with modification, are very useful tools in helping the alcoholic and his family to regain their place in society. Interviewing, counseling, insight, supportive therapy, to name a few, together with an acquired knowledge of the disease and a willingness to understand and accept the alcoholic as a sick person, will permit social workers to make contributions in this vast area of need.

For years our profession has been "urging that social work expand on the basis of a needed service. . . . social workers are now found in industry, research, urban renewal, peace corps, as consultants to many federal, state

and local governments, as well as in the anti-poverty programs."[6] Since social workers have in the past risen to accept the challenges on the basis of need, are we now to ignore the millions of alcoholics and their families who could benefit from our help?

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CHAPTER 17

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SERVICES AVAILABLE THROUGH A COMPREHENSIVE VOCATIONAL REHABILITATION CENTER FOR ALCOHOLICS

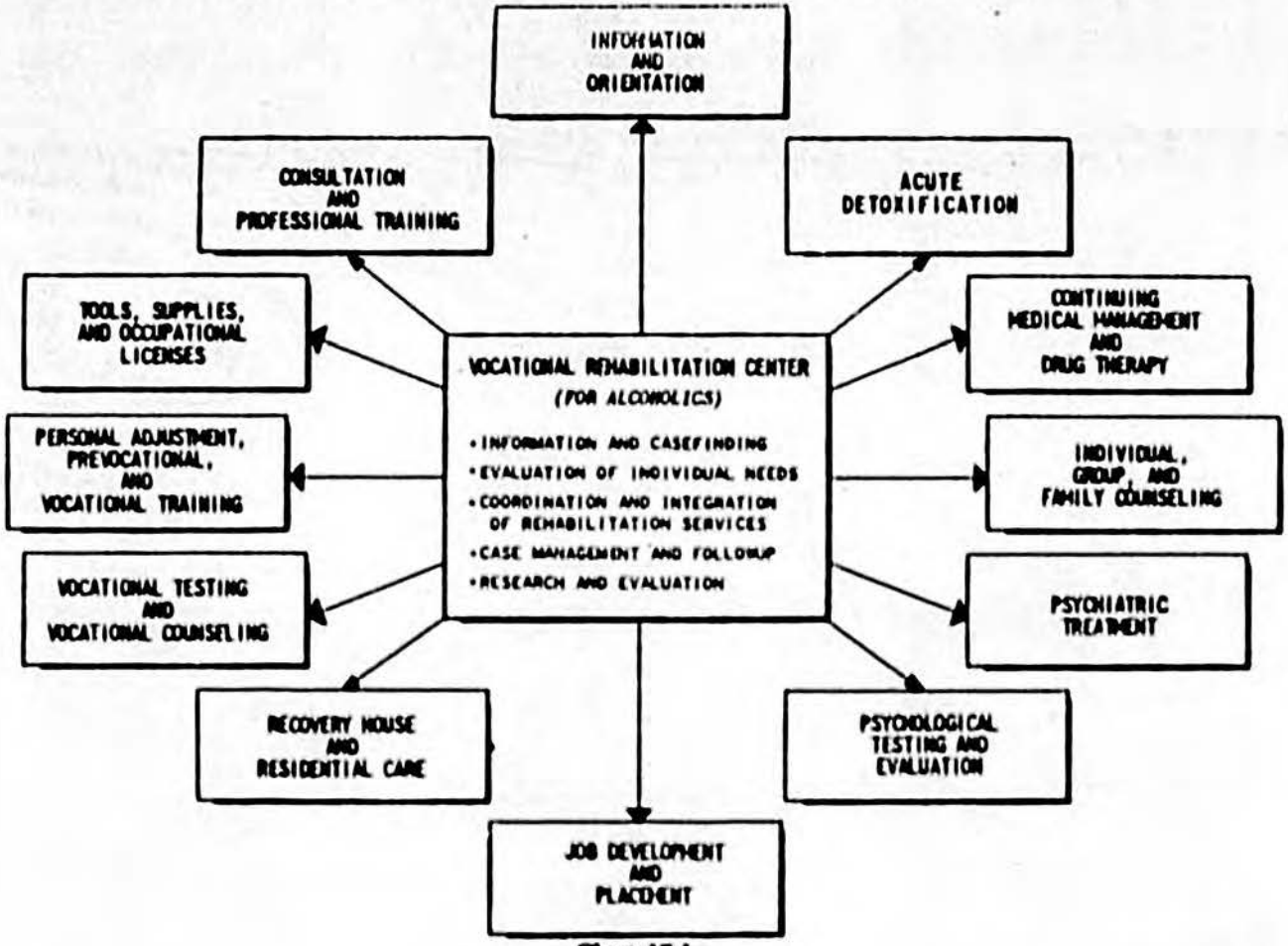


Chart 17-1.

Alcoholism: The Total Treatment Approach

some training, can often conduct groups effectively where the goal is to guide the alcoholic in dealing with reality situations. It is helpful, wherever possible, to employ rehabilitated alcoholics as ward personnel provided they have been dry a sufficient length of time and have demonstrated enough basic personality strength to be of assistance to the patients. It is important in maintaining morale to be certain that the opinions, observations, and feelings of all levels of personnel be shared, respected, and incorporated into the program when a consensus shows that they are acceptable. The director of a program of this sort has a grave responsibility in maintaining a high level of morale, in promoting respect for and acceptance of the patients, and the employment of his personnel to maximum effectiveness in keeping with their own personality attributes.

General Goals of a Rehabilitation Program

The general goals of a state hospital program for alcoholics may be epitomized as follows:

1. *To promote efforts which will help to reveal to the alcoholic his basic failure to handle anxiety, hostility, and depression effectively.* This is best done in constant interaction with others, because at the time the problem is brought into consciousness he has the group available both to clarify his thinking and to make suggestions as to how he can better handle his feelings.

2. *To encourage the alcoholic to ventilate his feelings, especially rage, and at the same time continue in maintaining his acceptance by the group.*

3. *To establish in the alcoholic the recognition that he has levels of tolerance for his own feelings, that these levels of tolerance can be heightened, and that the feelings can be drained off effectively without recourse to alcohol.*

4. *In group and in individual discussions, to encourage the alcoholic to see what aspects of his life, what environmental circumstances, and what personal relationships have led him to intolerable rage and anxiety reactions which have been assuaged only by alcohol.*

5. *To get the alcoholic to accept the realities of his relationship with people and events in his environment, to reinforce his personality strengths, and to understand the advantages and desirability of remaining sober.*

6. *To get him to understand while he is in the hospital that sobriety alone will not solve all his problems.* He must be helped to realize that financial, social, and cultural stresses will continue to arise in his external environment, but that there are methods available for translating his feelings into actions which are acceptable to himself and to the community without recourse to alcohol.

7. *Above all, to recognize that alcoholism as a problem and as an illness must be approached directly.* Indirect approaches through personality defects are futile and time-wasting. In this regard, Moore, quoting from Shea, has stated: "First of all alcoholism must be tackled directly; it cannot be expected to perish by attrition when the fundamental neurotic roots are crushed. Such technique, in my experience, always fails. The alcoholism flourishes protectively and the neurosis is never cornered. The surest way to tackle the alcoholism directly is to make non-alcoholism an effective issue with the patient."

THE CENTRAL ISLIP PROGRAM

History and Development

Central Islip State Hospital at Central Islip, New York, is a nine-thousand-bed State hospital with a variety of specialized services including a resident treatment centers for children, a geriatric rehabilitation unit, a narcotic addiction unit, research unit, and general psychiatric intensive care admission service. Prior to 1957, certified psychotic male alcoholics were domiciled in the admission unit or in continued treatment wards without special facilities. In that year an antiquated building was partly remodeled; male alcoholics only were admitted to the building; an interested psychiatrist supervised the building in addition to other duties; Alcoholics Anonymous contacts were encouraged. The results were encouraging, and by 1962 the New York State Department of Mental Hygiene had made available additional funds for greater improvement in the building and a full-time staff of medical and paramedical workers. Thus it became possible to admit nonpsychotic alcoholics directly on a voluntary basis. In 1965, Federal funds were made available to supplement the program, and, in 1966, a unit was opened for women which operates along the same general lines as the male unit. Although State law permits the certification of voluntary alcoholics, the patients selected for admission to the special rehabilitation units are either voluntary or have been converted to voluntary status while in the hospital. Each unit has sixty beds, and each is in a separate building with its own recreational, occupational, dining-room, and meeting-room facilities.

Staffing

Each rehabilitation unit has its own staff, consisting of a supervising psychiatrist, two senior psychiatrists (male unit)—one senior psychiatrist (female unit). Each unit has a full-time psychologist, recreational therapist, charge nurse, and psychiatric aides in a one-to-five ratio with patients. Two alcoholism counselors are assigned to the male unit, and one to the

Approach

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Alcoholism
The Total Treatment Approach

2. There has been very little difficulty with drinking during the patient's stay in the units. Despite their freedom to roam about the hospital grounds and to enter the nearby community with a pass, less than 3 per cent of the patients indulge in drinking while staying in the hospital.

3. Recidivism is a problem, in a sense, but patients are encouraged to return to the hospital as soon as possible if they encounter difficulties on the outside, preferably before they start to drink or shortly after drinking has occurred. There is evidence that with this liberal policy drinking bouts tend to become shorter, and periods of sobriety tend to become longer.

4. Because of difficulty in evaluating the success of the unit by follow-up procedures in a drifting population, the members of which are often lost in the large New York metropolitan area, it has been necessary to use psychological questionnaire techniques to determine whether or not a change in attitude toward alcohol occurs while the patient is in the hospital. Present evidence shows that there is a statistically significant change in attitude, with more realistic acceptance of the drinking problem, establishment of definite goals directed toward sobriety, and rudimentary understanding of emotional factors involved in drinking.

5. By the use of frequent informal conversations between personnel, the encouragement of the patient to engage in decision-making, the free exchange of opinion between staff and patients, and the combination of structured and unstructured programming, morale is high in both patients and staff. Patients tend to develop a healthy dependency on the unit and on staff members, are reluctant to "let the unit down," and often incorporate the unit morale into their defense against subsequent drinking.

6. Estimates of effectiveness are difficult, but it appears that between 15 and 20 per cent of the patients are remaining dry for periods up to a year after leaving the unit; many are now dry for as much as four years; and many others return to the hospital periodically and continue to get help even though they do lapse into drinking while outside. The latter group constitutes about one-third of the admissions, but they also constitute a group which, hopefully, will ultimately achieve complete sobriety.

SUMMARY

[redacted] established both in practice and in theory. Experience has shown that it is practical to establish rehabilitation units in state hospitals which are helpful in avoiding the chronicity and deterioration formerly seen in the state hospital alcoholic population. These units carry considerable promise for the future in reversing these processes and in producing functionally competent, socially acceptable citizens out of what formerly constituted one of the most hopeless segments of the hospital population.

Alcoholism
The Total Treatment Approach

planning and organization is being supplanted by the development of services to the individuals who need them.

Each community mental health center will decide on the manner in which it provides services for alcoholics and other problem drinkers, but, in making those decisions, the staffs of the centers can now request technical assistance from the National Center for the Prevention and Control of Alcoholism. The Consultation and Training Section of the National Center is responsible for liaison with community mental health centers programs and the state grants-in-aid programs to provide encouragement for, and advice on, the inclusion of alcoholism components in their service programs. As this liaison develops, alcoholism programs—developed locally—can receive the benefits of knowledge collected nationally as it relates to research, the training of manpower, and the content of service programs.

ALCOHOLISM AND MENTAL HEALTH

By establishing the National Center for the Prevention and Control of Alcoholism within the framework of the National Institute of Mental Health, the Federal government has decided, for its practical purposes, that there is a major relationship between alcoholism and mental health services.

Some individuals and organizations do not agree, and maintain that alcoholism is not a mental health problem, but one of "drinking," or of willpower, or religious conviction. However, when one accepts the premise that alcoholism is indeed a mental health problem, the relationships between mental health and alcoholism are diverse, and are still based on a variety of specific points of view.

Clinically, alcoholism is seen as an effect and/or a cause of mental disorder or emotional problems—for the individual whose drinking is uncontrolled, for his family, his colleagues, and any others affected by his actions.

Administratively, alcoholism programs, financed in whole or in part by state funds, are in some cases supervised by the state mental health agency and in other instances are independent of it.

Legally, the alcoholic is, in some jurisdictions, considered to be ill and mentally disabled, while in other places and circumstances he is subject to statutes delineating such matters as commitment or a jail sentence.

When he desires treatment, or when treatment is ordered, the problem drinker may be encouraged to seek treatment or other mental health services in a general hospital psychiatric ward or an outpatient psychiatric clinic. On the other hand, such facilities, by their admission and service policies, may expressly refuse to treat him.

Because of these, among many other reasons and attitudes directed toward him, the problem drinker, confused at best, is faced with confusion

among the health facilities, the health services, the social agencies, the courts and the correctional personnel, and the vocational rehabilitation programs existing and operating within his community, as well as by conflicting policies of voluntary organizations.

THE ROLE OF THE COMMUNITY MENTAL HEALTH CENTER

The community mental health center, taking all these factors into account, must decide the size, scope, and content of its program of services available to the problem drinker. There can be no doubt that services *will* be available to him, if the mental health center receives financial support from the Federal government, since that support is predicated on the equal availability of mental health services provided by the center to all residents of the area served by it.

The regulations of the Community Mental Health Centers Act, under which grants are awarded to centers, require that the center provide services of high quality to community residents, without discrimination as to race, ability to pay or not to pay, length of residence in the area, or the type or severity of emotional disturbance or mental disorder.

Before deciding, then, how to serve the patient whose primary diagnosis may be alcoholism, schizophrenia, mild anxiety, deep depression, or an acute suicidal crisis, it is first necessary to understand the concepts on which the entire national mental health program and the community-based service program were developed.

By 1963 it was obvious that treatment of the mentally ill was, in large measure, ignoring the available knowledge about treatment, and was settling in too many instances for impersonal care that was primarily custodial and, by its focus on large and isolated institutionalized settings, often harmful rather than curative.

Very simply, the concepts of the community mental health center were developed on these premises:

> That a community could and should provide treatment for mental illness and services to promote mental health within that community;
>
> That at least five basic services were necessary—inpatient service, outpatient service, partial hospitalization, emergency service, and consultative and educational services;
>
> That each individual patient should be treated at any given day in the service most appropriate for him in terms of the nature and severity of his illness, and that he should be transferred without delay to any of the other services when his recovery or regression indicated need for such a transfer.

When a community mental health center provides these elements of

HEALTH INSURANCE COVERAGE FOR ALCOHOLISM:

STATE LEGISLATIVE AND REGULATORY ACTIVITIES

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HEALTH INSURANCE COVERAGE FOR ALCOHOLISM:

STATE LEGISLATIVE AND REGULATORY ACTIVITIES

I. INTRODUCTION

This report is one of a series whose purpose is to explore and provide information on the various facets surrounding health insurance coverage for alcoholism.[1,2] These reports have been prepared for and sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as a part of their effort to enhance third-party payments for alcoholism treatment.[2]

The NIAAA and its predecessor, The National Center for Prevention and Control of Alcoholism, have long maintained an acute interest in the development of health insurance coverage for alcoholism. Preliminary studies in 1968 and 1972 served to provide baseline information on the nature and extent of health insurance coverage for alcoholism; importantly they identified major factors critical to more effective utilization of this health service payment mechanism.[1,2] For example, the 1972 study concluded that: (1) public and private insurers lag behind expressed or implicit service needs; (2) the insurance industry emphasizes hospital care as the treatment arena for alcoholism in spite of other less expensive alternatives; (3) the insurance industry frequently applies sanctions against claims for alcoholism treatment per se, yet appears to condone the use of pseudo-diagnoses which are used as a cover for alcoholism treatment; and (4) the costs of treating alcoholism (which are in fact poorly known) are frequently used as arguments against underwriting this condition.

Following these studies the NIAAA in late 1972 began to formulate a comprehensive work program designed to ultimately maximize third-party

payments for alcoholism focused on the development and costs of model health insurance benefit provisions, and the development of alcoholism treatment standards.* Another element of the work program which is the subject of this report, concerns the development and status of state insurance regulations specifically dealing with insurance benefits for the treatment of alcoholism. This report details the findings of a national survey of state insurance regulatory agencies as well as interviews with legislators from states in which legislation pertaining to health insurance coverage for alcoholism is pending or has been enacted.

*See for example J. B. Hallan, "Health Insurance Coverage for Alcoholism: Model Benefit Provisions," unpublished report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1973.

II. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study has examined the nature and extent of state legislative and regulatory activities concerning health insurance coverage for alcoholism. State insurance regulatory agencies were queries via a mailout questionnaire. Legislative activities were examined through structured interviews with state legislative officials.

The study revealed that only four states (Illinois, Massachusetts, Minnesota, and Wisconsin) have passed some form of enabling legislation or statute concerning mandatory inclusion of health insurance benefits for alcoholism. Comparison of enabling legislation between these four states reveals that all require mandatory inclusion of alcoholism treatment benefits for group insurance plans while only one state (Massachusetts) requires such coverage in individual plans. Actual benefits provided by the enabling legislation among the four states range from no specification to a fixed number of inpatient days of care; only one state requires outpatient care. State regulations promulgated from existing statutes contain essentially the same language as the enabling legislation, i.e. there has been no expansive or narrow interpretation of enabling legislation by regulatory agencies.

Six states (Alaska, Michigan, Mississippi, Nebraska, Oregon, and Washington) were found to have legislation pending concerning health insurance coverage for alcoholism. The pending legislation is encouraging inasmuch as a) four out of the six states will require coverage in individual plans (as well as group plans), and b) four states will require the provision of outpatient benefits.

Finally, only one state (Arkansas) which has no new or pending legislation concerning health insurance coverage for alcoholism is planning the development

of regulations in this area. Apparently sufficiently broad statutory authority exists for the Arkansas Insurance Department to take this step. About 90 percent of the state respondents however do not currently have such authority. It should be noted that none of the states with existing regulations or pending legislation make any explicit provisions for intermediate care.

Regulatory agency information needs, operations and perceptions regarding health insurance coverage for alcoholism may be summarized as follows:

(1) Those states with existing regulations have used information from a variety of sources as an aid in regulation development: uniform regulatory language was considered useful in such efforts,

(2) Little useful information concerning treatment costs, benefit payments or carrier effectiveness in handling claims is being collected,

(3) A majority of respondent states not only perceive that health insurance should provide coverage for alcoholism but also that statutes/regulations are necessary to assure such coverage, and

(4) Most states felt that current regulations do not assure adequate coverage for alcoholism coverage.

Interviews with legislative officials of eight states revealed:

(1) Legislation in most cases was originated by persons with a professional or intense personal interest in this area.

(2) Legislators operate from a less than ideal position inasmuch as little information is available to them which allows for adequate preparation of legislation.

(3) The insurance carrier industry has in general moved from a position of active opposition of health insurance coverage for alcoholism to a position of providing useful information and aid in the preparation of legislation.

(4) Labor and management groups have been supportive of this type of

legislation and have in general not expressed concern with treatment costs.

(5) Hospital and physician groups have favored legislation which specified hospital treatment by qualified physicians.

(6) In the past outpatient benefit provisions have received little support although the picture is changing as evidenced by pending legislation in the various states.

Thus in summary it appears that state efforts to achieve health insurance coverage for alcoholism are only beginning. While only four states have enacted legislation and six states have pending legislation, the majority of state regulatory agencies indicated the desirability of such legislation. Unfortunately the benefits assured by either passed or pending legislation are quite varied with minimal emphasis on individual contracts and more importantly on care received in an outpatient setting.

Conclusions suggested from the study include

(1) that there is indication of the carrier industry responding to the expressed concern of the public,

(2) that traditional health care providers are advocates of only traditional forms of care (i.e. inpatient, physician based treatment),

(3) that there is a need to provide legislators with accurate and timely information on the status of health insurance consumers and the emerging forms of care which are <u>not</u> of an inpatient nature,

(4) that state legislation is perhaps the most promising method of assuring adequate third-party payments from the private health insurance sector for alcoholism treatment, and

(5) that state legislation concerning health insurance coverage for alcoholism should have as a minimum provision which requires that alcoholsim be covered as any physical disease is covered and as a

maximum precise specifications for inpatient and outpatient coverage. Draft model regulatory language embodying these conclusions will be found in Appendix C to this report.

It would appear that an effective program concerning third-party payment mechanisms for alcoholism can best be mounted in an arena of cooperation and sharing of information; therefore,

(1) It is recommended that the National Institute on Alcohol Abuse and Alcoholism consider the establishment of an in-house staff position and a consultation group to actively seek out and provide consultation to states which are considering or have legislation pending concerning health insurance coverage for alcoholism. It will be the function of this group to

(a) develop a background package of materials (including a glossary, treatment cost data, experiences of other states, legislative language, etc.) to aid in the development of legislation appropriate for the state,

(b) to schedule meetings (on a routine basis) with the various legislators to provide information and support, and

(c) provide an interface between the insurance carrier industry and the National Institute on Alcohol Abuse and Alcoholism.

(2) It is also recommended that the National Institute on Alcohol Abuse and Alcoholsim consider the sponsoring of a series of regional seminars concerning the development of legislation for health insurance coverage for alcoholism. Potential attendees would be legislators and regulatory agency officials. The seminars would include a didactic presentation of existing and pending legislative efforts and their ramifications, alternative methods of treatment of alcoholics, treatment costs, and desirable health insurance coverage for alcoholism.

III. BACKGROUND

As alluded to above, interest in state regulation of health insurance coverage for alcoholism stemmed from recognition of (1) state authority and ability to impose or specify minimum health insurance benefits vendered by carriers operating within state boundaries, and (2) a growing interest by state legislatures in promulgating statutes which deal with health insurance coverage for alcoholism. For the purpose of this report, it is useful to explicate several salient aspects of the establishment and operational history of state regulatory insurance agencies or insurance departments. (More detailed explanations can be found in the many texts concerning insurance regulation, taxation and investments -- see for example: E. J. Faulkner, Health Insurance, New York: McGraw Hill Book Co., 1960.) During the early history of the United States the regulation of insurance was viewed as a power reserved for the states and beginning in the 1850's state agencies were charged with the responsibility of insurance regulation. In 1945, the McCarron-Ferguson Act (P.L. 15 of the 79th Congress) formally recognized the right of states to regulate and tax the business of insurance.[2] Because of the potential regulatory diversity among the various states, the National Association of (State) Insurance Commissioners was formed and over the years has done much to establish adequacy and uniformity.

In general states are empowered to regulate the nature and extent of insurance contracts, the cost of insurance and the conduct of the insurance carrier (i.e. policy, price, and procedure). In the area of policy, the National Association of Insurance Commissioners has been instrumental in the development of uniform guides for accident and sickness benefit provisions; it has not, however, recommended minimum benefit provisions because of a

feeling that public needs can better be met in a competitive market place. In the area of insurance costs there is also a tendency to let the competitive market place act as the regulation. The procedures or conduct of health insurance carriers on the other hand are rather strictly regulated through various state laws and rulings more or less uniform throughout the United States. Finally, state insurance departments have state statutes or laws as the legal basis for regulatory activities. The statute language may range from a broad to a highly explicit nature and from that authority various administrative rulings or interpretations are made. Thus actual regulation of carriers is accomplished through both statutory and administrative rule language.

During the past several years legislatures of the many states have displayed increasing interest in the consideration of legislation which mandates through regulation that insurance carriers provide some form of benefits for treatment of alcoholism. This report examines the nature and extent of enacted or pending legislation, regulations emanating therefrom and regulatory agency activities and perceptions related to health insurance coverage for alcoholism.

IV. METHODOLOGY

State regulatory activities concerning health insurance coverage for alcoholism were determined through the use of a survey instrument mailed to the regulatory agencies. The survey instrument was designed to gather information about the following:

(1) Agency functions and current or planned regulations concerning health insurance coverage

(2) The regulatory development process

(3) Agency operations

(4) Agency perceptions concerning health insurance coverage for alcoholism

Questionnaires were sent to all the states, the District of Columbia and to the territory of Puerto Rico. Telephone followups were made to non-responding states about three weeks following the questionnaire mailout. Overall response to the questionnaire was good with 47 out of 52 returned. In spite of repeated calls, the District of Columbia and the states of Massachusetts, New Jersey, New York, and Washington did not respond. A facsimile of the instrument used to survey the states will be found in Appendix A.

In addition to information gathered by the survey instrument, legislators were interviewed in eight states which had passed or were considering legislation concerning health insurance coverage for alcoholism. States in which the interviews took place included Alaska, Illinois, Massachusetts, Michigan, Mississippi, Nebraska, Washington, and Wisconsin. The interviews were of a structured nature, were designed to measure legislative activities as well as gather information on lobbying activities and perceptions of legislative needs. A copy of the structured interview guide will be found in Appendix B.

V. FINDINGS

A. Nature of Health Insurance Regulated by Agency Respondents

Table 1 provides a summary of health insurance regulated by the various 47 state agency respondents. Better than 90 percent of the respondents indicated that they regulate disability and hospital care insurance and about 70 percent indicated regulatory authority over health personnel insurance. Only about 37 percent indicated that they had regulations covering health maintenance organizations.

TABLE 1

NATURE OF HEALTH INSURANCE REGULATED BY STATE AGENCIES

Type of Insurance	Percent of 47 Agency Respondents
Disability	96
Hospital Care	
Group	93
Individual	91
Physician or Other Health Personnel Services	
Group	70
Individual	67
Health Maintenance Contracts	37

Source: Health Insurance Coverage for Alcoholism Survey Data, 1974.

B. Status of State Legislation Concerning Health Insurance Coverage for Alcoholism

The current status of state legislation relating to health insurance coverage for alcoholism as of February, 1974 is presented by state in Table 2; Tables 3 and 4 provide summaries of existing and pending state legislation respectively. As may be seen from Table 2 a majority of the states have neither enacted nor have pending legislation concerning health insurance coverage for alcoholism. Only four states (Illinois, Massachusetts, Minnesota, and Wisconsin) have passed some form of enabling legislation or statute concerning mandatory provision of health insurance benefits for alcoholism (see Table 3). Comparison of existing legislation between these four states as shown in Table 3 reveals that all require mandatory inclusion of alcoholism treatment benefits under group insurance plans while only one state (Massachusetts) requires such coverage under individual plans. Each of the four states requires inpatient benefits in their regulations, while only the state of Massachusetts requires outpatient benefits. The nature of the benefits provided for by the regulations is quite variable from state to state. Two states (Massachusetts and Minnesota) specify a minimum number of days of care, while the state of Illinois provides no specification. The state of Wisconsin specifies that alcoholism treatment benefits must be substantially equal to existing policy provisions for mental and nervous conditions or other general conditions. Outpatient coverage as provided for by the state of Massachusetts establishes a $500/year minimum benefit. Legislation enacted by these four states in general requires that care be provided in a hospital or other facility licensed by the state.

As shown in Table 4 legislation concerning health insurance coverage

TABLE 2

STATE LEGISLATION RELATING TO HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AS OF FEBRUARY 1974

State	No Legislation in Process or Enacted	Legislation in Process		Legislation Enacted into Law	Nature of Planned or Existing Legislation
		Senate	House		
ALABAMA	X				
ALASKA		Passed	Pending		Requires that all group health and disability insurance policies provide benefits for inpatient alcoholism care in a hospital or treatment facility licensed by the state as a comprehensive intensive treatment care facility for alcoholics.[1]
ARIZONA	X				
ARKANSAS	X				
CALIFORNIA	X				
COLORADO	X				
CONNECTICUT	X				
DELAWARE	X				
FLORIDA	X				
GEORGIA	X				
HAWAII	X				
IDAHO	X				
ILLINOIS				1973	Requires all group accident and health insurance to provide inpatient hospital coverage for alcoholism treatment. Covered treatment must be provided in a state licensed hospital or state approved alcoholism treatment facility.[2]
INDIANA	X				
IOWA	X				
KANSAS	X				
KENTUCKY	X				
LOUISIANA	X				
MAINE	X				
MARYLAND	X				

TABLE 2 continued

State	No Legislation in Process or Enacted	Legislation in Process		Legislation Enacted into Law	Nature of Planned or Existing Legislation
		Senate	House		
MASSACHUSETTS				1973	Requires group health insurance policies, group or non-group employee health and welfare funds, individual or group hospital service contracts and individual or group medical service contracts provide minimum inpatient benefits of 30 days per year and minimum outpatient benefits of $500 per year. Facilities must be so licensed by the State Department of Public Health.[3]
MICHIGAN		Pending	Passed		Requires individual insurance policies to offer coverage for inpatient treatment of alcoholism and drug abuse, and requires all group disability insurance policies to provide coverage for inpatient and outpatient treatment of alcoholism and drug abuse. Facilities must be approved by the Department of Public Health.[4a] Requires non-profit medical care corporations to offer benefits for group subscribers for the inpatient or outpatient treatment of alcoholism and drug abuse by a licensed physician or osteopathic practitioner in a facility approved by the Department of Public Health.[4b] Permits non-profit hospital service corporations to enter into contracts for alcoholism and drug abuse treatment with a licensed facility approved by the Department of Public Health which provides inpatient or outpatient care for alcoholism and drug abuse and which meets the standards set by the non-profit hospital service corporation for such contracting facilities.[4c]
MINNESOTA				1973	Requires all group health, medical, hospitalization, accident or sickness insurance policies or plans to provide for treatment of alcoholism in a licensed hospital or a licensed residential primary treatment program. Coverage shall be a minimum of 20 percent of total patient days allowed by the policy and must be at least 28 days per year.[5]

State	No Legislation in Process or Enacted	Legislation in Process		Legislation Enacted into Law	Nature of Planned or Existing Legislation
		Senate	House		
MISSISSIPPI		Passed	Pending		Requires that all group and nongroup accident or health insurance policies provide benefits for the care and treatment of alcoholism on the same basis as other health service benefits. Individual policy holders have the option to reject alcoholism benefits.[6]
MISSOURI	X				
MONTANA	X				
NEBRASKA		Pending in the single Nebraska legislative body			Requires group and individual accident and sickness insurance contract, policy, or certificate to provide hospital treatment of alcoholism. A hospital as used here is any facility providing inpatient alcoholism treatment and licensed by the Department of Health.[7]
NEVADA	X				
NEW HAMPSHIRE	X				
NEW JERSEY	X				
NEW MEXICO	X				
NEW YORK	X				
NORTH CAROLINA	X				
NORTH DAKOTA	X				
OHIO	X				
OKLAHOMA	X				
OREGON		Pending			Requires group health insurers to provide benefits for mental and nervous conditions. Benefits must include a minimum of 30 inpatient hospital days per year and 50 percent of major medical expenses (up to a maximum of $500 per year) while receiving non inpatient care.[8]
PENNSYLVANIA	X				
RHODE ISLAND	X				
SOUTH CAROLINA	X				
SOUTH DAKOTA	X				
TENNESSEE	X				
TEXAS	X				
UTAH	X				
VERMONT	X				
VIRGINIA	X				

TABLE 2 ...tinued

State	No Legislation in Process or Enacted	Legislation in Process: Senate	Legislation in Process: House	Legislation Enacted into Law	Nature of Planned or Existing Legislation
WASHINGTON		Pending	Passed		Requires all group disability insurance contracts (including those of a health maintenance organization nature) to provide benefits if care is received in an approved treatment facility or a facility accredited by the State's Department of Social and Health Services. All extended or major medical policies whether group or individual must contain similar benefits.[9]
WEST VIRGINIA	X				
WISCONSIN				1972	Requires all group accident and sickness contracts to provide inpatient hospital care benefits for alcoholism of a "substantially" equal nature to those provided for treatment of mental or nervous conditions or other general conditions.[10]
WYOMING	X				
DISTRICT OF COLUMBIA	X				
PUERTO RICO	X				

[1]Alaskan Senate Bill No. 35, Alaskan Senate, 1973.
[2]Public Act 78-767, General Assembly State of Illinois, 1973.
[3]Chapters 175, 176A, 176B, General Laws of the Commonwealth of Massachusetts, 1973.
[4a]House Bill #5263, Michigan House of Representatives, 1974.
[4b]House Bill #5390, Michigan House of Representatives, 1974.
[4c]House Bill #5391, Michigan House of Representatives, 1974.
[5]Senate File No. 1895, Minnesota State Senate, 1973.
[6]Senate Bill No. 1746, Mississippi Senate, 1974.
[7]Legislative Bill 127 and amendments, Legislature of Nebraska, 1973.
[8]Senate Bill 176, Oregon Legislative Assembly, 1973.
[9]House Bill No. 1077, Washington House of Representatives, 1974.
[10]Chapter 325, Laws of 1971, State of Wisconsin, 1972.

TABLE 3

SUMMARY OF EXISTING STATE LEGISLATION CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AS OF FEBRUARY 1974

State	Insurance Contracts Covered	Individual Coverage	Group Coverage	Inpatient		Outpatient	
				Benefits	Place of Care	Benefits	Place of Care
Illinois	Accident & health	No	Yes	Not specified	State licensed hospital	Not covered	---
Massachusetts	Health insurance	Yes	Yes	30 days minimum	Facility licensed by state	$500/yr. minimum	Facility licensed by state
	Employee & welfare funds	Yes	Yes				
	Hospital service	Yes	Yes				
	Medical service	Yes	Yes				
Minnesota	Health	No	Yes	Minimum of 20% of total days provided for in policy. Must be a minimum of 28 days/year.	State licensed hosp. or state licensed residential primary treatment program	Not covered	---
	Medical	No	Yes				
	Hospitalization	No	Yes				
	Accident or sickness	No	Yes				
Wisconsin	Accident & sickness	No	Yes	Substantially equal to policy provisions for mental or nervous conditions or other general conditions	Hospital	Not covered	---

TABLE 4

SUMMARY OF PENDING STATE LEGISLATION CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AS OF FEBRUARY 1974

State	Insurance Contracts Covered	Individual Coverage	Group Coverage	Inpatient		Outpatient	
				Benefits	Place of Care	Benefits	Place of Care
Alaska	Health & Disability	No	Yes	Not specified	Hospital or state licensed comprehensive intensive treatment care facility	None	---
Michigan	Health & Disability	Yes	Yes	Not specified	Facility approved by State Dept. of Public Health for hospitalization or treatment	(Group only) Not specified	Care provided by licensed physician or osteopathic practitioner in facility approved by State Dept. of Public Health
Mississippi	Accident & Health	Yes (But may be rejected by purchaser)	Yes	Same as other health service benefits in policy		Same as other health service benefits in policy	
Nebraska	Accident & Sickness	Yes	Yes	Not specified	State licensed hospital or facility which can provide inpatient alcoholism treatment	None	---
Oregon	Health	No	Yes	30 days minimum	Not specified	50% of major medical care up to $500/yr.	---
Washington	Disability & Prepaid Contracts	No	Yes	Not specified	Approved treatment facility or a facility accredited by the state	Not specified	Approved treatment facility or a facility accredited by the state
	Extended Care Policies	Yes	Yes	"	"	"	"

for alcoholism is pending in the states of Alaska, Michigan, Mississippi, Nebraska, Oregon, and Washington. Should the pending legislation pass in the current form, each of these states will provide for alcoholism treatment benefits under group insurance plans: in addition, the states of Michigan, Nebraska, and Washington make such benefits mandatory under individual insurance plans. While all of the states specify inpatient coverage for alcoholism treatment, only the states of Alaska and Nebraska do not provide for outpatient care. Four of the six states with pending legislation do not specify actual inpatient benefits to be provided: Oregon specifies that a minimum of 30 days of inpatient care must be provided while Mississippi requires that such benefits be equal to that of other health service benefits in a given policy. Outpatient benefits are in general not specified by these states, with the exception of Mississippi which requires that policies must provide the same outpatient benefits as provided for other conditions in a given policy. In general proposed legislation specifies that treatment must be provided in a hospital or facility which has been approved or licensed by the state to operate as such. The pending legislative efforts among the various states are encouraging inasmuch as (1) four out of the six states require coverage under individual plans (as well as group plans), and (2) four states require the provision of outpatient benefits.

C. Status of State Regulations* Concerning Health Insurance Coverage for Alcoholism

The status of regulations concerning health insurance coverage for alcoholism is presented in Tables 5 - 10. As can be seen from Table 5,

*State regulations are to be distinguished from state statutes or enabling legislation. Legislation is in effect a precursor of regulations: regulations are promulgated (in this instance by state insurance regulatory agencies) and as such are subject to expansive or narrow interpretation.

TABLE 5

STATUS OF STATE* REGULATIONS CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Regulation Status	Number of States
Existing regulations	4
Planning regulations	2
No regulations in effect	42
Unknown	4

*Includes District of Columbia and Puerto Rico

Source: Health Insurance Coverage for Alcoholism Survey data, 1974.

42 of the states have no regulations, two are currently planning regulations, and four have existing regulations: no information is available on four states. Table 6 provides summary data on existing and planned regulations concerning health insurance coverage by state. Tables 7 and 8 provide information on the nature of existing state health insurance regulations by type of care, i.e., inpatient or outpatient. It should be noted that each of the four states shown (Massachusetts, Illinois, Minnesota, and Wisconsin) have regulations which closely resemble the legislation described in earlier tables. Only two states indicated that state health insurance regulations were in a planning stage (see Tables 9 and 10). Interestingly enough there is no legislation pending in the Arkansas Legislature thereby indicating that the State Insurance Department in Arkansas apparently has existing statutory authority of a broad nature. Thus, in summary, state regulations apparently contain essentially the same language as enabling legislation, i.e., there has been no expansive or narrow interpretation of enabling legislation by regulatory agencies to date.

Finally, in response to a series of questions reporting status of regulations:

(a) about 90 percent of the state regulatory agencies indicated that it would be necessary to change or augment existing statutes in order to implement or develop regulations providing health insurance coverage for alcoholism,

(b) about 70 percent of the respondents indicated that they had no regulations which in any way specified, delimited or effected health insurance benefits for mental conditions,

(c) none of the three respondent states that have existing regulations

TABLE 6

SUMMARY OF EXISTING AND PLANNED REGULATIONS CONCERNING HEALTH INSURANCE COVERAGE BY STATE

State	Has Existing Regulations	Regulations are being Planned	Group Contracts			Individual Contracts		
			Inpatient Care	Outpatient Care	Other Care	Inpatient Care	Outpatient Care	Other Care
Illinois	Yes	---	Yes	No	No	No	No	No
Massachusetts	Yes	---	Yes	Yes	No	Yes	Yes	Yes
Minnesota	Yes	---	Yes	No	No	No	No	No
Wisconsin	Yes	---	Yes	No	No	No	No	No
Arkansas	---	Yes	(In early planning stages -- no specific information available)					
Mississippi	---	Yes	(Enabling legislation allowing development of regulations was enacted after receipt of questionnaire.)					

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews at State Legislatures.

TABLE 3

NATURE OF EXISTING STATE HEALTH INSURANCE REGULATIONS CONCERNING INPATIENT CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Both Group and Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Days of Care	Place(s) of Care
Illinois	Accident & Health	X			Unknown	Unknown	State licensed hospital or state approved alcoholism treatment facility
*Massachusetts	Health Employee & Welfare Funds Hospital Service Medical Service			X	Not specified	30 days	Facilities must be licensed by the State Dept. of Public Health
Minnesota	Health Medical Hospital Accident or Sickness	X			Not specified	20% of total days provided for in policy or min. of 20 days/year	State licensed hosp. or state licensed residential primary treatment program
Wisconsin	Accident & Sickness	X			Not specified	30 days	Hospital

*No questionnaire received. Information derived from legislation.

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews of State Legislatures.

TABLE 9

NATURE OF EXISTING STATE HEALTH INSURANCE REGULATIONS CONCERNING OUTPATIENT CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Applies to Both Group & Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Number of Outpatient Visits	Nature of Benefit: Place(s) of Care
Massachusetts	Health Employee & Welfare Funds Hospital Medical			X	$500/yr.		Facility licensed by state

Source: Interview of State Legislature.

TABLE 9

NATURE OF PLANNED STATE HEALTH INSURANCE REGULATIONS CONCERNING INPATIENT CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Applies to Both Group & Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Days of Care	Nature of Benefit: Place(s) of Care
Arkansas	(In early planning stages -- no specific information available.)						
Mississippi	Accident & Health			X	Same as other health service benefits in policy		

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews of State Legislatures.

TABLE 10

NATURE OF PLANNED STATE HEALTH INSURANCE REGULATIONS CONCERNING OUTPATIENT CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Applies to Both Group & Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Number of Outpatient Visits	Nature of Benefit: Place(s) of Care
Arkansas	(In early planning stages -- no specific information available.)						
Mississippi	Accident & Health			X	Same as other health service benefits in policy		

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews at State Legislatures.

are considering any plans to modify such regulations during the next two years, and

(d) among those states in which regulations currently exist none provide for any form of care other than inpatient or outpatient, i.e., transitional or intermediate care have not yet been specified within the regulations.

D. Regulation Development

Only three states with existing regulations responded to the questionnaire section dealing with the development of regulations. (Note that Massachusetts which has regulations did not return the questionnaire.) That section was designed to provide insights into information sources which may be useful in the development of regulations concerning health insurance coverage for alcoholism. Because of the low response rate the information source data will not be presented in tabular form. Information sources which appeared to have been the most useful in the development of regulations concerning health insurance include professional organizations or societies, consumer sources and the National Association of Insurance Commissioners. Further, those state regulatory agencies responding feel that information on health insurance regulations concerning coverage for alcoholism in other states would be useful as well as model regulatory language. Draft model regulatory language of potential utility to the states was developed subsequent to analysis of survey data and is attached to this report as Appendix C.

E. Agency Operations

Agencies were queried concerning the conduct of their agency and in particular how they were able to gauge the nature of carrier operations

within their state. The majority of the regulatory agencies indicated that they monitor the provisions in insurance carrier policies. Forty-six agencies indicated that they made routine or special examinations of health insurance carriers operating within the state and a majority of agencies indicated that they routinely collect data on carrier income and carrier benefit payments. Nearly half of the agencies responding indicated that they review and approve insurance rates, and a majority indicated that rates are in effect set or established by the competitive health insurance market place.

Table 11 provides a summary of data routinely collected by state insurance agencies which concerns health insurance coverage for alcoholism. As it may be seen only a small proportion of the states collect information related to benefits, cost of alcoholism treatment, or the effectiveness of carriers in handling claims concerning treatment for alcoholism. Three states (or some 6 percent of respondents) indicated that they had in the past collected data concerning the cost of alcoholism treatment. Specifically, these included (1) collection of data from a local institution which provided treatment for state employees, (2) collection and analysis of studies on the cost of alcoholism to employers, and (3) data generated by the Kemper Insurance Company concerning alcoholism costs. A single state, Wyoming, indicated that it collected state hospital reports concerning how carriers handled claims for alcoholism treatment. In general, it may be surmised that the states do not routinely collect illness specific data related to costs, benefits or carrier effectiveness.

TABLE 11

SUMMARY OF DATA COLLECTED BY STATE INSURANCE AGENCIES CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Data Area	Percent of States Collecting Data
Benefits paid out for treatment of alcoholism	0
Cost of alcoholism treatment	6
Effectiveness of carrier in handling claims	2

F. Agency Perceptions of Need for Health Insurance Coverage for Alcoholism

A series of questions were asked regarding perceptions of state insurance agencies concerning health insurance coverage for alcoholism as shown in Table 12. It should be noted that about 83 percent of the insurance agencies responding indicated that not only should health insurance provide coverage for alcoholism but that statutes and/or regulations are in fact necessary to ensure such coverage. Interestingly only about 23 percent of respondents indicated that their regulations assure adequate coverage for alcoholism treatment. Finally, about three-quarters of the responding agencies indicated that health insurance coverage for alcoholism should be provided for both individual and group policies (see Table 13).

TABLE 12

SUMMARY OF AGENCY PERCEPTIONS CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Area	Percent of States	
	Yes	No
Should health insurance provide coverage for alcoholism?	87	13
Are statutes and regulations necessary to assure health insurance coverage for alcoholism?	85	15
Do current regulations assure adequate coverage for alcoholism treatment?	27	73

TABLE 13

AGENCY PERCEPTIONS REGARDING ALCOHOLISM COVERAGE UNDER GROUP OR INDIVIDUAL CONTRACTS

Desired Form of Contract	Percent of Respondents
Group only	15
Individual only	9
Group and individual	76

C. Legislative Interviews

Legislators in eight states which have considered or are considering legislation concerning health insurance coverage for alcoholism were interviewed to gather information on various facets of the legislative process. States visited included Alaska, Illinois, Massachusetts, Michigan, Mississippi, Nebraska, Washington, and Wisconsin. Although the sample of states interviewed is small a picture emerges as follows:

(1) Origin of Legislation

The origin of the various passed or pending is quite variable. In one instance dissatisfaction with a state employee insurance plan which provided no health insurance coverage for alcoholism was a basis for legislation. In another state there was an expressed feeling that Federal alcoholism programs were of a demonstration nature or hard to find by the general public and could be terminated at any point in time--therefore, some third-party payment mechanism had to be developed. In two states legislation came about as a result of special study commissions. Finally, it appears that state senators or representatives who originated this type of legislation have either a professional or intense personal interest in the area of alcoholism.

(2) Technical Information Used in Preparation of Legislation

Little technical information concerning health insurance coverage for alcoholism has been available to those legislators who have sponsored or originated legislation in this area. In a number of cases the Wisconsin bill was used as a general guide inasmuch as it was the first legislation passed in the United States. Other states have relied on reports from insurance carriers, and the National Council on Alcoholism. Most of these reports apparently presented the problem

of alcoholism in general terms; in certain instances the costs of treatment were estimated. In several instances information provided by one professional organization focused on the hard core alcoholic and failed to indicate the potential benefits of early intervention.

(3) Legislation Provisions

Considerable variation existed in the benefit provisions developed and supported by legislators. Legislators seemed supportive of a range of views concerning the nature and extent of health insurance coverage for alcoholism, i.e. benefit provisions run from specifying that alcoholism must be covered in a manner similar to physical diseases to an outright specification of days of care or a number of outpatient visits or dollar expenditures. A majority of interviewees favor inpatient coverage only.

(4) Legislative Peer Support

Those legislators interviewed indicated that there was generally an expression of support for this legislation from legislative peers; most nonsupportive comments have concerned the area of costs of treatment and insurance carrier costs. Arguments by peers concerning treatment costs have frequently been overcome through discussion of the cost advantage of early intervention.

(5) Lobbying Activities

Interviews also focused on identification of lobbying groups either for or against such legislation. In general there has been no strenuous opposition to the legislation either passed or pending. In several states the insurance carrier industry has apparently moved from an initial position of opposition to such legislation to an ultimate position of support. Their positions reflected preference to

aid in the development of plausible legislation as long as a groundswell of support for such legislation exists. Support of a formal and an informal nature have included the National Council on Alcoholism, various religious groups, labor unions, management, hospital associations, medical societies, mental health societies, and other alcoholism professional groups. Little concern over treatment costs has been expressed by labor or management groups. Certain groups have informally pressed for either expansion or narrowing the proposed legislation. In certain cases religious and AA groups have opposed legislation from the standpoint that pending legislation was too restrictive and have pressed for expanding of legislation. In other instances, hospital associations and medical societies pressed for the narrowing of the pending legislation to limit coverage to hospital inpatient treatment under the care of a qualified physician.

(6) Legislative Process

A key factor associated with either passage of the bill or movement of the bill from one legislative house to another has been the extent and intensity of followup by the originators of the legislation. Many of the legislators interviewed indicated that extensive meetings and discussions were necessary to secure effective processing of the legislation.

REFERENCES

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2. Rosenburg, N. "Survey of Health Insurance for Alcoholism: Inpatient Coverage." National Center for Prevention and Control of Alcoholism, Washington, D. C.: National Institute of Mental Health, 1970.

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APPENDIX A

SURVEY OF HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Agency name: _____

Dept. or division: _____

Street address: _____

State & zip code: _____

Telephone No.: _____

Name & title of person completing form: _____

A. AGENCY FUNCTIONS AND REGULATIONS

(1) Please summarize, as briefly as possible, the major functions of your department: _____

(2) Please indicate the nature or type of insurance that is regulated by your department:

	Yes	No		Yes	No
a) Life	___	___	e) Physician or other health personnel services		
b) Automobile	___	___	Group contracts	___	___
c) Disability	___	___	Individual contracts	___	___
d) Hospital care			f) Other-Please specify		
Group contracts	___	___	_____		
Individual contracts	___	___	_____		

(3) Would it be necessary to change or augment the existing statutes of your state in order to develop or implement regulations requiring that health insurance contracts provide some form of coverage for the treatment of alcoholism? ___No ___Yes (please explain) _____

(4) Does your agency have regulations which specify, delimit, or in any other way affect health insurance benefits or coverage for treatment of mental conditions?

___Yes (if possible, please attach a copy of the regulations)
___Planned but not in effect (if possible, please attach a copy of the draft regulations)
___None in effect

(5) Does your agency have regulations which specify, delimit, or otherwise affect health insurance benefits or coverage for treatment of alcoholism?

___Yes (if possible, please attach a copy of the regulations)
___Planned but not in effect (if possible, please attach a copy of the draft regulations)
___None in effect (skip to Section C)

(6) Please indicate the type of health insurance contracts which are affected by your existing or planned regulations concerning treatment of alcoholism.

___Individual health insurance contracts
___Group health insurance contracts
___Both types of contracts
___Regulation does not specify type of contract
___Other (please specify)_____

(7) Do your existing or planned health insurance regulations concerning treatment of alcoholism specify provision for:

a) INPATIENT CARE? ___Yes ___No. If yes, please check places of treatment specified by the regulation and describe any minimum benefits which must be provided by an insurance contract.

1) Please check place(s) of inpatient treatment
___General hospital
___Mental hospital
___Community mental health center
___Alcoholism treatment center
___Other (please specify)_____

2) Please describe any minimum inpatient benefits which must be provided in an insurance contract:_____

b) OUTPATIENT CARE? ___Yes ___No. If yes, please check places of treatment specified by the regulation and describe any minimum benefits which must be provided by an insurance contract.

1) Please check place(s) of outpatient treatment
___Outpatient department of hospital
___Physician's office
___Other (please specify)_____

2) Please describe any minimum outpatient benefits which must be provided in an insurance contract:_____

c) OTHER FORMS OF CARE? ___Yes ___No. If yes, please indicate the other forms of care specified by the regulation and describe where each care takes place and any minimum benefits which must be provided by an insurance contract.

(8) If your agency has existing regulations concerning health insurance coverage for alcoholism do you have any plans to modify these regulations during the next two years? ___No
___Yes (please describe)_____

DEVELOPMENT AND STATUS OF REGULATIONS

(1) Please check the sources of information which have been (or are expected to be) useful in the development of regulations concerning health insurance:

_____ Professional organizations or societies
_____ Lobbying groups
_____ Consumer sources
_____ Expert consultants
_____ Federal government
_____ National Association of Insurance Commissioners
_____ Other (please specify)_____

(2) Would information concerning alternative methods of regulating health insurance coverage for alcoholism be of use to your department? ____No ____Yes.
If yes, in what form would the information be most helpful? (Check all that apply.)

_____ Reports on activities in other states
_____ Expert consultation and advice on specific problems
_____ "Model" regulations
_____ Other (please specify)_____

(3) Please indicate the status of your state legislation concerning health insurance coverage for alcoholism:

_____ No legislation considered within the past year
_____ Some legislation already in existence prior to one year ago (please describe briefly below)
_____ Legislation planned, or pending (please describe briefly below)
_____ Legislation rejected during the past year (please describe briefly below)
_____ Legislation enacted during the past year (please describe briefly below--including the date on which it goes into effect)

(4) Please indicate the legislative committees which are or have been active in developing legislation concerning health insurance coverage for alcoholism:

Name of Committee	Name of Committee Chairman if known

(5) Please indicate other groups who have expressed interest or opposition to legislation or regulations dealing with health insurance coverage for alcoholism:

Name of Group	Contact Person	Supported Legislation	Opposed Legislation

C. AGENCY OPERATIONS

(1) Please describe how your agency determines whether health insurance carriers operating within your state are in compliance with your regulations (check all that apply):

_____ Carrier must periodically file copies of policies and amendments for your review and approval
_____ Carrier periodically stipulates compliance
_____ No formal mechanism to assure compliance
_____ Competition among carriers tends to assure compliance
_____ Other (please specify)_____

(2) Does your agency make routine or special examinations of health insurance carriers operating within your state?

_____ No
_____ Yes (please explain)_____

(3) Does your agency call upon other state agencies concerned with licensing of health care facilities and personnel or professional health associations or groups for advice, consultation, review of regulations, etc.?

_____ No
_____ Yes (please explain)_____

(4) Does your agency collect on a routine basis data concerning various aspects of health insurance? Check those which apply.

_____ Data on consumer costs
_____ Data on carrier income
_____ Data on carrier benefit payments
_____ Data on illness costs (e.g., hospitals and physician care costs)
_____ Other data (please explain)_____

(5) Has your agency ever collected data which reflects:

a) the nature and extent of benefits paid out for treatment of alcoholism?
____ No
____ Yes (please explain)_____
_____

b) the cost of treatment for alcoholism?
____ No
____ Yes (please explain)_____
_____

c) the effectiveness of health insurance carriers in handling claims for payment of alcoholism treatment costs?
____ No
____ Yes (please explain)_____
_____

(6) Please describe how rates are established for health insurance policies:

____ Agency establishes rates independently (please describe)_____
_____
____ Carriers submit proposed rate schedules for agency review and approval
____ Rates are, in effect, established by the competitive health insurance carrier marketplace

D. PERCEPTIONS CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

(1) Do you think your current regulations assure adequate health insurance coverage for alcoholism?

____ Yes
____ No (please explain)_____
_____

(2) Do you feel that health insurance should provide coverage for treatment of alcoholism?

____ Yes
____ No (please explain)_____
_____

(3) Which type of health insurance contracts (group or individual) do you feel should provide coverage for treatment of alcoholism?

____ Group only (please explain)_____
_____
____ Individual only (please explain)_____
_____
____ Individual and group

(4) Do you think that statutes and/or regulations are necessary to assure that health insurance policies will contain provisions for coverage of treatment of alcoholism?

_____ Yes (please explain)_____

_____

_____

____ No (please explain)_____

_____

_____

E. HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

(1) Do HMOs fall under the insurance regulations of your state? ___Yes ___No.

(2) Do your health insurance regulations require that HMOs offer treatment for alcoholism? ___No ___Yes. If not, are such regulations planned? ___No ___Yes
(Please describe planned regulations)_____

_____

_____

_____

PLEASE RETURN COMPLETED QUESTIONNAIRE TO: Dr. J. B. Hallan
H-2, Inc.
P. O. Box 10503
Raleigh, N. C. 27605

APPENDIX B

LEGISLATIVE INTERVIEW GUIDE

Legislative Group Interviewed _____

Name & Title of Person Interviewed _____

_____

1. State _____

2. Legislative groups active in health insurance coverage for alcoholism (HICA)

   A. Senate

      Names 1. _____

      2. _____

      3. _____

      4. _____

   B. House

      Names 1. _____

      2. _____

      3. _____

      4. _____

3. Description of legislative activities concerning HICA during past two years

   ____ originators of hearings and bills

   ____ administration inputs

   ____ special study groups

   ____ lobbying groups and activities

   ____ deliberations of House or Senate

   ____ actions: ____ passage or ____ defeat

   ____ implementation time

4. Key factors in development, passage or defeat of bills

Development

Passage of Bill

Defeat of Bill

5. Information used in bill preparation: sources and types

Sources	Types
____ lobbying groups	_____
____ professional groups	_____
____ administration	_____
____ other states	_____
____ Federal Government	_____
____ other	_____

6. Perception of need and support for legislation

____ legislative peers

____ professional groups - providers

____ public - consumers

7. Description of bill provision

____ individual contract coverage

____ group contract coverage

____ exact nature of benefits specified

8. Relevant work in progress by either house, administration or lobbying groups

9. Planned future work

APPENDIX C

POTENTIAL UNIFORM REGULATORY LANGUAGE CONCERNING

HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

MINIMUM STANDARD BENEFIT LANGUAGE

All (issued or renewed) policies or plans of group or individual health (medical, hospitalization, accident and sickness, disability) insurance shall provide for the care and treatment of alcoholism on an equivalent basis to other health service benefits specified in the policy or plan.

STANDARD BENEFIT LANGUAGE

All (issued or renewed) policies or plans of group or individual health (medical, hospitalization, accident and sickness, disability) insurance shall provide for the inpatient, intermediate, and outpatient care and treatment of alcoholism provided that such care and treatment is given in a licensed treatment facility.

MAXIMUM STANDARD BENEFIT LANGUAGE

All (issued or renewed) policies or plans of group or individual health (medical, hospitalization, accident and sickness, disability) insurance shall provide for the following minimum benefits for the care and treatment of alcoholism:

(1) Inpatient benefits: no less than 14 days of inpatient care in a licensed treatment facility during any given inpatient benefit period.

(2) Intermediate care benefits: no less than 30 days of intermediate care in a licensed treatment facility during any given benefit period.

(3) Outpatient care benefits: no less than 45 outpatient visits to a licensed treatment facility during any given benefit period.

GLOSSARY*

BENEFITS: Services provided through and paid by the insurer under an insurance contract.

BENEFIT PERIOD: A period of time following initiation of some type of care during which a person may receive maximum benefits as provided for in the benefit specifications.

GROUP INSURANCE POLICY: Insurance covering a group of persons under one contract issued to an employer or organization for the benefit of employees or other members of the group.

HEALTH INSURANCE: The generic term covering forms of insurance relating to the health of human beings including but not limited to accident insurance, sickness insurance, disability insurance, hospital insurance, and medical expense insurance.

INDIVIDUAL INSURANCE POLICY: A contract insuring but one person or one person and his family.

INPATIENT CARE: Care provided on a 24 hour basis to a person domiciled within a given treatment facility; services are usually of a wide range and may include medical and psychosocial treatment.

INTERMEDIATE CARE: Care provided for persons not requiring full time inpatient care but who need either day or night care or sheltered living arrangements. Such care may involve (1) a range of services such as that found in inpatient care or (2) more limited services, e.g. social therapy.

LICENSED TREATMENT FACILITY: Any facility or service setting which has been licensed by an appropriate state authority to provide for the care and treatment of alcoholism.

OUTPATIENT CARE: Care provided by and in a facility, institution or service to a nonresident person. Such care may include a range of services on an emergency or nonemergency continuous basis.

PLAN: A document that sets out the insurance contract.

POLICY: A document that sets out the insurance contract.

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*Sources:
1) E. J. Faulkner, Health Insurance, NY: McGraw Hill Book Co., 1960.
2) J. B. Hallan, "Health Insurance Coverage for Alcoholism: Model Benefit Provisions," unpublished report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1973.
3) Joint Commission on Accreditation of Hospitals, Accreditation Manual for Alcoholism Programs, 1974, unpublished report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1974.

subterfuge diagnoses, or by nonmedical modalities, including those of clinical psychology, religious counseling, lay therapies, and, from the mid-1930s on, Alcoholics Anonymous; or, for the most part, they went untreated until they became totally disabled.

As time went on, and as the commercial insurance companies had no specific exclusions for mental illness, or for alcoholism, the States began submitting claims in the case of patients who had insurance to recover the costs of their hospitalization. Insurance companies countered by newly defining "hospitals" so as to exclude State mental hospitals. Even in the early 1950s, when coverage by health insurance for outpatient treatment of physical conditions was beginning to expand, there was no comparable expansion of mental health and alcoholism benefits *(10)*.

The current situation in mental health insurance coverage, mostly including alcoholism, is a far cry from that of 20 years ago. Approximately 63 percent of the civilian population now have some form of private health insurance which covers the in-hospital treatment of mental illness. About 61 percent have some coverage for physician in-hospital visits, and about 38 percent for physician office visits, for mental conditions *(24)*. Despite such seemingly extensive coverages, highly restrictive limitations often exist with regard to the type of facility in which the patient can be hospitalized, the length of stay, and, for outpatient treatment, the number of visits and the amount of reimbursement.

History of Federal Experience

Although some Federal agencies, such as Social Rehabilitation Services and the Social Security Administration, have been concerned with alcoholism services for populations under their jurisdiction, the major concern for health insurance coverage for alcoholism has been within the Department of Health, Education, and Welfare (DHEW) and more specifically, since its creation in 1970, in the National Institute on Alcohol Abuse and Alcoholism (NIAAA). DHEW's activities date back to before the establishment of the National Center for Prevention and Control of Alcoholism, the predecessor of NIAAA. At that time, an Advisory Committee to the Secretary of DHEW recommended that studies in the area of alcoholism be undertaken. One recommendation concerned the need to examine third-party reimbursements for alcoholism. In 1967, the National Center for the Prevention and Control of Alcoholism began accumulating data on inpatient coverage for alcoholism treatment under health insurance. A 1968 report released the following information *(25)*:

- Just over 60 percent of the general hospitals excluded the admission of persons needing alcoholism treatment.
- About 40 percent of the Blue Cross-Blue Shield plans excluded alcoholism from coverage.
- Independent health insurance plans had even greater exclusions for alcoholism than the Blue Cross-Blue Shield plans. Commercial insurance companies were not surveyed, but available information indicated that they were probably similar to Blue Cross and Blue Shield.

With the advent of the legislation that created NIAAA (the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970) the question of insurance coverage for alcoholism came to the forefront. As NIAAA encouraged programs for employed alcoholic persons (see chapter VIII) it emphasized also the advantages of insurance coverage for them.

In the spring of 1972 NIAAA sponsored an update of the 1968 report. This study *(11)*, released in the fall of 1972 (discussed in detail below), found that although there had been some improvement in health insurance coverage for alcoholism, it is still far behind benefits available for physical conditions. Among the companies that provided alcoholism coverage, the nature and extent of benefits varied widely.

Coinciding with the interests of NIAAA were those of the Public Policy Committee of the National Council on Alcoholism (NCA). This committee represented national voluntary efforts in developing public and private third-party payment mechanisms for the treatment of alcoholism. After the 1972 NIAAA study was released, a joint NCA-NIAAA committee was set up to act in an advisory capacity and to coordinate further efforts regarding health insurance coverage for alcoholism.

State Regulatory Activities

The McCarran Act of 1945 gave to the States the power to regulate the type and extent of

Director, Office of Public Affairs	MICHAEL F. WHITE, Acting.
Director, Office of International Health	ROBERT DECAIRES, Acting.
Director, Office of Health Legislation	C. GRANT SPARTH.
Director, Office of Equal Employment Opportunity	MATTIE K. WRIGHT.

Alcohol, Drug Abuse, and Mental Health Administration

5600 Fishers Lane, Rockville, Md. 20857
Phone, 301–443–4795

Administrator	GERALD L. KLERMAN.
Director, Office of Administrative Management	JOSEPH R. LEONE.
Director, Office of Communications and Public Affairs	JAMES C. HELSING, Acting.
Director, Office of Program Planning and Evaluation	ALFRED E. BURKE, Acting.
Director, Office of Program Coordination	SIDNEY C. WOLVERTON, Acting.
Director, National Institute of Mental Health	FRANCIS N. WALDROP, Acting.
Director, National Institute on Alcohol Abuse and Alcoholism	ERNEST P. NOBLE.
Director, National Institute on Drug Abuse	ROBERT L. DUPONT.

Center for Disease Control

1600 Clifton Road NE., Atlanta, Ga. 30333
Phone, 404–633–3311

Director	WILLIAM H. FOEGE.
Deputy Director	WILLIAM C. WATSON, Jr.
Assistant Director for Program	H. BRUCE DULL.
Assistant Director for Operations	DONALD R. HOPKINS.
Associate Director (CDC Washington Office)	JOHANNES STUART.
Special Assistant to the Associate Director (CDC Washington Office)	LARRY W. SPARKS.
Executive Officer	JAMES D. BLOOM.
Assistant Executive Officer	ELVIN R. HILYER.
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Director, Bureau of Epidemiology	PHILIP S. BRACHMAN.
Director, Bureau of Health Education	HORACE G. OGDEN.
Director, Bureau of Laboratories	ROSLYN Q. ROBINSON.
Director, Bureau of Smallpox Eradication	J. MICHAEL LANE.
Director, Bureau of State Services	J. DONALD MILLAR.
Director, Bureau of Training	WINTHROP N. DAVEY.
Director, Bureau of Tropical Diseases	ROBERT L. KAISER.
Director, National Institute for Occupational Safety and Health	J. DONALD MILLAR, Acting.
Deputy Director	EDWARD J. BAIER.
Executive Officer	ANTHONY M. SCARDACI.

Food and Drug Administration

5600 Fishers Lane, Rockville, Md. 20852
Phone, 301–443–3380

Commissioner of Food and Drugs	DONALD KENNEDY.
Deputy Commissioner	SHERWIN GARDNER.
Associate Commissioner for Medical Affairs	JOHN JENNINGS.
Associate Commissioner for Compliance	JOSEPH P. HILE.
Associate Commissioner for Science	RICHARD BATES.
Associate Commissioner for Administration	GERALD F. MEYER.
Assistant Commissioner for Planning and Evaluation	GERALD L. BARKDOLL.
Assistant Commissioner for Public Affairs	JOHN T. WALDEN.

Assistant Commissioner for Professional and C Programs	
Director, Executive Secretariat	
Director, Office of Legislative Services	
Equal Employment Opportunity Officer	
Director, Bureau of Foods	
Director, Bureau of Drugs	
Director, Bureau of Veterinary Medicine	
Director, Bureau of Radiological Health	
Director, Bureau of Biologics	
Director, Bureau of Medical Devices	
Director, National Center for Toxicological Resea	
Executive Director of Regional Operations	

Health Resources Administration

Center Building, 3700 East-West Highway, Hyatts
Phone, 301–443–6614

Administrator	
Deputy Administrator	
Associate Administrator for Operations and Manag	
Associate Administrator for Planning, Evaluatic Legislation	
Associate Administrator for Communications	
Associate Administrator for Health Resources O	
Deputy Programs	
Associate Administrator for Health Systems Liaisor	
Director, Bureau of Health Manpower	
Director, Bureau of Health Planning and Resour Development	
Director, Equal Employment Opportunity	

Health Services Administration

5600 Fishers Lane, Rockville, Md. 20857
Phone, 301–443–2086

Administrator	
Deputy Administrator	
Associate Administrator for Operations	
Associate Administrator for Management	
Associate Administrator for Communications and Affairs	
Associate Administrator for Planning, Evaluatio Legislation	
Associate Administrator for Regional Affairs	
Director, Indian Health Service	
Director, Bureau of Medical Services	
Director, Bureau of Community Health Services	

National Institutes of Health

9000 Rockville Pike, Bethesda, Md. 20014
Phone, 301–656–4000

Director	
Deputy Director	
Deputy Director for Science	
Assistant Director for Intramural Affairs	
Associate Director for Collaborative Research	

HE 20.8313: Second Special Report to the U.S. Congress on Alcohol and Health, June 1974
From the Secretary of Health, Education and Welfare

Findings

- Alcoholism and alcohol misuse continue to occur at high incidence rates within American society.

- The proportion of American youth who drink has been increasing. Most adolescents have at least tried alcohol, and the highest scores on an index of possible problem-drinking behaviors were recorded in the youngest age group for which data are available, the 18-20 year olds.

- The public suffers from much ignorance concerning alcohol and from ambivalent feelings toward it. Worse yet, heavier drinkers know less about alcohol than do lighter drinkers or abstainers. In general, American attitudes about drinking are marked by confusion and dissent.

- The economic cost associated with misuse of alcohol in the United States is estimated at $25 billion a year.

- The U.S. systems of alcohol controls are chaotic relics. They provide little support in mitigating alcohol problems and may induce a counterproductive ambivalence among the public.

- The excessive use of alcohol, especially when combined with tobacco, has been implicated as increasing the risk of developing certain cancers. Nonwhite men appear to be especially susceptible.

- Heavy drinking during pregnancy can adversely affect the offspring of alcoholic mothers. The significance of heredity in alcoholism is as yet unresolved.

- The development of a new animal model of liver cirrhosis gives promise of resolving the problem of cause in one of the severest damages suffered by alcoholic people, and may contribute to more effective treatment, and prevention.

- Moderate consumption of alcohol is generally not harmful. In some cases, such as among the elderly, it may have beneficial physical, social, or psychological effects.

- The nonexcessive use of alcohol does not appear to adversely affect the overall mortality rate, nor the mortality from a specific major cause of death, coronary heart disease. In fact, the mortality of drinkers is lower than that of abstainers and ex-drinkers.

- How alcohol intoxicates and how alcohol addiction develops are outstanding fundamental questions that require intensive research in several disciplines.

- Alcoholism is a treatable illness, but different treatments are required by different individuals. Increasingly, individual treatment needs can be determined on the basis of valid studies or clinical experience.

- Early identification and treatment of alcoholic people are seriously constrained by the fact that the United States lacks a national consensus on what constitutes responsible use of alcohol. Furthermore, the current lack of parameters with regard to safe versus comparatively unsafe drinking patterns provides an inadequate and ineffective clinical base for the diagnosis of alcoholism.

Recommendations

On May 14, 1974, the President signed Public Law 93-282, continuing and giving renewed emphasis to the Nation's settled commitment to deal with alcohol abuse and alcoholism as initially expressed by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. The new amendments build on the experience since 1970 and sharpen that comprehensive commitment:

> "It is the policy of the United States and the purpose of this Act to (1) approach alcohol abuse and alcoholism from a comprehensive community care standpoint, and (2) meet the problems of alcohol abuse and alcoholism not only through Federal assistance to the States but also through direct Federal assistance to community-based programs meeting the urgent needs of special populations and developing methods for diverting problem drinkers from criminal justice systems into prevention and treatment programs."

On the basis of this legislative mandate and the findings of this *Report*, the Secretary of Health, Education, and Welfare recommends—

THAT THE GROWING STORE OF KNOWLEDGE ABOUT ALCOHOL AND ALCOHOLISM BE MADE MORE READILY AVAILABLE FOR USE BY SPECIALISTS AND THE PUBLIC.

The need to systematize and process the growing world-wide experience, study, and research so that it will be available to scholars, researchers, legislators, educators, administrators, professionals, and all citizens is critical. The further development of the National Clearinghouse for Alcohol Information, in collaboration with appropriate academic and other sources, should therefore be pursued energetically.

THAT EDUCATIONAL RESOURCES FOR PROFESSIONALS AND SCHOOLS BE EXPANDED AND DEVELOPED.

The rehabilitation of problem drinkers and alcoholic people requires the help of a wide variety of professional and allied personnel with special skills and understanding. Resources for the training and accreditation of such specialized personnel should be identified in model form, and States or regional consortiums should be encouraged to adopt these approaches as appropriate to their own needs.

The long-range prevention of alcohol misuse depends in part on the transfer of knowledge about alcohol, and the understanding of its use and nonuse, to the younger generation. Schools throughout the Nation have an important role in this process. Suitable modules of alcohol education should be developed by the National Center for Alcohol Education and Regional Centers. State and local school systems can adapt these modules for their curriculums.

THAT EFFORTS TO DECRIMINALIZE AND INSTEAD PROVIDE COMMUNITY CARE FOR ALCOHOLISM AND PUBLIC INTOXICATION BE REDOUBLED.

The Uniform Alcoholism and Intoxication Treatment Act recommended to the States by the National Conference of Commissioners on Uniform State Laws and by the Secretary of Health, Education, and Welfare provides a model for States to decriminalize alcoholism and public intoxication and establish the legal framework within which to approach them from a community care

standpoint. This action has been recommended by the courts, Presidential Commissions, and professional organizations. A special grant in Public Law 93-282 to States that adopt this legal framework and approach is a fundamental recognition of its importance by Congress and the Administration.

THAT THE NEW LAWS PROTECTING THE PRIVACY AND CONFIDENTIALITY OF ALL CITIZENS WITH DRINKING PROBLEMS BE STRICTLY AND IMMEDIATELY ENFORCED.

Public Law 93-282 amends section 333 of the Alcoholism Act to provide the first comprehensive approach to the issue of confidentiality and privacy for people with drinking problems.

THAT EFFORTS BE SPEEDED UP TO ASSURE QUALITY CARE FOR AND TO REDUCE THE CARNAGE OF ALCOHOLISM AMONG SPANISH-SPEAKING AMERICANS, INDIANS, AND OTHER NATIVE AMERICANS, YOUNG BLACK MEN, AND HIGHWAY TRAVELERS.

THAT THE VALUES OF EARLY IDENTIFICATION AND TREATMENT PROGRAMS IN BUSINESS AND INDUSTRY BE GENERALLY RECOGNIZED THROUGHOUT THE COUNTRY.

The magnitude of the cost to the Nation's economy stemming from problem drinking and alcoholism is staggering. It is imperative to encourage the wider establishment, in Government as well as in the private sector, of the types of program that, with the cooperation of labor and management, have successfully restored substantial majorities of affected personnel to health and normal function. The economic benefits of effective early identification and treatment programs demonstrably outweigh the cost, and the human benefits are beyond valuation.

THAT QUALITY AND COMPREHENSIVE CARE BE EXTENDED TO ALCOHOLIC PEOPLE THROUGH COVERAGE UNDER HEALTH AND DISABILITY BENEFITS AND THE ESTABLISHMENT OF STANDARDS FOR CARE.

Total coverage for the treatment of alcoholism through traditional and other third-party payment plans should continue to be studied. The application of such coverage in both general and special therapeutic settings should be explored, with particular consideration to the continuum of health and human-service needs of alcoholic people in the process of recovery and rehabilitation. Standards and certification for such care are crucial to insurance coverage and to the quality of care that can be obtained by alcoholic people.

THAT NEW AND REVISED POLICIES AND GUIDELINES GOVERNING THE DISTRIBUTION AND SALE OF ALCOHOLIC BEVERAGES BE DEVELOPED.

Current laws and regulations need to be reevaluated to determine whether they are fulfilling their intended purposes. To the extent that they are not, a set of model codes of alcohol-beverage control should be formulated, which States and communities may adopt with modifications to suit their own needs.

THAT IT BE RECOGNIZED THAT THE MULTIPLICITY AND EXTENT OF ALCOHOL-RELATED PROBLEMS CANNOT BE THE EXCLUSIVE RESPONSIBILITY OF THE FEDERAL GOVERNMENT. ACCORDINGLY WE SHOULD FIND WAYS—

To strengthen the involvement and the role of private enterprise in reducing the problems of alcohol misuse and alcoholism;

To enhance the role of voluntary agencies, and support by State and local governments, in activities related to the care of the afflicted, and in contributing to preventive efforts.

THAT EFFORTS BE MADE TO INTENSIFY THE STUDY OF THE RELATION OF ALCOHOL USE TO—

Cancer
Heart disease
Liver disorders
Pregnancy and fetal health
Aging
Longevity and mortality
Brain function and the addictive process

THAT A NEW NATIONAL CONSENSUS CONCERNING WHAT CONSTITUTES RESPONSIBLE USE AND NONUSE OF ALCOHOLIC BEVERAGES BE FORMULATED AND ARTICULATED.

Current concepts and mores concerning the use and nonuse of alcoholic beverages are confused, inconsistent, and sometimes destructive. Knowledge about the use and misuse of alcohol needs to be shared more widely and continually so that citizens and especially our young people are given the opportunity to base their decisions to drink or not to drink on the best information that is available. In addition, new and alternative recreational and social settings may be considered in which drinking will be a coincidental function rather than the main reason for people frequenting them.

Most Americans drink. Drinking is learned mostly at home or from adolescent peers. Being a drinker—rather than an abstainer—is thus an American norm. But there is no universal American drinking pattern, and no common American attitude toward alcoholic beverages.

Amount, frequency, and style of drinking differ according to sex, age, ethnic origin, religion, education, occupation, socioeconomic status, group membership, residence, and, in some, uncontrollable individual needs. Some people have a drink just a few times in a year. Some have a drink, or two or three, nearly every day. Some have many, many drinks at a time—even getting drunk—quite often.

The more affluent, the better educated, and the urbanites are more likely to be drinkers. The younger and the poorer are more likely to experience problems in connection with their drinking. Consistently—except if they become problem drinkers—women drink less, and less often, than men.

Heavier drinking—and getting into some trouble in connection with it—tends to prevail during the home-leaving and courtship years. With settling down and advancing years, it tends to taper off—in some to total abstinence. But some people learn to drink too well and become helplessly enmeshed in "problem drinking" or "alcoholism."

TABLE 1

APPARENT CONSUMPTION OF SPIRITS, WINE, AND BEER, AND OF ABSOLUTE ALCOHOL FROM EACH, AND OF TOTAL ALCOHOL, IN U.S. GALLONS PER PERSON IN THE DRINKING-AGE POPULATION, U.S.A. AND BY STATES, 1972

State	Distilled Spirits	Absolute Alcohol	Wine	Absolute Alcohol	Beer	Absolute Alcohol	TOTAL Absolute Alcohol	Rank Order
Alabama	1.86	0.80	0.63	0.09	16.93	0.76	1.65	48
Alaska	5.06	2.18	2.93	0.43	27.87	1.25	3.86	4
Arizona	2.61	1.12	2.46	0.36	34.70	1.56	3.04	9-10
Arkansas	1.38	0.59	0.95	0.14	17.66	0.79	1.52	50
California	3.17	1.36	4.66	0.68	26.60	1.20	3.24	6
Colorado	2.95	1.27	2.64	0.38	29.61	1.33	2.98	12
Connecticut	3.26	1.40	2.43	0.35	21.81	0.98	2.73	21
Delaware	3.79	1.63	1.87	0.27	28.15	1.27	3.17	8
Florida	3.69	1.59	2.36	0.34	28.99	1.30	3.23	7
Georgia	2.69	1.16	1.11	0.16	20.64	0.93	2.25	36
Hawaii	2.56	1.10	1.91	0.28	24.43	1.10	2.48	29
Idaho	1.80	0.77	1.94	0.28	30.65	1.38	2.43	32
Illinois	3.16	1.36	2.18	0.32	27.36	1.23	2.91	14-15
Indiana	1.72	0.74	0.88	0.13	22.76	1.02	1.89	41
Iowa	1.63	0.70	0.56	0.07	25.27	1.14	1.86	43
Kansas	1.59	0.68	0.57	0.08	21.32	0.96	1.72	47
Kentucky	1.93	0.83	0.70	0.10	22.39	10.1	1.94	39
Louisiana	2.04	0.88	2.20	0.32	28.11	1.26	2.46	30
Maine	2.35	1.01	1.68	0.24	29.92	1.35	2.60	26
Maryland	3.37	1.45	2.10	0.30	28.68	1.29	3.04	9-10
Massachusetts	3.18	1.37	2.54	0.37	26.50	1.19	2.93	13
Michigan	2.51	1.08	1.92	0.28	31.25	1.41	2.77	20
Minnesota	2.65	1.14	1.41	0.20	25.88	1.16	2.50	27-28
Mississippi	1.82	0.78	0.82	0.11	21.93	0.99	1.88	42
Missouri	2.18	0.94	1.34	0.19	25.86	1.15	2.28	35
Montana	2.52	1.08	1.14	0.16	34.95	1.57	2.81	16-19
Nebraska	2.42	1.04	1.10	0.16	28.81	1.30	2.50	27-28
Nevada	8.26	3.55	5.23	0.76	41.86	1.88	6.19	1
New Hampshire	7.41	3.19	2.67	0.39	40.93	1.84	5.42	2
New Jersey	3.14	1.35	2.90	0.42	25.32	1.14	2.91	14-15
New Mexico	2.38	1.02	2.42	0.35	32.08	1.44	2.81	16-19
New York	2.93	1.26	3.06	0.44	25.78	1.16	2.86	15
North Carolina	2.08	0.89	1.50	0.22	18.33	0.82	1.93	40
North Dakota	2.80	1.20	1.15	0.17	29.26	1.32	2.69	24
Ohio	1.84	0.79	1.40	0.20	38.33	1.72	2.71	22-23
Oklahoma	1.79	0.77	1.05	0.15	19.67	0.88	1.80	44
Oregon	2.13	0.92	3.29	0.48	28.15	1.27	2.67	25
Pennsylvania	1.88	0.81	1.50	0.22	28.68	1.29	2.32	34
Rhode Island	2.77	1.19	2.97	0.43	30.62	1.38	3.00	11
South Carolina	2.95	1.27	1.52	0.22	21.17	0.95	2.44	31
South Dakota	2.19	0.94	1.15	0.17	23.44	1.05	2.16	38
Tennessee	1.50	0.64	0.79	0.11	22.09	0.99	1.74	45
Texas	1.76	0.76	1.42	0.21	31.95	1.44	2.41	33
Utah	1.27	0.54	1.05	0.15	18.15	0.82	1.51	49
Vermont	4.41	1.90	3.15	0.46	34.78	1.56	3.92	3
Virginia	2.35	1.01	1.51	0.22	22.29	1.00	2.23	37
Washington	2.36	1.01	3.03	0.44	28.05	1.26	2.71	22-23
West Virginia	1.74	0.75	0.69	0.10	20.00	0.90	1.75	46
Wisconsin	3.04	1.31	1.87	0.27	38.73	1.79	3.37	5
Wyoming	2.81	1.21	1.30	0.20	32.10	1.44	2.85	17
District of Columbia	9.91	4.26	6.31	0.91	38.56	1.37	6.54	
U.S.A.	2.60	1.12	2.16	0.31	28.62	1.20	2.63	

Amounts calculated from tax-paid withdrawals only. The drinking-age population is taken as 15 years and older.

Source: Efron, Keller and Gurioli (20).

The Pacific and New England regions consume the greatest amount of alcohol, while the East South Central region consumes the least.

Figure 1a. APPARENT CONSUMPTION OF ABSOLUTE ALCOHOL, IN U.S. GALLONS PER PERSON IN THE DRINKING-AGE POPULATION, BY REGION, U.S.A. 1972



Source: Efron, Keller and Gurioli [20].

Note: The regions are the standard regions of the U.S. Census Bureau. Amounts and population calculated as in Table 1.

consumption of those States, at the same time causing an underestimation of the true consumption in their own States.

Somewhat more realistic indices of apparent consumption are shown in figures 1a and 1b, in which the consumption is divided among the populations of larger geographic units, the Bureau of the Census regions. Here the consumption, per drinking-age person, is shown as the absolute alcohol contained in the various beverages (figure 1a) and the proportion of the total absolute alcohol contributed by each major class of beverage (figure 1b).

Interesting and perhaps important differences between areas come to light in these figures. At one extreme, inhabitants of the South Central regions apparently consume the least alcohol, and those in the Pacific and New England regions the most. An interesting trend is that the Mountain rate is not far behind that of the Pacific and New England regions. The Mountain region has traditionally had a relatively low consumption rate, but it has been increasing steadily and is now the third highest.

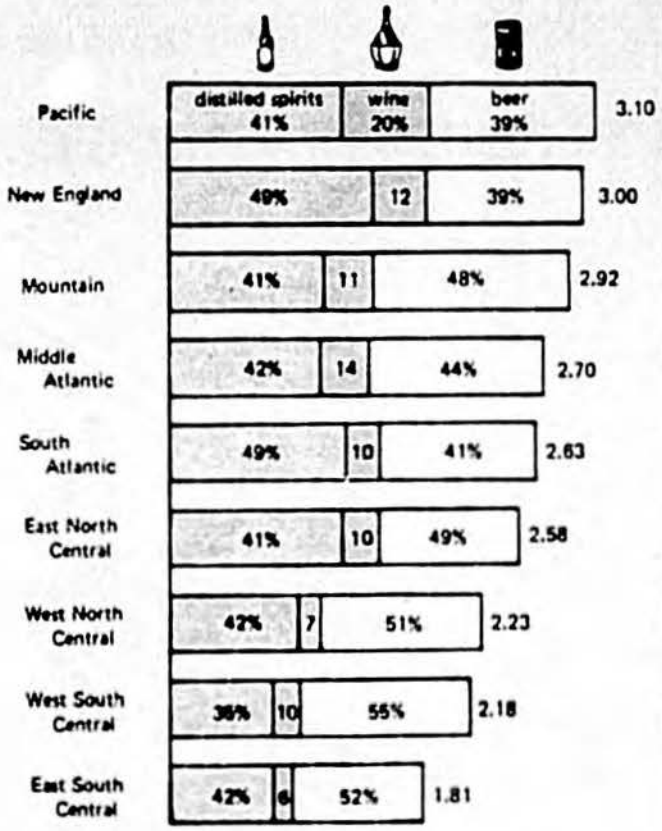
As for different classes of beverages (figure 1b), at one extreme the residents of the West South Central region drink mostly beer (55 percent of their alcohol is consumed in that form), while at the other extreme the New England and the South Atlantic regions favor distilled spirits (49 percent of their alcohol is consumed in that form). Only the Pacific region obtains a substantial portion of its alcohol (20 percent) from wine. In the United States as a whole the largest proportion of alcohol consumed is in the form of beer (46 percent of the total), followed by distilled spirits (42 percent) and wine (12 percent).

Today's American drinking-age population consumes not much more than half as much distilled spirits per capita as 125 years ago. As absolute alcohol, distilled spirits accounted for almost 90 percent of the total consumed in 1850, but for less than half in recent years *(20)*. These proportions reflect a long-term shift from distilled spirits to less concentrated beer and wine. Most of this change was completed by the last years of the 19th century. It is likely, too, that a much larger portion of the spirits was consumed undiluted in past times than nowadays, when ice and mixers are available and popular.

In the 15 years following World War II, alcohol consumption in the United States was

Inhabitants of the West South Central region consume only 35% of their alcohol from spirits and 55% from beer, while those in the South Atlantic States consume 49% from spirits and 41% from beer. The Pacific Region stands out by taking 20% of its alcohol in the form of wine.

Figure 1b. APPARENT CONSUMPTION OF TOTAL ABSOLUTE ALCOHOL IN ALL BEVERAGES, AND PROPORTION OF ALCOHOL FROM SPIRITS, WINE AND BEER, IN U.S. GALLONS PER PERSON IN THE DRINKING-AGE POPULATION, BY REGION, U.S.A., 1972



Source: Efron, Keller and Gurioli [20].

Note: The regions are the standard regions of the U.S. Census Bureau. Amounts and population calculated as in Table 1.

fairly stable at slightly more than 2 gallons of absolute alcohol per person in the drinking-age population. In the 12 years since then the total consumption has risen by over 25 percent *(20)*. By class of beverage, consumption of alcohol in beer has risen about 23 percent, in wine about 44 percent, and in distilled spirits about 30 percent. The higher percentage increase of wine may indicate a new development in public taste and customs, especially as the trend has favored the milder wines (about 13 percent alcohol) rather than the stronger ones (about 20 percent alcohol). But wine still contributes only some 12 percent of the total absolute alcohol consumed in this country. It has been suggested *(32)* that not all the rise in apparent consumption of alcohol represents a real increase in the average amount consumed per drinker: A part of the total may reflect a higher proportion of actual drinkers within the drinking-age population, especially of women and youth, and a part of the distilled-spirits rise may reflect substitution of legal (hence recorded) sources for declining moonshine.

International Comparisons

The long-term shift to lighter beverages has also occurred in many other countries with a tradition of heavy spirits consumption, and the popularity of lighter beverages and particularly

TABLE 2

CHANGE IN ALCOHOL CONSUMPTION IN 17 COUNTRIES FROM LATE 1950s TO EARLY 1970s

Country	Dates of Data	Percentage Increase (+) or Decrease (−) in Consumption of: Spirits	Wine	Beer	Total
France	1955 - 1968	+20%	−18%	+3%*	−9%
Italy	1957 - 1968	+80	−8	+149	+1
W. Germany	1957 - 1970	+66	+85	+54	+61
Switzerland	1950/55 - 1966/69	+38	+11	+6*	+13
Australia	1955/56 - 1968	+28	+45	+8	+15
Belgium	1956 - 1967	+42	+3881	+12*	+33
New Zealand	1956 - 1967	−11	+158	+13	+13
U.S.A.	1958 - 1971	+42	+45	+20	+32
Denmark	1956 - 1969	+119	+49	+44	+54
Canada	1956 - 1969	−27	+79	+101	+17
United Kingdom	1957 - 1970	+35	+89	+9	+20
Sweden	1957 - 1970	−5	+71	+93	+26
Ireland	1955 - 1970	+65	+103	+29	+41
Netherlands	1956 - 1969	+31	+186	+137	+83
Finland	1955 - 1969	−2	+37	+357	+50
Norway	1957 - 1970	+23	+64	+52	+42
Iceland	1952 - 1971	+31	+102	+21	+33

Source of Data: Keller and Efron (33); Efron, Keller and Gurioli (20). The time-period between observations in these two reports ranged from 11 to 19 years; changes in all countries were reduced to a 10-year rate by arithmetical interpolation. Countries are listed in order of their total consumption at the latest report.

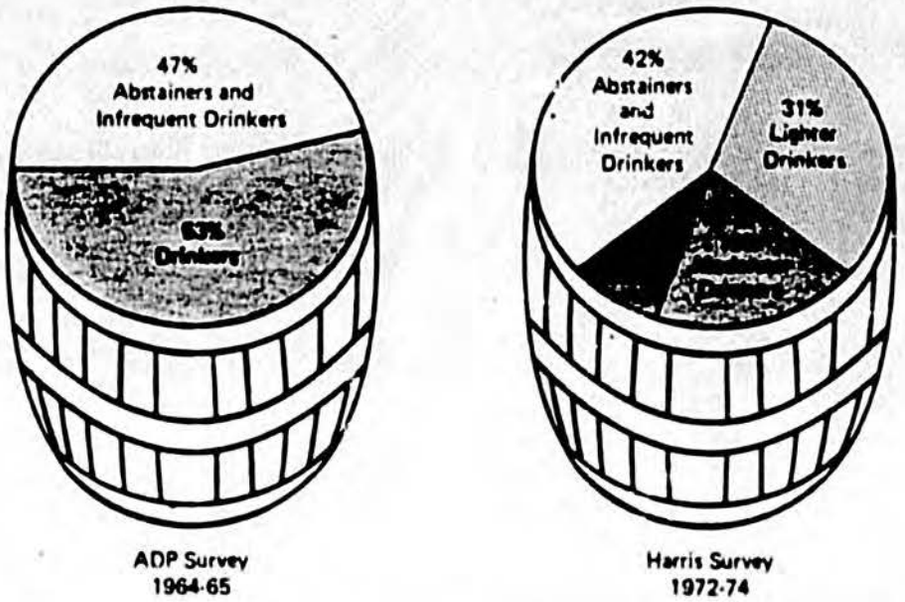
*Includes cider.

of beer has continued to increase in recent times. Comparing the consumption trends in the United States with those in other industrialized countries in recent times (table 2), it is apparent that in some respects the United States is reflecting overall trends but not in others. In fact, 12 of the 16 European and British Commonwealth countries shown in table 2 outranked the United States, in the period from the late 1950s to around 1970, in the percentage increase of wine use. The total consumption of alcoholic beverages rose enough in the same period in some of the other countries so that the United States is outranked by 8 of the 16 in average annual percentage increase in overall consumption.

On the other hand, the United States now outranks all but 2 of the 25 other countries from which reports are available in per capita consumption of distilled spirits *(20)*. Although proportional increases in spirits consumption have been higher in several other countries in recent years, the United States is somewhat exceptional in its persistent high level of spirits consumption, compared to the general 20th-century trend toward beer drinking *(54, 55)* in industrialized countries with a history of heavy spirits consumption.

Whether the alcohol strength or other properties of beverages affect the damage that heavy intake may cause is now under new study. Most governments, including those in the United States, have taxed spirits, per unit of absolute alcohol, more heavily than lighter beverages *(1)*, often with the explicit purpose of discouraging the consumption of stronger beverages. There are indications that some health problems are more often associated with stronger than with weaker beverages *(56, 60)*; support for this hypothesis has recently been assembled in a report commissioned by the Canadian Brewers Association *(1)*. On the other hand, there are indications that some diseases may be associated with beer drinking *(25)*, though the nature of the relationship is unexplained. It appears likely that at least some of the differences are related more to amount and manner of use than to the alcohol content or chemical composition of the types of beverage. As for alcoholism itself, some investigators *(18)* have argued against any association with specific beverages, noting that the beverages chosen by alcoholic persons tend to match the popular preferences of the country in which they live. Thus the question whether the important aspect of consumption is the types of beverage or the total of absolute alcohol remains to be resolved.

Figure 2. PERCENTAGE OF DRINKERS AND TYPES OF DRINKERS AMONG ADULTS, U.S.A., 1964–1974



The ADP Survey includes adults aged 21+, whereas the Harris Survey includes adults aged 18+. In the Harris Survey, type of drinker is based upon a quantity-frequency index score which equals the average ounces of absolute alcohol consumed per typical day.

- Abstainers and Infrequent Drinkers – Drink less than once a month or not at all.
- Drinkers – Drink once a month or more.
  - Lighter drinkers – Drink less than 0.22 ounce absolute alcohol per day.
  - Moderate drinkers – Drink over 0.22 but less than 1.0 ounce absolute alcohol per day.
  - Heavier drinkers – Drink 1.0 ounce or more absolute alcohol per day.

The 1974 Harris survey was conducted during a period which included holidays, when many infrequent drinkers choose to drink. The proportion of adults in this latter survey period who chose not to drink may provide the most accurate reflection of the current rate of abstainers, which approximates the percentage found in the 1964-65 ADP survey (about 32 percent).

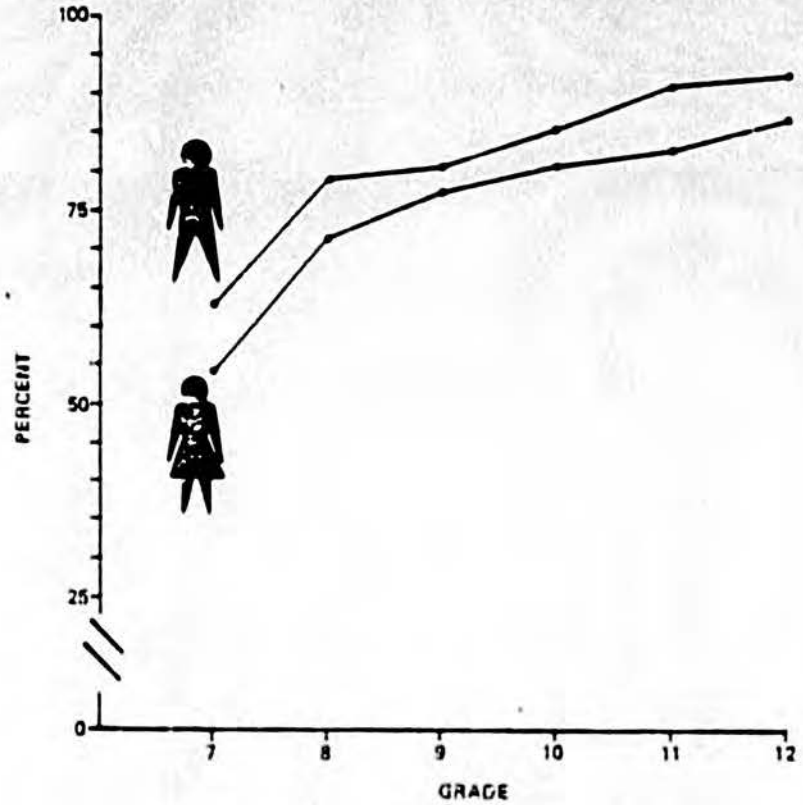
Trends in Teenage Drinking

Surveys of adults leave out a sizable portion of drinkers. Numerous studies of younger populations, mostly in high school, reveal that a substantial proportion of teenagers drink *(3, 39)*. Estimates based on an aggregation of such surveys show that, in recent years, from 71 to 92 percent of high school students have at least tried alcoholic beverages *(3)*. In view of the common practice of drinking in the American lifestyle, it comes as no surprise that a vast majority of teenagers have been introduced to alcohol.

Preliminary findings from the 1974 national survey of high school students indicate that among 7th graders, 63 percent of boys and 54 percent of girls have had a drink. As figure 3 indicates, the proportion of teenage ever drinkers increases with grade to 93 percent of boys and 87 percent of girls in the 12th grade.

Figure 4 shows that the frequency of drinking also increases with age. Beer is the most preferred beverage, especially among boys. Drinking beer at least once a week increased from 10 percent among 7th-grade boys to 42 percent among 12th graders. Half of the boys reported consuming two drinks or less per drinking occasion, compared to one or less per occasion among girls. Generally, the quantity of alcohol consumed at any one time by both boys

Figure 3. PERCENTAGE OF TEENAGERS WHO HAVE EVER HAD A DRINK OF WINE, BEER, OR SPIRITS, BY SCHOOL GRADE AND SEX, U.S.A. 1974



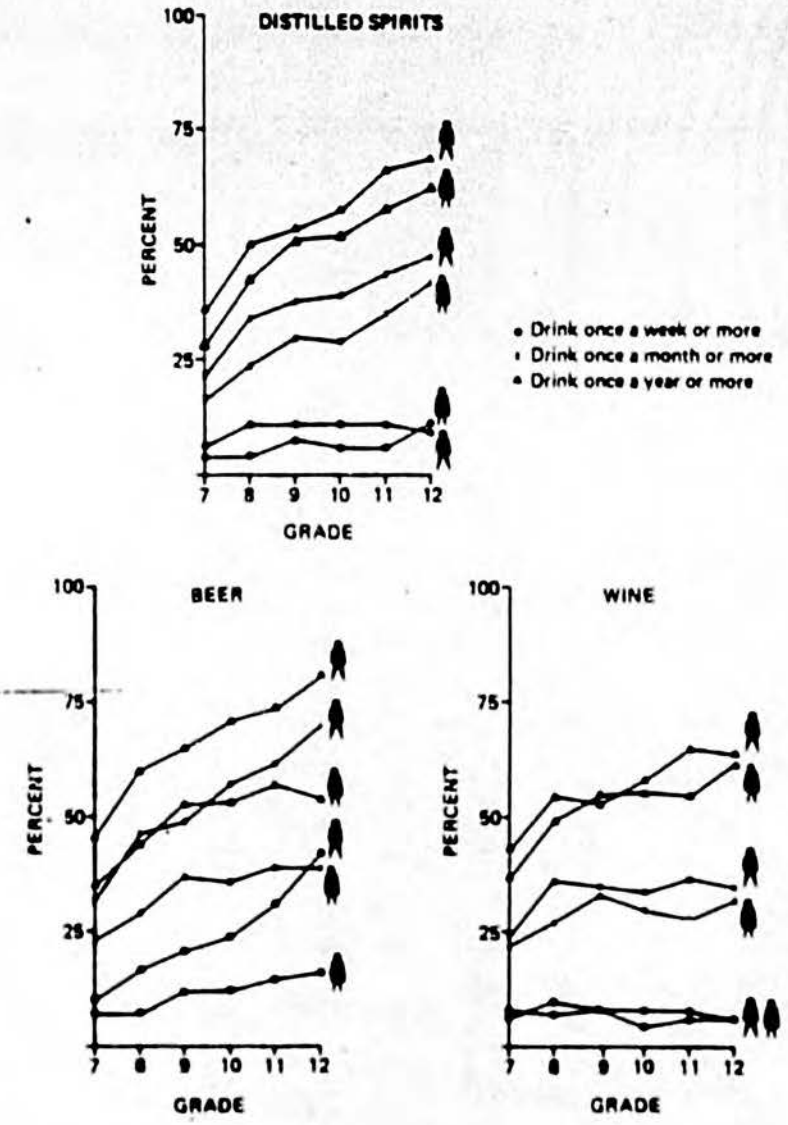
and girls increased with school grade, regardless of beverage type.

Preliminary estimates of drug use (other than alcohol) among teenagers indicate that marihuana ranks second to alcohol in frequency of use. Approximately 40 percent of boys and 36 percent of girls in senior high schools (grades 10-12) reported having used marihuana. These proportions are somewhat higher in the northeastern United States and considerably lower in the South. Drinking was more common among marihuana users. Among teenagers who reported marihuana use, approximately 92 percent drink, while among teenagers who drink, approximately 34 percent have used marihuana. Much smaller proportions of teenagers reported having used other nonalcoholic drugs. Approximately 12 percent of senior high school boys and 9 percent of senior high school girls had used hallucinogens and amphetamines. Less than 3 percent of them reported having used "hard" drugs such as heroin or cocaine.

Little information is available about drinking by school dropouts. The dropout populations that have been examined are those which, for the most part, have been incarcerated *(38, 40, 42, 43, 50)*, and one group *(35)* consisted of Job Corps trainees. In these studies, except one in New York in 1962 *(40)*, the nonstudents had a higher proportion of drinkers than the school populations. These findings suggest that the numbers of adolescent drinkers and the frequency and amount of their alcohol consumption may be underestimated.

The findings from annual surveys conducted in California *(49)* between 1968 and 1973 indicate an increase in the proportion of students who began drinking during each previous year (52 percent of 7th-grade boys in 1969, 72

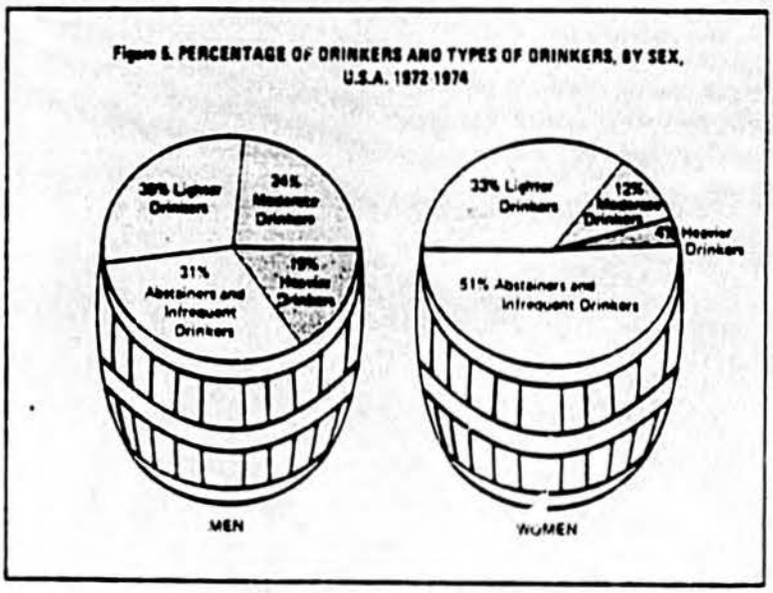
Figure 4. PERCENTAGE OF DRINKERS AMONG TEENAGERS BY SEX, SCHOOL GRADE, FREQUENCY OF DRINKING, AND TYPE OF BEVERAGE, U.S.A. 1974



percent in 1973); girls showed similar trends (38 percent in 1969, 67 percent in 1973).

A survey of students in grades 7 through 12 in Duval County, Florida *(19)*, also showed increases in the number of students who reported using alcoholic beverages at all, as well as in drinking once a week and once a month.

Three surveys in Toronto, in 1968, 1970, and 1972, examined adolescents' alcohol use *(52)*. In 1968, 47 percent of the students had used alcohol during the 6 months before the survey; this proportion increased to 60 percent in 1970 and 70 percent in 1972. These percentages were similar to those reported in San Mateo County, California, in 1972 *(49)*. The shift in Toronto does not seem attributable to the lowering of the "legal age" in 1971 from 21 to 18 years, for no change in legal age had occurred in California during the similar increase in proportion of adolescent drinkers. A 1962 survey of New York



About half of these elderly people drank alcoholic beverages, but only two could be considered problem drinkers. This is nearly identical with the proportions reported in national probability samples of people in the same age range *(11, 24)*. Although their drinking frequency varied considerably, there was very little difference among them in the amount they drank per occasion—most had one or two drinks each time. The more frequent drinkers were somewhat younger, in better health, of European ancestry, and reported considerable

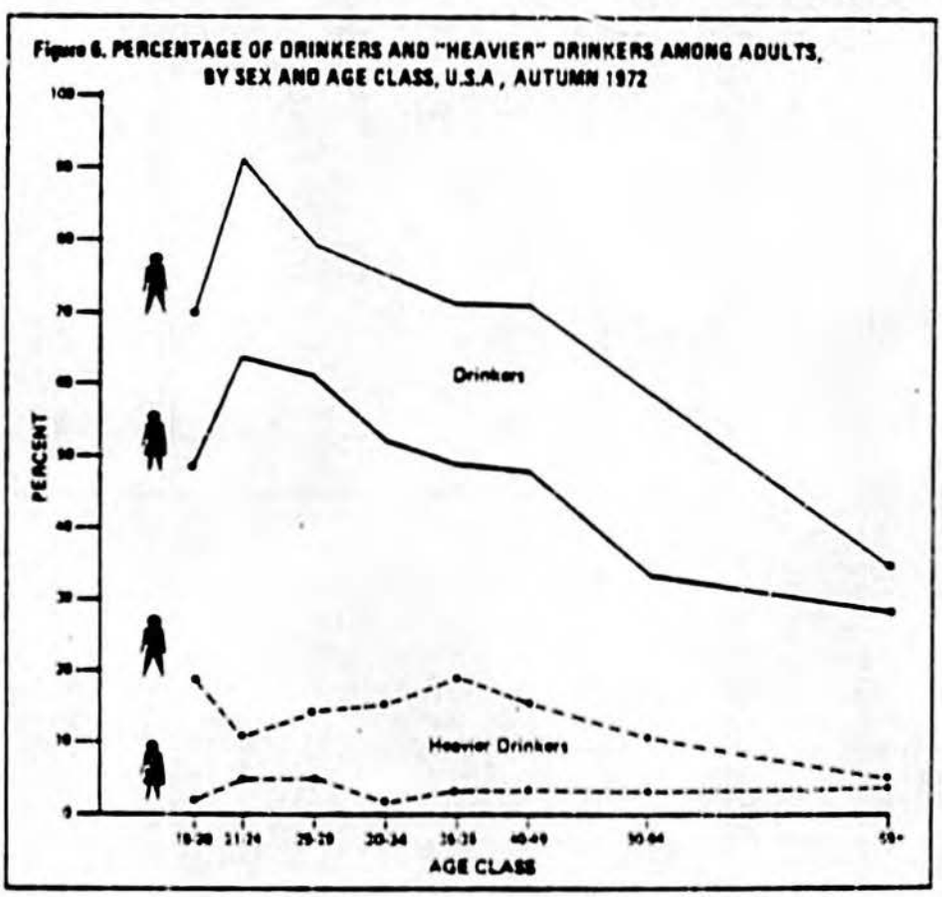


TABLE 3

SOCIAL CONTEXTS OF DRINKING APPROVED BY AMERICAN BUSINESS EXECUTIVES

OCCASIONS	% WHO SAY "NOT IMPROPER" TO DRINK	% WHO SAY WOULD DRINK ON OCCASION
Before Dinner	92	71
After Round of Golf	88	56
After-Theatre Party	83	56
After Dinner	74	34
Office Christmas Party	69	56
Business Lunch	60	34
Football Game	51	21
One-Day Sales Conference	48	32

Source: Caravan Surveys (14)

would probably have one or more drinks. As table 3 shows, more executives felt it was proper to drink on each of various occasions than acknowledged they probably would drink on those occasions.

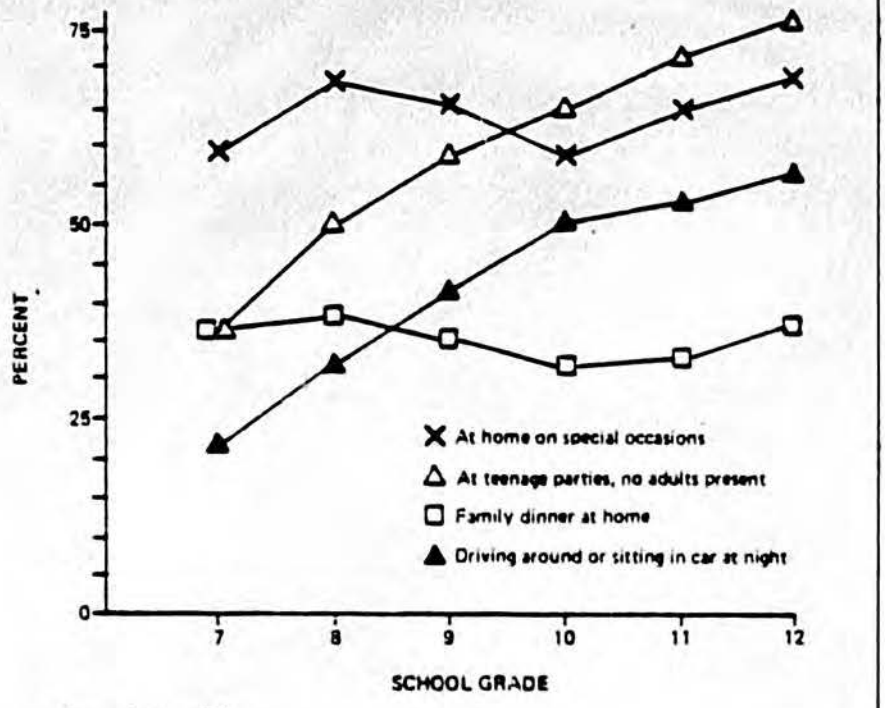
Adolescents: The social contexts in which adolescents drink are subject to special restrictions. Many teenagers drink before they can legally buy alcoholic beverages or patronize licensed premises. These restrictions naturally affect the contexts in which they drink and the channels through which drink is obtained. Alcohol may be obtained illegally from licensed merchants in a permissive community, but in a restrictive community it is obtained illegally from unlicensed merchants *(22)*. Studies of Scandinavian youth indicate that the main impact of rigid control is to increase the amount of out-of-doors drinking *(8)*.

The occasions on which adolescents drink vary with age. Most teenagers who begin to drink do so at home under parental supervision *(3, 39)*. Much of this drinking occurs on holidays and other special occasions *(3)*. As teenagers grow older, they tend to drink more often outside the home, until the most likely drinking places are those where adults are not present *(30)*. The preliminary 1974 teenage survey data in figure 7 highlight these age trends. Sixty percent of 7th graders reported drinking at home with their parents on special occasions, while considerably fewer (22 to 36 percent) drink away from home without parental supervision. Though the proportion of teenagers at each grade who report drinking at home tends to remain the same, away-from-home drinking increases with age. Between the 7th and 12th grades the proportion of teenagers who drink at night in cars doubles, rising to 50 percent, while the proportion who drink at teenage parties nearly triples, rising to 75 percent.

The quantity of alcohol consumed and the drinking contexts were examined in a recent survey of students in Scotland *(17)*. Parents often offer an alcoholic beverage in the home but for the younger child confine it to special occasions. Among boys, drinking at home decreased with age, as did drinking at home on special occasions. These trends were less pronounced among girls. Although the quantity of drink consumed by boys at home increased with age, even greater quantities were consumed at each age level at friends' homes. There is a general tendency for older boys and girls to drink more in that setting than at home. Among boys, contrary to the findings in America, drinking outdoors declined with rising age, while the frequency of drinking in pubs increased markedly.

Ethnic differences: In most social contexts, Irish-Americans tend not to drink more often than Italian-Americans (table 4). An outstanding exception—in that it appears as the most isolated situation—is drinking at a bar alone, in which Irish-Americans exceed Italian-Americans born in the United States by more than 50 percent, but, interestingly, this difference does not apply to first-generation Italian-Americans. There are noteworthy differences also in drinking at meals and drinking at home alone. Social drinking tends to vary according to interpersonal closeness and group solidarity in both nationalities, and among the Italians by generations. The more socially isolated a person is, the less likely he is

Figure 7. WHERE ADOLESCENTS USUALLY DRINK, BY SCHOOL GRADE (IN PERCENT), U.S.A. 1974.



Source: Johnston (30).

to drink, but the more primary-group involvement there is in a situation, the more likely he is to drink, excepting Irish-Americ. s at meals. The Italian custom of drinking with meals decreases with American acculturation; and though first-generation Italian-Americans give such reasons for drinking as improving the appetite or digestion, later generations of Italian-Americans emphasize pleasure as the reason for drinking at meals.

When respondents were asked about reasons for drinking in a variety of social contexts, it appeared that first-generation Italian-Americans were more swayed by external influences (drinking to conform) than were later generations of Italian-Americans.

Further data about the social contexts of drinking were obtained from a comparison of teenagers in New York and Rome *(36)*. As table 5 indicates, most Italian teenagers drink at home with other members of the family at meals. The Italians drink much more regularly and begin regular drinking at an earlier age than American teenagers. Only 5.5 percent of the American teenage sample reported daily drinking, and most of them were of Italian extraction. This is also reflected in solitary drinking which, among the Italians, occurred exclusively at meals when other family members happened not to be present.

The frequency of drinking at home by American adolescents was less than that reported in Rome and decreased further with age. Also, the frequency of drinking at special family events increased with age among the Italians, but decreased among the Americans. Drinking on "dates" was reported only by the American teenagers.

Drinking by adolescents in the Italian samples was associated primarily with family meals and snacks during the day. Among older teenage boys, evening drinking was limited to social life. In contrast, drinking at dinner by American teenagers was only an occasional experience. Evening drinking included beer and distilled spirits, generally in the company of friends and away from home.

TABLE 4

WHEN AND WHERE IRISH-AMERICANS AND ITALIAN-AMERICANS DRINK, BY COUNTRY OF BIRTH (IN PERCENT)

	IRISH-AMERICANS	ITALIAN-AMERICANS	
	Born in U.S.A.	Born in U.S.A.	Born in ITALY
At a wedding	92	93	93
On family occasions	84	90	93
At a party	87	91	87
When visiting a friend's home	82	85	87
At a bar with friend	71	72	67
At home alone	40	38	55
At a bar alone	33	20	32
At meals	44	59	87

Source: Blane (5).

TABLE 5

WHERE AND WHEN TEEN-AGERS DRINK IN ROME AND NEW YORK, BY AGE (IN PERCENT)

	Rome		New York	
	13-15 yrs.	16-20 yrs.	13-15 yrs.	16-20 yrs.
At home	95	93	74	22
Parties at home	4	0	24	5
Special family events	33	56	24	6
Parties away from home	53	67	42	51
With friends	21	30	33	38
With dates	0	0	3	17
Alone*	50	20	0	11.5
Breakfast	26	10	2	0
Lunch	73	79	0	0
Dinner	64	71	42	49
Afternoon	63	56	26	11
Evening	31	53	43	97

*Drinking alone entailed circumstances of meals separated from other members of the family and in the Italian sample involved the use of wine.

Source: Lolli et al. (37).

Problem Drinking

Many of the difficulties in defining alcoholism apply equally to problem drinking. It is thought to encompass such features as frequent intoxication and binge drinking, symptomatic drinking (including signs attributed to physical dependence and loss of control), psychological dependence, and disruption of normal social behavior patterns (problems with spouse or relatives, friends or neighbors, employers, and the police). These signs are indistinguishable from those attributed to alcoholism as seen in research focused on institutionalized persons. But recent studies have tended to deal with drinking problems and related sociocultural characteristics of people in the general population.

Surveys conducted in the 1960s analyzed various factors associated with alcohol-related problems *(9, 11, 13)*. Findings from those

CHART 1a
PROFILE ANALYSIS OF PERSONS MOST LIKELY TO HAVE NO ALCOHOL-RELATED PROBLEMS

Lowest rates of alcohol-related problems for respondents in the 1973 national survey were found among:

- Women
- Persons over 50
- Widowed and married persons
- Persons of Jewish religious affiliation
- Residents of rural areas
- Residents of the South
- Persons with postgraduate education
- Persons who are mostly "wine drinkers"

CHART 1b
PROFILE ANALYSIS OF PERSONS WITH HIGH ALCOHOL-PROBLEM RATES

Highest rates of alcohol-related problems for respondents in the 1973 national survey were found among:

- Men
- Separated, single, and divorced persons (in that order)
- Persons with no religious affiliation
- Persons who are beer drinkers as compared with those who are mostly hard liquor or wine drinkers
- Persons who were more likely (compared to other persons in the survey) to say:
  "Drunkenness is usually *not* a sign of social irresponsibility" and
  "Drunkenness is usually a sign of just having fun"

studies indicated that the greatest number of alcohol-related problems were found among poorer men under 25 years, city residents, persons who had moved from rural areas or small towns to large cities, those with childhood disruptions such as broken homes, Catholics and liberal Protestants, persons who did not attend church, and single and divorced men (chart 1).

Women were not as problem-prone as men, which is not surprising since more women are abstainers and, of those who drink, many fewer are heavy drinkers. Whereas 43 percent of the men in the 1967 survey *(13)* reported experiencing one or more problems connected with drinking during the previous 3 years, only 21 percent of the women reported such problems. Of the sampled persons with more severe involvement (high problem-drinking scores, possibly "problem drinkers"), 15 percent of the men but only 4 percent of the women were affected.

Men in their early 20s most frequently had experienced some problems connected with their drinking, and the proportion declined sharply among men in the late 50s. Women most frequently had problems in their 30s and 40s, again with a sharp dropoff among those in the 50s. There are several theories about why problems associated with drinking are more prevalent among younger people, but this fact is unlikely to be explained until results of longitudinal studies, which follow individuals over extended periods, are available.

Recent surveys *(24)* have examined the sociocultural correlates of drinking problems among men and women aged 18 years and older. The findings are consistent with those of the earlier surveys, but there are some differences in the areas of marital status, degree of urbanization, and age. Separated persons now have higher problem-drinking rates than single and divorced persons, although the last two groups still have more problems than married or widowed persons.

Figure 8 shows the division of the population into problem drinkers, potential problem drinkers, and nonproblem drinkers by age classes in 1973. It is evident that the 18-20 year olds have the largest proportion who had experienced some problem in connection with drinking (1[illegible] percent), followed by those aged 21-24 (1[illegible] percent) and those 35-39 (15 percent). The 18-20 year group was not included in the earlier surveys, in which the highest ratio of alcohol-related problems was reported among those aged 21-25.

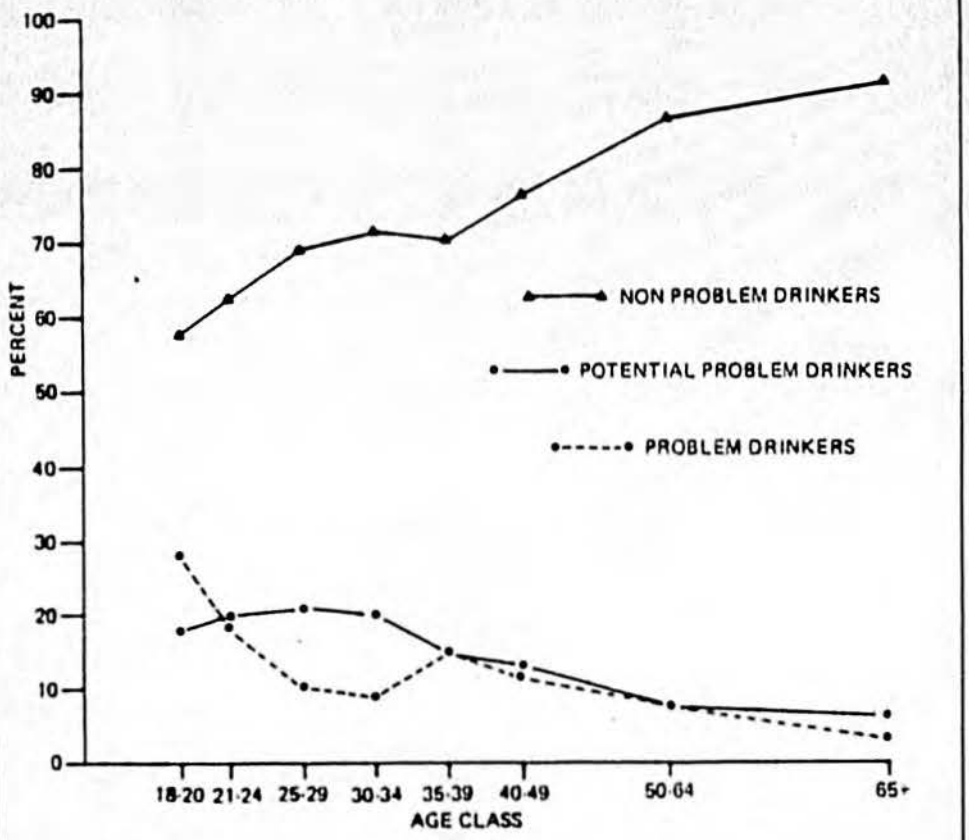
People living in cities were more problem-prone than residents of suburbs, towns, and rural areas in earlier surveys, but these residential differences are fading. The proportions of people with the highest problem scores are nearly the same in cities, suburbs, and towns, and only those living in rural areas have slightly lower rates.

The Military

A survey of drinking in the Army in 1972 found the highest rate of problem drinking among enlisted men under 30 years old, with less than a college education, and not accompanied by their wives *(12)*. The best single correlate of serious drinking problems among commissioned and warrant officers was that the father had been a heavy drinker, and the second best was that his wife was not with him at his duty station.

Rates of drinking problems tended to decline as age, grade, and years in service increased. Marital difficulties were the most frequently reported problem, regardless of pay grade.

Figure 8. DRINKERS, PROBLEM DRINKERS AND POTENTIAL PROBLEM DRINKERS (IN PERCENT), BY AGE CLASS, U.S.A., SPRING 1973



Source: Louis Harris & Associates (24).

Family separation was associated with sharp increases in reported drinking but not so sharp an increase in drinking problems.

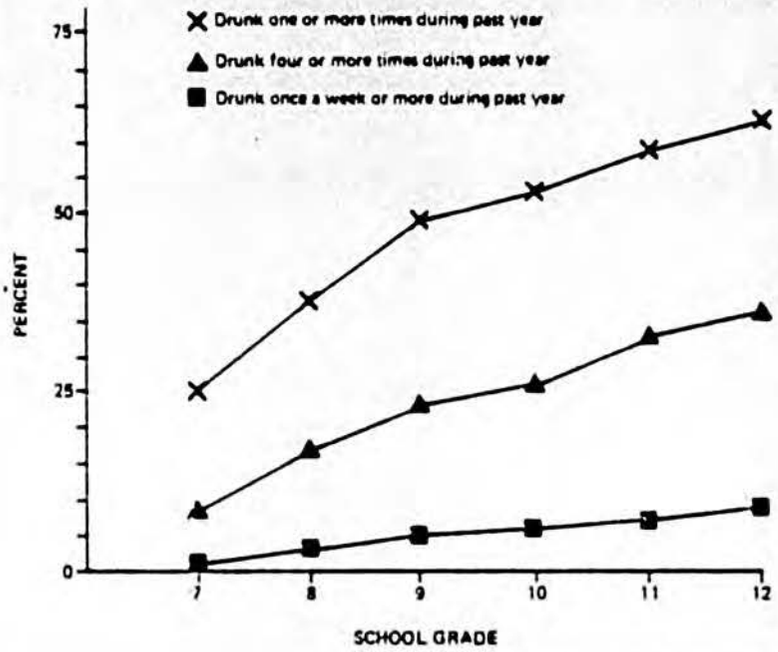
Problems associated with drinking were much more common among enlisted men than among civilians or officers. The enlisted men were much more likely to suffer adverse social, health, and economic consequences of drinking and to manifest more uncontrolled drinking, belligerence when drinking, and problems with friends and neighbors, the job, the police, and finances. The specific problems of the officers were roughly similar to those of civilian men of the same age in both nature and extent.

The 1972 survey of drinking in the Navy *(10)* showed that enlisted men had more problems of every type, except marital, than officers; and that junior enlisted men had more problems of every kind, except marital, than senior enlisted men. Of the junior enlisted men, 15 percent reported that they had had job-related problems in the past 3 years, and 21 percent reported having been "high" or "tight" while on duty at least once during that time.

Adolescence

"Problems" associated with drinking by adolescents may have different meanings and characteristics from those that describe problem drinking by adults. Thus, according to some criteria, any drinking by an adolescent may be defined as a problem. If we adopt a problem-drinking criterion of getting "high" or "tight" at least once a week *(9, 13)*, preliminary estimates from the 1974 survey indicate that approximately 5 percent of the students are problem drinkers. By a less conservative criterion of getting drunk four or more times a year, approximately 23 percent of the students

Figure 9. PERCENTAGE OF TEEN-AGE DRINKERS WHO REPORT GETTING DRUNK OR VERY HIGH, BY FREQUENCY AND SCHOOL GRADE, U.S.A. 1974



exhibited potential problem-drinking signs. As can be seen in figure 9, the proportion of students who report getting drunk (or very high) increases with school grade. These self-reports are responsive to questions that did not precisely define "drunk" or "high," and thus the percentages represent the criteria of the students themselves. It is therefore interesting that only 2 percent of the students reported that drinking had been a problem for them during the past year, and this proportion did not vary with school grade. Other survey estimates of the proportion of adolescents who experience problems associated with drinking vary from 1 to 15 percent *(39, 40)*.

Among juvenile delinquents, however, the incidence of deviant drinking is decidedly higher than in the general teenage population *(4, 45)*. This suggests that those who are maladjusted or antisocial misbehave typically in a variety of ways, one of which is overdrinking. For these reasons many investigators view adolescent problem drinking as one of a class of behaviors, commonly referred to as antisocial, that involve the potential for getting into trouble *(6, 26, 27, 61)*.

A recent longitudinal study of 388 high school students *(27)* examined problem drinking within the framework of a variety of behavioral, personality, and social factors in the children's lives. As might be expected, problem drinking was not an isolated behavior; the problem drinkers engaged in more of other deviant behavior than did the nonproblem drinkers. The problem drinkers valued and expected achievement less than the nonproblem drinkers but esteemed independence more. They were also much more tolerant of deviant behavior. The problem-drinker girls were less compatible with their parents, and both boys and girls who were defined as problem drinkers were more supportive of drinking by adolescents.

In light of these findings, problem drinking seemed to be a logical outcome in the lives of many of the adolescents. The longitudinal design of the study enabled the investigators to employ their sociopsychological framework to predict the shift from nonproblem to problem drinking over time. They believe that some of the indicative factors could be used to identify individuals who would become problem drinkers a year later.

Abstinence is more common among older people. Some of them are lifelong abstainers. Others have given up drinking for reasons of health, or because they live in environments where alcoholic beverages are not available.

The healthier and more active elderly are more likely to be drinkers. Experiments in providing alcoholic beverages in a social setting to older persons living in nursing homes and residences for the aged yielded some beneficent effects and caused no apparent harm.

Alcoholism is less frequent among the elderly than among the young—in part because many problem drinkers do not survive to old age. But some people become problem drinkers only when they grow old and for reasons specially connected with aging. As the proportion of older people is growing, alcoholism among the aged may become an increasingly important problem.

Chapter II

Alcohol and Older Persons

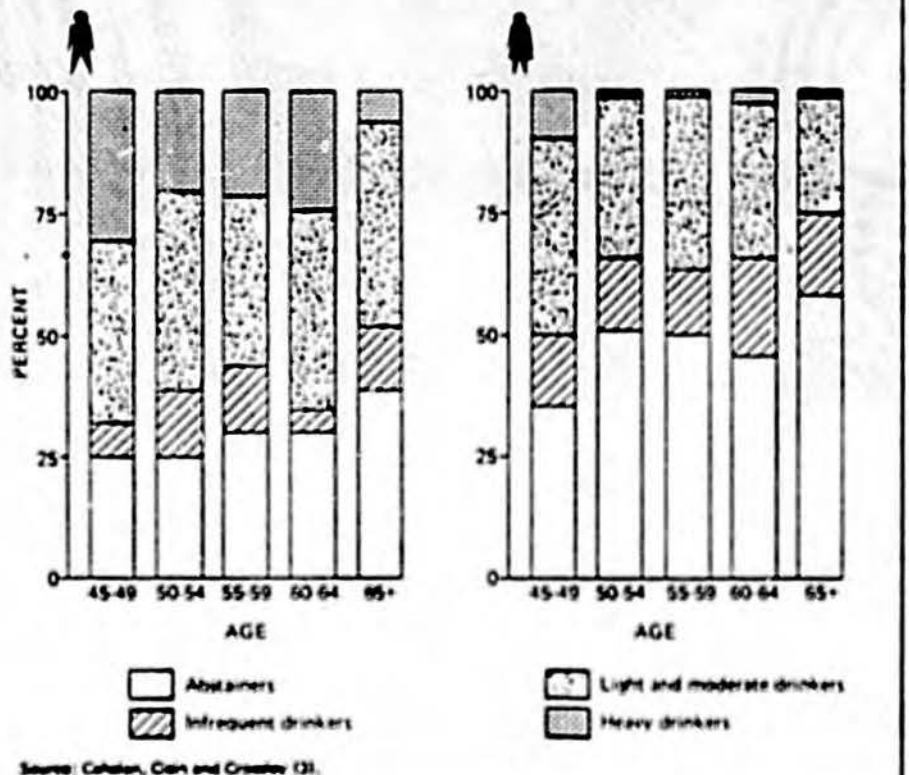
Older persons comprise a special population which has unique features of interest for the study of drinking. The incidence of drinking problems in this group is relatively low. Cahalan and his co-workers *(3)* have shown that with advancing age many people decrease their alcohol consumption. While it is possible that lower rates of problem drinking among the elderly are due simply to the reduced life span of alcoholic people (see chapter V, part 4), there are also indications that alcoholism may be a self-limiting disease, with a tendency toward autonomous recovery in some older persons *(8)*. There are, indeed, well documented reports, reviewed by Wallgren and Barry *(13)*, of problem drinkers who became abstainers or, sometimes, moderate or controlled drinkers as they grew older. Nevertheless it is hardly public-health policy to sit back waiting for the sometimes autonomous recoveries in those alcoholic persons who survive long enough. An important consideration from this perspective is that the proportion of older persons in the United States population has increased greatly in the last few decades (U.S. Census, 1970) and may be expected to continue increasing as medical advances further prolong life, and more so if the birth rate continues to decline. The care and welfare of the elderly is thus a growing social problem, only partly and unsatisfactorily dealt with by the establishment of more nursing homes and by Medicare benefits.

Until recently, alcoholism research devoted little attention to the special population of older people. This may reflect a general tendency to ignore the problems of aging in a youth-oriented society. However, three major research projects in the past few years have addressed this special problem. One was a survey of drinking practices in a population of older persons living in Manhattan Borough, New York City *(10)*; another was a series of studies of problem drinking in older persons *(5)*; the third was an experimental study of the physical and psychological effects of introducing social drinking occasions during several weeks in a nursing home and in a residence for the elderly *(1)*. Most of what we now know about drinking and alcoholism in the special population of older people has been reported in these recent studies. Therefore, the present chapter primarily summarizes these three reports.

Drinking Practices

The drinking practices of American men and women at different ages were reported by Cahalan et al. *(3)* and summarized in the *First Special Report to Congress on Alcohol and Health (12)*. A more detailed summary of the age differences from 45 years onward is shown in figure 1. At all ages, more men than women drink, and men drink more than women. But the proportion of heavy drinkers decreases substantially after the age of 49 in both sexes and with

Figure 1. CUMULATIVE PERCENTAGES OF ABSTAINERS AND TYPES OF DRINKERS, AMONG ADULTS AGED 45-65+, BY AGE AND SEX, U.S.A. 1964-65

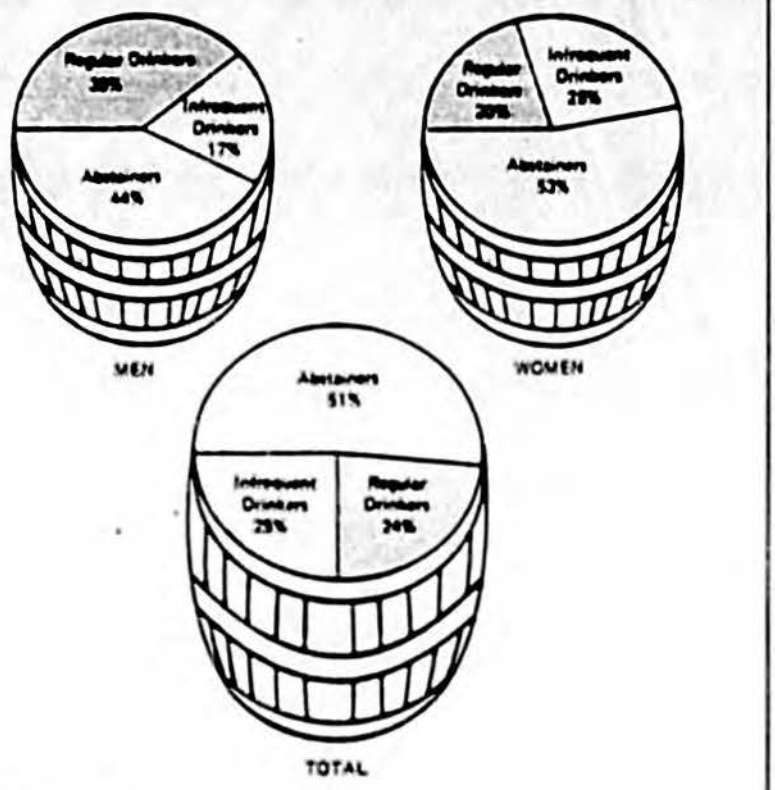


an added decline after 64 in men. The proportion of women abstainers increases substantially after age 49, and again in both sexes after 64. In general, drinking in the oldest age class decreases from a fairly stable level during the preceding 15 years.

A study by Cahalan and Room *(4)* of problem drinking by men under the age of 60 provides corroborative evidence for a reduced amount of drinking with advancing age. The proportion of abstainers, only 18 percent at ages 50-54, was 31 percent at ages 55-59, while the proportion of those with a high score (7 or more) on drinking problems was 17 percent at ages 50-54 compared with only 11 percent at ages 55-59. They found a striking difference among men at ages 50-59 on the basis of socioeconomic status: Of those with the highest Index of Social Position, 32 percent drank heavily (problem or potential problem drinkers) and only 12 percent abstained. But of those with the lowest Index of Social Position, much higher proportions both drank heavily (51 percent) and abstained (28 percent). The same trends were found in the earlier survey by Cahalan et al. *(3)* but with less clear differentiation between the socioeconomic groups.

The higher proportion of abstainers and lower proportion of heavy drinkers among older Americans probably reflects a decrease in drinking as people grow older. Cahalan et al. *(3)* found that among men aged 60 years and over, more than half were former drinkers, and about half of these former drinkers had stopped after the age of 44. Among women of 60 or older, most of the abstainers had never been drinkers but half of the former drinkers had stopped after the age of 44. Drinkers of both sexes frequently reported that they used to drink more than at present, but the quantity they customarily drank on an occasion declined even more sharply with advancing age than the frequency of drinking occasions.

Figure 2. PERCENTAGES OF ABSTAINERS AND TYPES OF DRINKERS AMONG ADULTS AGED 60+, MANHATTAN SAMPLE, 1973

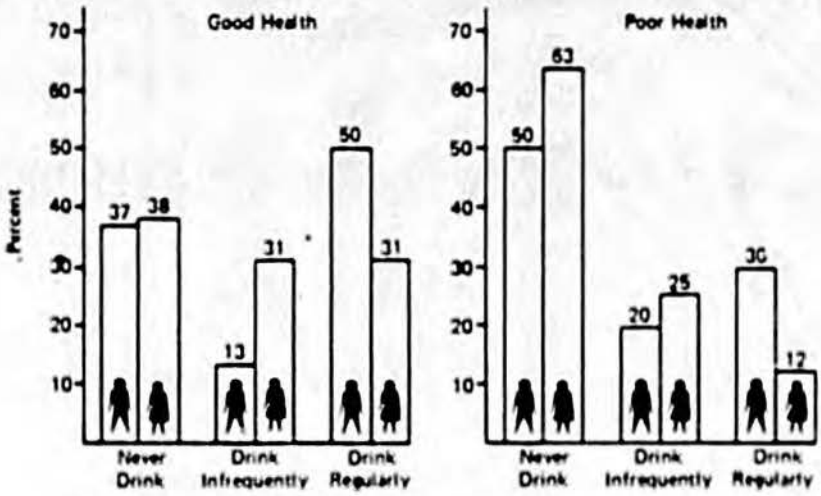


The people in the different age groups were studied at the same time, so that the older respondents were born in earlier years. Although many contemporary older people have given up drinking, the present middle-aged and young drinkers will not necessarily show the same trend of an increasing proportion of abstainers as they grow older. The cultural patterns in which contemporary older persons grew up included a strong temperance tradition, especially for women, and the period of national prohibition. Many people who took up drinking as a youthful rebellion against parental standards or prohibition, or in response to the repeal of prohibition, might have tended to return to their early traditions of abstinence as they grew older. It will not be possible to know until several decades from now whether the increase of abstinence is a general tendency among older persons, applying also to those who are reared in the more permissive contemporary traditions. Some indication that the drinking habits of older people do not change when the social traditions favor drinking is the finding of a low proportion of abstainers (12 percent among Americans 50-59 years old) in the highest social position category *(4)*. But even though a well-established custom of drinking usually continues into old age, it seems likely that the amount of alcohol consumed decreases. The surveys, however, do not provide very good evidence on this for people aged 60 and older.

One of the recent studies, by Johnson *(10)*, was a survey of 169 people aged 65 years and over, living on the upper east side of Manhattan, in New York City. Most of them were from lower socioeconomic groups, living alone or in a small household. This study also revealed that men drink more often than women, and consume a larger average quantity on each occasion.

Figure 2 summarizes the drinking categories for the 54 men and 112 women separately, and for both sexes combined. Comparing regular drinkers (daily, frequently, or occasionally) with

Figure 3. PERCENTAGES OF ABSTAINERS AND TYPES OF DRINKERS, AMONG ADULTS AGED 65+, BY SEX AND CONDITION OF HEALTH. MANHATTAN SAMPLE, 1973



Drink Regularly = Drink daily, frequently, or occasionally.

Source: Johnson (10).

the other categories, the sex difference is statistically significant. One of the largest sex differences was in the percentage of current abstainers who formerly drank at least occasionally: 61 percent of the men and only 29 percent of the women. Compared with the national sample of persons aged 65 and over, summarized in figure 1, the proportion of abstainers in the Manhattan sample is slightly higher among men and slightly lower among women, but the correspondence is fairly close. This may be due to the balancing circumstance that, while in the eastern urban location of Manhattan one would expect a lower proportion of abstainers, in the predominantly lower social status of the sample we would expect the opposite effect.

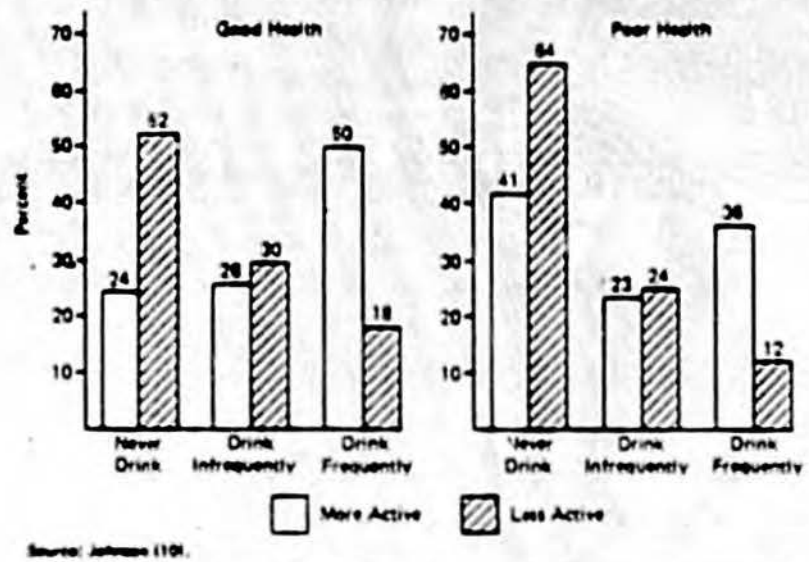
The respondents were asked various questions about their activities and feelings in addition to their drinking. Their self-reported physical health was strongly associated with drinking: there was a greater likelihood of drinking among people in good health than among those in poor health. In figure 3, the drinking behaviors of men and women are compared according to two health categories. The tendency for people in poorer health to drink less was stronger among women than among men.

The drinking behaviors of active and less active people in the two health categories were also compared, high activity being defined as reported participation in 8 or more out of 16 activities such as shopping, reading, playing games, and social or cultural functions. Men were more active than women, but the sex difference was fairly small. As would be expected, highly active respondents were more likely to report good health. Figure 4 shows that regular drinking was preponderant among the highly active people in good health; abstinence was preponderant among the less active people, especially those whose health was only fair or poor.

Some additional measures show a similar pattern of relationships with drinking. People who reported good psychological well-being, and seeing friends, tended to report good health, high activity, and regular drinking. Seeing relatives was less closely related to health and drinking; perhaps contact with relatives can indicate infirmity or limitations on self-reliance. The measure of activity, shown in figure 4, appeared to be the one most consistently related to drinking.

Among the 34 nondrinkers who formerly drank, 50 percent had stopped because it made them sick or was thought to be bad for their

Figure 4. PERCENTAGES OF ABSTAINERS AND TYPES OF DRINKERS AMONG ADULTS AGED 65+ BY LEVEL OF ACTIVITY AND CONDITION OF HEALTH, MANHATTAN SAMPLE, 1973



health. However, past excessive drinking or physical damage attributed to drinking did not appear to characterize these former drinkers. The proportion of them who reported good health (30 percent) was similar to the proportion (28 percent) among those who had always abstained.

In general, the amount of drinking was rather light in this sample of older persons. The drinking which did occur was part of a pattern of good health, psychological well-being, and an active social life. This probably reflects a greater enjoyment of drinking and ability to cope with the effects of alcohol.

While poor health was the cause of giving up drinking in a portion of this sample, the good health and high level of activity associated with drinking by another portion of the sample might be attributable to beneficial effects of the drinking. Moreover the person who abstains may coincidentally refrain from some of the social and convivial activities which are associated with many drinking occasions. The men, notably, were more likely to drink regularly and also tended to report better health and a slightly higher level of activity.

A study of a nursing home and a residence for the elderly in Boston *(1)* yielded some data on drinking practices of older persons before they came to live in these institutions. The mean age (77 years) was substantially higher than in the Manhattan residential sample. Of the total Boston sample of 145, 72 percent were women. Drinking data were obtained from only 98 of these people, and the investigators combined the sexes for the analysis of their findings. In this sample, 30 percent reported having drunk regularly, 50 percent rarely, and 20 percent never. These proportions agree closely with the sample shown in figure 1, assuming that the drinking category did not include very many who had drunk at an earlier age and stopped prior to institutionalization. When current self-reported health was compared with former drinking practices, no significant differences were found. The sample included 8 percent who reported having stopped drinking on advice of a doctor.

A serious limitation of these surveys is their reliance on self-reports by the respondents. People may deceive themselves or the interviewer, especially about their former drinking practices. Objective, independent verification of the self-reports would be desirable and should be an important goal of future research. However, these studies have provided some new information about drinking by older persons, and at least preliminary inferences may be drawn from them.

About 25 billion dollars is estimated as the economic cost to society of alcohol misuse in the United States in 1971. The main losses were incurred through reduced production, illness, and traffic accidents.

Imperfections in data and methods require that this estimate be regarded as a first approximation rather than a precise value.

Chapter III

Economic Costs of Alcohol-Related Problems

A recent study of the economic effects of alcohol-related problems in the United States estimated, for the year 1971, a loss to society of over $25 billion *(3)*. The estimate (table 1) was based on an analysis of six areas of social behavior which past or current research had explicitly or implicitly identified as sources of significant economic costs that might be related to misuses of alcohol.

One cost estimate was developed for the market value of the lowered production of adult male workers with alcohol problems. Also, the costs to society in the form of output required in 1971 because of the socially dysfunctional effects of alcohol misuse and alcoholism were estimated separately for motor vehicle accidents and for health problems. The study estimated that over $23 billion of the quantifiable costs occurred in these three areas. Finally, estimates were also prepared of the costs of alcohol-related programs, costs to the criminal-justice system for alcohol-related offenses in 1971, and costs of the social-welfare system related to alcoholism. An effort to assign a portion of the economic cost of fire losses to alcohol misuse did not succeed owing to the lack of adequate reliable data.

A comprehensive economic evaluation of the effects of the production and consumption of alcoholic beverages would take account not only of the costs to society associated with their misuse but also of numerous economic benefits arising from their use. This could not be accomplished in the present study. Thus, while health and medical costs of misuses have been calculated, the possible value of health-promoting uses has been left out of the account. A further limitation of its scope is that no account is taken of the value of personal and social gratifications from use, or of the emotional sufferings caused by misuse; no attempt has been made to measure these human effects in economic terms. The present study, thus, is limited to an attempt to quantify only the economic costs of alcohol misuses and alcoholism.

Economic cost was defined as "the value of output of production that must be foregone by society because of alcohol misuse and alcoholism" *(3)*. Costs arise from the socioeconomic process of allocating limited resources to meet, through the production of goods and services, the unlimited wants of society. If economic resources are reduced by or reallocated to alcohol-related effects, the economic cost to society is the value of the output which the resources would have produced if it had not

TABLE 1

ECONOMIC COSTS OF ALCOHOL MISUSE AND ALCOHOLISM, U.S.A. 1971

	Billions of Dollars
Lost production	$ 9.35
Health and medical	8.29
Motor vehicle accidents	6.44
Alcohol programs and research	0.64
Criminal-justice system	0.51
Social-Welfare system	0.14
Total	$25.37

Source: Berry et al. (3).

TABLE 2

ECONOMIC LOSS DUE TO DIMINISHED PRODUCTIVITY OF MEN, U.S.A. 1971

Age of Head	Estimated Number of Families (1000's)[a]	Percent of Families with Problem-Drinking Men[b]	Estimated Number of Families with Problem-Drinking Men (1000's)	Mean Gross Deficit in Family Income of Problem-Drinking Men[b]	1968 Estimate of Economic Loss of Problem-Drinking Men (billions of dollars)
21-29	7,197	21%	1,314.9	$1,011	$1.329
30-39	10,744	13	1,243.1	1,860	2.312
40-49	11,506	12	1,228.8	2,356	2.895
50-59	10,063	11	974.1	1,565	1,524
			1968 Estimated Total		$8.06 Billion
			Adjusted 1971 Estimated Total[c]		$9.35 Billion

[a] Derived from Statistical Abstracts of the U.S. (22), Table 54, p. 41, 1971.
[b] From Cahalan and Room (5).
[c] To adjust for inflation, the 1968 estimated total of $8.06 billion was multiplied by the percentage increase in the Consumer Price Index (16 percent) between 1968 and 1971.

been for alcohol misuse and alcoholism. The measurement of economic cost is greatly facilitated if the market prices are available for the resources which are either reduced or reallocated as a result of alcohol misuse. Because the general understanding of the relationship between alcohol and various behaviors is in a comparatively primitive state, however, estimates of the costs of some possibly significant aspects of behavior could not be formed. As a result, the estimate of loss of about $25 billion in 1971 due to alcohol misuses may be conservative. Some considerations which would suggest that this amount may constitute an overestimate, as well as still other elements of underestimate, will be dealt with below.

Methods

The study was a pioneering attempt to derive systematic quantitative economic cost estimates based on the observed behavior of people with alcohol-related problems. Ideally, cost estimation is a two-stage process: First, research identifies and quantifies specific behaviors which can be attributed to alcohol misuse and alcoholism. The behavioral data are then analyzed from an economic perspective. This process was followed as closely as possible.

Two variations of the method were employed: (a) Behavioral research on alcoholism was surveyed and the economic costs of that illness were estimated; (b) cost studies of other alcohol-related behaviors were analyzed and a proportion of the costs was allocated to alcohol misuse and alcoholism.

The conclusions follow, separately, for each of six main identified cost areas.

Lost Production

The largest single area of economic cost—amounting to $9.35 billion—was the lost production of the goods and services which could be attributed to the reduced productivity of alcohol-troubled male workers.

The cost of lost production was estimated on the basis of observations of the difference in earnings of families with and without problem drinkers. The estimate was limited to a [illegible] period (1971) for noninstitutionalized men aged 21 to 59. A summary of the information and findings is presented in table 2. The study

includes, possibly for the first time, estimates of lost production derived from data on people with drinking problems in the general population rather than only those seen in treatment environments, and taking into account age and income as well as prevalence. It was not possible, however, to take into account other factors, such as ethnicity, region, urbanization, parents' status, psychiatric disablements other than problem drinking, and some other factors which may also be related to both income and drinking problems.

Another important aspect of the present lost-production estimate is that it was prepared from the perspective of society as a whole. Many individual firms and large organizations, including the Federal Government, have conducted studies on the relationship between employees' wages and their productivity and have generally employed alcohol misuse as a factor in lost production.

Pell and D'Alonzo *(19)* have clearly outlined the source of lost productivity among alcohol-troubled workers:

> The cost of alcoholism to industry is made up of several components, including loss of efficiency, absenteeism, lost time on the job, faulty decision making, accidents, impaired morale of co-workers, and the cost of rehabilitation programs. A large significant portion of the economic impact of alcoholism also includes premature disability and death, resulting in the loss of many employees in their prime who have skills that are difficult to replace.

However, the cost of production as estimated by an industry is necessarily limited. In general, it does not include the cost of the unemployed worker. Nor need it even consider the costs of the reduced productivity of alcohol-troubled workers if their wages are reduced correspondingly, and there are indications that such downward adjustments in the pay of problem drinkers do occur. Society, on the other hand, must include the costs of reduced production by all these individuals in its estimate of the costs of alcohol-related problems. Although the wider view was taken in the present study, the estimate is not completely general. The information about some groups within society is too inadequate to allow cost estimates based on their characteristics and behavior.

The lost or reduced production of women, and of alcoholic persons who are institutionalized or living on skid row, is not included in the $9.35 billion estimate.

The economic cost of the lost production among women is probably substantial. For several reasons, however, these costs cannot be easily calculated: (a) No reliable market prices are available which would indicate the value of women's services in household or nonmarket production. (b) There is no reliable estimate of the actual number of alcoholic women; estimates range from 900,000 alcohol addicts *(9)* to as many as 4.5 million problem drinkers *(3)*. (c) There have been no systematic studies of the changes in the economic roles of family members under the impact of either an alcoholic wife or husband. Thus any estimate at this time of the cost of lost production among alcoholic women would be little more than conjecture.

Similar difficulties apply to any attempt to estimate lost production costs among institutionalized and skid row problem drinkers.

While these latter insufficiencies indicate that the amount entered in tables 1 and 2 as the cost of diminished production is an underestimate, an important caution must be entered here. To begin with, no allowance has been made for the losses that would presumably have occurred in the same population even in the absence of any drinking problem—for example, because of other psychiatric disablements. This consideration gains force from the hypothesis, as enunciated by Schuckit *(20)*, that for some people—men in particular, in contrast to women—alcoholism represents a "choice of symptoms" as against an affective disorder. Further, the present estimate is based on comparing income of families of men exhibiting some drinking problems with income of families of men not having such problems, controlled only for age, and all the difference is assigned to the drinking problem. This leaves at least three important components out of account: (1) Since a sizable proportion of alcoholic persons are unmarried, the use of family income as a base tends to inflate the resulting loss value. (2) There may be factors other than age which are related to both drinking problems and income. For example, members of some ethnic and religious groups with relatively high rates of problem drinkers are also more likely to be workers in occupations

with lower status and income. (3) The method used herein simply attributes all reduced income of problem drinkers to the misuse of alcohol. But it is of course possible that some misuse of alcohol is caused by socioeconomic disadvantagement as manifested in lower income. These various factors, not allowed for in the present estimate, render it to some extent an overestimate. There is no basis at present for gauging to what degree the overestimating and underestimating factors may balance each other. All that can be said is that the estimate of a $9.35 billion loss of production is the best that can be derived from the presently available data. It should be thought of as a first approximation. Intensive study of a multiplicity of relevant factors, and critical refinements of methodology, will be needed to formulate a more satisfactory estimate.

Health and Medical Costs

Treatment for alcohol-related conditions accounted for more than 12 percent of the $68.3 billion health bill *(8)* for adult Americans in 1971. Approximately $8.29 billion was expended for alcohol-related health and medical problems, making this the second largest component of the economic costs of alcohol misuse, problem drinking, and alcoholism.

Included in these costs are expenditures for the major types of health care and for medical construction, training, and education. These expenses are adjusted so that they reflect only the share attributable specifically to alcohol-induced problems. Account was taken of the costs for medical care that these patients would have been expected to incur even if they had not been impaired by alcohol, and these were excluded in arriving at the final estimate of $8.29 billion.

Of the $8.29 billion expended for alcohol-related health services, $5.3 billion was for hospital care; $0.9 billion for physicians' services; nearly $0.3 billion for drugs; and more than $1 billion for administration and construction. The $5.3 billion for hospital care is nearly 20 percent of the total hospital expenditures for adults in 1971.

Three independent sources of information were analyzed in the health-medical cost estimate. The literature on the relation between alcohol and medical care utilization was surveyed; the information system of the Nation's Alcoholism Treatment Centers was used to obtain data on hospital utilization by alcoholic patients; and field interviews were conducted among medical and health experts in the alcohol field to obtain estimates of health-care utilization by the general alcoholic population. The weakness of the bases for estimating utilization is recognized, and more reliable sources and methods should be developed in future research.

Expenditures for dental care were not included. Field interviews established that problem drinkers use fewer dental services than the general population. This appears to be reflected in the poorer dental health of alcoholic persons *(15, 16)*.

Motor Vehicle Accident Costs

The third largest economic cost associated with alcohol misuse is that proportion of the costs of various types of motor vehicle accidents which can be attributed to that cause. It comes to $6.44 billion. A review of the literature suggested that the appropriate dividing line at which responsibility may be attributed to the presence of alcohol is the finding of a blood alcohol concentration of 0.05 percent or higher in the driver or pedestrian *(4)*. This appears to be the dividing line at which the likelihood of being involved in an alcohol-caused accident begins. In this section, therefore, "alcohol misuse" indicates such a finding.

Three types of accidents were studied: fatal, personal injury, and property damage.

Based on data supplied by the National Highway Traffic Safety Administration, alcohol misuse contributed to 43 percent of the nonpedestrian traffic fatalities (19,000 deaths) in 1971; 38 percent of the adult pedestrian fatalities (2,700 deaths); 14 percent of the personal-injury accidents; and 6.8 percent of the property-damage accidents. Thus, about 40 percent (21,700) of the motor vehicle deaths were believed attributable to alcohol in 1971. This estimate does not include nonadult pedestrian deaths or any sober adult pedestrians who may have been killed by drivers under the influence of alcohol.

When these accident proportions are applied to the National Highway Traffic Safety Administration's estimates of costs in each category,

the cost of alcohol-related accidents can be determined as follows:

Fatal accidents	$ 3.56 billion
Injury accidents	2.38 billion
Property damage	0.50 billion
Total	$ 6.44 billion

Other sections of the study, such as those on lost production and health and medical costs, undoubtedly include some expenditures which rightfully belong in the motor vehicle category. Double counting could not be avoided completely and this may have inflated the estimate, although care was taken to estimate these costs conservatively. It is, however, the assignment of the cost of any accident in which the driver or pedestrian had a blood alcohol concentration of 0.05 percent to alcohol misuse that introduces a possibility of error on the side of overestimation. The assumption that the person with any blood alcohol concentration—even higher than 0.05 percent—was at fault in an accident is clearly arbitrary. In two-vehicle or automobile-pedestrian accidents the other person, or both, could be at fault. Moreover, 0.05 percent is the lowest blood alcohol concentration at which motorists are thought to be impaired.

In most jurisdictions the criterion of impairment is set at 0.08 percent, 0.10 percent and higher. From this viewpoint the $6.44 billion estimate represents a maximum. The development of more precise information on joint or "other person" culpability, as well as a more rational basis for using a presumptive blood alcohol level other than 0.05 percent, with supporting data on incidence of other blood alcohol levels, will allow a more confident estimate of the costs of traffic accidents attributable to alcohol misuse. Thus the present estimate should be regarded as the best first approximation that could be developed at this time.

Program and Research Costs

The expenditures for alcohol and alcoholism-related programs, including diagnosis, treatment, rehabilitation, prevention, education, and research, were estimated to have totaled approximately $0.64 billion in 1971. Federal, State, and voluntary private agency budgets were reviewed to obtain these cost estimates.

The tremendous surge of interest in and awareness of the problems of alcohol since 1971 has resulted in increased program expenditures. Estimated Federal Government expenditures for alcoholism programs in 1971 were $127 million. Since that time, new agencies, including the National Institute on Alcohol Abuse and Alcoholism, have been created, and more funds are being allocated especially for alcoholism treatment programs, so that current expenditures are substantially greater.

Costs to the Criminal-Justice System

The study estimated that violent and antisocial behavior linked to alcohol misuse cost the Nation's criminal-justice system more than half a billion dollars in 1971. This amount represents a small but not inconsiderable proportion of the $10.5 billion expended by the police, courts, and correctional institutions in that year *(21)*. These estimates represent only the costs to the criminal-justice system, not any costs of the crime to the victim or to the perpetrator.

No presumption was made that alcohol is the causal agent of any crime. Nonetheless, it is recognized that a certain proportion of all crime that comes to the attention of the authorities has some alcohol involvement. As the National Commission on Causes and Prevention of Violence *(17)* has put it, "No drug, narcotic, or alcoholic beverage presently known will, by itself, lead to violence. Nevertheless, these substances may, through misuse or abuse, facilitate behavior which may result in violence to persons or property."

Costs were determined first by reviewing the literature on alcohol and criminal behavior. The reports indicated that alcohol is frequently associated with certain violent crimes such as homicide, assault, and rape. Other offenses, such as drunkenness, disorderly conduct, driving under the influence of alcohol, and vagrancy, were classified as 100-percent alcohol-related, but liquor-law violations were excluded entirely from this accounting, since they do not bear on alcohol misuse. In 1971, violent crimes associated with alcohol, and the 100-percent alcohol-related offenses, accounted for 3.6 million arrests, equal to 41 percent of all arrests.

Cost estimates were assigned on the basis of determining what percentage of the various crime categories could be attributed to alcohol. The number was then multiplied by average cost

TABLE 3

SUMMARY OF ALCOHOL-RELATED COSTS TO THE CRIMINAL-JUSTICE SYSTEM, U.S.A. 1971

		Violent Crimes	100-Percent Alcohol-Related Offenses
Police			
Cost per case	$17.80		
Total for alcohol-involved arrests		$236.9 million	$ 58.6 million
Court			
Cost per case	$4.69		
Total for alcohol-involved procedure		$ 28.1 million	$ 15.4 million
Jail			
Cost per day per inmate	$6.10		
Total for alcohol-involved inmates			$ 71.4 million
Prisons			
Cost per day per inmate	$6.00		
Total for alcohol-involved inmates		$ 76.2 million	
Other			
Crime prevention (alcoholism rehabilitation)			$ 25.0 million
Grand Total			$511.5 million

data for arrests, trials, and incarceration in each category.

Drunkenness, driving under the influence, disorderly conduct, and vagrancy were found to have cost $74 million in the year 1971. This is based on the finding that there were 3.3 million arrests for those offenses that year, and on an estimate *(7)* that police and court costs for each arrest came to $22.49 per offense. More than $71.4 million was expended for incarceration as a result of these nonviolent crimes. The estimate of police and court costs per arrest was based on findings in a study conducted for the City of Phoenix, Arizona *(7)*, and to the extent that these costs may not be representative for the entire country the estimate would have to be modified. At the present time the Phoenix study is the only one that provides a basis for formulating a reasonable estimate.

An association with alcohol was recorded in 64 percent of all murders *(26)*, 41 percent of all assaults *(18)*, 34 percent of all forcible rape *(1)*, and 29 percent of all other sex crimes *(12)*.

Arrest and court costs for violent crimes were calculated as follows:

	Police cost	Court costs
	(In millions of dollars)	
Criminal homicide	$ 13.5	$10.8
Aggravated assault	209.5	15.5
Forcible rape	13.9	1.8
Total	$236.9	$28.1

Nearly 35,000 persons were incarcerated for violent crimes associated with alcohol use during 1971. The estimated average cost of maintaining a person in prison is $6 per day *(24)* and in jail, $6.10 *(25)*. When multiplied by the 34,805 alcohol-involved prisoners, the cost of the imprisonment is $208,830 per day or $76,222,950 per year. The loss of income by these prisoners has not been taken into account. On the other hand, this estimate has assumed that each of these persons was in prison a full year.

In addition to these costs, and based on an estimate of the U.S. Office of Management and Budget *(23)*, $25 million was assigned as the cost of crime prevention or alcoholism rehabilitation activities by the criminal justice system.

The total costs are summarized in table 3.

Social-Welfare System Costs

Alcohol-related expenditures by the social-welfare system can be divided between two categories: social-services costs and transfer payments. Transfer payments represent a transfer of income to the needy in order to arrest the decline in the standard of living of one whose job may have been lost because of alcoholism. These payments, except for administrative costs, are not additional economic costs. They do not measure reduced or foregone output, which is measured directly by the amount of the total reduced earnings of workers. However, these income maintenance payments do have social and political significance, for they represent a financial burden to the taxpayer. If these payments were not socially mandated, the funds could have been used for alternative purposes, either by the taxpayer or the appropriste level of government. Income-maintenance payments attributable to alcoholism were estimated to be $2.2 billion in 1971.

Social-service costs which do meet the criterion of economic cost totaled some $135,100,000 during 1971. The social-service costs were incurred in the areas of child welfare and special welfare. This amount probably represents only a fraction of the economic cost of the weakening and, in some cases, the total disruption of family structure under the impact of alcoholism.

Social and related research has begun to identify some of the destructive effects of alcoholism on the family. Some of these effects may have complex economic as well as social implications. Chafetz et al. *(6)* found marital instability in 41 percent of the families of alcoholic persons. As many as 15 to 20 percent of all applications to some family-service agencies involve a drinking problem *(2)*, and the family court in New York City has been reported to estimate that 40 percent of the problems brought to it are directly or indirectly attributable to problem drinking *(11)*.

Economic Cost of Fire

Preliminary research suggested that a considerable portion of the more than $4.5 billion *(10)* suffered in property loss and expended to combat fires in 1971 might be attributed to the misuse of alcohol. For example, one study *(13)* attributed more than 80 percent of all fire-related deaths in Memphis over an 8-year period to alcohol. Another study *(14)* tentatively concluded that "alcohol was a major contributor in approximately 30 percent" of 89 fires in which fatalities occurred during a 2-year period: "Smoking was established to be the major ignition source in approximately 50 percent of the fires, but alcohol was present in significant quantities in 60 percent of the 'smoking' fires." The data are suggestive, but the existing studies are not extensive enough to allow the development of cost estimates attributable to alcohol misuse; such estimates were therefore not included in the present study.

Summary

The adverse effects of alcohol misuse impose a significant economic burden on society. It is not possible, at present to place a reliable economic value on all adverse effects—such as broken homes and disturbed children. And because of insufficient data or still inadequate methodology, it is not yet possible to arrive at a cost value of certain effects in which the economic component is obvious, such as fires or loss of production in homemaking. In six areas, however, estimates could be developed of the costs of alcohol misuse in the United States in 1971. The cost assigned to lost business-industrial production was $9.35 billion, to health-medical services $8.29 billion, to traffic accidents $6.44 billion, to the criminal-justice system $0.51 billion, to the social-welfare system $0.14 billion, and to alcohol-related programs and research $0.64 billion, for a total of $25.37 billion. Some factors which would cause under- and overestimations in the three largest categories could not be taken into account, nor was account taken of any counterbalancing beneficial effects of alcohol use. These estimates should therefore be regarded not as precise values but as reasonable first approximations, for the present, of the economic costs of alcohol misuse. They represent, moreover, a distinct advance in understanding, as well as a foundation for continued study.

TABLE 1

RELATIONSHIP BETWEEN CANCER AT VARIOUS SITES AND THE USE OF ALCOHOL AND TOBACCO

Sites	Number of Cases	Relationship with Use of Alcohol	Relationship with Use of Tobacco	Sex Ratio (M:F)
Hypopharynx	4,225	very strong	very strong	28.0
Larynx	5,524	very strong	very strong	27.4
Esophagus	5,007	very strong	strong	16.6
Lung	4,616		very strong	11.8
Oropharynx	3,216	strong	very strong	11.6
Tongue	4,856	very strong	strong	9.3
Oral cavity (other sites)	4,145	strong	very strong	8.6
Lips	3,609		strong	8.1
Bladder and other urinary organs	962		strong	2.6

Source: Flamant et al. (15).

habits, including the amount of alcohol intake. It is known to be a difficult task to establish reliably how much alcohol is consumed by heavy drinkers. Moreover, there is the confounding condition that people who drink heavily often also smoke heavily. The latter fact was first taken into account by Flamant et al. *(15)*, who assessed both factors and reported, based on analysis of previous research (table 1), that there was a "strong" or "very strong" association of alcohol intake with cancer of those sites that came most strongly in contact with alcohol (tongue, hypopharynx, larynx, esophagus), but no association in sites lacking such contact (lung, lips, bladder, other urinary organs). On the other hand there was also a strong or very strong association of tobacco use with cancer of all these sites—those without as well as those with alcohol contact. The frequent coexistence of alcohol and tobacco use has made it difficult to identify the influence of each independently in relation to cancer.

The means by which alcohol might exert a carcinogenic effect in man are unknown, but several have been suggested and are being studied. Among the possibilities are effects of prolonged and repeated contact of body tissues with alcohol in various forms, especially in strong solutions; a role of alcohol as a cocarcinogen with tobacco, or as a trigger mechanism for a hypothetical viral cause; indirect consequences of alcoholism, such as malnutrition, anemia, and poor hygiene; and the possible presence of carcinogenic substances in some alcoholic beverages. Each of these hypothesized mechanisms becomes important in consideration of the possible effect on specific sites and types of cancer.

Alcohol and Specific Sites of Cancer

Upper Aerodigestive Tract

Cancers of the upper aerodigestive tract (the mouth, pharynx, and larynx) appear to be related to heavy drinking in the United States and other parts of the world where these cancers occur with high frequency in men. Tobacco use and alcohol consumption each contribute separately to increased risk of cancer; and the data suggest that heavy use of both has an additive and possibly even a synergistic effect in increasing risk *(47)*. Laboratory experiments indicate that alcohol and tobacco augment the carcinogenic effect of 7-14-dimethyl-benzanthracene in hamsters and mice *(14, 54)*, giving some laboratory support for this epidemiological observation.

The use of tobacco in one form or another is the most important worldwide link to cancer of the mouth *(18)*. This has been demonstrated in many studies of tobacco chewing, snuff dipping,

TABLE 2

RELATIVE RISK OF ORAL CANCER ACCORDING TO LEVEL OF EXPOSURE TO ALCOHOL AND SMOKING

Ounces of Absolute Alcohol per Day	Cigarette Equivalents per Day			
	0	Less than 20	20 – 39	40 or More
No alcohol	1.00	1.52	1.43	2.43
Less than 0.4 oz.	1.40	1.67	3.18	3.25
0.4 – 1.5 oz.	1.60	4.36	4.46	8.21
More than 1.5 oz.	2.33	4.13	9.59	15.50

Risk is expressed relative to a risk of 1.00 for persons who neither smoked nor drank.
Source: Rothman and Keller (47).

the chewing of betel (mixed betel nuts, tobacco, and lime), beedi smoking (Indian home-rolled tobacco), and cigarette, cigar, and pipe smoking. Risk is further increased among people who also drink heavily *(63)*. It should be noted that while cancer of the lip has been specifically linked to clay and metal pipe smoking, cancer of the skin adjacent to the lips is related to exposure to the sun's ultraviolet rays and not to alcohol or tobacco use, demonstrating the specificity of discrete sites to different carcinogenic factors.

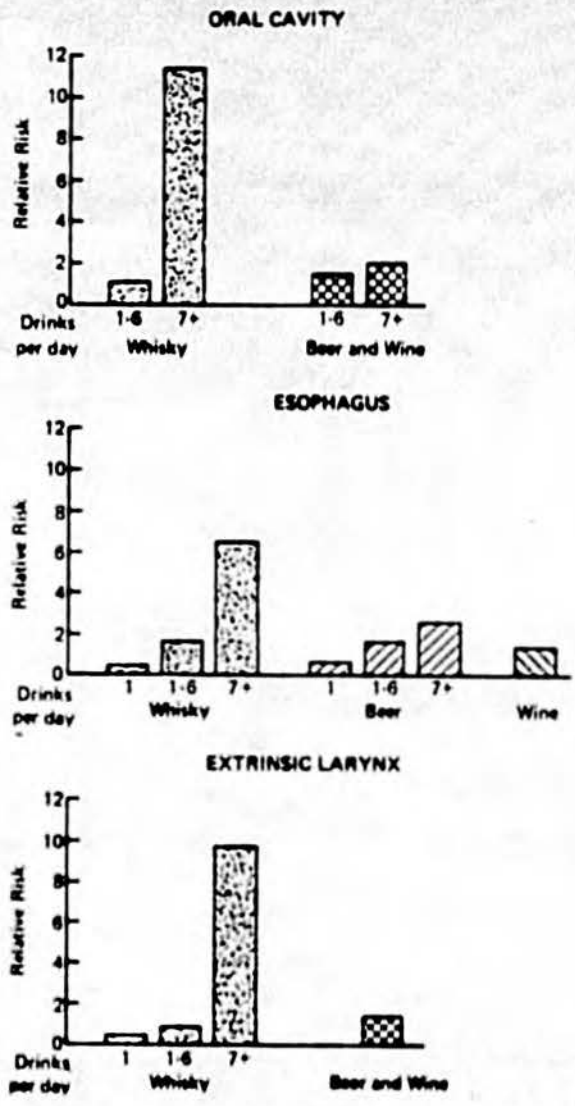
The roles of smoking and drinking in cancers of the upper aerodigestive tract have been difficult to separate due to the association of heavy drinking and smoking in the same individuals. One study *(13)* showed that 93 percent of the men and 91 percent of the women in a group of alcoholic outpatients were smokers, proportions far higher than in the general population. A recent preliminary report by Kissin et al. *(25, 26)* revealed that patients who had primary cancers of the floor of the mouth, the hypopharynx, and the esophagus, had a higher drinking-to-smoking ratio than patients with primary cancers of the roof of the mouth, the larynx, and nasopharynx, who smoked more than they drank. Since alcohol comes in closer contact with the "ingestion tract" and tobacco smoke comes in closer contact with the "inhalation tract," a possible differential contributory relationship was suggested. In addition, patients with cancer of the ingestion tract had used more distilled spirits than those with cancer of the inhalation tract.

Attempts to separate tobacco from alcohol as a risk factor in cancer of the mouth and pharynx require sophisticated epidemiological models. A four-level gradation for each exposure to alcohol and a matrix of 16 relative risk estimates were used in a study by Rothman and Keller *(47)*. These estimates were tabulated to permit inspection of either alcohol intake or cigarette smoking as the independent variable (table 2). The increasing relative risk at the higher levels of both drinking and smoking suggests the possibility of a synergistic effect, though based on these data alone the simple additive model cannot be excluded. These findings accord with earlier reports *(31, 32)* that the relative risk of buccal and upper respiratory tract cancer among those who use both alcohol and tobacco was greater than the sum of either risk alone.

Toward the end of the 1950s Wynder and his colleagues in a series of studies *(63–66)* found that patients with oral and laryngeal cancers were considerably heavier drinkers than control patients. By separating individual risk factors in oral cancer, the conclusion was reached *(66)* that "heavy drinkers" had roughly a 10 times greater risk of developing cancer of the mouth than "minimal" drinkers. When amount of alcohol consumed increased, the relative risk of cancer of the mouth, extrinsic larynx, and esophagus was also increased (figure 1), much more so with whisky than beer and wine.

It has been suggested that the heavy smoking might initiate and the heavy drinking synergistically promote laryngeal cancer (69).

Figure 1. RELATIVE RISKS OF DEVELOPING CANCER OF THE ORAL CAVITY, ESOPHAGUS, AND LARYNX, BY TYPE AND AMOUNT OF BEVERAGE CONSUMED



Reproduced from Wynder and Mabuchi 1981 by permission of Academic Press.

A case-control study of oral and pharyngeal cancer among veterans led Keller *(23)* to conclude that there is a strongly positive association between drinking more than 1.6 oz. of absolute alcohol per day plus smoking 40 or more cigarettes per day and cancer of the mouth and pharynx. Of the cancer patients in that study, 43 percent were classified as "heavy drinkers" (over 1.6 oz. of absolute alcohol per day) compared to 20 percent of the control subjects.

Other investigators *(38, 39, 57, 60)* have reported an apparent association between drinking and cancer of the mouth, pharynx, larynx, and esophagus that persisted when control subjects were matched for tobacco use. Lung cancer was found to be associated with tobacco but not with alcohol use, while cancer of the stomach, which has been declining in recent years, was associated with neither alcohol nor tobacco use. No association was found between

TABLE 3

ALCOHOL CONSUMPTION AND PERCENTAGE OF PERSONS WITH ALCOHOLISM AMONG CANCER PATIENTS AND NON-CANCER CONTROL GROUP (WORKERS IN THE PARIS AREA)

	Number of Cases	Quantity Consumed: Ounces of Absolute Alcohol Consumed Daily	Quantity Consumed: Gross Significance	Quantity Consumed: Significance Level after Adjustment for Tobacco	Quantity Consumed: Significance Level after Adjustment for Tobacco and Age	Percentage with Alcoholism: %	Percentage with Alcoholism: Gross Significance	Percentage with Alcoholism: Significance Level after Adjustment for Tobacco	Percentage with Alcoholism: Significance Level after Adjustment for Tobacco and Age
Site of Cancer									
Tongue	43	5.2	***	*		74	***	***	***
Buccal cavity (other locations)	23	5.4	**	*	*	83	***	***	**
Oropharynx	24	4.9	**			56			
Hypopharynx		5.5	***	*	*	82	**	*	*
Larynx	63	5.4	***	**	*	81	**	*	**
Esophagus	100	5.3	***	**	**	58	**	*	*
Control group	366	4.0				43			

*p <.05; **p <.01; ***p <.001.

Source: Schwartz et al. (52).

cirrhosis of the liver and cancer of the mouth, pharynx, larynx, or esophagus. From these epidemiological indications Terris and Keller *(57)* inferred that alcohol may act as a carcinogen or cocarcinogen on susceptible tissues of contact but not indirectly through impaired liver metabolism.

Research in France has provided important evidence on the relation of alcohol to cancer of several sites. Schwartz et al. *(52)* investigated 3,937 cancer patients according to the amount they drank and whether they showed signs of alcoholism—diagnosed by the occurrence of tremors of the extremities, spider telangiectasis, and morning drinking. They also studied another group of 1,307 patients to determine the possible interaction of alcohol and tobacco. Their results showed that patients with cancer of the mouth, hypopharynx, larynx, and esophagus drank considerably more than the control subjects, even after adjustment for tobacco use and age (table 3). This relationship was particularly striking in cancer of the esophagus. Alcoholism was also significantly more common among patients with cancers of the same sites, and also among those with cancer of the tongue, even after adjusting for tobacco use and age.

Three prospective studies of the drinking patterns of alcoholic persons and their risk of developing cancer have been conducted in Canada, Norway, and the United States (table 4). The first study, by Schmidt and DeLint *(49)*, a followup of 5,000 men and 1,000 women treated at the Toronto Addiction Research Foundation between 1951 and 1963, showed that cancer of the upper aerodigestive tract occurred five times more frequently among the alcoholic persons than in the general Ontario population.

In a followup to the end of 1962 of 1,722 men who had been treated for alcoholism in Oslo, Norway, between 1925 and 1940, Sundby *(56)* showed that these men faced a multifold increase in the risk of death from cancer of each of the upper aerodigestive tract sites, nearly the same increased risk from cancer of the larynx, and a smaller increased risk of death from lung cancer. No excess mortality from cancers of the stomach, pancreas, liver, or intestines was observed.

A comparison by Pell and D'Alonzo *(43)* of 900 alcoholic employees of an American corporation with an equal number drawn from among 75,000 nonalcoholic employees of the same company showed that the alcoholic employees had a nearly fourfold excess of cancer deaths (26 cases versus 7) involving the mouth, pharynx, esophagus, and lung.

In the latter three studies, however, smoking was not taken into account. The data on lung

TABLE 4

NUMBER OF DEATHS FROM CANCER AMONG ALCOHOLIC PERSONS COMPARED WITH DEATHS IN MATCHED CONTROL GROUPS

Cause of Death	Schmidt & DeLint (Toronto)			Sundby (Oslo)			Pell and D'Alonzo (U.S.)		
	Deaths		Ratio	Deaths		Ratio	Deaths		Ratio
	Alcoholic Group	Control Group		Alcoholic Group	Control Group		Alcoholic Group	Control Group	
All Causes	639	315.2	2.03	1,061	496.9	2.14	102	32	3.22
Cancer (all forms)	77	58.1	1.33	118	85.5	1.38	26	7	3.71
Lung	30	13.9	2.16	19	5.4	3.54	5	2	2.50
Larynx	7	0.8	8.75	5	0.6	8.20	3	0	*
Oral[a]	6	1.7	3.53	22	1.7	12.94	3	0	*
Esophagus	6	1.3	4.62	40	3.4	11.82	1	1	1.00
Number of People	5,395 Men			1,722 Men			842 Men 57 Women		
Number of Person-years	34,445			34,951			4,240[b]		

[a]Mouth and esophagus combined. [b]Estimated. *Indeterminate.

cancer in two of them *(43, 56)*, however, suggest an important role of smoking in these samples, and this reemphasizes the difficulty of evaluating any possible contributory role of drinking when smoking—and, possibly, other relevant factors—are not taken into consideration simultaneously.

In parts of Asia (particularly India), where drinking by the general population is relatively minimal and alcoholism is presumed to be rare, cancer of the mouth is among the most common neoplasms *(18)*. Tobacco is thought to be the most potent carcinogenic factor. Prolonged exposure of oral tissues to tobacco may result in leukoplakia, lesions which have a high risk of malignant transformation and are generally considered to be precancerous *(45)*. The heterogeneous nature of the etiology of upper aerodigestive tract cancer becomes clear when the worldwide incidence is considered (figure 2), but heavy alcohol intake appears to be a significant contributing factor in the United States and other Western countries.

Malnutrition and anemia are also associated with increased risk of oral, hypopharyngeal, and esophageal cancer. This is evident in the relationship of Plummer-Vinson syndrome to nutritional deficiencies, especially vitamin-B-complex and iron *(67)*, and the association of that syndrome with cancer of the mouth, pharynx, and esophagus in women in Sweden *(68)*. A study of American women with oral cancer *(66)* revealed a Plummer-Vinson-like syndrome of glossitis, brittle nails, and early loss of teeth, which appeared to be related to dietary deficiencies. It is possible thus that the increased risk of oral cancer in alcoholism may be related to the nutritional defects associated with heavy alcohol intake.

In a prospective study of 3,000 alcoholic persons, 8 were found with carcinomas of the mouth, pharynx, or larynx but none in 3,000

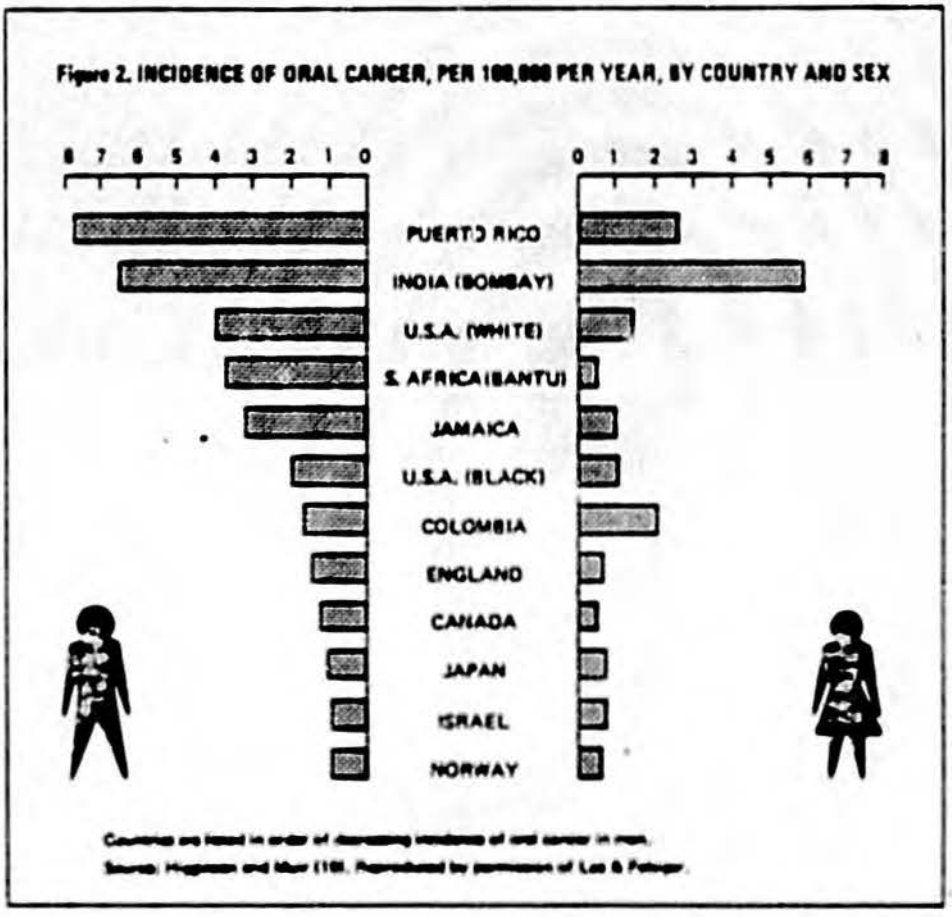


Figure 2. INCIDENCE OF ORAL CANCER, PER 100,000 PER YEAR, BY COUNTRY AND SEX

Countries are listed in order of decreasing incidence of oral cancer in men.

Source: Higginson and Muir (18). Reproduced by permission of Lea & Febiger.

matched nonalcoholic control subjects *(27)*. The 8 alcoholic patients who developed carcinoma had longer average smoking and drinking histories than the noncancerous alcoholic subjects. The duration of exposure to a carcinogenic factor and the latent period between exposure and the development of cancer are important areas for study in understanding and prevention of these carcinomas.

Despite the association of parotid gland swelling with excessive drinking, no association has been observed between parotid gland carcinoma and alcohol intake.

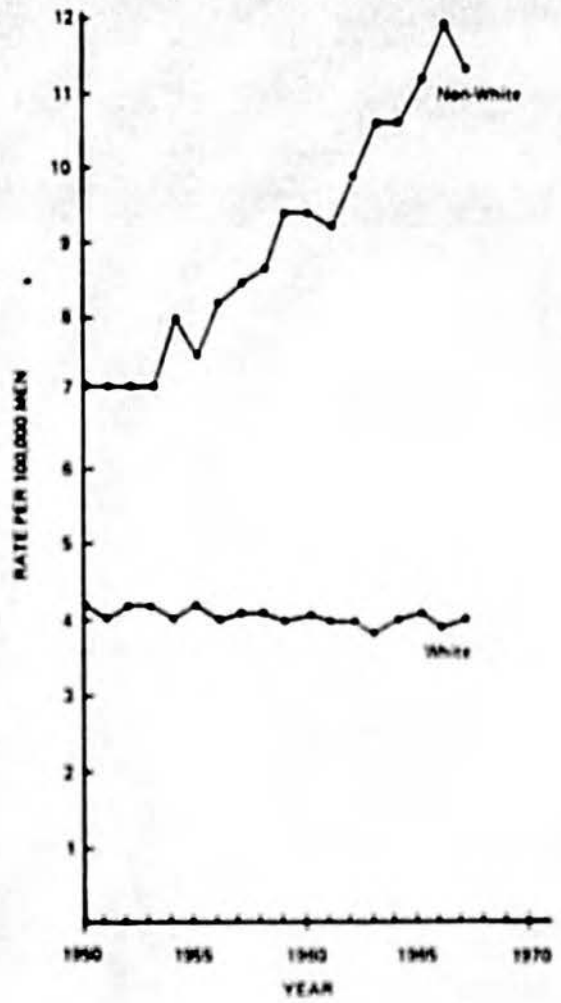
The Esophagus

The highest incidence of cancer of the esophagus, a usually rapidly fatal disease, is reported in the eastern Iranian province of Mazanderan, in the adjacent Kazakhstan and Turkmenistan republics of the Soviet Union, in certain parts of Africa, and in the Brittany region of France. Alcohol consumption in these areas varies from almost nil in Iran to very high in Brittany. The wide differences in esophageal cancer incidence between the sexes and between adjacent communities *(58)* indicate that external factors may be important. In Western countries, where esophageal cancer occurs mostly in men, excessive drinking is thought to be a major contributor to increased risk, with tobacco use playing a synergistic role *(62, 68)*.

In the United States esophageal cancer death rates are now stable among white men but increasing among nonwhite men (figure 3). The reasons for this striking increase among nonwhite men require study and a careful assessment of their drinking, smoking, and possibly other relevant habits. Increased heavy smoking and drinking among nonwhite men, together with improved living standards, changes in diet, and urbanization have all been suggested as factors requiring investigation.

A recent retrospective study by Lynch et al. *(36)* revealed that while there were only 2.7 cases of esophageal cancer per 100,000 population in the United States in 1957, 69 percent

Figure 3. DEATH RATES FROM CANCER OF THE ESOPHAGUS IN MEN, U.S.A. 1950-1967



Source: Burbank [6].

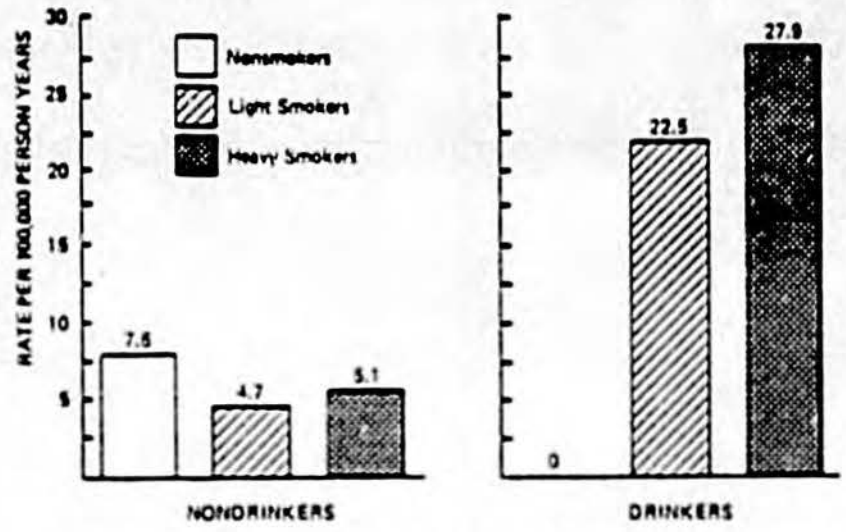
of the patients with cancer of this site also had a history of alcoholism. A higher frequency of alcoholism among patients with cancer of the esophagus than among those with cancer of the colon has also been reported *(22)*.

Several investigators have shown a relationship between heavy drinking, especially of whisky or other spirits *(58, 62)*, and esophageal cancer after correction for age and tobacco use was made *(15, 52)*. In one study *(52)* smoking was found to be less important than alcohol in esophageal cancer, and in another *(62)*, smoking in the absence of heavy drinking appeared to have little or no effect on its development.

A correlation analysis in 41 States of the United States by Breslow and Endstrom *(4)* showed that alcohol consumption was related to increased risk of esophageal cancer mortality among both white men and white women.

Other environmental factors, however, may also play a role in the pathogenesis of esophageal cancer *(26)*. An epidemiological analysis of mortality from this disease in the United States showed a significant correlation between urbanization and per capita cigarette and alcohol sales *(50)*. After partial correlation coefficients were calculated, to remove the effect of the other independent variables, urbanization still remained significantly correlated with esophageal cancer. Poverty and the particular hazards of

Figure 4. DEATH RATES FROM CANCER OF THE ESOPHAGUS IN MEN, BY SMOKING AND DRINKING CHARACTERISTICS, JAPAN 1978



The number of person years observed varied from 19,000 to 96,000 in the several groups.
Source: Hirayama (19).

It is important to note that in Hirayama's study there are not yet enough person-years of exposure on record to assess the risk for the development of esophageal cancer among the nonsmoking drinkers. The latent period for environmentally related cancers is often 20 years or more, and since cigarette smoking in Japan is primarily a post-World War II phenomenon, the smoking factor may have had only a meager effect so far. It is difficult to assess the interaction of multiple factors at this early point in the study, especially in view of the demonstrated importance of the duration of exposure *(26)*.

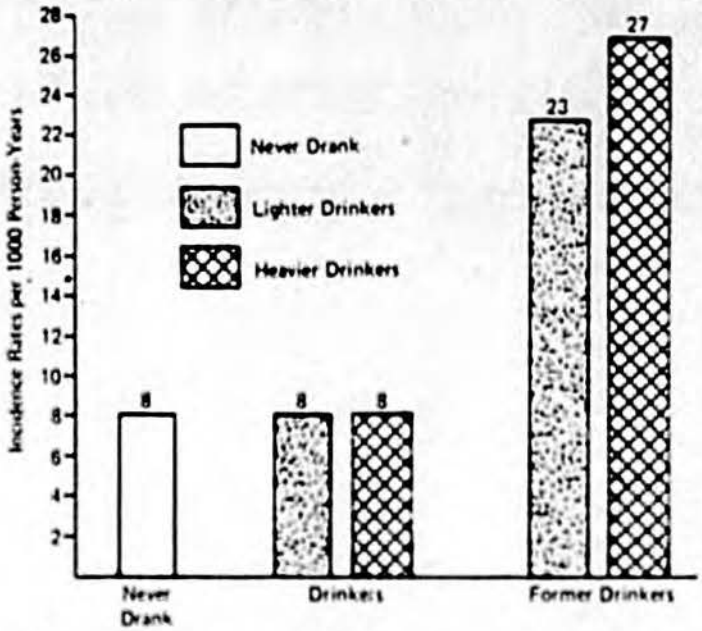
A large prospective study of a million people in the United States being conducted by the American Cancer Society *(2)* will become an important source of similar information about an American population. Both prospective and retrospective studies are hampered by the reluctance of people to report accurately how much they drink. Underestimation of intake may have biased previous studies, particularly retrospective ones in which the relation of alcohol and cancer was known to be under examination. Prospective studies may be able to obtain more accurate data about drinking since a wide spectrum of questions about personal habits can be asked.

In addition to the large-scale prospective studies of alcohol and cancer in Japan and the United States, the World Health Organization's International Agency for Research on Cancer (IARC) in Lyons, France, with support from the U.S. National Institute on Alcohol Abuse and Alcoholism, has intensified its epidemiological research on the possible relations of alcohol to cancer in its various forms and sites.

Prospective studies now under way in Norway may clarify some of the possible relations and provide leads for more specific studies of mechanisms involving alcohol that increase the risk of cancer. Preliminary results from studies of patients with alcoholic cirrhosis in the United Kingdom show a significant relation between heavy drinking and primary liver-cell cancer *(21)*.

The IARC expects to complete these studies, as well as those in France mentioned previously, in 1974. Their findings and more definitive

Figure 1. CORONARY HEART DISEASE RATES IN MEN WHO WERE AGED 45-59 AT THE START OF THE TECUMSEH STUDY, BY DRINKING PATTERN



Coronary heart disease was defined as myocardial infarction.
Lighter drinking was defined for this analysis as 4 ounces of absolute alcohol per week (about 10 ounces of distilled spirits) or less; heavier drinking as any larger amount.

Source: Ullman et al. [6].

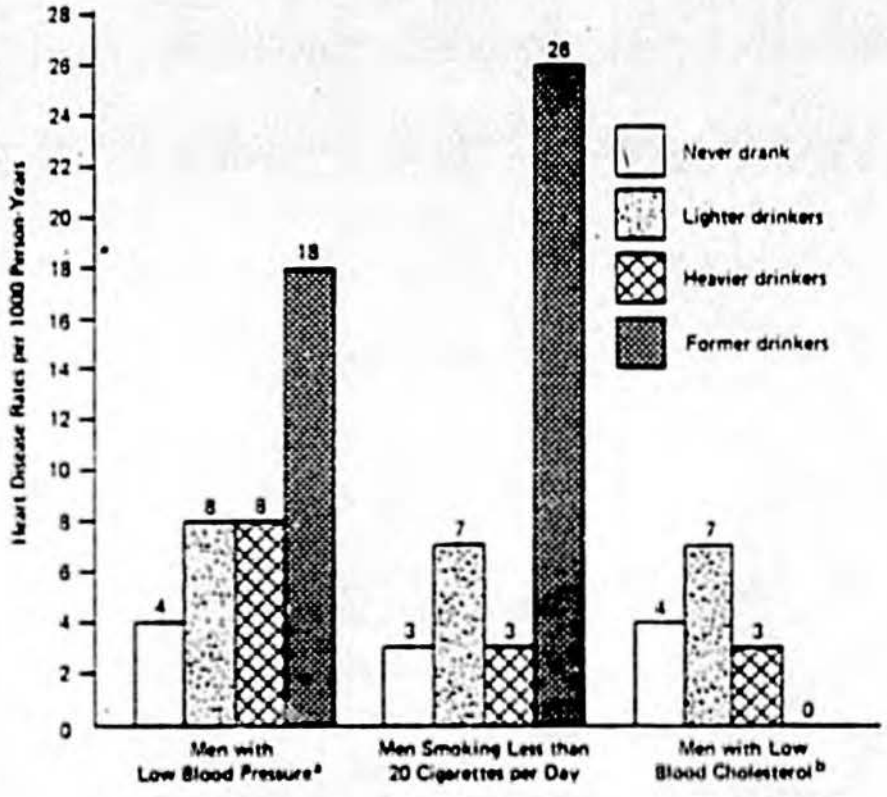
in 1962-65 and 1967-69. A special analysis of the Tecumseh data by Ullman et al. *(6)* revealed fairly complicated relationships between alcohol use and coronary heart disease.

Questions about alcohol use were asked and answers recorded when the study began in 1959; the incidence of heart disease was assessed throughout the 8- to 10-year study period. Figure 1 shows the rates of coronary disease in men who were aged 45 to 59 at the start of the study. Persons who never drank had the same rates as those who drank at either lighter or heavier levels (8 events per 1,000 person-years). On the other hand, persons who were former drinkers but had stopped drinking before the start of the study were about three times as likely to have experienced a heart attack than the drinkers or lifelong abstainers. It should be noted that for the purpose of this analysis, lighter drinkers are those who consume 4 ounces or less of absolute alcohol per week and heavier drinkers are those who consume more than 4 ounces of alcohol per week. (This quantity of absolute alcohol is equal to about 10 ounces of distilled spirits.) Also, heavier drinkers are not necessarily problem drinkers or alcoholic persons.

It is not clear at this time why the former-drinking group has a higher rate of coronary disease. The former drinkers did not differ from the other groups with regard to risk factors known to predict heart disease, such as blood pressure, blood cholesterol level, or cigarette smoking. A special inquiry about the reasons why these persons had stopped drinking revealed that 20 to 25 percent cited health reasons. It is possible, then, that the former-drinking group included many more persons in poor health than the other groups—in spite of similar blood pressure or cholesterol levels—leading to greater susceptibility to coronary disease.

Whether or not alcohol use had caused their poorer health is not clear. The former lighter drinkers—those who drank 4 ounces or less of alcohol per week—had coronary rates almost as high as the former heavier drinkers, yet there is

Figure 2. ALCOHOL USE AND CORONARY HEART DISEASE RATES IN LOW-RISK MEN AGED 45 – 59



[a]Lower two-thirds of distribution (systolic pressure lower than approximately 150 mm. Hg).
[b]Lower two-thirds of distribution (approximately 290 mg. per 100 ml. or lower).
Source: Ullmann et al. (68), Tecumseh Study.

no evidence that alcohol consumption at the level of about 10 ounces of spirits per week—an average of about one 1½-ounce drink per day—is physically damaging. Moreover, the heavier drinkers who had not stopped drinking showed rates no different from those who never drank at all. Thus, if alcohol was a causal factor in the former-drinking group, it had an adverse effect only in this relatively small subpopulation.

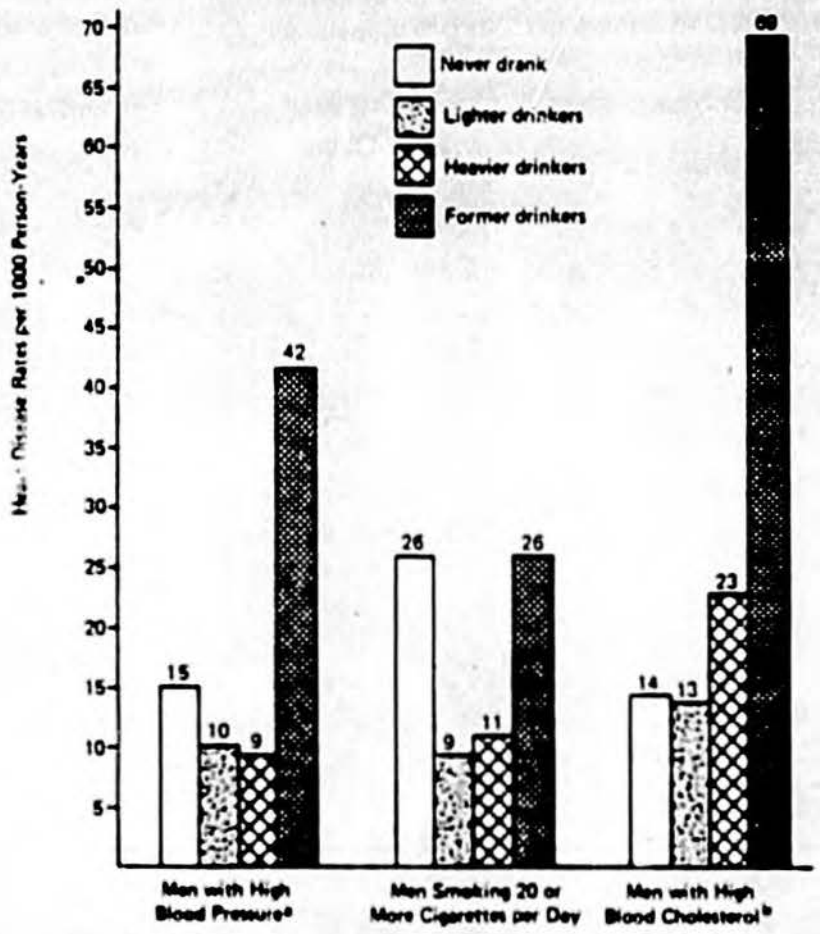
Another possible explanation of these findings would be that the stopping of drinking itself caused the higher rates. This would imply that in an organism accustomed to alcohol, cessation of its use could cause coronary disease. But at present there is no known physiological basis for such an effect.

One unascertained factor, however, is the age composition of the several groups. It is known that many Americans tend to become abstainers as they grow older (see chapter I). If the former-drinking groups included a disproportionate number of older people, then age could account for a higher incidence of coronary heart disease among them.

Many studies have established that certain characteristics are associated with higher risks of coronary heart disease. Three of the most consistent risk indicators are blood pressure, cigarette smoking, and blood cholesterol level. Middle-aged men with high levels of blood pressure, smoking, or cholesterol are two to three times as likely to have heart attacks as those with lower levels. In an attempt to further clarify the relationship between alcohol and heart disease, the Tecumseh study examined coronary disease rates and alcohol consumption in both low-risk and high-risk persons.

Figure 2 shows the relation between coronary disease and alcohol use in the lower-risk men. The relationships are complex. There is no

Figure 3. ALCOHOL USE AND CORONARY HEART DISEASE RATES IN HIGH-RISK MEN AGED 45 – 59



[a]Upper third of distribution (systolic pressure higher than approximately 140 mm. Hg)
[b]Upper third of distribution (over approximately 260 mg. per 100 ml.).

Source: Ullman et al. (6), Tecumseh Study.

consistent pattern when the two classes of drinkers are compared with lifelong abstainers, but the rates are generally low in both drinkers and those who never drank. Former drinkers, however, have the highest rates, except that those with low cholesterol levels had no incidents of coronary heart disease at all during the 10-year study.

The results in the high-risk groups are shown in figure 3. As was to be expected, the rates are consistently higher than in the low-risk groups. Interestingly, the two drinking groups have lower rates than the lifelong-abstainer and former-drinking groups of men with high blood pressure and men who are heavy smokers. But among men with high cholesterol levels, heavier drinkers have higher rates of heart disease than abstainers. The most striking relationships, however, are found in the former drinkers. Men with high blood pressure or with high cholesterol levels who stopped drinking have rates four to five times greater than most of the other groups.

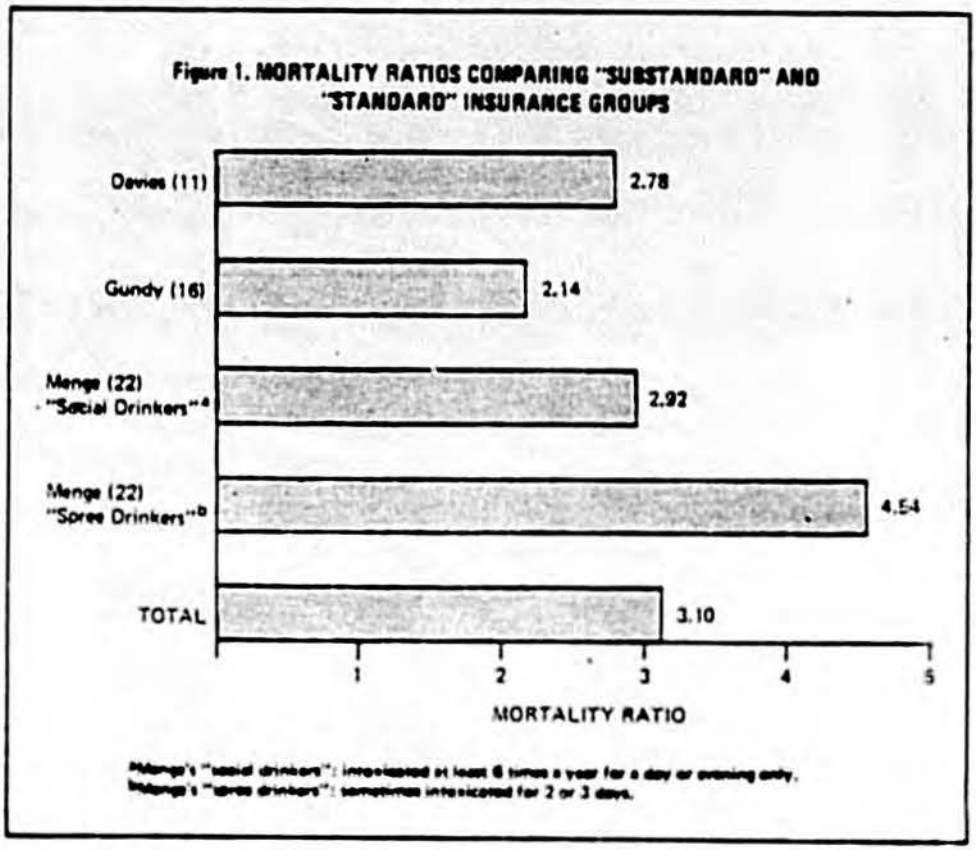


Figure 1. MORTALITY RATIOS COMPARING "SUBSTANDARD" AND "STANDARD" INSURANCE GROUPS

for Women in London and became its first dean.) "Anstie's limit," then, was as follows *(1)*:

> the equivalent of
> 1.5 ounces of absolute alcohol per day;
> that is, 3 ounces of whisky, well diluted;
> or, ¼ bottle of table wine;
> or, 4 glasses of beer.

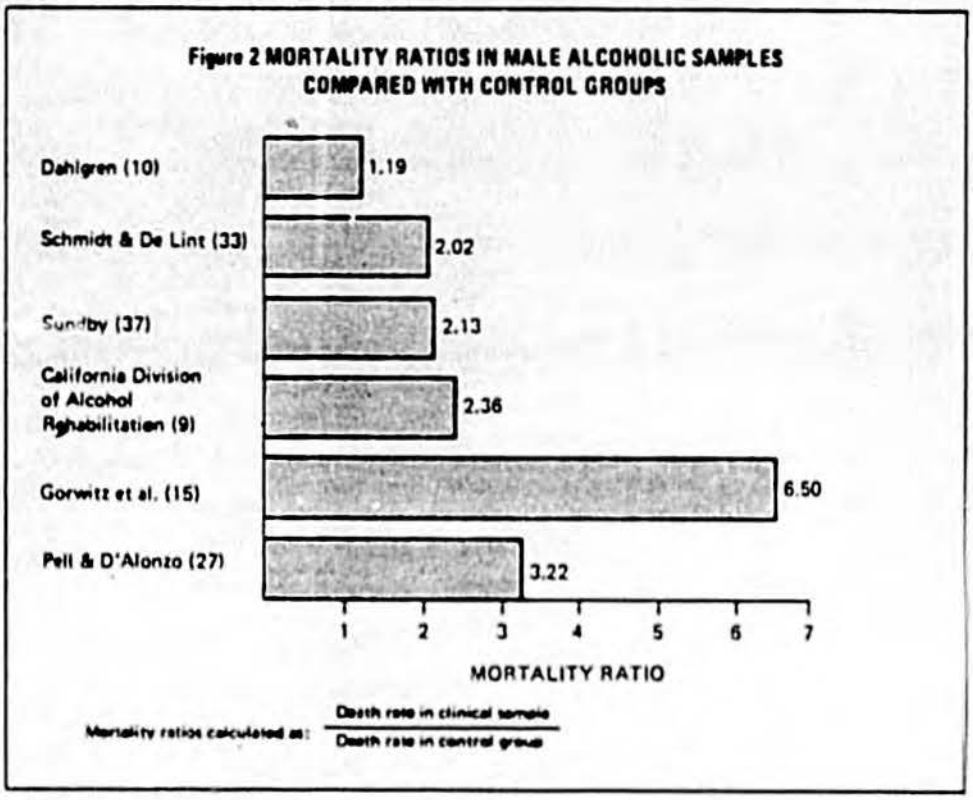
This daily limit was to be imbibed only with meals.

The concern about a safe limit more or less disappeared from view in the present century, although the learned researchers of the American Committee of Fifty did not forget it in their report *(4)* published in 1903. But in the heyday of the teetotal temperance movement, the issue became one of drinking versus nondrinking, and the question of a safe amount became irrelevant. Later on, the popularization of the medical concept of alcoholism, as a specific disease defined by a loss of control over drinking, diverted attention from studying the risks of drinking by "normal" people to studying clinical samples. These two currents of thought produced characteristic forms of studies.

Insurance Studies: Drinking vs. Nondrinking

During the late 19th and early 20th centuries numerous studies were sponsored by insurance companies comparing the mortality of "total abstainers" with that of "drinkers" *(24)*. The problem with these early insurance studies is that they lumped all drinkers together, thereby overlooking the possibility that some patterns of drinking might be highly associated with excess mortality and others not at all *(26)*.

Since the end of prohibition, insurance-company studies have moved toward a different two-class comparison: "standard" vs. "substandard" policyholders, the latter being those whose records include adverse information about their drinking. Although the "substandard" group is sometimes subdivided by drinking patterns *(22, 28)*, the total group represents a small and relatively extreme part of the spectrum of drinking patterns. Again, the relation of moderate drinking to mortality cannot be determined, but the studies do yield useful information on the excess mortality associated with heavy drinking. As can be seen in figure 1, mortality was consistently higher in the groups



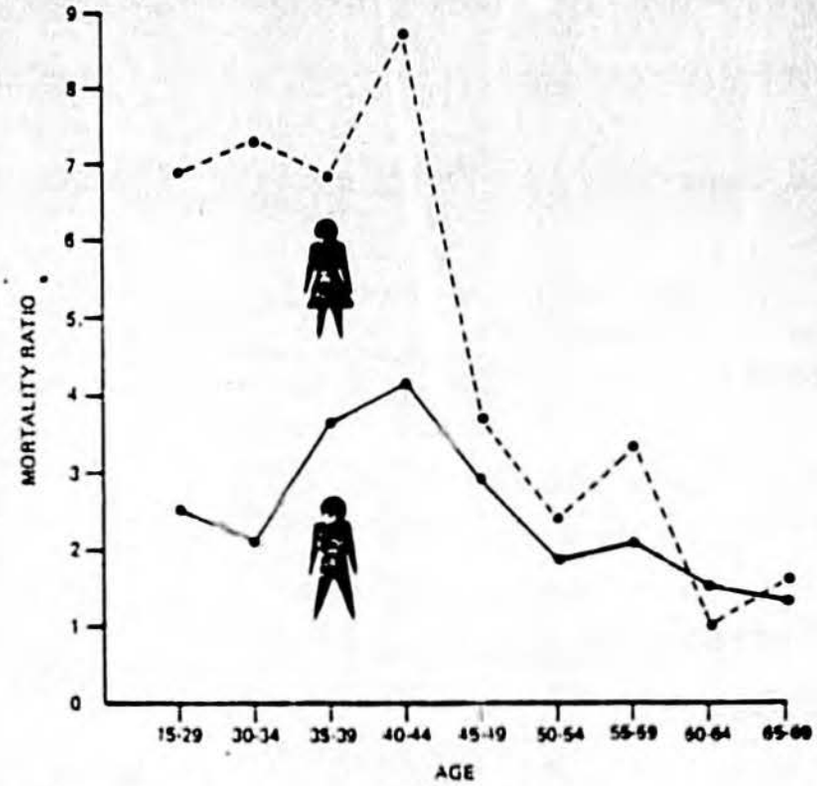
judged substandard because of drinking habits (ranging from 2.14 to 4.54 greater mortality) than in the standard groups. The ratio is particularly high in what Menge *(22)* called "spree drinkers," and in the younger age groups. It should be noted that a high mortality *ratio* does not necessarily indicate a very high actual *rate* of death. In the younger age groups death is still a relatively rare event.

Several factors need to be borne in mind in interpreting the relevance of these studies to patterns in the general population. Insurance-company studies exclude segments of the population which do not seek life insurance—for example, people with lower income. They also exclude those who are rejected for insurance, including those whose drinking habits are considered too extreme for them to be insurable. The latter would be expected to have a higher mortality than the standard population. On the other hand, those who are designated as substandard on account of their drinking habits may be substandard on other mortality-relevant factors. Moreover, the "standard" population with which the "drinking habits" cases are compared is specially selected by the insurance company to have low mortality, that is, to be not "substandard." For these and still other reasons, the results from insurance-company studies are likely to differ from those of the population at large.

Clinical Samples

The conception of alcoholism as a disease has led to several studies in recent years comparing the mortality experience of clinical samples—persons who have been in treatment for alcoholism—with that of the population in general. The data from such followup studies of alcoholic patients *(9, 14, 33, 37)* are rather consistent. As can be seen in figure 2, with one exception the mortality ratios fall within a relatively narrow range. Like the substandard insurance groups, clinical populations show higher mortality ratios in the younger compared to the older patients. All these findings are confirmed in the newest study of mortality in alcoholism, a followup by Nichols et al. *(25)* of 678 men and 257 women 10 to 15 years after they were discharged from 4 hospitals in England. The ratio of observed to expected deaths in the men was 2.65, and in the women, 3.07. In both sexes combined the ratio of those

Figure 3. MORTALITY RATIOS COMPARING MEN AND WOMEN IN A CLINICAL ALCOHOLIC SAMPLE WITH MEN AND WOMEN IN THE GENERAL POPULATION IN ONTARIO

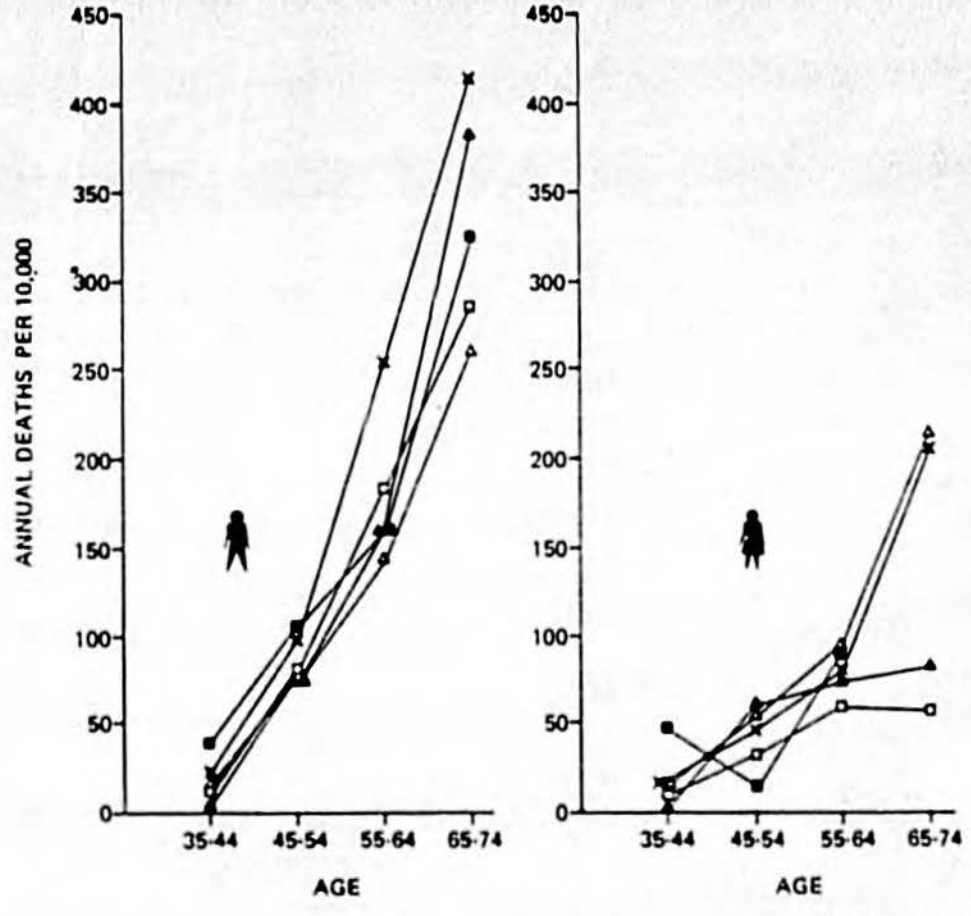


Source: Schmidt and DeLint (33).

aged under 40 was 9.21; in the age classes 40-49, 5.21; 50-59, 3.21; 60-69, 1.86; 70-79, 1.73, and even in those aged 80 or over, still higher than expected—1.31. Figure 3 illustrates the finding that women, when studied, had higher rates of death than men.

Results from clinical samples are not necessarily applicable to drinker categories in the general population. Obviously those who end up in treatment for alcoholism have a history of heavy drinking *(29)*; but, beyond this, there is reason to believe that such persons are not a random selection of all heavy drinkers in the general population. Recent work by Cahalan and Room *(8)* suggests that certain drinking patterns are less likely to be associated with problems in general-population samples than in clinical samples; and that, in general, the clinical population of problem drinkers—those who come into treatment—are distinguished from other problem drinkers by the multiplicity and long duration of their problems. Differential clinical diagnosis by social class, race and sex, has also been noted *(5, 15)*, and the known likelihood of preferential admission on the basis of poor physical status is confirmed by Schmidt and DeLint's data *(33)* showing an increased mortality upon initial entry to the patient population. The same conclusion may be drawn from data on enlisted men in the U.S. Navy and Marine Corps, as reported by Schuckit and Gunderson *(34)*: The mortality of men hospitalized for alcoholism between 1965 and 1971 in each of the services was 15 per 1000, compared with overall rates of 2 in the Navy and 10 in the Marines. Thus these individuals have not only drinking problems but serious physical problems that may precipitate their appearance at hospitals and clinics. Their mortality rates, therefore, cannot be assumed to

Figure 4. MORTALITY RATES, BY DRINKING BEHAVIOR, SEX, AND AGE, FRAMINGHAM, MASS.



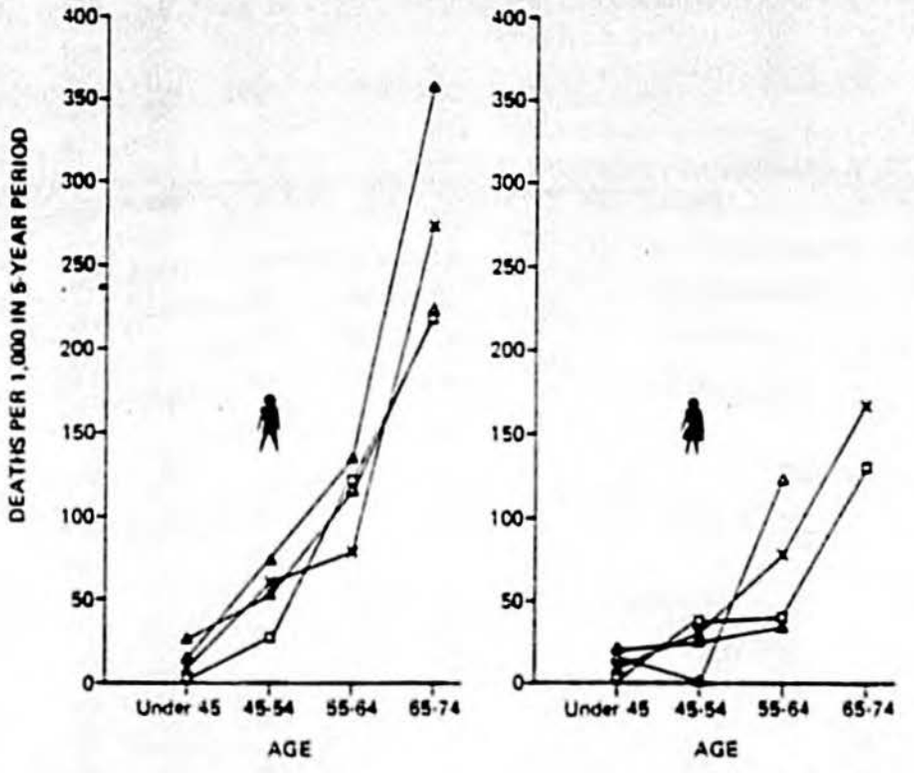
Drinking behavior was classified according to the number of ounces of absolute alcohol consumed per month. (See key at right.) The drinking categories used by Shurtleff have been combined in this figure to yield sufficient mortality data for stable results. Data are not shown for age groups with insufficient numbers to compute.

Source: Shurtleff (38).

terms of overall volume of drinking per month, which tends to equate infrequent heavy and frequent light patterns of drinking. In this study, at all ages and in both sexes, the data tend to show an excess mortality of both abstainers and high-volume drinkers. The high-volume drinkers show the highest excess mortality at younger ages, while the abstainers show the highest at older ages.

The study by Belloc *(2)*, conducted in Alameda County, California (figure 5), measured drinking in terms of the usual amount per occasion, of the type of beverage (beer, wine, or spirits) usually drunk in the largest amount. The top category on this measure, then, includes those who usually drink 5 or more drinks of any beverage, whether they drink frequently or only intermittently, but only if they do not also drink that beverage more frequently at lesser amounts. The results from this study are less clear than those from Framingham. Heavier drinkers show a higher mortality among younger men, but in other sex and age groups the results vary without a clear pattern emerging, other than a slight tendency for light drinkers to show the lowest mortality on an age-adjusted basis.

Figure 5. MORTALITY RATES, BY DRINKING BEHAVIOR, SEX, AND AGE, ALAMEDA COUNTY, CALIFORNIA



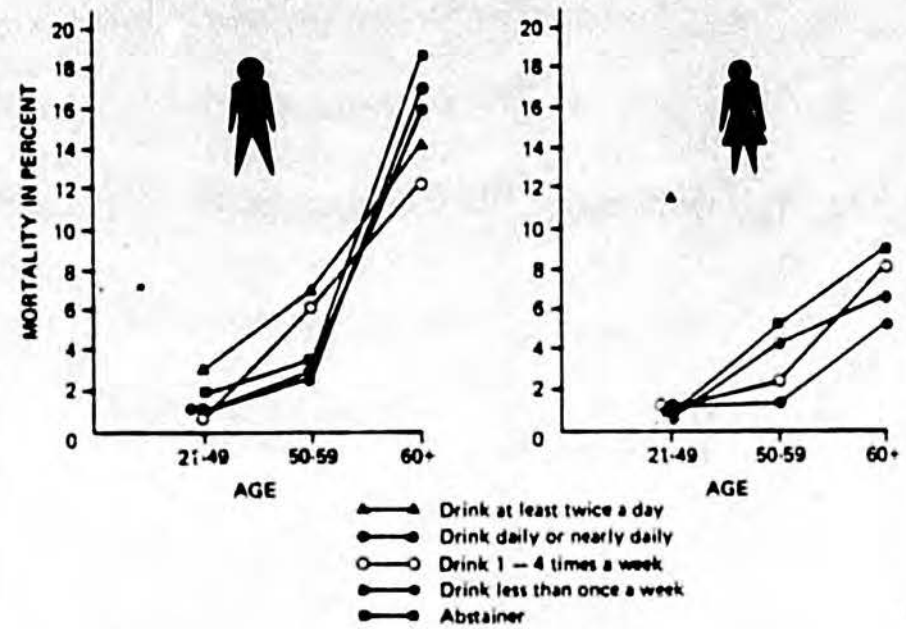
Drinking behavior was classified according to the number of drinks consumed on an occasion, of the beverage usually drunk in the largest amount. (See key at right.) Data are not shown for age groups with insufficient numbers to compute.

Source: Belloc (2).

Overall, these two community studies show lower mortality ratios than were found in the insurance and clinical studies comparing heavier drinking with other patterns. Reasons for expecting higher ratios in insurance and clinical samples than in the general population have already been explored. However, there are some additional probable causes for the lower ratios in the Framingham and Alameda studies. Neither study used a measure of drinking which isolates a pure group of relatively heavy drinkers. The highest category in the Framingham data, as reproduced here (figure 4), consists of those drinking approximately two drinks a day or more, which probably includes some frequent light drinkers. The highest category in the Alameda data is fairly arbitrary, since it includes some infrequent drinkers but leaves out many heavy drinkers who happen also often to drink lightly. Furthermore, both studies, as has been usual in surveys of drinking practices, asked only about current patterns of drinking. It is possible that the generally higher mortalities of abstainers than of moderate drinkers are due in part to those who are now abstaining because of health problems, including those whose health had been damaged by drinking. Controlling for health status or asking for a history of drinking patterns might thus have given higher mortality ratios in the drinking population, and especially in ex-drinkers.

Despite recent reports on alcohol-related mortality in general populations, the nature and strength of the relationship remains unresolved.

Figure 6. MORTALITY RELATED TO OVER-ALL FREQUENCY OF DRINKING, AGE, AND SEX, U.S.A. GENERAL POPULATION SAMPLES



Data are not shown for age groups with insufficient numbers to compute.

Source: Room and Day (31).

Some preliminary findings from a study by Room and Day *(31)* are presented below. Since this study is specifically aimed at drinking behavior and problems, the relation between drinking patterns and increased mortality can be explored in much greater detail than in previous studies.

The analysis by Room and Day is based on four separate samples of the general population: two samples of adults in San Francisco, and two nationwide samples of adults. One of the San Francisco samples and one of the nationwide samples are limited to men aged 21-59. The pooled data are of course not representative of any particular U.S. population but can be described as reflecting patterns in the general U.S. population, with an overrepresentation of urban and younger men. It should be kept in mind that the samples exclude those not living in households and those who refused or were not found for interviewing; and that self-reports of drinking tend to underreport the recorded total U.S. consumption *(30)*. The samples have been followed for varying lengths of time, ranging from 4 to 11 years, and the rates are therefore expressed in weighted person-years of experience. Since lost cases and those not traced for the whole period are treated as alive, the total mortality reported in this analysis is somewhat underestimated.

Figures 6-9 show the mortality rate of men and women at different ages in relation to four measures of drinking practices and problems. In terms of overall frequency of drinking (figure 6), the lowest mortality in each sex and age group is at an intermediate drinking level. Under age 60, the highest death rates occur at the highest frequency of drinking; above age 60, the highest death rates are among abstainers. As in previous studies, there is a consistent tendency for those who are currently abstainers to show a higher mortality than those who are currently moderate drinkers.

Figure 7 shows mortality rates by frequent heavy drinking, a measure of the frequency with which the respondent drinks 5 or more drinks on an occasion. Among women over age 50 and men over 60, such relatively heavy drinking is so rare that mortality cannot be computed. Among those under 50, increased mortality appears to be specific to those drinking 5 or more drinks 4 or more times a week, while among men in their

Figure 7. MORTALITY RELATED TO FREQUENT HEAVY DRINKING, AGE, AND SEX, U.S.A. GENERAL POPULATION SAMPLES



Data are not shown for age groups with insufficient numbers to compute.

Source: Room and Day (31).

50s, those drinking such amounts 1 to 3 times a week seem to show some elevation of mortality.

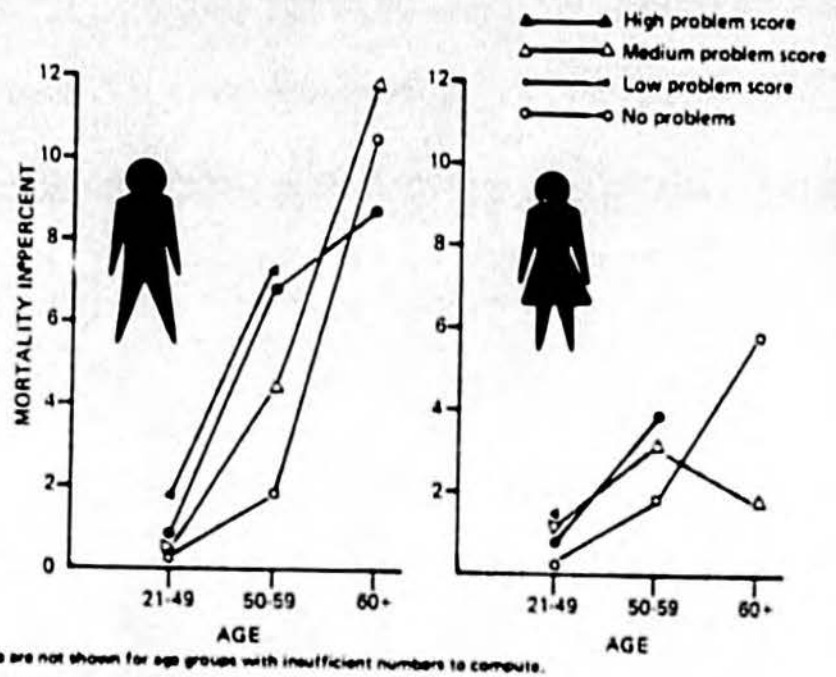
Figures 8 and 9 show sex and age-specific mortality according to overall measures of problems with drinking: one for problems during the "current" period (the last 1 to 3 years) and one for problems "ever" experienced (any time in the respondent's life, including the current period). These overall scores include measures of the severity of social and health problems associated with drinking, feelings of dependence on drinking, and behaviors indicating heavy and symptomatic drinking.

These results show some consistent tendencies with different measures of drinking practices and problems. The highest mortality ratios among heavy compared with light drinkers occur in the youngest cohort, although the absolute rates of death are much lower at younger than at older ages irrespective of amount of drinking.

As in previous studies, current abstainers have a generally higher mortality than light drinkers. Since the present series of studies included a question on the respondent's overall estimate of his health, it is possible to test the extent to which this relationship seems to be due to abstinence because of perceived bad health.

Table 1 shows the mortality in men not in poor health—that is, in those who replied "excellent" or "good" or "fair" when asked about their overall health—in relation to various measures of drinking behavior. A report of poor health is indeed associated with subsequent mortality: among men under 60 in poor health, the mortality rate was 12 percent, while among the remainder it was 1 percent. By the measure of overall frequency of drinking, table 1 reveals that the mortality of the most frequent drinkers (at least twice a day) is the highest, 2.7 percent. But the more moderate drinkers (less than once a week to daily) have mortalities ranging from 0.7 to 1.3 percent, while the mortality of abstainers is 2.0 percent. It turns out that the removal of those in poor health from the other comparisons does not substantially affect the relative mortalities. Thus, even when the comparison is limited to those in good health, abstainers show a higher mortality than moderate drinkers. Furthermore, when the interrelationships of the measures of drinking among

Figure 8. MORTALITY RELATED TO CURRENT OVER-ALL DRINKING-PROBLEMS SCORE, AGE, AND SEX, U.S.A. GENERAL POPULATION SAMPLES



Data are not shown for age groups with insufficient numbers to compute.

Source: Room and Day (31).

men under 60 not in poor health are cross-tabulated, the relation of higher mortality to frequency of drinking is quite specific to those who are frequent heavy drinkers, with a mortality of 4.5 percent. Likewise, higher mortality among those with an "ever" overall drinking-problems score is specific to those who show at least a medium score on current overall drinking problems. It appears, thus, that those in the general population who had some problem

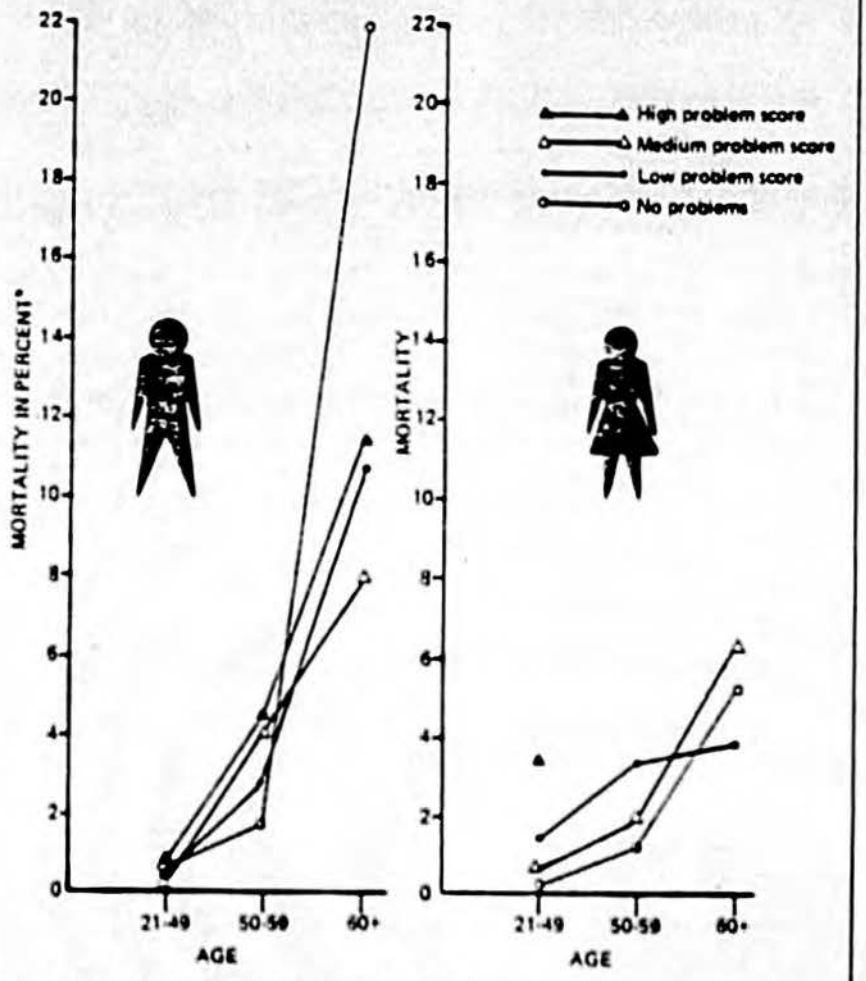
TABLE 1

MORTALITY OF MEN UNDER AGE 60 NOT IN POOR HEALTH, BY DIFFERENT MEASURES OF DRINKING BEHAVIOR, U.S.A. GENERAL POPULATION SAMPLES

		Percent Mortality
Over-All Frequency of Drinking		
At least twice a day		2.7
Daily or nearly daily		1.3
1–4 times a week		1.1
Less than once a week		0.7
Abstainers		2.0
	Average	1.2
Frequent Heavy Drinking (5+ drinks in a day)		
At least 4 times a week		4.5
1–3 times a week		0.9
All other frequencies		1.0
	Average	1.2
Current Over-All Drinking-Problems Score		
High		1.9
Medium		1.3
Low		0.8
None		0.8
	Average	1.1

Source: Room and Day (31).

Figure 9. MORTALITY RELATED TO LIFETIME OVER-ALL DRINKING PROBLEMS SCORE, AGE, AND SEX, U.S.A. GENERAL POPULATION SAMPLES



Data are not shown for age groups with insufficient numbers to compute.

Source: Room and Day (31).

associated with drinking in the past but have few or no current problems do not show an excess mortality.

The data on mortality in the combined San Francisco and national samples thus consistently show excess mortality among those in the most extreme categories of frequent heavy drinking and of current drinking problems. These results apply more certainly to men, since few women fall into these heavy-drinking and high-problems categories. Even among men under 60, only 5 percent report frequent heavy drinking and 7 percent high current overall problems, so the mortality rates are based on relatively few deaths. Since the excess mortality is specific to the top category of frequent heavy drinking and current overall drinking-problems score, it is also possible that within that category the excess mortality is confined to those with patterns substantially above the minimum criteria for inclusion in the category.

The analysis thus far has not taken into account the possible confounding of the relation of alcohol to mortality with the relation of alcohol to other factors of status and lifestyle which in turn are related to mortality. For instance, in other studies it has been shown that drinking problems are associated with low social

TABLE 2

MORTALITY RATIOS AMONG HEAVY DRINKERS COMPARED TO CONTROL GROUPS, BY SPECIFIC CAUSES OF DEATH

	Calif. Div. of Alcohol Rehab. [9]	Pell & D'Alonzo [27]	Sunday [27]	Dahlgren [10]	Schmidt & DeLint [33]		Davies [11]	Monge [22]	U.S. 1960 Over-All Mortality Rate per 100,000 [29]
					Men	Women			
Accidents	2.4			2.82	2.52	12.40	5.00[a]	1.03	51.3
Suicide			7.98	3.62	7.80	8.69	2.67	1.30	10.6
Accidents and Homicide			2.71				4.38	1.09	56.0
Diseases of digestive system				1.11			4.67		
Cirrhosis	7.0		9.88		11.49			4.5	11.3
Digestive system minus cirrhosis			1.54		0.69	0.95			
Ulcer					3.55	6.66			6.4
Malignancies		3.98		1.31			2.32	0.85	
Oral and upper respiratory			11.68		2.79	1.88			1.7
Arteriosclerotic and degenerative heart disease		2.09			1.79	4.10	2.63	1.33	307.4
Cardiovascular disease	0.58	2.28	1.86	1.04	1.14	2.43	1.33		
Tuberculosis			2.11	0.85				0.56	5.6
Diabetes			3.72						16.7
Chronic alcoholism						33.33			1.2

[a] Motor vehicle accidents only.

Mortality ratios calculated as: Cause specific mortality rate in cases / Cause specific mortality rate in controls

A preliminary analysis of the interaction of various habits and statuses associated with increased mortality suggests that the relation between heavy drinking and mortality is, if anything, stronger when other factors (age, health, social status) are taken into account. But the prediction of mortality from alcohol intake in the general population remains less strong than in alcoholic populations seen in clinics and hospitals. This imposes a need for caution in extrapolating findings from clinical populations to the alcoholic population at large.

All in all, the data on general mortality suggest that for amount of drinking there may be some kind of threshold below which mortality is little affected. In the absence of further evidence, the classical "Anstie's limit" seems still to reflect the safe amount of drinking which does not substantially increase the risk of early death.

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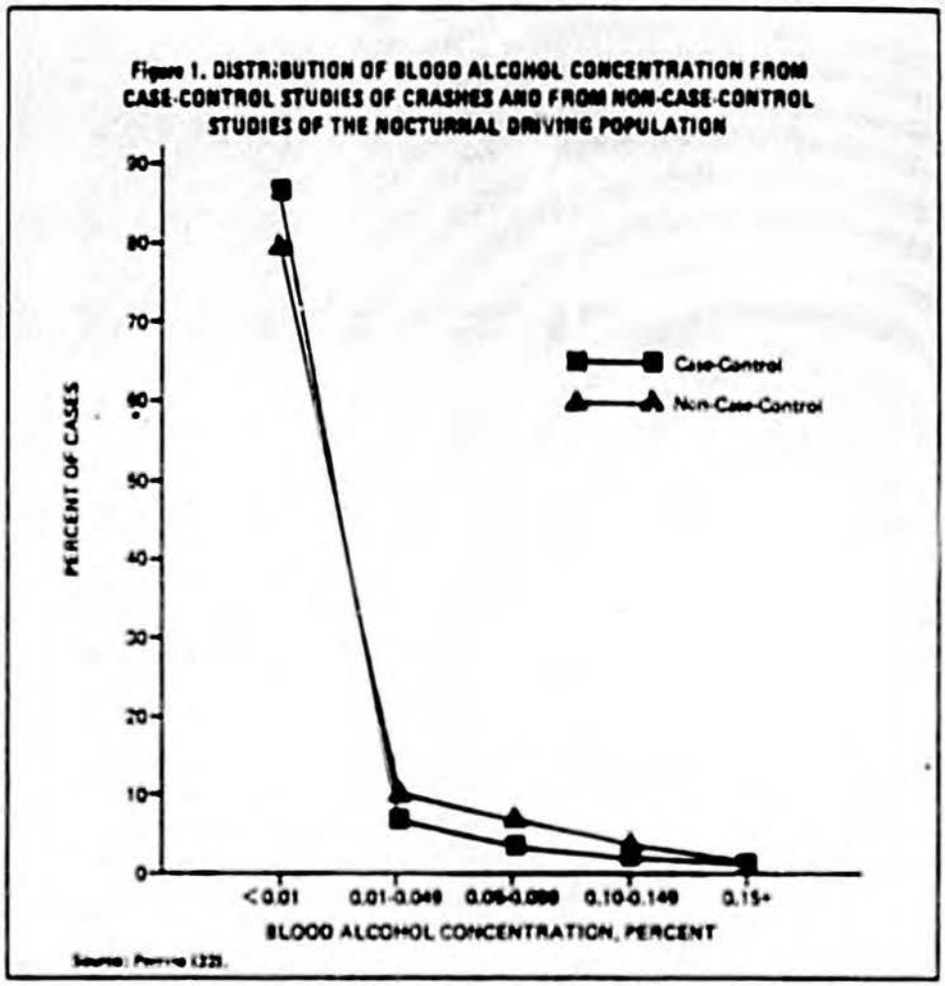
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high enough—and no DWI's was low enough—to be in this transition range.

Nonfatal Crashes

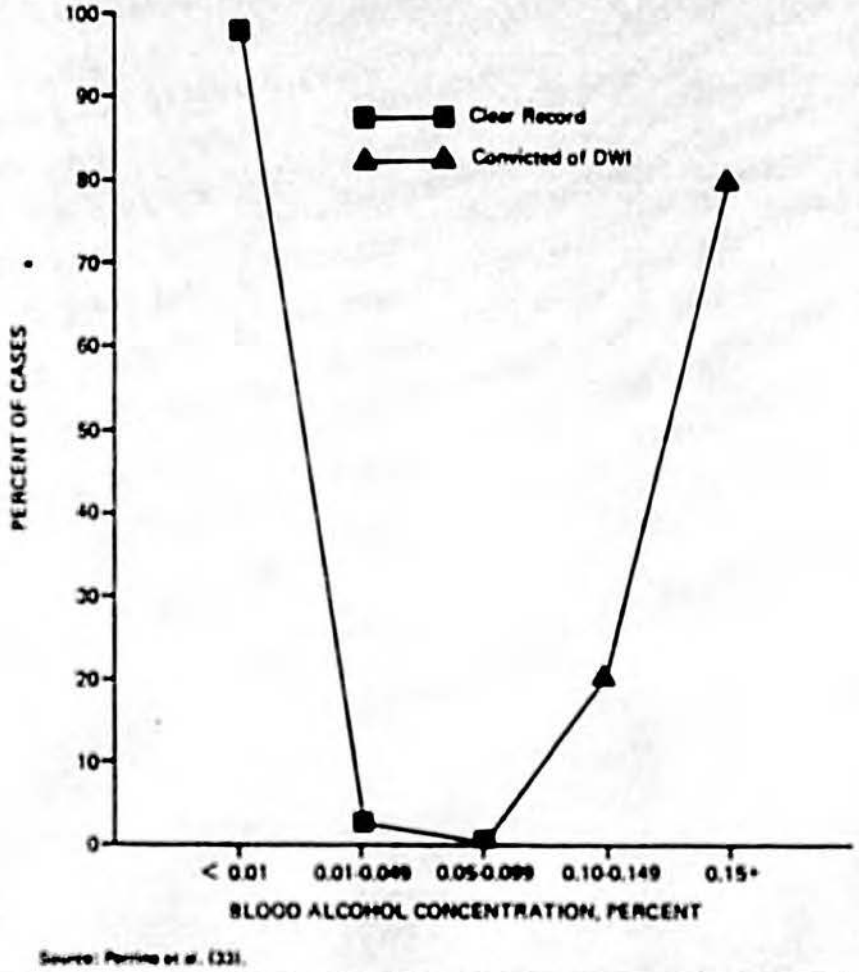
Despite probable underreporting due to selective sampling and to legal and logistical problems, it seems safe to estimate that impaired drivers (0.10 percent BAC or higher) are involved in 5 to 10 percent of the run-of-the-mill accidents and 10 to 35 percent of the serious-injury crashes *(4, 6, 15, 27, 33, 35)*. Furthermore, injury to the driver is more likely after drinking, and both the probability and the severity of injury appear to increase as the amount of alcohol rises. The likelihood of being responsible for the crash is greater if the driver has been drinking, and higher BACs are associated with higher proportions of drivers responsible for the crashes.

Fatal Crashes

More complete data are available about fatal crashes than about other types. In general, about 45 percent (ranging from 40 to 55 percent) of all fatally injured drivers have BACs of 0.10 percent or more, and a surprisingly large proportion of these drivers exceed the highest BACs found in the population-at-risk *(13, 22, 24, 25, 33, 43)*. However, in order to obtain a more accurate portrayal of the contribution of alcohol to fatal crashes, it is useful to distinguish between multiple- and single-vehicle accidents and, more importantly, to determine whether or not the fatally injured driver was responsible.

When drivers fatally injured in multiple-vehicle crashes are considered as a separate subgroup, regardless of estimated responsibility, approximately one-third (ranging from about one-quarter to one-half) have BACs of 0.10 percent or higher *(13, 24, 25, 33, 43)*.

Figure 2. DISTRIBUTION OF BLOOD ALCOHOL CONCENTRATION IN CLEAR-RECORD CONTROL DRIVERS AND IN THOSE CONVICTED OF DRIVING WHILE INTOXICATED

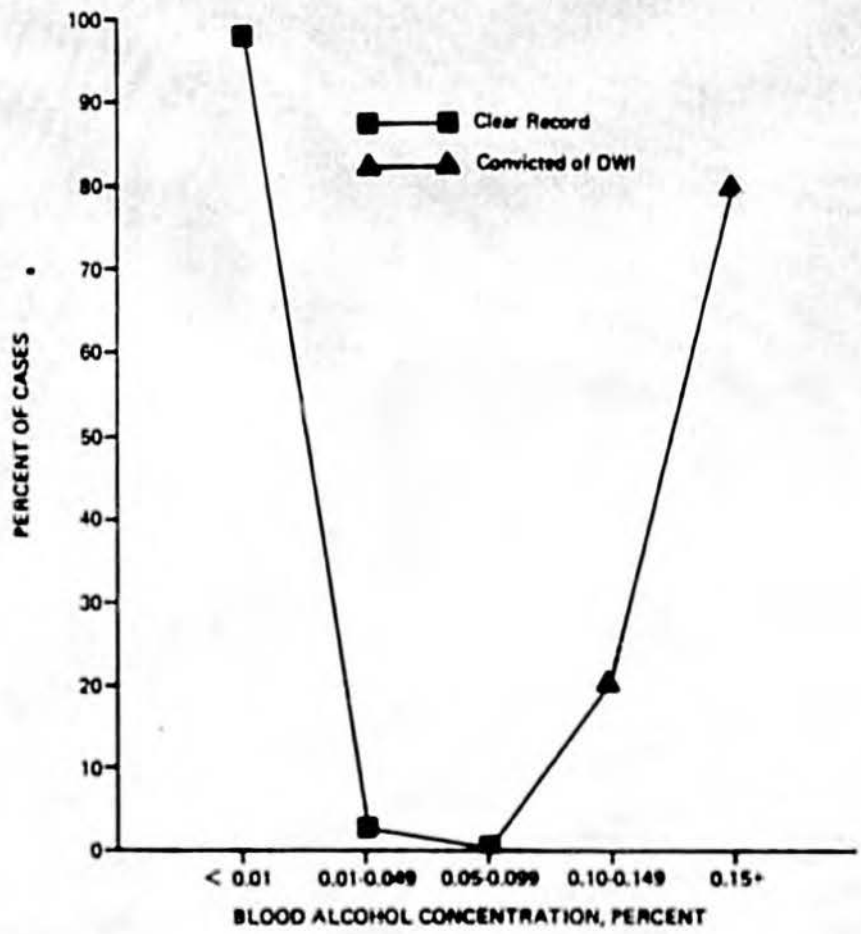


Source: Perrine et al. [33].

When drivers fatally injured in single-vehicle crashes are examined as a subgroup, between 55 and 65 percent have BACs of 0.10 percent or higher *(13, 22, 26, 33, 43)*. Single-vehicle and multiple-vehicle crashes occur with approximately equal frequency; each represents about 40 percent of all fatal crashes (pedestrian fatalities account for the remaining 20 percent). Thus a disproportionately large part of the high-BAC driver fatality problem is contributed by the drivers in single-vehicle crashes. This overrepresentation becomes even greater when responsibility is considered.

A useful system for assigning crash responsibility was first reported by McCarroll and Haddon *(22)* and has been utilized in a number of studies since that time. In this system, a driver-vehicle combination is assumed to be responsible if it is the only vehicle involved, or it has struck a nonmoving object, or it played an unambiguous role in initiating the crash. If two vehicles were involved and both contributed substantially to the event, responsibility is treated as unascertained, contrary to the common practice among enforcement agencies. Based on a composite of studies by Neilson *(26)* and by Perrine et al. *(33)*, Zylman *(48)* has determined that about 43 percent of drivers designated as "responsible" had legally impairing BACs of 0.10 percent or higher, whereas only 10 percent of those designated as "not responsible" had BACs in that range. Thus, a composite of all drivers assumed responsible in nonpedestrian fatal crashes (that is, all drivers from single-vehicle crashes, as well as from about two-thirds of the multiple-vehicle crashes according to the

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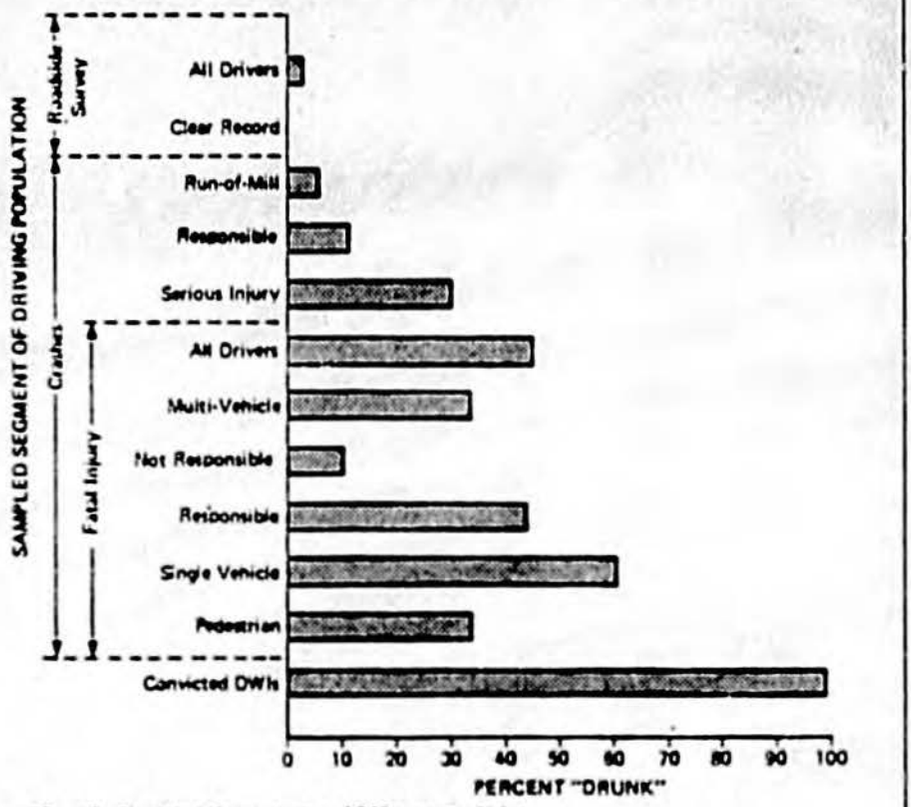


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Figure 3. PERCENTAGE OF "DRUNKEN" DRIVERS AND ADULT PEDESTRIANS IN VARIOUS SEGMENTS OF THE ROAD TRAFFIC POPULATION

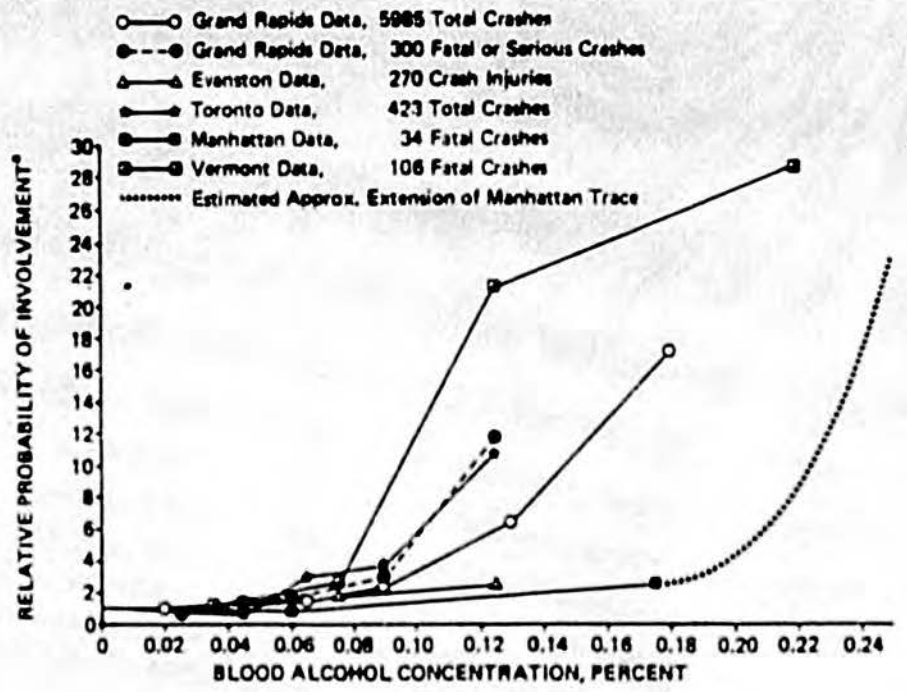


"Drunk" = Blood alcohol concentration of 0.10 percent or higher.
Source: Perrine (32).

probability of being presumed responsible for a fatal crash can be estimated for subsets of the fatally injured drivers in two of the case-control studies, the Manhattan and Vermont. Because of the larger sample size, the Vermont data are used in figure 5, which shows the relative probability of being responsible for initiating a fatal crash in relation to BAC. It appears that at low BACs (less than 0.05 percent), the probability of being responsible for a fatal crash is essentially the same among fatally injured drivers as it is among control drivers (exposed to similar circumstances of time and place but not involved in a crash). At BACs between 0.05 and 0.10 percent, however, the relative probability of fatal-crash responsibility begins to increase appreciably, so that at a BAC of 0.10 percent a driver would be seven times more likely to be responsible for having a fatal crash than he would with no alcohol. The relative-hazard curve rises very steeply above this lower limit for a DWI violation (0.10 percent in most States): at a BAC of 0.15 percent a driver would be 25 times more likely to be responsible for a fatal crash; at 0.18 percent, 60 times more likely; and at 0.20 percent (the average BAC found among those convicted for DWI and among fatally injured drivers who would have been eligible for conviction) he would be at least 100 times more likely to be responsible for a fatal crash than if he had not been drinking at all.

Similar results were obtained in the Grand Rapids study of drivers assumed responsible (using another system) for all crashes, regardless of severity. A comparison of drivers assumed responsible for crashes in three case-control studies (Grand Rapids, Manhattan, and Vermont) has been presented by Hurst *(13)*. P[illegible] et al. *(33)* concluded from these studies that BACs of 0.08 percent or higher "are incompatible with safe driving, and the higher the concentration, the greater the incompatibility."

Figure 4. RELATIVE PROBABILITY OF CRASH INVOLVEMENT IN RELATION TO BLOOD ALCOHOL CONCENTRATION



*Relative probability at zero alcohol = 1.0.

Source: Hurst (18, Figure 1).

Small increases in BAC above 0.08 percent result in "disproportionately large increases in crash risk." For example, among fatally injured drivers in the Vermont study who were assumed to have been at fault, 52 percent had BACs of 0.08 percent or higher, compared with only 14 percent among those not at fault.

Personal Characteristics, Crashes, and Alcohol

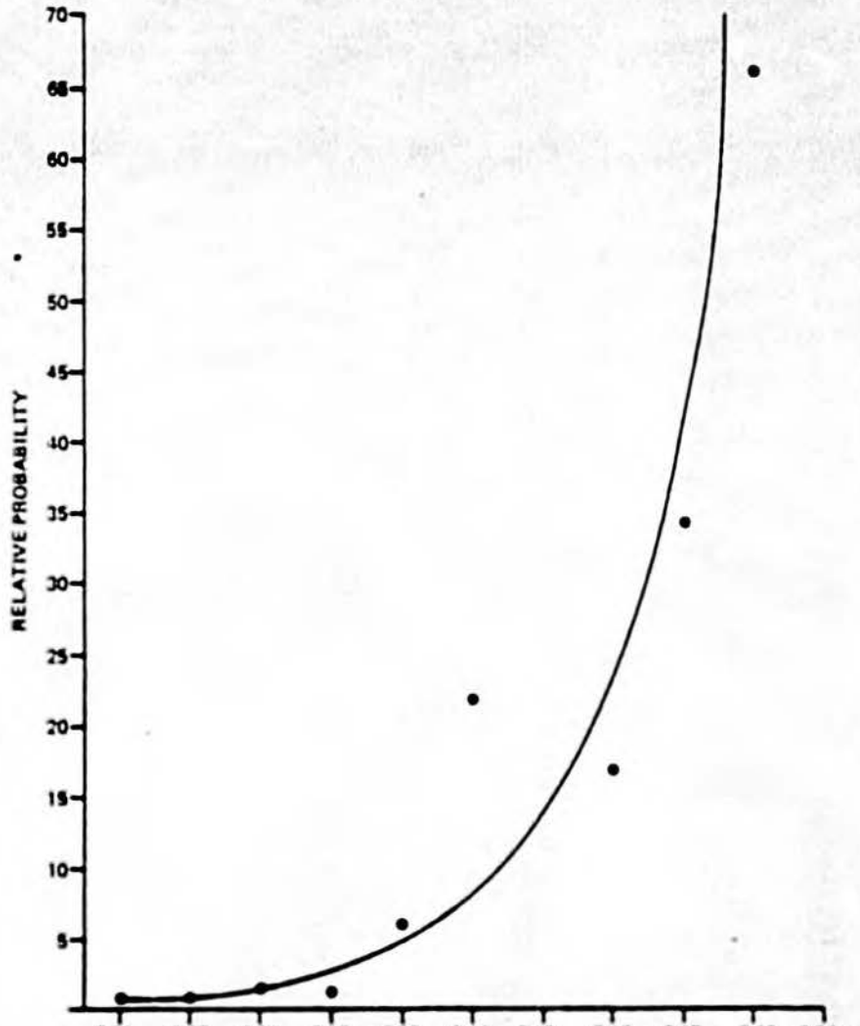
The biographical and psychological characteristics of drivers who are involved in highway crashes or citations have been studied in the belief that such information can be helpful in identifying problem drivers and designing appropriate countermeasures for different subgroups. The relevant personal variables tend to fall into three general classes, the first essentially demographic (sex, age, etc.), the second two essentially behavioral: (a) driving history and drinking-and-driving patterns, and (b) patterns of alcohol use.

Biographical Variables

A number of studies have found significant relations between crashes, alcohol, and the following biographical variables: sex, age, marital status, and occupational level. Less consistent but still potentially useful findings have been reported for such single and combined variables as ethnicity, religious affiliation, educational level, socioeconomic status, social stability, social mobility, leisure activities, and contact with social agencies *(1, 4, 5, 6, 7, 9, 10, 11, 13, 19, 20, 28, 29, 30, 33, 41, 43, 45, 47)*.

Sex. Drinking-and-driving is predominantly a male behavior. In contrast to approximately equal representation in the adult population, men comprise a larger proportion of licensed drivers (about two-thirds), a larger proportion of drivers sampled during roadside surveys (about 80 percent), a larger proportion of fatally injured drivers (about 90 percent), and virtually all (about 98 percent) convicted DWIs *(9, 10,*

Figure 5. RELATIVE PROBABILITY OF BEING RESPONSIBLE FOR A FATAL CRASH IN RELATION TO BLOOD ALCOHOL CONCENTRATION

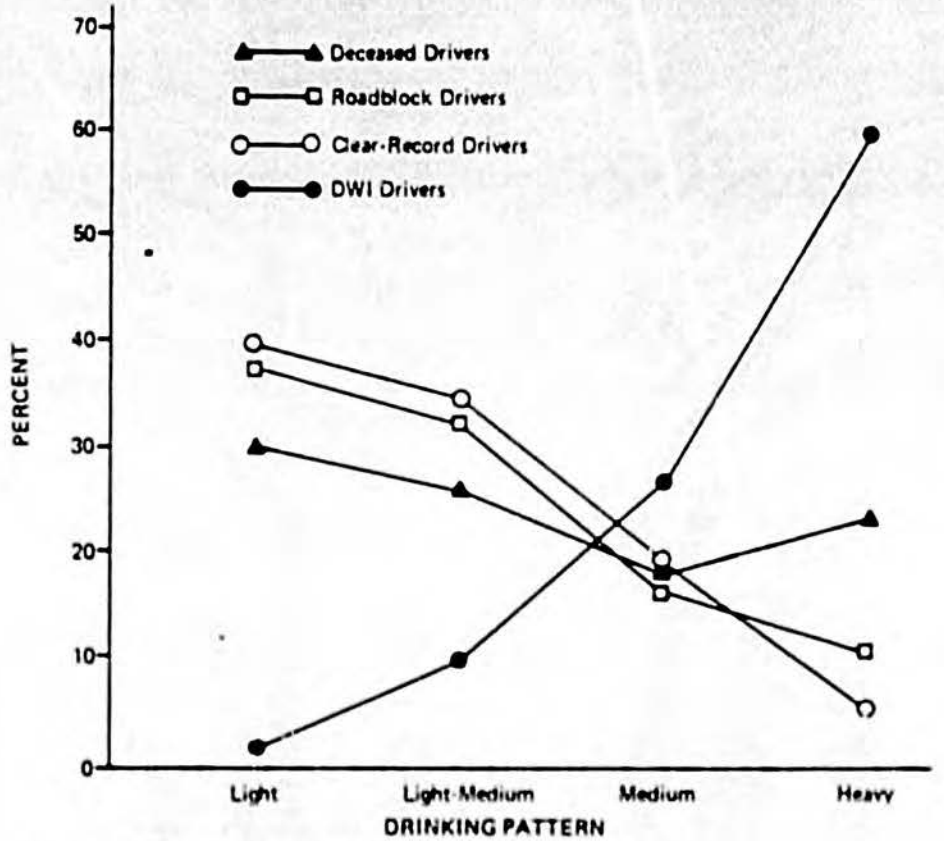


Source: Perrine et al. [33].

33). A larger proportion of women (about 90 percent) than men (about 80 percent) do not drive after drinking *(10)*. A recent study of alcohol use by the nocturnal driving population *(5)* found that at night women drivers are relatively less involved in single-vehicle crashes and are less likely to have been drinking than men, but when drinking they are more likely to be involved in crashes—and at relatively low BACs (0.05 percent). Since women drive less at night and drink less than men, Carlson *(5)* suggests that, as with young male drivers, inexperience with drinking-and-driving probably results in the higher risk of alcohol-related crashes.

Age. Younger drivers who get into alcohol-related trouble on the highways do so at lower average BACs than do older people *(33)*. However, two important additional factors must also

Figure 6. DRINKING PATTERNS OF ROADBLOCK, CLEAR-RECORD, DWI, AND KILLED DRIVERS AS CLASSIFIED BY QUANTITY-FREQUENCY INDEX OF PREFERRED BEVERAGE, IN PERCENT



Source: Perrine et al. [33], Vermont Study.

The roadblock and clear-record drivers are distinguished by mostly light and light-medium drinking patterns, with very few heavy drinkers. In sharp contrast, those convicted of DWI have a large proportion of heavy drinkers.

The proportion of men to women and of unmarried to married people increased as the QFI increased. A surprisingly large proportion of the very young drivers could be categorized as heavy and frequent drinkers, and the quantity of alcohol typically consumed apparently decreased with increasing age. Although there were no significant differences by occupation, there was some indication that drivers with high QFIs were more likely to have had a greater number of job changes during the 5 years immediately preceding the interviews.

Two parallel generalizations were offered by the investigators as evidence that the BAC sampled at one point in time during the study was a reliable indicator of usual patterns of driving after drinking: (a) the higher the frequency of driving after drinking, the heavier and more frequent the reported usual alcohol consumption; and (b) the lighter and less frequent the reported usual alcohol consumption, the lower the frequency of driving after drinking.

No clear-cut patterns of difference beyond those of the basic distributions were obtained from cross-tabulations of crashes or license suspensions by QFI, except that control drivers with higher QFIs tended to have more violations in the previous 5 years than those with lower QFIs.

An unexpected finding in the Vermont study was a high correlation of BACs of 0.10 percent or more with frequent heavy consumption of beer. Thus, when compared with both fatally

TABLE 1

CHARACTERISTICS OF CLIENTS AT TIME OF INTAKE TO DIFFERENT KINDS OF TREATMENT PROGRAMS COMPARED TO GENERAL U.S. POPULATION

	U.S. Population[a]		ATC Program[b]		ASAP/AC Program[c]	Public Inebriate Program
	Total	Drinkers	All Clients	DWI Clients	AC DWI Clients	All Clients
Heavy Drinking						
Average years			14.3	13.2	11.6	15.8
Prior Treatment						
Av. no. of times, all clients			0.9	0.4	0.2	1.7
Av. no. of times by clients reporting prior treatment			2.5	2.2	1.6	3.3
% No treatment			63.2%	84.1%	85.4%	48.5%
Alcohol Consumption (preceding month)						
Average ounces per day[d]	0.4	0.8	7.2	2.5	1.4	8.3
Average days drank			14.9	10.2	9.9	14.6
% Abstained	42.5%	0.0%	13.0%	21.7%	17.2%	13.6%
Behavioral Pattern (preceding month)						
Impairment index[e]	0.7	1.2	13.4	5.9	3.3	16.7
% Quarreled	3.2%	5.6%	37.9%	23.3%	14.2%	39.9%
% Drank on job	3.5%	6.1%	42.2%	19.4%	11.1%	46.5%
% Missed work	0.5%	0.9%	43.1%	17.9%	9.4%	62.2%
Number of Intakes			13,261	2,813	1,711	2,239

[a] Data from Louis Harris & Associates national cross-sectional survey of U.S. population (1580 persons, age 18 and over).
[b] ATC stands for comprehensive NIAAA Alcoholism Treatment Centers.
[c] NIAAA Alcoholism Centers associated with Alcohol Safety Action Projects.
[d] Absolute alcohol calculated from all beverages.
[e] Impairment index ranges from 0 for no impairment to 33 for maximum impairment.

exhibits some data on the personnel who provide services at the centers. Only 56 percent of their time was devoted to direct services to clients, most of the remainder being devoted to administrative and other service activities.

The potential exists, through the data system, to learn a great deal about the delivery of alcoholism services as they relate to specific measures of client status. Furthermore, the standardized data base serves as an adjunct to special studies in which, for example, a sample of clients may be interviewed a year or two after initial intake to augment the existing information with knowledge about longer-term changes in their condition, sequences of treatment services received from other resources, and so forth.

Summary

Although ill-defined treatment concepts and inadequately tested methods have impeded progress, significant advances in methods of treating alcoholism and in the delivery of services to greater numbers of problem drinkers have been made. Attention is being given increasingly to the needs of special populations—women, the young and the old, ethnic groups, the public inebriates, and polydrug addicts. Programs are being developed in a wider array of intermediate-care facilities as well as in general hospitals, while negative professional attitudes are undergoing modification and new cadres of helpers are being enlisted and trained. New developments in caregiving are seen in the areas of detoxication, family therapy, behavior modification and transactional-analysis techniques, and in activities associated with Alcoholics Anonymous. More thought is being given to the motivation of therapists than to that of problem drinkers.

Current data show that alcoholism is treatable, though rates of reported success vary

TABLE 2

CHANGE IN CLIENT CHARACTERISTICS SIX MONTHS AFTER INTAKE TO NIAAA ALCOHOLISM TREATMENT CENTERS

	ALL CLIENTS			DWI CLIENTS[a]		
	Intake	6 Mos.	% Change	Intake	6 Mos.	% Change
Alcohol Consumption (during preceding month)						
Average ounces per day[b]	6.3	1.6	75%	2.0	0.6	70%
Average days drank	13.7	5.3	61%	8.7	5.1	41%
% Abstainers	15.4%	54.6%	355%	27.8%	49.9%	80%
Behavioral Pattern (during preceding month)						
Impairment index[c]	12.4	4.3	65%	5.5	1.7	69%
% Quarreled	37.2%	14.8%	60%	21.6%	6.6%	69%
% Drank on job	38.7%	16.1%	58%	15.6%	7.1%	54%
% Missed work (1 or more times)	40.1%	14.8%	63%	17.6%	6.2%	65%
Employment Data (during preceding month)						
Average days worked (labor force)	12.4	14.9	20%	16.8	18.3	9%
% unemployed (labor force)	40.5%	25.4%	37%	17.8%	12.2%	31%
Average earned income (all clients)	$275	$313	14%	$430	$451	5%
Number of clients – range for variables shown[d]	1443 – 1846			377 – 424		

[a] Driving while intoxicated.
[b] Absolute alcohol calculated from all beverages.
[c] Impairment index ranges from 0 for no impairment to 33 for maximum impairment.
[d] Number of clients at intake and 6 months after intake is the same for any given variable.

TABLE 3

PROFILE OF STAFF AND DISTRIBUTION OF STAFF TIME AT NIAAA ALCOHOLISM TREATMENT CENTERS

STAFF MAN HOURS BY DISCIPLINE	Percent
Physicians	4
Nurses	14
Psychologists	3
Social workers	10
Alcoholism counselors	18
Other counselors – therapists	19
Non-health administrative staff[a]	32
Total	100
DISTRIBUTION OF STAFF TIME	
Direct services to clients	56
Indirect program services	13
General administration	31
Total	100

[a] Does not include health professionals devoting time to administration.

greatly. It has become increasingly evident that no one treatment modality can be successful with all persons who exhibit drinking problems. Because individual problems, needs, and resources vary greatly, a variety of treatment strategies should be available in each community, and they should be utilized discriminatively by caregiving personnel. The future availability of large comprehensive data bases for evaluating outcomes should aid substantially in creating better treatment and rehabilitative services.

REFERENCES

(1) American Hospital Association. *A Plan for the Hospital Care of the Alcoholic Patient.* Chicago, 1973.

Discriminatory clauses in many health insurance policies have denied access to treatment for alcoholism except under subterfuge diagnoses. Growing recognition of alcoholism as an illness, for which treatment is more economical than neglect, is beginning to transform the picture. New attitudes, legislation, regulations, personnel policies, payment sources, and a variety of NIAAA-fostered actions, are expected to stimulate new health insurance practices that will enable most alcoholic people to obtain treatment and rehabilitation services openly and earlier.

Chapter IX

Alcoholism and Health Insurance

Despite recognition by the foremost medical authorities throughout the world that alcoholism is an illness *(1, 2, 9, 16, 27)*, some segments of society have been slow to respond to its import as a major public health problem. One of the reluctant segments is the network of public and private agencies involved in providing insurance or other forms of financial compensation for health services. As a result, persons afflicted with the illness of alcoholism have often been denied the treatment-cost benefits provided for the health-care needs of persons manifesting other—especially physical—diseases. In this respect alcoholism is comparable to other forms of emotional illness.

A recent examination of coverage for alcoholism in various forms of health insurance in the United States *(11)* revealed a spectrum of widely differing benefits and limitations under various policy restrictions. Some health insurance policies, for example, provided payments only for intensive treatment in strictly medical settings. Explicit exclusion of alcoholism from policy benefits was common.

Nevertheless, some insurance companies have recognized that actually they are often paying for the treatment of alcoholism, but under subterfuge diagnoses. There are signs of a growing sensitivity to the needs of alcoholic persons for health-care services and for appropriate insurance-type coverage. Recently the House of Delegates of the American Medical Association *(2)* formally resolved "that insurance companies and prepaid plans be urged to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism, recognizing that alcoholism is an illness."

Background

Traditionally, to the extent that alcoholism has been covered by insurance or other prepaid plans, it has been under the umbrella of mental health benefits. But third-party payments (payments made by an agency acting for the patient) by public and private insurance companies, Medicare and Medicaid, for illnesses labeled as "mental" have lagged far behind those for the forms of illness labeled as "physical," and alcoholism has been included in the lag. Partly accounting for this discrepancy was the fact that in the late 1920s and early 1930s the public response to mental and emotional illness in general, and to alcoholism specifically, was to hide the condition, presumably because of the social stigma then associated with it. The treatment of choice for emotionally ill patients was to institutionalize them in "mental" hospitals, which were supported by State governments *(10)*. Coverage through third-party reimbursement for the treatment of individuals exhibiting such illnesses was therefore not needed, since the costs were subsidized by the tax dollar. Under these conditions, however, for the most part only those alcoholic persons who developed acute or chronic "brain syndromes" were admitted to the State mental hospitals—a small percentage of the total. The rest were treated privately or in private sanitariums at their own expense, or in general hospitals often under

subterfuge diagnoses, or by nonmedical modalities, including those of clinical psychology, religious counseling, lay therapies, and, from the mid-1930s on, Alcoholics Anonymous; or, for the most part, they went untreated until they became totally disabled.

As time went on, and as the commercial insurance companies had no specific exclusions for mental illness, or for alcoholism, the States began submitting claims in the case of patients who had insurance to recover the costs of their hospitalization. Insurance companies countered by newly defining "hospitals" so as to exclude State mental hospitals. Even in the early 1950s, when coverage by health insurance for outpatient treatment of physical conditions was beginning to expand, there was no comparable expansion of mental health and alcoholism benefits *(10)*.

The current situation in mental health insurance coverage, mostly including alcoholism, is a far cry from that of 20 years ago. Approximately 63 percent of the civilian population now have some form of private health insurance which covers the in-hospital treatment of mental illness. About 61 percent have some coverage for physician in-hospital visits, and about 38 percent for physician office visits, for mental conditions *(24)*. Despite such seemingly extensive coverages, highly restrictive limitations often exist with regard to the type of facility in which the patient can be hospitalized, the length of stay, and, for outpatient treatment, the number of visits and the amount of reimbursement.

History of Federal Experience

Although some Federal agencies, such as Social Rehabilitation Services and the Social Security Administration, have been concerned with alcoholism services for populations under their jurisdiction, the major concern for health insurance coverage for alcoholism has been within the Department of Health, Education, and Welfare (DHEW) and more specifically, since its creation in 1970, in the National Institute on Alcohol Abuse and Alcoholism (NIAAA). DHEW's activities date back to before the establishment of the National Center for Prevention and Control of Alcoholism, the predecessor of NIAAA. At that time, an Advisory Committee to the Secretary of DHEW recommended that studies in the area of alcoholism be undertaken. One recommendation concerned the need to examine third-part reimbursements for alcoholism. In 1967, th National Center for the Prevention and Contrc of Alcoholism began accumulating data o inpatient coverage for alcoholism treatmen under health insurance. A 1968 report release the following information *(25)*:

- Just over 60 percent of the general hosp tals excluded the admission of person needing alcoholism treatment.
- About 40 percent of the Blue Cross-Blu Shield plans excluded alcoholism fror coverage.
- Independent health insurance plans ha even greater exclusions for alcoholism tha the Blue Cross-Blue Shield plans. Commer cial insurance companies were not surveyed but available information indicated tha they were probably similar to Blue Cros and Blue Shield.

With the advent of the legislation that create NIAAA (the Comprehensive Alcohol Abuse an Alcoholism Prevention, Treatment, and Rehabili tation Act of 1970) the question of insuranc coverage for alcoholism came to the forefront As NIAAA encouraged programs for employe alcoholic persons (see chapter VIII) it empha sized also the advantages of insurance coverag for them.

In the spring of 1972 NIAAA sponsored a update of the 1968 report. This study *(11)* released in the fall of 1972 (discussed in deta below), found that although there had bee some improvement in health insurance coverag for alcoholism, it is still far behind benefit available for physical conditions. Among th companies that provided alcoholism coverag the nature and extent of benefits varied widely

Coinciding with the interests of NIAA were those of the Public Policy Committee o the National Council on Alcoholism (NCA). Thi committee represented national voluntary e forts in developing public and private third-part payment mechanisms for the treatment o alcoholism. After the 1972 NIAAA study wa released, a joint NCA-NIAAA committee was s up to act in an advisory capacity and t coordinate further efforts regarding health insu ance coverage for alcoholism.

State Regulatory Activities

The McCarran Act of 1945 gave to the Stat the power to regulate the type and extent

insurance contracts, the cost of insurance, and the conduct of the insurance company (i.e., policy, price, and procedure). In recent years State legislatures have increasingly considered legislation which mandates that insurance companies provide benefits for the treatment of alcoholism.

A recent survey *(13)* has sought to determine what action toward health insurance for alcoholism has been taken by the 50 State regulatory agencies. Responses from 47 States indicate that legislative efforts to achieve insurance coverage for alcoholism are only beginning. The majority of State regulatory agencies favor health insurance for alcoholism, but only five States (Illinois, Massachusetts, Minnesota, Washington, and Wisconsin) have passed some form of legislation mandating inclusion of benefits for alcoholism in group health insurance policies. Actual benefits provided by the enabling legislation in the five States range from no specification to a fixed number of inpatient days of care; only Massachusetts includes outpatient as well as inpatient care.

In five States (Alaska, Michigan, Mississippi, Nebraska, and Oregon) legislation concerning health insurance for alcoholism is pending *(13)*; in four of these, individual as well as group coverage will be required, and in four, outpatient benefits will be required.

Personal visits by the survey staff to legislative officials in eight States indicated that the health insurance industry has generally shifted from opposing coverage for alcoholism to providing information which would be of use in the preparation of legislation. Labor and management groups too have supported this type of legislation and have not shown undue concern about treatment costs. Hospital and physician groups tend to favor legislation for alcoholism benefits which would limit coverage to inpatient treatment by qualified physicians.

California has initiated a pilot occupational health insurance program for all State employees, financed by State funds. The insurance covers alcoholism as a primary diagnosis for employees, their spouses, and all family members. The Comprehensive Alcoholism Treatment Program is based on the NIAAA model (described further below). The benefits include 6 days of detoxication, 21 days in a general hospital or specialized alcoholism treatment center, 30 days in a recovery home or other residential facility, and 45 outpatient visits. All insurance carriers currently offering basic health care coverage to State employees participate in the program. The experience gained during this pilot will be used in developing an ongoing alcoholism health insurance program to be included as part of the basic health care provided for all employees in public and private industry in the State.

State legislation has been one means of gaining adequate third-party payments for alcoholism treatment from the private health insurance industry. In the future, national health insurance may become the important means.

The Private Health Insurance Industry

According to a Social Security Administration estimate *(24)*, about 80 percent of the civilian population now have some type of private insurance for hospitalization. As noted above, however, alcoholism is often excluded, or limited under mental health coverage, although the insurance industry is showing signs of becoming more responsive to the needs of problem drinkers. A 1973 survey *(14)* indicated that in a representative sample of the U.S. population 66 percent favored health insurance which would include treatment for drinking problems and alcoholism.

The 1972 study mentioned earlier *(11)* concerned available health insurance coverage for alcoholism. There are three major components in the U.S. private health insurance industry:

- Blue Cross and Blue Shield companies: Blue Cross is concerned with hospital services, Blue Shield with professional services. These nonprofit organizations operate in conjunction, through independent area plans, throughout the United States.
- Independent companies: These are a composite of employer-employee plans, community plans, and private group clinics and dental service corporations, both nonprofit and profitmaking.
- Commercial insurance companies: These are life and casualty insurance companies as well as others whose activities are limited to the health area. Most are stockholder private enterprises.

Blue Cross and Blue Shield

Blue Cross and Blue Shield cover an estimated 38 percent of the private health insurance enrollment *(11)*. Approximately 75 percent of the

Blue Cross plans, and approximately 62 percent of the Blue Shield plans, provide some type of alcoholism coverage *(7)*.

Among the Blue Cross plans which include alcoholism as a compensable illness, about half provide only a limited set of benefits, less than those afforded for other conditions *(11)*. Limited benefits are usually in the range of 30 to 45 inpatient-care days. A serious limitation of Blue Cross plans is that they generally cover only expenses incurred in a hospital recognized by the American Hospital Association and by the Joint Commission on Accreditation of Hospitals. Thus, care in many psychiatric or special alcoholism facilities which do not meet the accreditation criteria is not compensable. Only about 9 percent of the Blue Cross plans cover psychiatric or special alcoholism facilities.

In April 1974 Blue Cross of Maryland *(3, 4)* announced that it was expanding its group health coverage to include the rehabilitation of alcoholic persons at private residential treatment centers. Alcoholism can be added to group health contracts for $0.45 a month for an individual, and $1.00 a month for husband and wife. Coverage is limited to a lifetime maximum of 60 inpatient days, restricted to 30 days per confinement per person. Semiprivate room and board, medical and nursery services, and rehabilitation services are included. Both premium reduction and expansion of coverage to outpatient care are under consideration by this Blue Cross plan.

Medicaid

The Medicaid program grants funds to all States for health care for the categorically needy and the medically indigent, provided the State program meets certain standards. The types of services vary greatly, since Medicaid is primarily a State operation. Even though Federal matching money is available, many States do not include in their plans coverage for mental health outpatient services through general hospitals, psychiatric hospitals, community mental health centers, or other services in nonresidential settings.

Medicaid programs are required to include persons receiving financial assistance through programs for the aged, blind, disabled, and families with dependent children; also, other persons who would be eligible for financial assistance except that they do not meet certain State requirements. The States may also offer care to certain medically indigent persons under age 21 and other needy persons *(24)*.

Medicaid funds are used for physician services, inpatient and outpatient hospital and nursing home services, and other related costs, as well as psychiatric services. Medicaid State programs may not deny medical care to eligible persons on the basis of diagnosis, although they may, and many do, limit the amount of care to be provided, such as the number of hospital days or the number of physician visits. If the patient goes to a general hospital, he is eligible for the total benefits allowed by State plans, but if he goes to a public mental hospital, he must be either over 65 or under 21 years of age to be eligible.

National Health Insurance

In recent years third-party mechanisms to finance all or part of the costs of health care have become increasingly important. For the first time in 1965, national legislation (Medicare) provided publicly sponsored health insurance for a limited segment of the population. Since then, Congressional proposals and enactments for health insurance have been increasing.

More than a dozen proposals for various forms of national health insurance are now pending before the U.S. Congress. Others may be added in the near future. They range from minimal to comprehensive coverage, and many of them provide coverage for alcoholism under the aegis of mental health.

In a recent survey of a cross section of U.S. households *(14)*, the respondents were asked whether treatment of drinking problems and alcoholism should be included in a national health insurance program; 73 percent thought it should be, 10 percent were not sure, and 17 percent felt that it should not be included.

It is expected that whichever bill is passed will be a compromise. Under such a national health insurance program it is hoped that there will be adequate coverage for alcoholism; that the program which emerges will encourage not only the utilization of innovative nontraditional types of health-care settings, such as community-oriented alcoholism treatment centers, but also the integration of alcoholism services into the mainstream of the health-care delivery system; and that emphasis for alcoholism services will be placed on outpatient rather than inpatient care, in most instances a less expensive and more effective means of treating alcoholism *(18)*.

Disability Insurance

Disability insurance is a means of providing income to the insured when normal work activities and income are interrupted due to accident or illness. The two types, public and private, seem to differ mainly in the amount of payment and the length of time for which insurance can be collected.

Public disability insurance falls into two categories: Workmen's Compensation, which provides income in the event of a work-connected accident or illness; and temporary disability insurance, which provides income when wage loss is caused by a nonwork-connected disablement. At the present time, only five States (Rhode Island, California, New Jersey, New York, and Hawaii) and Puerto Rico offer temporary disability. In all 50 States, however, Workmen's Compensation is in effect, although there is considerable variation in the coverage offered for work loss due to alcoholism. The pertinent State statutes vary widely, "from mere existence of intoxication at the time of injury (as an exclusion from benefits) to intoxication being the sole cause of the injury" *(11)*. To date only a few instances have been reported of compensation for injured workers who suffer from alcoholism or who develop other alcohol-related problems after and due to their injuries. In such cases, compensation benefits are paid for the alcohol-related problem.

Persons with private disability insurance are generally eligible for benefits if they have disabilities connected with alcoholism *(11)*.

Health Maintenance Organizations

With the passage of the Health Maintenance Organization (HMO) Act of 1973, a new opportunity has become available to provide alcoholism services in a new health delivery system.

In general, an HMO is an organization which offers health services to an enrolled group of persons for a fixed prepaid fee. All HMOs receiving Federal assistance under the Act must provide basic health services on a prepaid basis to an enrollment group which includes the various age, social, and income groups within the area it serves; at their option, they may also provide supplemental health services on either a prepaid or fee-for-service basis.

Some of the provisions of the Act relate specifically to alcoholism. Others do so by indirection and are susceptible to varying interpretations.

The basic services which relate directly to the treatment of alcoholism are defined by the Act to include (a) short-term, outpatient evaluative and crisis-intervention mental health services; and (b) medical treatment and referral services (including referral to appropriate ancillary services) for the abuse of or addiction to alcohol.

The supplemental services which relate indirectly to the treatment of alcoholism include (c) mental health services not included as a basic service under (a) above; and (d) long-term physical medicine and vocational rehabilitation services.

Of the provisions cited, only item b specifically refers to alcoholism, while provisions a, c, and d are matters of interpretation. Regulations and guidelines specifying HMO involvement with alcoholism are currently under preparation.

Thus the inclusion of alcoholism services in the benefit package is required of all HMOs receiving Federal assistance. Information is not now available as to how many of the estimated 117 operational HMOs and the 125 HMOs in process of formation offer these services. There is no doubt, however, that most HMOs are currently treating alcoholism and alcohol-related problems, although in many cases under other diagnoses. The question for the future is not whether HMOs will provide services for alcoholic persons, but whether they will provide an effective and adequate scope of services.

Currently, HMOs which offer alcoholism services must provide or arrange treatment for those who request it. This is in contrast to other health insurance programs, whose commitment is only to pay for treatment once it has been received.

Insurance Coverage for Alcoholism Among U.S. Corporations

It has been estimated that well over half of the alcoholic persons in the United States are gainfully employed. Most of them, however, are unable to work to their fullest capacity and may become disabled if they do not resolve their alcoholism problems. These persons are thought to miss work about 2½ times as often as the general employed population. Without doubt alcoholism is responsible for the loss of capable and experienced personnel, one of the most valuable resources of any company *(12)*.

A survey *(23)* in 1972 by the National Council on Alcoholism sought to determine the extent of health insurance coverage for alcoholism among 21 U.S. corporations representing a total employee population of about a million. Only one corporation excludes alcoholism coverage for its employees, and two do not offer inpatient coverage. Approximately 40 percent of the corporations provide some type of outpatient coverage.

The 21 corporations use a combination of health coverages: Approximately 14 percent, including both large and small firms, are self-insured; about 38 percent are insured by Blue Cross and Blue Shield; and almost 50 percent by other insurance companies. Three corporations use a combination of Blue Cross-Blue Shield and another insurance company; in each case the other insuror provides major-medical coverage. About 40 percent of the corporations impose no limitations because of alcoholism.

In another survey *(6)* 503 top executives in the largest U.S. corporations were asked whether they felt that company medical insurance should pay for help to employees with alcohol problems. While 3 percent had no opinion and 15 percent felt it was not worth the cost, 82 percent thought the company should pay.

An effective alcoholism program for employees should provide insurance coverage for the treatment of alcoholism similar to what is provided for other illnesses. A 1973 study *(15)* reported that when employees of Illinois Bell Company utilized the alcoholism benefits offered by their health insurance, and were successfully treated, claims for alcohol-related illnesses and accidents were markedly reduced. During the 5 years prior to their rehabilitation, alcoholic employees had 662 incidents of sickness disability. In the 5 years after rehabilitation, sickness disabilities among them were reduced to 356, saving the company an estimated $459,000 in wage replacements alone. The incidence of on-duty accidents was also greatly reduced.

A study in 1970 of absenteeism by employees of a large corporation, comparing alcoholic and nonalcoholic persons, found that 63 percent of the absences by alcoholic employees were attributed to respiratory infections and digestive and musculoskeletal disorders *(22)*. The alcoholic employees used up a greater amount of group hospitalization insurance, regardless of whether alcoholism treatment was included or excluded in the insurance policy. The reporting of secondary diagnoses, rather than the primary diagnosis of alcoholism, is common, so that when an employee is ill due to alcoholism and is admitted to a hospital for treatment, it is often reported as a respiratory ailment, gastritis, or a musculoskeletal disorder.

It is important to note that the funds paid out under group hospitalization coverage vary only slightly whether alcoholism is included or excluded in the contract *(22)*.

Companies which currently include alcoholism in their health benefits package do not as yet find a need for increasing group hospitalization rates as a result of alcoholism claims. But due to the social stigma involved, employees are reluctant to take advantage of this health benefit. Through utilization of the alcoholism provision, however, many previously unacceptable claims will become reimbursable.

Although two large insurance companies have recently included alcoholism benefits in their group hospitalization plans at no increased premium, some resistance on the part of private industry to acceptance of this benefit has been reported. In a survey of executives *(6)* early in 1974, 83 percent of those questioned considered alcohol misuse to be less than a very serious problem among their employees.

Federal Actions

Social Security Amendments of 1972

The Social Security Amendments of 1972 (P.L. 92-603, commonly referred to as H.R. 1) increased benefits under the Old-Age, Survivors, and Disability Insurance Program, provided for improvements in the Medicare, Medicaid, and Maternal and Child Health Programs, and federalized certain other programs for the aged, blind, and disabled. Three major areas of concern for alcoholism treatment in H.R. 1 are as follows:

- One who qualifies as an "aged, blind, or disabled individual" solely by reason of a disability is not eligible for benefits under the Supplemental Security Income Program established by section 301 of P.L. 92-603 if it has been determined that he is an alcoholic person and is not undergoing appropriate treatment at an institution or facility approved by the Secretary of Health, Education, and Welfare.

TABLE 1

MEDIAN COSTS OF ALCOHOLISM SERVICES
(BASED ON 2 TO 11 SAMPLES IN EACH CATEGORY)

	Cost per Day	Cost per Stay
Emergency Care		
General hospital	$172	$ 589
Specialized alcoholism hospital	58	231
Other specialized hospital	97	472
Hospital-affiliated medical emergency care center	79	148
Hospital-affiliated nonmedical emergency care center	16	53
Inpatient Care		
General hospital	87	788
Specialized alcoholism hospital	34	270
Other specialized hospital	94	924
Hospital-affiliated inpatient care under medical supervision	117	1,174
Intermediate Care		
Partial hospitalization	74	1,274
Recovery home	13	681
Other 24-hour residential center	21	735
Specialized alcoholism hospital	27	793
Outpatient Care		
Hospital-based outpatient clinic	20	60
Family or neighborhood alcoholism center	15	220
Community mental health center	32	301

Source: Blood, Allen & Hamilton ISI.

- Individuals who qualify for financial assistance under H.R. 1 will receive their benefits through a third-party payee. Such a requirement of a representative payee seems to imply that alcoholic persons are incapable of managing funds even if they are undergoing treatment for their problems.
- Individuals eligible for disability benefits, including disablement by alcoholism, under H.R. 1 are also eligible for Medicare, thus enabling them to take advantage of the limited alcoholism treatment benefits offered under Medicare at the present time.

NIAAA Activities

In cooperation with broad representation from the alcoholism field, NIAAA has tried to meet some of the inadequacies in the third-party reimbursement area. NIAAA has defined and scheduled a 2-year Operational Planning Objective (H-21) to increase coverage by private health insurance companies for alcoholism treatment. This objective should be instrumental in clarifying many of the issues involved and help to reduce current exclusions or limitations related to alcoholism.

Under the aegis of H-21 a model health insurance benefit package has been designed to reflect the current "state of the art" and to act eventually as a guideline to companies providing alcoholism coverage in health insurance plans. It is important to note that this proposed package, which will be made available to all State alcoholism authorities, employers, trade unions, and the insurance industry, needs practical testing before it can be implemented.

In addition, preliminary data on the costs of treating and caring for alcoholic persons have recently been compiled (table 1). It is recognized that these costs may be conservative, especially in view of the rapidly changing picture in the field of health services.

Standards for alcoholism treatment services are either lacking or poorly defined. In an effort to resolve this problem, NIAAA has contracted with the Joint Commission on Accreditation of Hospitals to develop a Standards Manual for alcoholism treatment programs together with a procedure for ongoing surveys leading to accreditation. Through another contract, standards leading toward certification of nondegreed professional treatment staff are being formulated. It is expected that during the coming year

a "certifying" body will work to gain acceptance of the standards and to implement the certification of nondegreed alcoholism counselors.

In an effort to stimulate health insurance coverage and third-party payments NIAAA is exploring the possibility of using incentive contracts with profitmaking organizations. The Institute hopes to demonstrate that contractual incentives can yield facilities of a nature satisfactory both to the alcoholic population and to health insurers covering this population. This should attract enough third-party payments to enable the contractor to become self-sustaining in a relatively short time. Contractor fees will be determined by the level of third-party payments they are able to generate. For example, a contractor would receive the most profit if he were able to generate 25 percent of his total receipts from third-party payments by the end of the first 6 months of the contract, 50 percent by the end of the first year, and 75 percent by the end of the second and final year.

Other current NIAAA activities are the development of a model cost-accounting system for use by alcoholism programs and an examination of legislation and licensure requirements for State facilities.

Alcoholism Care Costs

The costs of treating the several million Americans who manifest drinking problems cannot be supported by government funds alone. One of the more financially viable means to ensure that alcoholic people receive timely and appropriate care is through the mechanism of third-party reimbursement. Yet cost is often the reason cited for not including alcoholism treatment in health insurance plans. For example, data from the NIAAA Alcoholism Treatment Center Monitoring and Evaluation System *(20)* indicate that these Centers currently receive only 7 percent of their income from third-party reimbursement, of which approximately 2 percent is from private health insurance.

Determining alcoholism treatment costs is especially difficult because they vary greatly from program to program. Information from the recent preliminary study *(5)* of the costs of different types of alcoholism treatment (table 1) may be applied tentatively to a model benefit package. It should be noted that this model does not represent a policy statement by NIAAA concerning an appropriate treatment program but is merely a practical measure, obtained by analysis of present treatment programs, to provide insurance companies with some basis for projecting a reasonable range of possible costs in all the settings in which alcoholism treatment is delivered. This model is seen as part of an experimental effort rather than as a plan ready for wide implementation, and NIAAA urges recognition of the fact that selected aspects of the proposal have not been thoroughly tested.

The model benefit package projects, as the basis for treatment in each type of setting, the following maximum lengths of stay:

Inpatient emergency	6 days
Inpatient care	14 days
Outpatient care	30 visits
Intermediate care, short term	30 days
Intermediate care, long term	60-90 days

The results of the study *(5)* obtained by site visits to 27 alcoholism treatment programs throughout the United States, covering a total of over 60 treatment settings, are as follows (table 1):

Inpatient Emergency Care. Within the inpatient emergency care modality, the general hospital treatment settings cost from over 2 to 10 times as much as settings in specialized alcoholism hospitals, other specialized hospitals, hospital-affiliated medical emergency care centers, and hospital-affiliated nonmedical emergency care centers.

Inpatient Care. The specialized alcoholism hospital is the least costly of the four inpatient treatment settings.

Intermediate Care. The partial-hospitalization treatment setting costs more than twice as much as the other three settings—specialized alcoholism hospitals, recovery home or halfway houses, and other 24-hour nonmedical residential centers.

Outpatient Care. Costs varied greatly in the three treatment settings analyzed (family or neighborhood alcoholism centers, hospital-based outpatient clinics, and community mental health centers), but costs in family and neighborhood alcoholism centers tended to be the lowest.

A preliminary conclusion from this study is that it is reasonable and economical to provide

care for alcoholism through the vehicle of the model benefit package in certain types of settings. However, it should be noted that the costs shown in table 1 indicate trends rather than exact values (the number of sites in the different categories varied from 2 to 11) and, for the reasons cited previously, may be conservative. Eventually, further studies based on this model should provide valuable information to health insurance purchasers, labor unions, and insurance companies, and facilitate the design as well as the negotiation of alcoholism policy benefit provisions.

Summary

Public opinion favors the inclusion of alcoholism in health insurance plans, in line with growing awareness of alcoholism as an illness and of the fact that insurance companies can cover alcoholism without incurring excessive additional costs.

The insurance industry is becoming more sensitive to the needs of alcoholic individuals. Nevertheless, the majority of policies which currently cover alcoholism limit benefits to treatment in accredited general hospitals, thus excluding more economical treatment programs. Some health insurance companies are beginning to bring about change within the industry. With new developments in the areas of treatment effectiveness, cost data, licensing of facilities, certification of personnel, it is anticipated that health insurance companies will expand their benefits to meet the needs of alcoholic persons.

As State and Federal legislation addresses itself more substantially to insurance activities in the alcoholism field, significant changes are occurring. Currently a number of national health insurance proposals have been introduced in Congress which should have a profound effect on third-party reimbursement if enacted. The removal of financial barriers through national health insurance will almost certainly increase the demand for frankly labeled alcoholism services, including manpower and treatment resources, and many more alcoholic persons will become eligible for treatment.

The extent to which a recent movement in some States to regulate the health insurance industry will continue may depend on the measures taken by the industry to include alcoholism benefits provisions, as well as on the direction taken by national health insurance.

For the alcoholic person considering treatment the availability of effective health insurance coverage can in many cases make the difference between seeking and not seeking help, and between seeking it sooner rather than later.

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TABLE 1

AMERICAN ATTITUDES TOWARD ALCOHOL FROM 1971 TO 1973

	1971	Sept. 1972	March 1973	Sept. 1973	% Change, 1971 to Sept. 1973
Heavy drinking is a very serious problem in the country today:	59%	64%	67%	72%	+22%
Alcohol is a drug:	61%	67%	71%	72%	+18%
No known cure for a hangover:	45%	52%	53%	50%	+11%
Drunkenness is usually like an overdose of drugs:	31%	38%	41%	43%	+39%
Host who encourages heavy drinking by guests can be described as a					
— drug pusher:	19%	31%	33%	33%	+74%
— bad host:	50%	58%	56%	58%	+16%

Source: Louis Harris & Associates (12)

lives where wise interventions can assist them vitally.

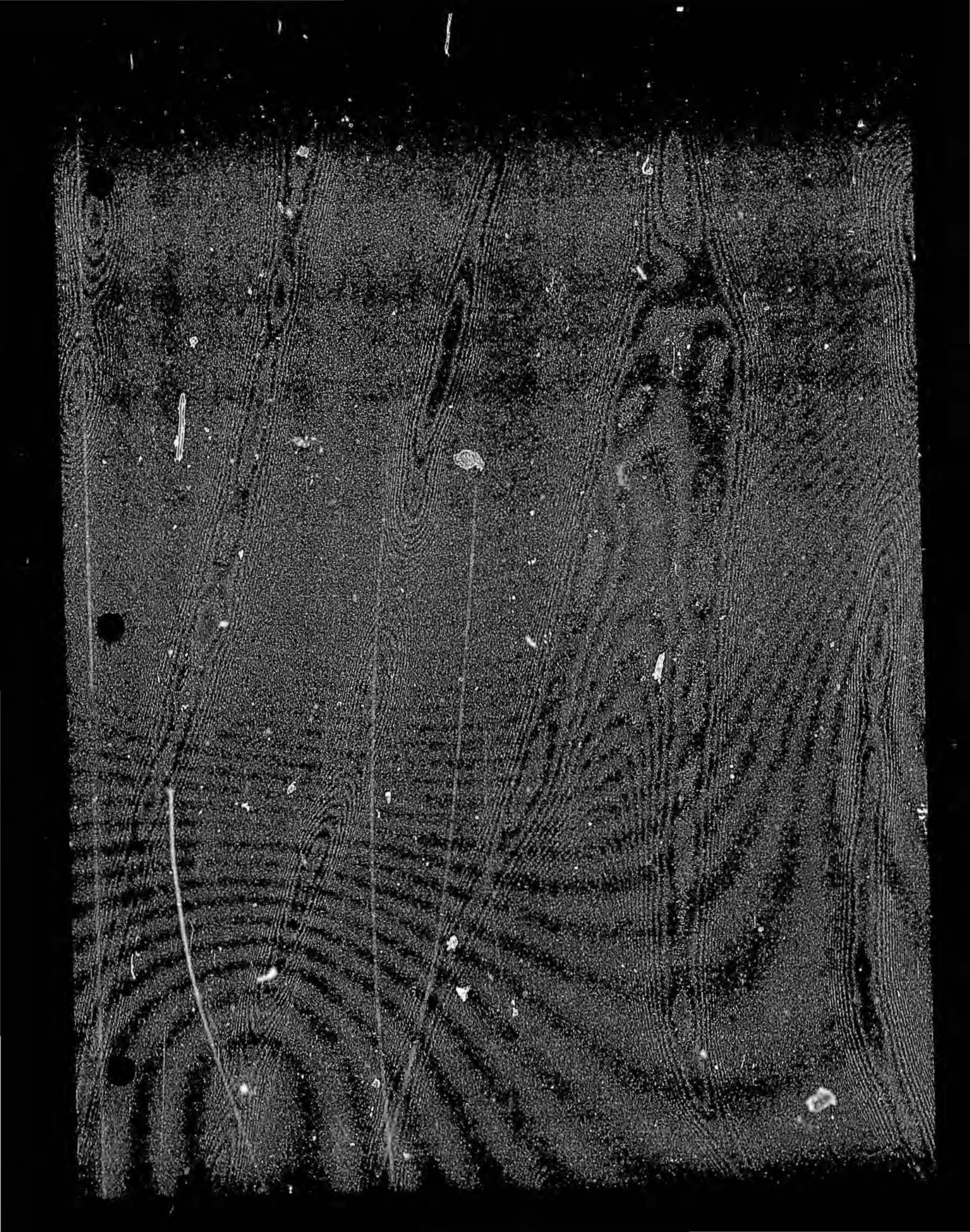
Considering the multiple factors involved, several should be of the greatest importance in dealing with alcohol-related behavior. First are the attitudes toward taking alcohol. Second come the actual sets of behaviors that people engage in, which are of course not always necessarily the same as their attitudes. A third major factor includes the laws and customs that contribute so much to our patchwork quilt of inconsistent drinking-related practices. The patterns of drinking, including the economics of the availability of beverages and the availability of money to buy them, are certainly involved. The environments in which people live and work and drink, discussed earlier in this *Report*, are also critical in providing clues about the extent to which their behavior deviates from generally accepted norms.

Attitudes Toward Alcoholism

There is reason to believe that attitudes toward alcohol are changing. A small experimental Government prevention campaign has yielded a multiplied growth in free public exposure of some four to five times the dollar investment in radio, television, magazine, newspaper, and outdoor advertising about alcoholism. One reason for this enormous public involvement is the fact that techniques of public communication have been used effectively to catch and sustain attention. The effectiveness of this campaign has been measured independently by a public-opinion research organization by means of standard population polls *(12)*. The data in table 1 address the questions whether the public is aware of the campaign, and whether attitudes toward the use of alcohol have changed. As can be expected from a limited experiment, the results are modest, but they are clear.

It may reasonably be concluded that Americans' attitudes toward alcohol have changed over the last few years. Moreover, since public information campaigns by voluntary organizations are continuing and growing in volume, it is likely that heightened public awareness of alcoholism as a major social problem will also be sustained.

The problem now becomes one of taking constructive steps to capitalize on the increased sensitivity of the public. Studies of public attitudes and practices, including house-to-house surveys, are continuing *(5)*, but in the meantime the information currently at hand must be used appropriately. Not only is it inimical to our democratic ideals to impose any sort of behavioral practices upon people, but it is unlikely that compulsion will lead to sustained behavior in a given direction. Indeed, there is evidence that even people living under authoritarian governments manage to ignore official anti-alcohol propaganda which goes against long-ingrained popular practices *(16)*. On the other hand, there is great potential value in stimulating open public discussion about the values and practices related to drinking that characterize various groups of Americans. In this way tacit assumptions can be scrutinized and mutual understanding achieved.



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National Institute on Alcohol Abuse and Alcoholism

Third Special Report to the U.S. Congress on Alcohol and Health, June 1978

From the Secretary of Health, Education and Welfare

The First Special Report to the Congress on Alcohol and Health (1971) broadly described historical and contemporary alcohol uses and abuses, the causes of alcoholism, and treatment methods. Effects of alcohol on the nervous system, and the legal status of intoxication and alcoholism were discussed in detail.

The Second Special Report on Alcohol and Health (1974) focused on the advances in knowledge gained in the interim between the two reports and supplemented the first volume with discussions of health consequences and of alcohol use among adults, young people, and the elderly.

This Third Special Report on Alcohol and Health incorporates the most significant findings of recent research in the field of alcoholism. The findings are described in extensive detail in the Technical Report in Support of the Third Special Report on Alcohol and Health. The latter, to be published separately by the National Institute on Alcohol Abuse and Alcoholism, will be appropriate for those seeking references, as well as for additional data and discussion.

INTRODUCTION

Beyond the obvious role of the Federal Government in translating public moral judgments about alcohol and alcoholism into law during the past 200 years, the history of active Federal involvement in the alcoholism field has been a short one indeed. As late as 1965, there was but one identifiable alcoholism specialist among the entire staff of the National Institute of Mental Health. In 1967, a small National Center for the Prevention and Control of Alcoholism was established within the National Institute of Mental Health, but its budget of less than $3 million was a very small sum to combat an illness that afflicted millions of Americans. It remained for landmark legislation at the end of 1970 to initiate a new era of significant Federal leadership and commitment to the problem of alcohol abuse and alcoholism.

When the National Institute on Alcohol Abuse and Alcoholism was established 7 years ago, the field of alcoholism was fragmented, and many aspects of the subject were virtually unexplored. It was essential to develop a substantial body of research and information on which to base program and policy development. In 1971, the First Special Report to the Congress on Alcohol and Health represented the first effort in the history of the Federal Government to collect and transmit to the American people a substantial portion of the current knowledge about alcohol and its effect on health. The Second Special Report, published 2-1/2 years later, covered the new knowledge gained in the field since the initial report was issued. As the Institute has matured, along with the alcoholism field, our knowledge base has grown tremendously, as reflected in this Third Special Report to the Congress on Alcohol and Health.

This Third Special Report stands as important testimony to the continuing progress we have made in the alcoholism field. But its negative aspects cannot be ignored. We now know that the problems are far more extensive than we realized at the time of the First Special Report. We currently estimate that there are 10 million problem drinkers (including alcoholic people) in the United States, and each of them directly affects the lives of many others--family members, coworkers, employers, friends, innocent bystanders--so that literally tens of millions of Americans face some form of negative consequences due to alcohol misuse. In purely economic terms, the alcohol-related cost to our society in 1975 is estimated at nearly $43 billion in lost production, medical expenses, motor vehicle accidents, violent crime, fire losses, and the maintenance of social mechanisms to deal with the problems--and that figure covers only the losses we can measure. Alcoholism shortens life expectancy by an estimated 10 to 15 years. It also contributes significantly to such serious conditions as heart disease, cancer, and diseases of the liver. Patients with alcohol-related problems occupy an unwarranted proportion of the Nation's hospital beds. Alcohol may be involved in as many as one-third of all suicides, half of all homicides, half of all traffic fatalities, and one-quarter of all nontraffic accidental deaths. Furthermore, alcohol is now suspected to be a major factor in child abuse and marital violence. In total, more than 200,000 premature deaths each year may be associated with alcohol misuse and hundreds of thousands more people suffer alcohol-related illnesses or injuries.

Table 1. Apparent Consumption,[1] of Alcoholic Beverages in U.S. Gallons per Capita of the Drinking-Age Population,[3] U.S.A. by States, 1976

State	Distilled Spirits		Wine		Beer		Total Ethanol Volume	Rank Order
	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume		
Alabama	1.99	0.86	1.04	0.15	19.64	0.88	1.89	48
Alaska	5.08	2.18	3.58	0.52	34.83	1.57	4.27	4
Arizona	2.56	1.10	2.64	0.38	36.60	1.65	3.13	12
Arkansas	1.56	0.67	0.86	0.12	19.26	0.87	1.66	51
California	3.11	1.33	4.84	0.70	29.47	1.33	3.36	7
Colorado	3.20	1.37	3.16	0.45	32.48	1.46	3.29	9
Connecticut	2.93	1.26	2.51	0.36	22.72	1.02	2.64	28
Delaware	3.32	1.43	1.72	0.25	27.69	1.25	2.93	18
Florida	3.37	1.45	2.45	0.36	29.65	1.33	3.14	11
Georgia	2.85	1.22	1.16[2]	0.17[2]	21.89	0.98	2.37	35
Hawaii	3.01	1.29	2.95	0.43	33.16	1.49	3.21	10
Idaho	1.86	0.80	1.87	0.27	33.94	1.53	2.60	30
Illinois	3.01	1.29	2.31	0.33	29.12	1.31	2.93	19
Indiana	1.75	0.75	1.00	0.14	24.21	1.09	1.98	43
Iowa	1.81	0.78	0.72	0.10	28.63	1.29	2.17	40
Kansas	1.60	0.69	0.77	0.11	25.04	1.18	1.93	44
Kentucky	1.84	0.79	0.69	0.10	22.60	1.02	1.91	47
Louisiana	2.47	1.06	1.98	0.29	28.53	1.28	2.63	29
Maine	2.50	1.07	1.76	0.25	31.46	1.42	2.74	24
Maryland	3.37	1.45	2.24	0.32	29.50	1.33	2.10	14
Massachusetts	3.04	1.31	2.62	0.38	29.09	1.31	3.00	16
Michigan	2.47	1.06	2.06	0.30	31.81	1.43	2.79	22
Minnesota	2.79	1.20	1.45	0.21	28.92	1.30	2.71	25
Mississippi	2.02	0.87	0.87	0.13	22.75	1.02	2.02	42
Missouri	1.89	0.81	1.37	0.20	26.65	1.20	2.21	38
Montana	2.62	1.13	1.40	0.20	39.75	1.79	3.12	13
Nebraska	2.26	0.97	1.18	0.17	31.01	1.39	2.53	32
Nevada	9.31	4.00	5.89	0.85	45.54	2.05	6.90	1
New Hampshire	7.04	3.03	3.66	0.53	42.43	1.91	5.47	3
New Jersey	2.77	1.19	2.88	0.42	24.09	1.08	2.69	26
New Mexico	2.28	0.98	2.32	0.34	34.84	1.57	2.89	20
New York	2.89	1.24	3.05	0.44	24.84	1.12	2.80	21
North Carolina	2.02	0.87	1.61[2]	0.23[2]	22.07	0.99	2.09	41
North Dakota	2.80	1.20	1.10	0.16	29.35	1.32	2.68	27
Ohio	1.78	0.76	1.41	0.20	27.55	1.24	2.20	39
Oklahoma	1.81	0.78	0.95	0.14	22.26	1.00	1.92	45
Oregon	2.22	0.95	3.46	0.50	28.84	1.30	2.75	23
Pennsylvania	1.83	0.79	1.54[2]	0.22[2]	29.26	1.32	2.33	36
Rhode Island	2.84	1.22	3.27	0.47	30.83	1.39	3.08	15
South Carolina	2.76	1.19	1.39	0.20	24.30	1.12	2.51	33
South Dakota	2.48	1.07	1.19	0.17	25.16	1.13	2.37	34
Tennessee	1.72	0.74	0.77	0.11	23.77	1.07	1.92	46
Texas	1.90	0.82	1.39	0.20	34.89	1.57	2.59	31
Utah	1.41	0.61	1.04	0.15	20.81	0.94	1.70	50
Vermont	4.11	1.77	3.42	0.50	31.79	1.43	3.70	5
Virginia	2.22	0.95	1.65	0.24	25.13	1.13	2.32	37
Washington	2.59	1.13	3.33	0.48	30.20	1.36	2.97	17
West Virginia	1.91	0.82	0.69	0.10	20.91	0.94	1.86	49
Wisconsin	3.05	1.31	1.87	0.27	40.00	1.80	3.38	6
Wyoming	3.07	1.32	1.45	0.21	40.53	1.82	3.35	8
District of Columbia	8.24	3.54	6.46	0.94	29.01	1.33	5.81	2
Average	2.54	1.09	2.26	0.33	28.09	1.26	2.68	

SOURCE: Data updated from Mark Keller and Carol Gurioli, *Statistics on Consumption of Alcohol and on Alcoholism*. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1976.

[1]For comparative purposes only. Amounts calculated according to tax paid withdrawals.

[2]Data are from 1975; 1976 data were not available.

[3]Data are based on a drinking-age population 14 years and over.

Table 2. Apparent per Capita Consumption,[1] in Gallons, of Alcoholic Beverages by Persons 15 Years Old and Older in 26 Countries[2]

Rank	Country	Year Of Latest Data	Distilled Spirits		Wine		Beer		Total	
			Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Persons 15 Yrs. and Older	Entire Population
1.	Portugal	1974	1.20[3]	0.46	43.91	5.27	10.87	0.54	6.27	4.60
2.	France	1972	2.34	0.80	37.40	4.07	20.11[6]	0.99	5.87	4.43
3.	Italy	1973	1.32	0.66	37.91	3.79	4.74	0.24	4.69	3.55
4.	Switzerland	1971-73	1.88	0.75	15.41	1.70	28.72[3,6]	1.39	3.85	2.95
5.	Spain	1971	2.67	1.07	19.83	2.18	1.34	0.53	3.78	2.85
6.	W. Germany	1974	2.39[3]	0.91	7.78	0.82	50.50	2.02	3.75	2.88
7.	Austria	1972	2.10	0.84	11.87	1.25	36.30	1.63	3.72	2.79
8.	Belgium	1973	1.21	0.61	5.96	0.63	48.90[6]	2.15	3.39	2.61
9.	Australia	1972-73	0.82[3]	0.47	3.71	0.45	48.08	2.40	3.32	2.36
10.	Hungary	1972	2.00[3]	1.00	13.36	1.54	19.70	0.69	3.23	2.51
11.	New Zealand	1972	0.85[3]	0.49	2.94	0.35	46.85	2.34	3.18	2.17
12.	Czechoslovakia	1973	2.29	0.92	4.66	0.57	49.69	1.49	2.98	2.30
13.	Canada	1974	2.54[3]	1.01	2.00	0.32	30.27	1.51	2.84	2.07
14.	Denmark	1973	1.25	0.53	3.69	[illegible]	38.85	1.71	2.79	2.14
15.	U.S.A.[2]	1976	2.65	1.14	2.34	0.34	29.03	1.31	2.78	2.08
16.	United Kingdom	1974	0.93[3]	0.53	2.32	0.28	38.92	1.94	2.76	2.11
17.	Netherlands	1974	1.94[3]	0.97	3.66	0.44	26.74	1.34	2.75	2.04
18.	Ireland[2]	1975	1.36[3]	0.78	1.31	0.14	32.43	1.56	2.47	1.70
19.	Soviet Union[7]	1972	3.30[3]	1.22	6.05[3]	0.91	6.93[3]	0.21	2.34[7]	1.69
20.	Poland	1974	2.87	1.43	2.40	0.29	12.94	0.49	2.21	1.63
21.	Finland[2]	1976	2.81	1.07	1.60	0.24	17.58	0.82	2.14	1.61
22.	Sweden	1973	2.23	0.87	2.42	0.30	15.17	0.67	1.84	1.46
23.	Japan[2]	1974	1.33[3,4]	0.44	5.60[3,5]	0.86	11.63	0.46	1.77	1.34
24.	Norway	1974	1.47	0.63	1.11	0.15	15.24	0.69	1.47	1.11
25.	Iceland	1973	2.30	0.94	0.85	0.10	6.01	0.12	1.16	0.76
26.	Israel	1974	0.97	0.48	1.47	0.18	3.96	0.20	0.86	0.58

SOURCE: Data updated from Mark Keller and Carol Gurioli, *Statistics on Consumption of Alcohol and on Alcoholism*. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1976.

NOTE: Only per capita consumption by actual drinkers produces a satisfactory comparison among countries. For the same years as shown in the table, consumption of ethanol per drinker has been calculated for the following countries: Canada, 3.56 gallons, U.S., 3.92 gallons, Ireland, 4.35 gallons; Finland, 3.38 gallons.

[1]For comparative purposes only.
[2]A drinking age population other than 15 years and older seems more accurate in at least these countries: U.S., 14 years and older, total consumption in this group – 2.69 gallons; Ireland, 18 years and older, total consumption in this group – 2.68 gallons; and Japan, 20 years and older, total consumption in this group – 1.90 gallons.
[3]Values converted from ethanol.
[4]Includes shochu.
[5]Includes saki.
[6]Includes cider.
[7]Illegally produced samogon is estimated to increase total consumption to about 2.97 gallons per capita.

Table 3. Apparent Consumption,[1] of Alcoholic Beverages in U.S. Gallons per Capita of the Drinking-Age Population,[2] U.S.A., 1850-1976

Year	Distilled Spirits		Wine		Beer		Total
	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	
1850	4.17	1.88	0.46	0.03	2.70	0.14	2.10
1860	4.79	2.16	0.57	0.10	5.39	0.27	2.53
1870	3.40	1.53	0.53	0.10	8.73	0.44	2.07
1871-80	2.27	1.02	0.77	0.14	11.26	0.56	1.72
1881-90	2.12	0.95	0.76	0.14	17.94	0.90	1.99
1891-95	2.12	0.95	0.60	0.11	23.42	1.17	2.23
1896-1900	1.72	0.77	0.55	0.10	23.72	1.19	2.06
1901-05	2.11	0.95	0.71	0.13	26.20	1.31	2.39
1906-10	2.14	0.96	0.92	0.17	29.27	1.47	2.60
1911-15	2.09	0.94	0.79	0.14	29.53	1.48	2.56
1916-19	1.68	0.76	0.69	0.12	21.63	1.08	1.96
			— PROHIBITION —				
1934	0.64	0.29	0.36	0.07	13.58	0.61	0.97
1935	0.96	0.43	0.50	0.09	15.13	0.68	1.20
1936	1.20	0.59	0.64	0.12	17.53	0.79	1.50
1937	1.43	0.64	0.71	0.13	18.21	0.82	1.59
1938	1.32	0.59	0.70	0.13	16.58	0.75	1.47
1939	1.38	0.62	0.79	0.14	16.77	0.75	1.51
1940	1.43	0.67	0.01	0.16	16.29	0.73	1.56
1941	1.58	0.71	1.02	0.18	17.97	0.81	1.70
1942	1.89	0.85	1.11	0.20	20.00	0.90	1.95
1943	1.46	0.66	0.94	0.17	22.26	1.00	1.83
1944	1.00	0.76	0.02	0.17	25.22	1.13	2.06
1945	1.95	0.88	1.13	0.20	25.97	1.17	2.25
1946	2.20	0.99	1.34	0.24	23.75	1.07	2.30
1947	1.65	0.76	0.90	0.16	24.56	1.11	2.03
1948	1.56	0.70	1.11	0.20	23.77	1.07	1.97
1949	1.55	0.70	1.21	0.22	23.48	1.06	1.98
1950	1.72	0.77	1.27	0.23	23.21	1.04	2.04
1951	1.73	0.78	1.13	0.20	22.92	1.03	2.01
1952	1.63	0.73	1.22	0.21	23.20	1.04	1.98
1953	1.70	0.77	1.19	0.20	23.04	1.04	2.01
1954	1.66	0.74	1.21	0.21	22.41	1.01	1.96
1955	1.71	0.77	1.25	0.22	22.37	1.01	2.00
1956	1.31	0.81	1.27	0.22	22.18	1.00	2.03
1957	1.77	0.80	1.26	0.22	21.44	0.97	1.99
1958	1.77	0.80	1.27	0.22	21.35	0.96	1.98
1959	1.86	0.84	1.28	0.22	22.15	1.00	2.06
1960	1.90	0.86	1.32	0.22	21.95	0.99	2.07
1961	1.91	0.86	1.36	0.23	21.47	0.97	2.06
1962	1.99	0.90	1.32	0.22	21.98	0.99	2.11
1963	2.02	0.91	1.37	0.23	22.51	1.01	2.15
1964	2.01	0.95	1.41	0.24	23.08	1.04	2.23
1965	2.21	0.99	1.42	0.24	23.07	1.04	2.27
1966	2.26	1.02	1.40	0.24	23.52	1.06	2.32
1967	2.34	1.05	1.46	0.25	23.81	1.07	2.37
1968	2.44	1.10	1.51	0.26	24.33	1.09	2.45
1969	2.51	1.13	1.62	0.28	24.90	1.12	2.51
1970	2.56	1.15	1.84	0.29	26.95	1.17	2.61
1971	2.62	1.18	2.08	0.33	25.90	1.17	2.68
1972	2.60	1.12	2.16	0.31	26.62	1.20	2.63
1973	2.61	1.12	2.25	0.33	27.49	1.24	2.69
1974	2.57	1.10	2.13	0.31	27.76	1.25	2.66
1975	2.58	1.11	2.24	0.32	28.08	1.26	2.69
1976	2.54	1.09	2.26	0.33	28.09	1.26	2.68

SOURCE: Data updated from Mark Keller and Carol Gurioli, *Statistics on Consumption of Alcohol and on Alcoholism*, New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1976.

[1] For comparative purposes only. Amounts calculated according to tax-paid withdrawals.

[2] Data through 1973 are based on a drinking-age population 15 years and over; data since 1973 are based on a drinking-age population 14 years and over.

Figure 1. Trends in per Capita Ethanol Consumption in U.S. Gallons, Based on Beverage Sales in Each Major Beverage Class in the United States, 1946-1976

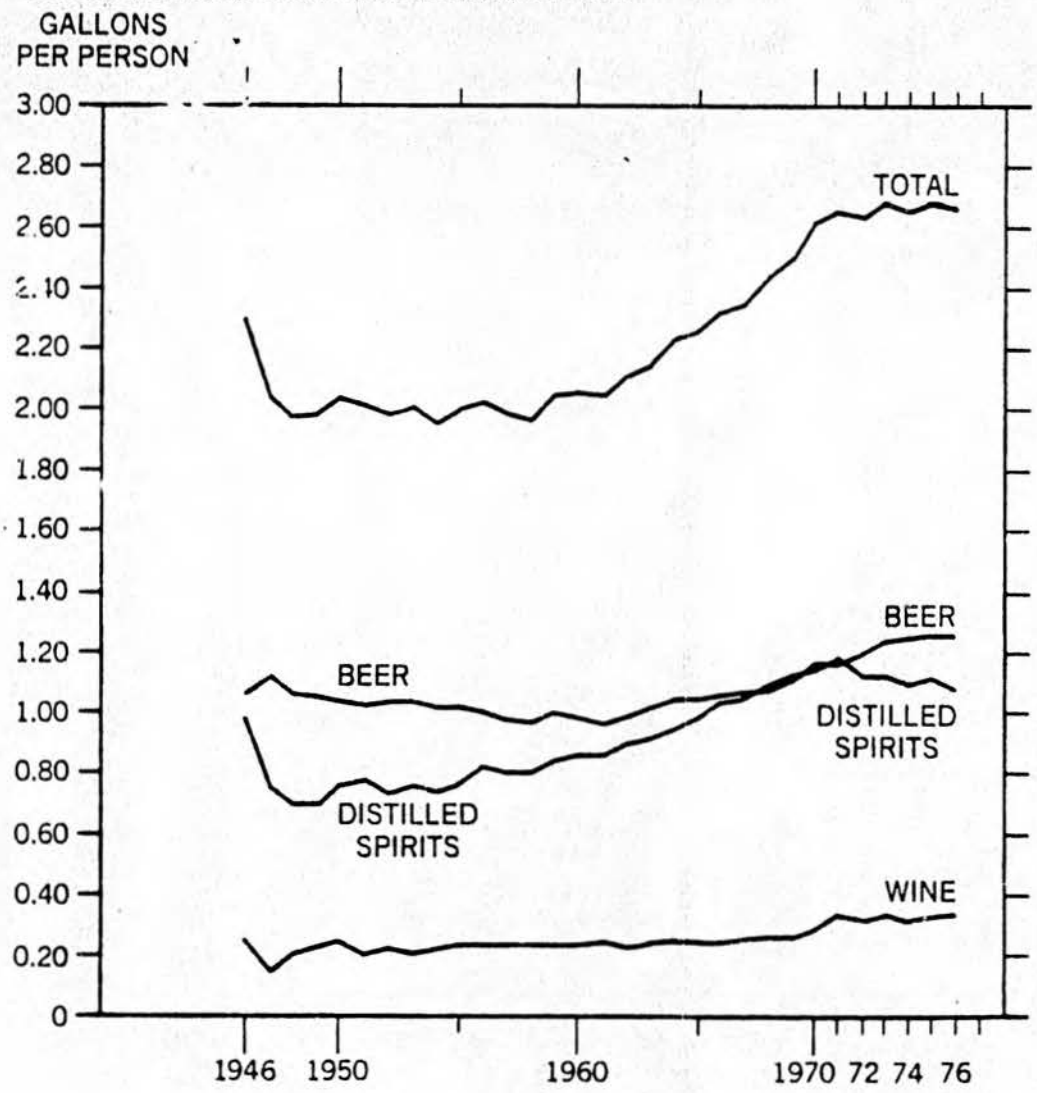


Table 4. Trends in Alcohol Consumption, 1971-1976

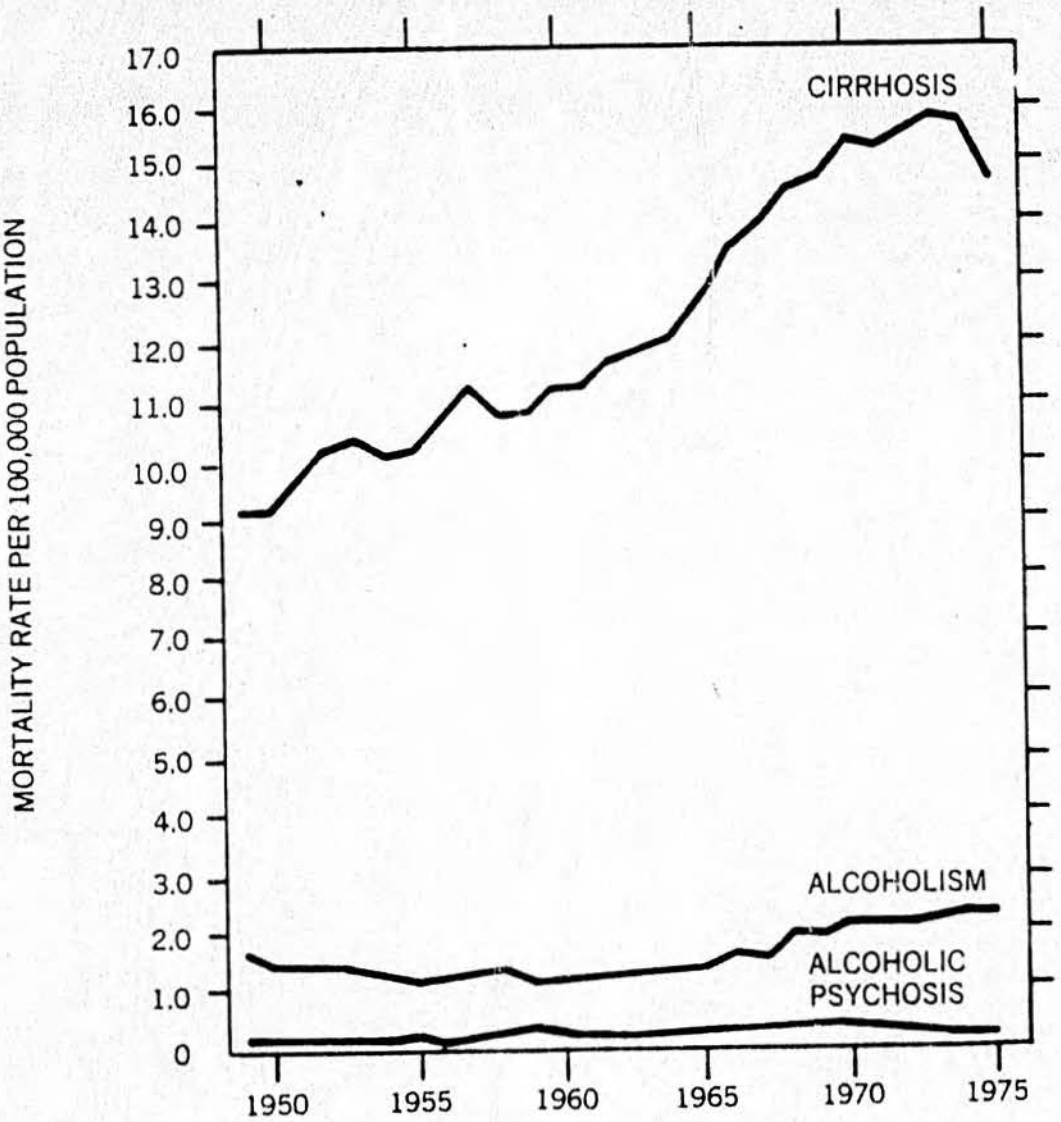
Type of Drinker	Percentage in Each Drinking Category							6 Yr. Average	Ounces of Ethanol Consumed in 1 Day[1]	Amount Consumed[2]
	1971	1972	1973, Spring	1973, Fall	1974	1975	1976			
Abstainer	36	36	34	37	33	36	33	35	0	Drinks less than once a year or never
Lighter	34	32	29	30	28	31	38	32	0.01-0.21	One drink a year up to 3 drinks/week or 12 drinks/month
Moderate	20	23	23	21	28	21	19	22	0.22-0.99	4 to 13 drinks/week or 13 to 58 drinks/month
Heavier	10	10	14	11	11	12	10	11	1.0 or more	2 or more drinks/day or 14 or more drinks/week
(N)	(2,195)	(1,544)	(1,588)	(1,603)	(1,578)	(1,071)	(2,510)	(12,090)		

SOURCE: Paula Johnson, David Armor, Susan Polich, and Harriet Stambul, U.S. adult drinking practices: Time trends, social correlates, and sex roles. Draft report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0020 July, 1977

[1] The measure is derived from the frequency of drinking each type of beverage (beer, wine, and distilled spirits) expressed in number of occasions per day, multiplied by the amount of ethanol consumed on a typical drinking day (assuming ethanol proportions of 0.04 for beer, 0.15 for wine, and 0.45 for distilled spirits).

[2] A drink is the equivalent of one 12-oz. can of beer, one 4-oz. glass of wine, or one 1-oz. shot of distilled spirits, each of which contains approximately ½ oz. of ethanol.

Figure 2. Trends in Selected Mortality Rates in the U.S., 1949-1975



SOURCE: Data from National Center for Health Statistics, *Vital Statistics of the United States, 1949-75.* Washington, D.C.: U.S. Government Printing Office, 1975.

Table 5. Estimated Deaths Related to Alcohol in the United States, 1975

Cause of Death	Number of Deaths, 1975	Percent Related to Alcohol	Estimated Number Related to Alcohol
Alcohol as a direct cause			
Alcoholism	4,897	100	4,897
Alcoholic psychosis	356	100	356
Cirrhosis	31,623	41-95	12,965-30,042
Total	36,876		18,218-35,295
Alcohol as an indirect cause			
Accidents			
Motor vehicle	45,853	30-50	13,756-22,926
Falls	14,896	44.4	6,614
Fires	6,071	25.9	1,572
Other*	33,026	11.1	3,666
Homicides	21,310	49-70	10,442-14,917
Suicides	27,063	25-37	6,766-10,013
Total	148,219	29-40	42,816-59,708
Overall Total	185,095		61,034-95,003

SOURCE: Data from Nancy Day, *Alcohol and mortality*. Paper prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. NIA-76-10(P). January, 1977; and National Center for Health Statistics, *Vital Statistics of the United States, 1972, Vol. II*: Washington, D.C.: U.S. Government Printing Office. 1975.

*Includes all accidents not listed above; but excludes accidents incurred in medical and surgical procedures.

Table 6. Rates of Problem Drinking Among U.S. Drinkers, by Drinking Population, 1973-1975

Drinking Population	Percentages for Each Survey			
	Mar. 1973	Jan. 1974	Jan. 1975	June 1975
All Drinkers				
No problems	64	70	65	63
Potential problems[1]	26	24	24	26
Problem drinkers[2]	11	6	10	10
Males				
No problems	57	66	62	57
Potential problems[1]	29	27	23	31
Problem drinkers[2]	14	8	15	13
Females				
No problems	74	77	70	73
Potential problems[1]	21	19	27	21
Problem drinkers[2]	5	4	3	6

SOURCE: Paula Johnson, David Armor, Susan Polich, and Harriet Stambul, U.S. adult drinking practices: Time trends, social correlates, and sex roles. Draft report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0020. July, 1977.

[1]A potential problem drinker experienced two or three of sixteen problem drinking symptoms frequently or four to seven symptoms sometimes.

[2]A problem drinker experienced four or more of sixteen problem drinking symptoms frequently or eight or more symptoms sometimes.

Table 7. Economic Costs of Alcohol Misuse and Alcoholism in the United States, 1975

Item	Cost (billion $)
Lost production	19.64
Health and medical	12.74
Motor vehicle accidents	5.14
Violent crime	2.86
Social responses	1.94
Fire losses	0.43
Total	$42.75

SOURCE: Ralph Berry, James Boland, Charles Smart, and James Kanak, *The Economic Costs of Alcohol Abuse and Alcoholism—1975.* Report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0016. 1977.

Table 8. Estimated U.S. National Health Expenditures for Alcohol-Related Problems in 1975, According to Type of Expenditures

Type of Expenditure	Total Adult Population Health Expenditures (billion $)	Expenditures Resulting from Alcohol Abuse (billion $)	Expenditures Resulting from Alcohol Abuse as a Percentage of Total Expenditures (%)
Health service and supplies			
Hospital care	42.3	8.40	19.9
Physician's services	17.9	1.30	7.3
Dentist's services	6.2		
Other professional services	1.7	0.12	7.3
Drugs and drug sundries	8.9	0.28	3.2
Eyeglasses and appliances	2.0		
Nursing home care	8.8	0.19	2.2
Expenses for prepayment and administration	3.9	0.78	19.9
Government public health activities	3.0	0.33	13.1
Other health services	2.5	0.39	13.1
Research and medical facilities construction	6.1	0.78	13.1
Training and education	2.3	0.17	7.3
Total	$105.6	$12.74	12.1%

SOURCE: Data from Ralph Berry, James Boland, Charles Smart, and James Kanas, *The Economic Costs of Alcohol Abuse and Alcoholism—1975* Report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0016. 1977

Fires

The net cost of alcohol-related fires in 1975 was $434.1 million. Problem drinking may contribute to the cause of a fire and may intensify the consequences. There is evidence that alcohol misuse contributes to a number of fire fatalities and burn injuries. This estimate is tentative and reflects only a best approximation based on limited data.

Social Response Systems

The cost of social response systems for alcohol abuse and alcoholism in 1975 was estimated at nearly $1.94 billion. There are two general kinds of government-financed social response programs for alcohol misuse--direct and indirect. Direct programs are established specifically to combat alcoholism and are directed toward detection, prevention, treatment, rehabilitation, research, and education. Indirect programs such as social welfare systems are directed toward alleviating various social problems that may be partly a consequence of alcohol misuse.

The total economic cost of alcohol abuse and alcoholism may well have been lower because of the social responses to it. To the extent that these programs succeed, the economic costs of alcohol-related problems will decrease.

SUMMARY

- Drinking practices are influenced by population characteristics, availability of alcoholic beverages, drinking contexts, and geographical location.

- Increased availability of alcoholic beverages has occurred as a result of the lowering of the drinking age in several States, a trend to longer hours of sale, and an increase in the number of retail outlets.

- Americans generally drink in their own and their friends' homes, although drinking in bars, taverns, and restaurants is most common among 18- to 29-year-olds.

- Since 1971, per capita alcohol consumption in the United States has been the highest since 1850, ranging from 2.63 to 2.69 gallons of absolute ethanol per person 14 years and older. During the 1970's, there has been little change in total per capita alcohol consumption.

- There are an estimated 9.3 to 10 million problem drinkers (including alcoholics) in the adult population--7 percent of the 145 million adults (18 years and older).

- Of adults who drink, 36 percent can be classified as either being problem drinkers or having potential problems with alcohol (10 percent and 26 percent, respectively). Similar to consumption patterns, combined rates of problem drinkers and those having potential alcohol problems are substantially less for women (27 percent) than for men (44 percent).

- In addition to adult problem drinkers, there are an estimated 3.3 million problem drinkers among youth in the 14 to 17 age range--19 percent of the 17 million persons in this age group. (Youth problem drinking is defined differently than for adults, because youth problems tend to be acute rather than chronic.)

- The concern over increased alcohol consumption in youth is heightened by the observation that early drinking behavior predicts drinking habits in later life. Specifically, a recent study showed that those who were problem drinkers in college were most likely to be problem drinkers and least likely to be abstainers 25 years later.

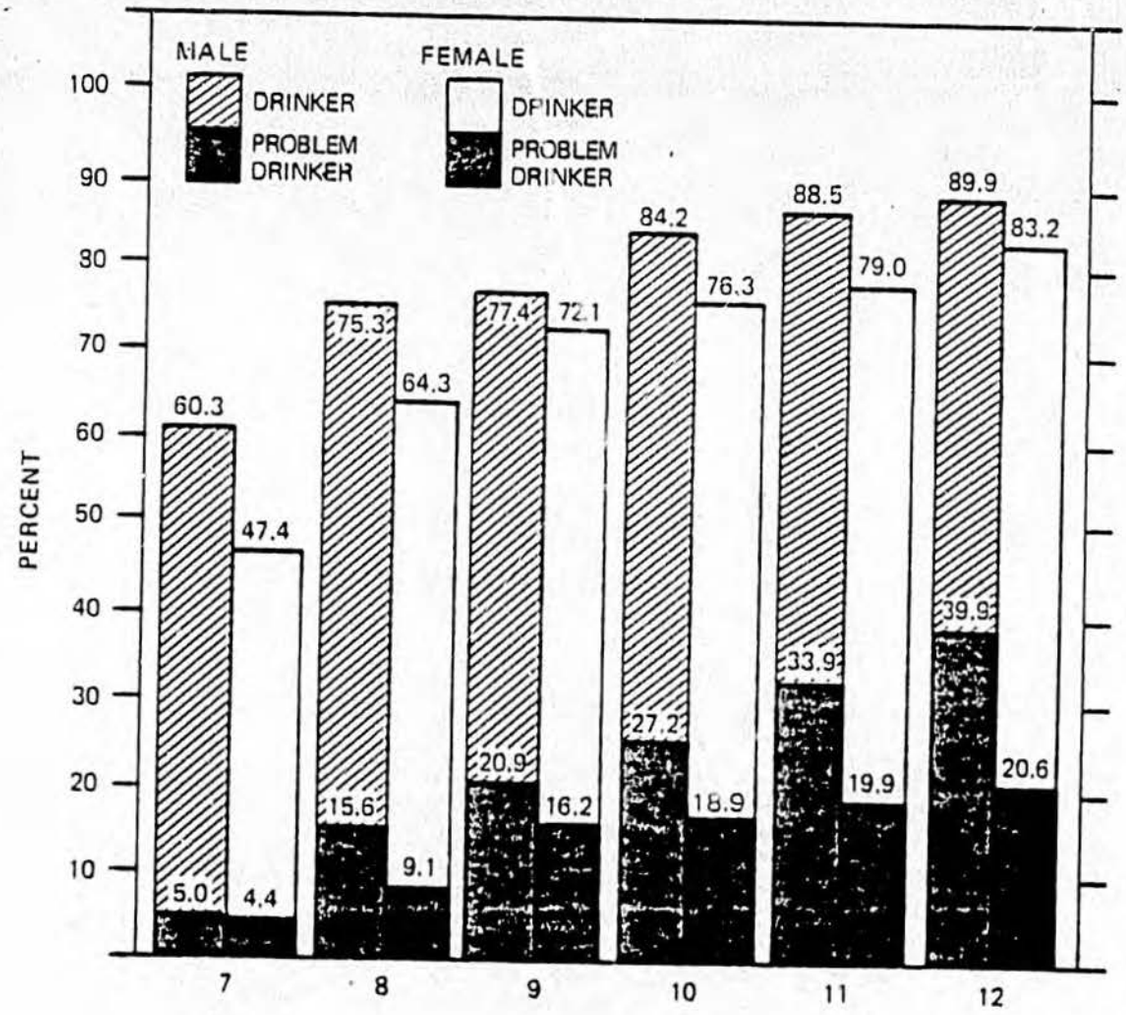
- The rate of total cirrhosis deaths increased by 36.6 percent from 1960 to 1970, followed by a gradual leveling during the early 1970's and a decrease of 6.3 percent from 1974 to 1975. Even though this decrease is encouraging, liver cirrhosis still ranked as the sixth most common cause of death in the United States in 1975, with up to 95 percent of those cases estimated to be alcohol related.

- It is estimated that alcohol-related deaths may run as high as 205,000 per year (11 percent of the 1.9 million deaths in 1975). In fact, clinical studies consistently show that various types of alcohol problems in males are associated with mortality rates two to six times higher than rates in the general population.

- Studies of international alcoholic statistics demonstrate a high correlation between the per capita level of consumption and the rate of cirrhosis deaths. Preliminary results from a recent study also show that alcohol taxes and prices are related negatively to alcohol consumption.

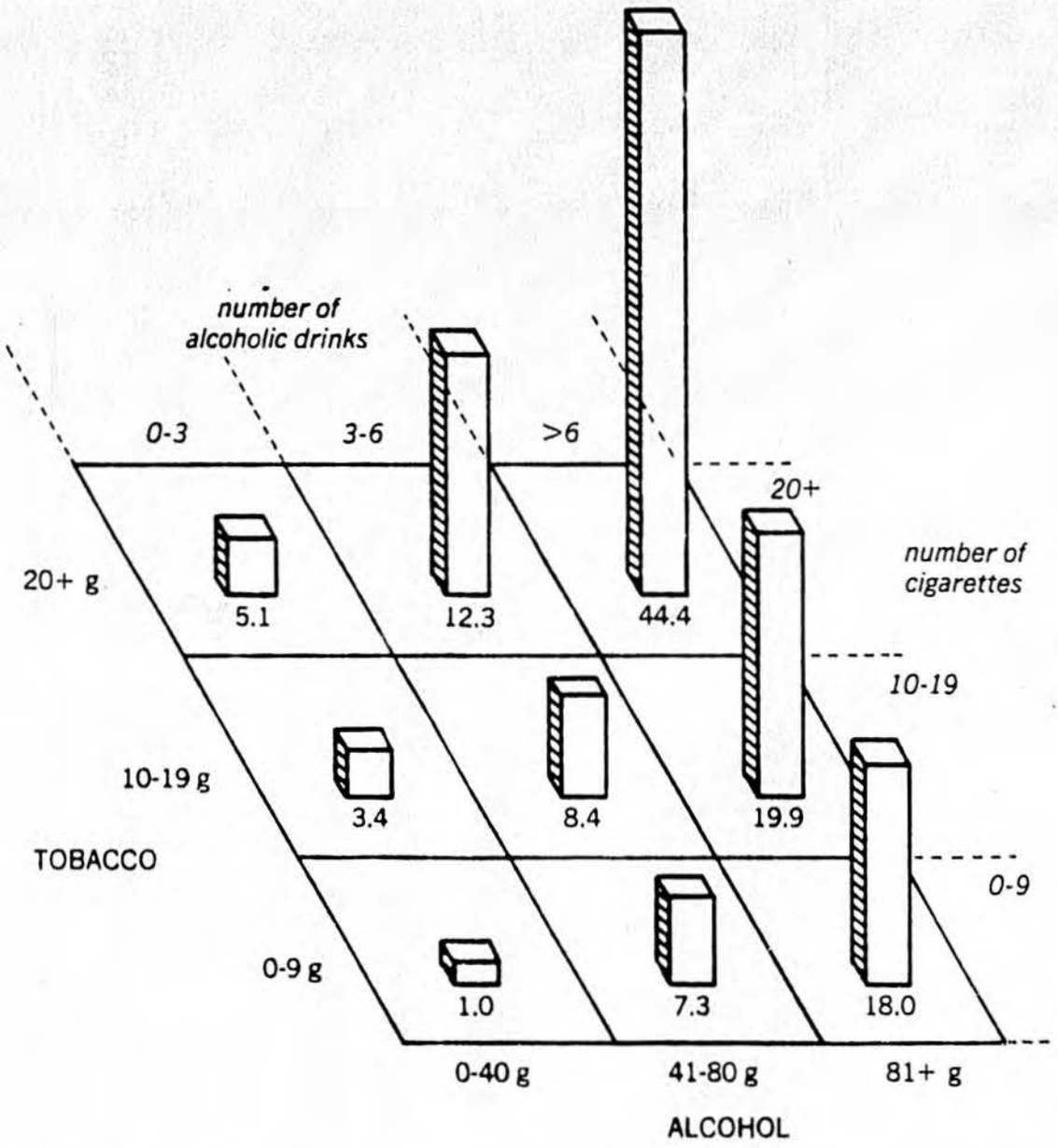
- Alcohol abuse and alcoholism cost the United States nearly $43 billion in 1975--including $19.64 billion in lost production, $12.74 billion in health and medical costs, $5.14 billion in motor vehicle accidents, $2.86 billion in violent crimes, $1.94 billion in social responses, and $0.43 billion in fire losses.

Figure 1. Drinking and Problem Drinking by Sex and Grade in School



SOURCE: Data from John E. Donovan and Richard Jessor, Adolescent problem drinking: Psychosocial correlates in a national sample study. *Quarterly Journal of Studies on Alcohol*. In press.

Figure 2. Relative Risks of Esophageal Cancer in Relation to the Daily Consumption of Alcohol and Tobacco



SOURCE: Data from A. J. Tuyns, G. Pequignot, and O. M. Jenson, Le cancer de l'oesophage en Ille et Vilaine en fonction des niveaux de consommation d'alcool et de tabac: Des risques qui se multiplient. *Bulletin du Cancer*, 65(1):45-60. 1977.

Note: The risk is 44.4 times greater for individuals consuming 20 g or more of tobacco and 80 g or more of alcohol per day (upper right block) than for individuals consuming little or none of either drug (lower left block). One ounce of ethyl alcohol is approximately 23.4 grams, thus 40 grams is 1.7 oz. or approximately equivalent to 3 drinks.

CHAPTER IV. THE FETAL ALCOHOL SYNDROME AND OTHER EFFECTS ON OFFSPRING

In February 1977 NIAAA sponsored a workshop to assess the state of knowledge gained from research on the intrauterine effects of alcohol. Reports were presented from human epidemiologic investigations, animal studies, behavioral assessments in animals and infants, and mechanistic studies exploring the biochemical consequences of maternal alcohol ingestion on metabolic function of fetal tissue. The evidence gathered from these studies clearly indicates that alcohol is a substance that can cause birth defects and behavioral impairment in offspring of mothers who consume it while pregnant. In particular, a unique pattern of dysmorphology with mental impairment occurs in some offspring of women who consume alcohol heavily; this condition has been termed the fetal alcohol syndrome (FAS) (see table 1).

When moderate levels of alcohol are involved, it is not easy to implicate alcohol as a unique factor in the development of birth defects and mental impairment. Furthermore, with human subjects, it is difficult to separate alcohol's effects from those of substances such as caffeine and nicotine. As a result, animal studies have become increasingly important as a means of studying the dangers of alcohol use during pregnancy and evaluating threshold limits.

Based upon the evidence presented and discussed at the workshop, the participants recommended that NIAAA issue a cautionary statement on alcohol use during pregnancy. On June 1, 1977, the following statement was released:

> Recent research reports indicate that heavy use of alcohol by women during pregnancy may result in a pattern of abnormalities in the offspring, termed the Fetal Alcohol Syndrome, which consists of specific congenital and behavioral abnormalities. Studies undertaken in animals corroborate the initial observations in humans and indicate as well an increased incidence of stillbirths, resorptions, and spontaneous abortions. Both the risk and the extent of abnormalities appear to be dose-related, increasing with higher alcohol intake during the pregnancy period. In human studies, alcohol is an unequivocal factor when the full pattern of the Fetal Alcohol Syndrome is present. In cases where all of the characteristics are not present, the correlation between alcohol and the adverse effects is complicated by such factors as nutrition, smoking, caffeine, and other drug consumption.
>
> Given the total evidence available at this time, pregnant women should be particularly conscious of the extent of their drinking. While safe levels of drinking are unknown, it appears that a risk is established with ingestion above 3 ounces of absolute alcohol or six drinks per day. Between 1 ounce and 3 ounces, there is still uncertainty but caution is advised. Therefore, pregnant women and those likely to become pregnant should discuss their drinking habits and the potential dangers with their physicians.

A version of this statement appeared in the June 3, 1977 (vol. 26, no. 22) Morbidity and Mortality Weekly Report, circulated by the Center for Disease

Table 1. Most Consistent Features of the Fetal Alcohol Syndrome

Growth and Performance

- Prenatal onset growth deficiency, more pronounced in length than in weight
- Concomitant microcephaly (small head circumference) even when corrected for small body weight and length
- Postnatal growth deficiency in weight and length, usually below 3rd percentile
- Delay of intellectual development and/or mental deficiency (mean IQ from Seattle study = 64, range 16-92)
- Fine motor dysfunction (poor coordination)

Head and Face

- Microcephaly
- Short palpebral fissures (narrow eye slits)
- Midfacial (maxillary) hypoplasia (underdevelopment of midfacial region)
- Flattened, elongated philtrum (middle of upper lip) associated with thin, narrow vermilion lip borders (highly specific to FAS)
- Minor ear anomalies including low set ears

Limbs

- Abnormal creases in the palm of the hand
- Minor joint anomalies
  - —syndactyly (fingers or toes joined together)
  - —clinodactyly (abnormal bending of fingers or toes)
  - —camptodactyly (one or more fingers constantly flexed at one or more phalangeal joints)

Heart

- Ventricular and atrial septal defect (valve defects)

Brain

- Absence of corpus callosum
- Hydrocephalus (excess fluid in cranium)
- Brain cell migratory abnormalities

Other

- Minor genital anomalies
- Hemangiomas (benign tumors made up of blood vessels) in infancy

SOURCE: Data from Kenneth L. Jones and David W. Smith, The fetal alcohol syndrome. *Teratology*, 12(1):1-10, 1975.

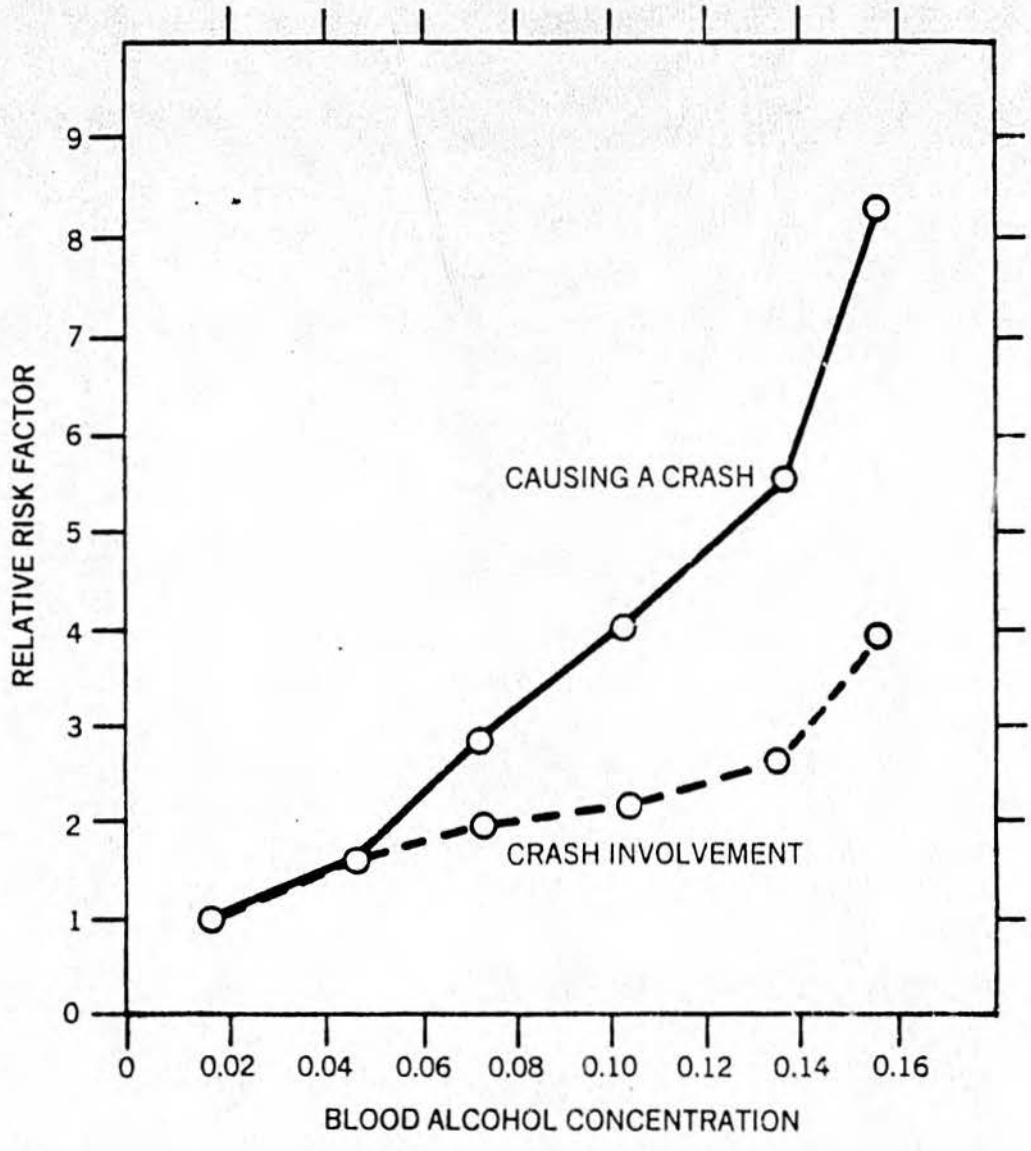
Table 1. Use of Other Drugs Among Current Drinkers and Those Who Are Not Current Drinkers*

Use of Other Drugs	Percentage of Youth: Ages 12 to 17 Years		Percentage of Adults: Ages 18+ Years	
	Current Drinkers	Not Current Drinkers	Current Drinkers	Not Current Drinkers
Size of sample (unweighted base)	302	684	1622	968
Nonmedical psychotherapeutic pill user				
Yes	18.8	6.5	18.9	9.4
No	81.2	93.5	81.1	90.6
Ever used marihuana				
Yes	44.3	11.8	31.4	6.9
No	55.7	88.2	68.6	93.1
Ever used other illicit drugs				
Yes	36.7	10.2	19.7	4.7
No	63.3	89.8	80.2	94.6

SOURCE: H. I. Abelson and P. M. Fishburne, *Nonmedical Use of Psychoactive Substances*. Princeton, NJ: Response Analysis Co., 1976.

*Those who report drinking alcoholic beverages within the past month.

Figure 1. Relative Probability* that a Driver Causes and Is Involved in a Crash as a Function of BAC Level



SOURCE: Marc Aarens, Tracy Cameron, Judy Roizen, Ron Roizen, Robin Room, Dan Schneberk, and Deborah Wingard, *Alcohol Casualties and Crime*. Special report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0027. Berkeley, CA: Social Research Group, University of California, 1977.

*Relative to the probability that a driver with a BAC of less than 0.03% is in or causes a crash.

Table 1. Changes in Alcohol Consumption in Four NIAAA-Funded Programs During 1976*

Program	Drinking behavior during past 30 days:						Number of Cases
	Percent Abstaining		Average Ethanol Consumed per Day (oz)		Average Number of Drinking Days		
	At Outset	6 Months Later	At Outset	6 Months Later	At Outset	6 Months Later	
Comprehensive alcoholism treatment program (ATC)	12	53	5.8	1.6	15	6	4280
Drinking driver program	8	44	2.5	0.8	12	5	1551
Occupational program	11	64	2.8	0.6	16	4	254
Public inebriate program	9	58	10.8	3.4	18	6	384
Average across programs	10	55	4.4	1.6	15	5	

SOURCE: Harriet Stambul, *Treatment outcomes*. Paper prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. NIA-77-10(P). April, 1977.

*All changes are statistically significant at or better than $p < 0.05$.

Table 2. Changes in Alcohol Consumption for Participants in NIAAA ATC Programs at 18-Month Followup

Group	Abstained Last Month (%)		Abstained Last 6 Months (%)	Ethanol Consumed per Day (oz)		Number of Cases
	At Outset	18 Months	18 Months	At Outset	18 Months	
Male non-DWI[1]	8	46[2]	24	8.3	2.5[2]	600
Female non-DWI[1]	13	56[2]	39	4.5	1.3[2]	158
Male DWI[1]	22	29	18	1.7	0.9	162

SOURCE: Harriet Stambul, *Treatment outcomes*. Paper prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. NIA-77-10(P), April 1977

[1] DWI denotes enrollment in connection with a driving-while-intoxicated incident.
[2] Changes are statistically at or better than $p < 0.05$.

the other facilities offered outpatient care as well as other services ranging from consultation to education. An assessment of nongovernment agencies indicated that Alcoholics Anonymous was most often cited as a treatment resource, followed by voluntary and private hospitals and clinics, councils on alcoholism, and private alcoholism residential programs. Although councils on alcoholism ranked third, they offered the broadest range of services--education, consultation, management and support, outreach, aftercare, and outpatient care.

Data compiled by NIAAA indicated that there were at least 1.1 million admissions for alcoholism treatment in 1976. The number of admissions by treatment sources is shown below.

NIAAA Funded Projects	337,000
Private Physicians	305,000
Mental Health Facilities	260,000
Veterans' Administration Hospitals	97,000
Department of Defense Facilities	40,000
Halfway Houses	36,000
Department of Transportation (Driving-While-Intoxicated) Programs	28,000
	1.1 million

In addition, it was estimated that in 1976 there were 320,000 admissions to Alcoholics Anonymous programs and 481,000 to short-stay hospitals.

The growth of treatment resources over the past decade is illustrated dramatically in the increase in occupational or industrial rehabilitation programs (see Chapter X, Occupational Alcoholism Programing), halfway houses, and programs funded by NIAAA. National surveys have shown that the number of halfway houses has grown from 40 in 1963 to more than 750 in 1976. In addition to providing transitional support to the alcoholic moving from inpatient care back to the community, halfway houses provide more cost-effective care than institutions. Since 1971 NIAAA has provided direct funding assistance to more than 850 treatment programs that have served more than 1 million clients. By 1976, 330,000 clients had been served in 554 treatment programs, representing a wide variety of treatment settings and modalities.

Although substantial numbers of treatment resources exist, several problems must be resolved. Most people with alcohol-related problems do not receive treatment for them. Various aspects of the barriers to treatment are discussed in this chapter, as well as in chapter II; issues surrounding the financing of treatment are presented in chapter XI. Greater understanding is needed of the mixture of services necessary to provide the most effective and efficient treatment to the largest number of people.

BARRIERS TO TREATMENT

There may be several major reasons why only a small proportion--approximately 10 percent--of the Nation's 10 million problem drinkers (including alcoholics) receive treatment each year. A number of psychological, sociological, and economic factors interfere with the utilization of treatment

CHAPTER XI. FINANCING ALCOHOLISM TREATMENT SERVICES

The magnitude of the alcohol problem in this country and the economic costs to society of alcohol-related problems have been discussed in chapter I of this report. It has been noted that health care costs directly attributable to alcohol-related problems are an estimated 12.1 percent of U.S. national health expenditures. There is a significant opportunity for reducing health care expenditures if effective alcoholism treatment services are supported. Recognition of this opportunity has led to funding by Federal, State, and local governments, as well as to modifying health insurance policies to cover alcoholism services. This chapter discusses these and other funding sources that currently are being used to finance alcoholism treatment services.

GOVERNMENTAL SUPPORT

Since its inception in 1970, the National Institute on Alcohol Abuse and Alcoholism has been helping to establish alcoholism programs by funding service projects directly and by making Federal formula grants available to States. An added source of Federal moneys became available from NIAAA in 1974 when incentive grants to the States were authorized to encourage the adoption of the Uniform Alcoholism Treatment and Intoxication Act. In addition, Federal support from other agencies (table 1) totaled approximately $207 million in 1976.

The financial base at the local level has expanded as States and other local governments either matched Federal funds or appropriated other sources of support. Federal, State, and local administrators consequently have sought to determine what resources are available for alcoholism programs and to identify what services these moneys are buying. This information is compiled in NIAAA's State Alcoholism Profile Information System (SAPIS), developed to discover the impact of formula grants within the States. According to a 1977 SAPIS report of 43 States providing information, average financial sources were formula grants, 13 percent; other NIAAA funds, 17 percent; local sources, 17 percent; and State and other Federal funds, 53 percent. An average of $7,322,000 per State was available to the States in FY 1976.

Information about resources undoubtedly will be improved by the SAPIS program, the impact of 1976 legislation requiring an accounting of States' public and private alcoholism service facilities in formula grant applications, and a recent NIAAA initiative to compile an annual report on all Federal activities related to alcohol problems.

Whatever the precise level of public funding of treatment services may be, nonpublic support clearly is required if adequate treatment resources are to be made available. Therefore, the extent of health insurance coverage for alcoholism treatment is of great concern. To illustrate the situation, table 2 shows the amount of insurance coverage of clients of selected NIAAA programs in 1976. The proportion of individuals with health insurance at all and with alcoholism coverage in particular varies

Table 1. Federal Agency Alcoholism Obligations for Treatment Services

Treatment and Rehabilitation	1976 Actual (Thousands of Dollars)
DHEW:	
ADAMHA (NIAAA)	$ 93,616
Human Development	32,414
Subtotal	$126,030
HUD	$ 2,693
Department of Defense	14,109
Veterans Administration	62,286
Department of Transportation	253
Department of Justice	291
Other	925
Total Treatment and Rehabilitation	$206,587

Table 2. Health Insurance Reports by Clients of Selected NIAAA Programs (1976)

	Alcoholism Treatment Programs (%)	Public Inebriate Programs (%)	Occupational Programs (%)	Problem Drinking Driver Programs (%)	Cross Population Programs (%)
Clients with Health Insurance	48.0	21.0	85.0	56.0	48.0
Health Insurance Covers Alcoholism	18.0	10.0	45.0	10.0	18.0
Medicare	2.3	1.6	0.2	0.5	1.6
Medicaid	3.9	4.5	1.5	0.7	5.3
Blue Cross/Blue Shield	4.8	1.8	22.8	3.7	5.6
Private Insurance	3.7	1.3	11.6	2.2	3.1
Other	3.6	1.2	9.2	2.8	3.0
No. of Projects Reporting	39	20	14	19	47

SOURCE: Data from D. C. Jones, D. T. Kay, and B. B. Silber, *Implementation of the State Alcoholism Profile Information System (SAPIS)*. Final report prepared for National Institute for Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0003. 1977.

widely with the type of program. Health insurance coverage varies from 21 to 85 percent and alcoholism coverage from 10 to 45 percent. The proportion of individuals with health insurance who also have alcoholism coverage ranges from 18 percent to 53 percent.

HEALTH INSURANCE

Health insurance has been made available specifically for alcoholism only within the last decade. In the past, alcoholism was a hidden illness, and treatment usually took place in a State-supported institution because care in the private sector was either unavailable or prohibitively expensive. Little is known about the nature or extent of insurance coverage for alcoholism before the mid-1960's. However, it is safe to assume that many alcoholics received treatment under the mental health benefits of their insurance policies.

By the late 1960's it became clear that insurance carriers and providers were applying obvious sanctions to the treatment of alcoholics. Hospitals frequently blocked the admission of alcoholics, and health insurance policies limited coverage in many ways. With the dramatic surge of health care costs in this era and the increased recognition of the extent of alcoholism and alcohol abuse, the need to establish effective private third-party payment mechanisms was clear. NIAAA worked with representatives of health agencies and insurance carriers to study the status of alcoholism insurance coverage, to identify barriers to improved coverage, and to develop model benefit provisions.

PRIVATE SECTOR PLANS

The private sector has three major components: Blue Cross-Blue Shield plans, commercial insurance companies, and independent plans. Blue Cross-Blue Shield is a confederation of two private nonprofit corporations. Commercial companies include life and casualty insurance companies as well as other companies that provide health coverage. Finally, independent plans include employer- or employee-sponsored programs, health maintenance organizations, private group clinics, and dental service corporations.

Blue Cross-Blue Shield

An estimated 84 million subscribers are covered by the approximately 70 Blue Cross and Blue Shield associations operating in the United States and Puerto Rico. In 1976, the Blue Cross Association (BCA) and NIAAA initiated a nationwide study to determine the feasibility of offering comprehensive benefits for alcoholism treatment throughout the Blue Cross health insurance system. The study has produced a series of technical assistance documents designed to address the essential components needed in comprehensive alcoholism coverage. They were (1) a marketing package, including the benefit structure, a defined target population, rates, and a subscriber education program; (2) an administrative segment covering contracts with health care providers, legal constraints, and control of benefit utilization; (3) a guideline for test-site selection; and (4) a program for evaluating test-site results.

Some individual Blue Cross plans are offering increasingly comprehensive alcoholism benefits. In 1974, for instance, Capital Blue Cross in Pennsylvania introduced an alcoholism benefit that provided rehabilitation treatment immediately following detoxification in institutions specializing in alcoholism treatment. Premiums were not increased for this benefit because the plan's administrators realized that alcoholism treatment previously had been paid for under other diagnoses. Current data indicate that the benefit will reduce the number of claims and the total costs incurred by the carrier.

Blue Cross of Maryland provides alcoholism treatment benefits through one program in residential nonhospital settings and through another in outpatient care. Substance-abuse benefits--including alcohol and other drugs--were made available to the approximately 1 million members of the United Auto Workers Union, their spouses, and dependent children by Blue Cross and Blue Shield of Michigan.

Commercial Carriers

The trend among major commercial carriers is toward offering coverage for alcoholism treatment. The percentage of policies specifying exclusions or limitations on alcoholism coverage dropped from 16.5 percent in 1972 to 13 percent in 1975, according to one survey.

Independent Plans

Health Maintenance Organizations (HMO's). HMO's provide basic and supplemental health care on a prepaid basis to their membership. To qualify for Federal subsidies, an HMO must offer medical treatment and referral services for alcohol or other drug abuse. The Group Health Association of America, a national voluntary organization of group health plans, initiated an alcoholism treatment feasibility project to test the potential of comprehensive alcoholism treatment services in prepaid group practice plans. Although the data are too limited to be conclusive, indications are that there is a reduction in total health care use when alcoholism is identified and treated appropriately.

The Harvard Community Health Plan. This plan in Cambridge, Mass., which includes both inpatient and outpatient alcoholism benefits, reported a monthly cost for alcoholism treatment of only $0.05 per member. During the first year, no client used the inpatient treatment beyond the benefits provided.

Employee Benefit Plans. The industries sponsoring occupational alcoholism programs usually have policies that cover inpatient services, according to one survey. Considerably less coverage was provided for outpatient treatment.

Unions and Health Insurance Plans. The Nation's labor unions have participated actively in encouraging health insurance coverage for treating alcoholism and other drug abuse. Unions affiliated with the AFL-CIO and major independent unions such as the United Auto Workers, the United Mine Workers, and the Teamsters are implementing and expanding alcoholism treatment benefits.

PUBLIC SECTOR PROGRAMS

Several health insurance assistance programs are provided by law under Federal or State auspices and are financed through taxes. Benefits, fixed by law, are available to those who qualify under the plan. These publicly supported programs include medicare, medicaid, CHAMPUS (Civilian Health and Medical Care Program for the Uniformed Services), the Veterans' Administration program, and State temporary workers' compensation systems.

Medicare

Primarily, medicare pays medical expenses to individuals aged 65 or older who are entitled to retirement benefits under title II of the Social Security Act or under the Railroad Retirement System. Administered by the Social Security Administration, medicare's benefits and eligibility requirements are uniform for all participants and include hospital insurance and supplementary medical insurance for the aged and disabled. Medicare categorizes alcoholism and drug abuse treatment under psychiatric or mental health services, and the coverage is less than that available for physical illness.

Medicaid

Medicaid provides medical assistance to low-income individuals. Treatment cost is shared by the States and the Federal Government. A major limitation is that persons aged 21 to 64 cannot receive care in a psychiatric hospital under medicaid. In several States, however, medicaid plans provide reimbursement for treatment of problems associated with drug or alcohol abuse. Because services for alcohol or drug abuse problems are not mentioned in the medicaid statutes, the States determine whether treatment should be excluded or included.

A 1976 telephone survey revealed a wide range of practices. Most States reimburse for inpatient treatment of organic illnesses caused by or related to alcoholism, and 85 percent of the States reimburse for outpatient care for these illnesses. The proportion of States that reimburse for direct treatment of alcoholism is substantially lower. Approximately two-thirds reimburse for treatment at a community health center; nearly one-third pay for care at an alcoholism treatment center or from an alcoholism counselor; and about one-tenth absorb treatment costs at a halfway house or similar facility.

Title XVI

Under title XVI of the 1973 Social Security Act, supplemental security income (SSI) is granted by the Federal Government to those eligible for Aid to Families with Dependent Children, to the blind, to persons who are otherwise disabled, and to needy persons over the age of 65. The present social security law requires an alcoholic SSI recipient to designate a third party to receive his or her supplementary income. Often, this procedure undermines the self-confidence of recovering alcoholics. Pending legislation would enable the attending physician of the facility where an individual is undergoing treatment to certify that direct payment of SSI benefits

to the patient would be beneficial. The costs of alcoholism treatment generally are not covered by the SSI program.

Title XX

Title XX, a 1975 amendment to the Social Security Act, currently contributes $2.7 billion annually to the States for social services. The required State comprehensive plans may include alcoholism treatment services if they are defined explicitly. A 1976 analysis of services available for treatment of alcoholism and drug abuse under State title XX plans revealed that 10 States provide services specifically concerned with treatment of alcohol abuse; 11 pay for services related to both alcohol and drug abuse, and 16 reimburse for specific mental health services.

CHAMPUS and CHAMP-VA

This insurance program for dependents of military personnel covers inpatient and outpatient care for alcoholism. However, inpatient rehabilitative care beyond detoxification is limited to a lifetime maximum of three admissions, and outpatient treatment is limited to psychiatric services. A similar program, CHAMP-VA, is available to the dependents and survivors of some disabled veterans.

Disability Insurance

Public disability programs involving workers' compensation are available in all 50 States. Compensation is limited by 27 States if alcoholism or problem drinking is the cause of injury resulting in a claim.

OTHER FEDERAL INVOLVEMENT

National Health Insurance

In view of the tremendous health, social, and economic costs related to alcoholism, benefits for alcoholism and related health problems should be considered in the development of health insurance coverage. These should include a range of service components to assure a minimum level of continuity of care for alcoholism treatment.

A recent cost-benefit study of alcoholism treatment centers reinforces the argument for including coverage for alcoholism care in any health insurance package. The study found that the national economy will realize 10 years of benefits, estimated at close to $22 million, from the operation of 41 alcoholism treatment centers during the last half of 1974. However, half of the 20 legislative proposals for national health insurance introduced in the 94th Congress did not mention alcoholism specifically.

Civil Service Plans

The Federal Government offers 55 health insurance plans to its employees. Most of these include some benefits for alcoholism, although the extent

of the coverage varies widely. Some plans have a specific alcoholism benefit, but most alcoholism treatment is part of the mental health benefits or some other benefit category.

NIAAA Activities

NIAAA has sponsored a range of studies to plan increased health insurance coverage for alcoholism treatment and has developed experimental projects to demonstrate the feasibility of this type of insurance. The agency helped to develop standards for treatment facilities that, when implemented, lead to accreditation. When a facility is accredited by the Joint Commission on Accreditation of Hospitals (JCAH), more carriers are willing to insure the care provided there. More than 200 alcoholism programs nationwide have been accredited by JCAH.

One of the agency's feasibility studies resulted in a model alcoholism treatment package designed to provide insurance companies with a basis for projecting a range of costs in various alcoholism treatment settings. The model benefit package recommends 6 days of inpatient emergency care, 14 days of inpatient care, 30 days of outpatient care, 30 days of short-term intermediate care, and 60 to 90 days of long-term intermediate care. This package was tested for 2 years in the California State Employees' Insurance Alcoholism Program.

NIAAA is concerned with State and local service programs in several administrative areas, including training, cost accounting systems, and policy procedures, and is working with others in the field to develop certification standards for alcoholism counselors.

STATE INVOLVEMENT

State Regulatory Agencies

Since State insurance departments are empowered by statute to regulate the extent and cost of insurance contracts and the conduct of insurance carriers, State legislative actions have become important in setting minimum standards for alcoholism treatment. A mid-1976 survey of State legislative activities showed that insurance coverage for alcoholism treatment had increased considerably since 1974. Unfortunately, the enacted legislation often emphasizes inpatient care and limits outpatient treatment, although recently some States have mandated more extensive outpatient benefits. By mid-1977, 20 States had enacted legislation into law, and 11 other States had introduced legislation related to health insurance coverage for alcoholism (figure 1).

California State Employees' Insurance Alcoholism Program

This 2-year pilot alcoholism program was based on the model benefit package described briefly above and more extensively in the Second Special Report on Alcohol and Health. It offered benefits for 158,000 State employees and more than 300,000 family members, through nine insurance carriers. The program involved no risk for the various moneys paid for both alcoholism treatment claims and carrier administrative expenses.

Figure 1. State Legislative Activities Relating to Health Insurance Coverage for Alcoholism, 1971-77



SOURCE: Data from Jerome Hallan and Becky Hayward, Health insurance coverage for alcoholism: Current status. Unpublished report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0023. Raleigh: H-2, Inc. 1977.

The alcoholism benefit package provided

- inpatient care in a hospital or other licensed facility, including up to 6 days of detoxification services and 21 days of treatment a year;
- day or night residential care in a licensed recovery home for a maximum of 30 days annually; and
- outpatient care limited to 45 visits a year to a physician or to a licensed or certified professional or paraprofessional mental health worker.

For each of the 766 persons participating in the program, the average expenditure was approximately $600. Some 422 inpatient admissions were recorded at an average cost of $1,392. An estimated 540 persons each attended an average of nine outpatient sessions at an average cost of $17 a session. Outpatient care benefits represented approximately 16 percent of the total benefits paid. Recovery-home care was the least used service.

For one evaluation, data were collected on nonalcoholism health care for 2 years before treatment began and continued during treatment. Preliminary findings indicate that average monthly nonalcoholism treatment costs were reduced by approximately 25 percent after a person began treatment for alcoholism.

If the State of California had not paid for all costs of the pilot program, the additional average premium for each family enrolled in the State and public employees' program would have been only $2.05 a year, or $0.17 per month, to cover the cost of alcoholism treatment. However, these estimates are based on a relatively low utilization rate for the available services.

SUMMARY

- Federal, State, and local government funds constitute a significant proportion of the resources for alcoholism treatment. If adequate treatment coverage is to be provided to alcoholics, a major increase in the share of this support must be provided by health insurance.
- Lack of third-party reimbursement has limited the number of service providers. Until recently, insurance carriers were reluctant to cover treatment of alcoholism, but the trend is changing. For example, in 1972 approximately 25 percent of all Blue Cross plans specifically excluded alcoholism. By 1976, only 4 of 60 plans responding to a survey excluded alcoholism treatment.
- Although some private insurance carriers still exclude or limit alcoholism treatment, increasing numbers are providing coverage.
- Increasingly comprehensive alcoholism benefits are being offered by individual Blue Cross plans. Some offer alcoholism treatment in special inpatient centers and others provide innovative outpatient

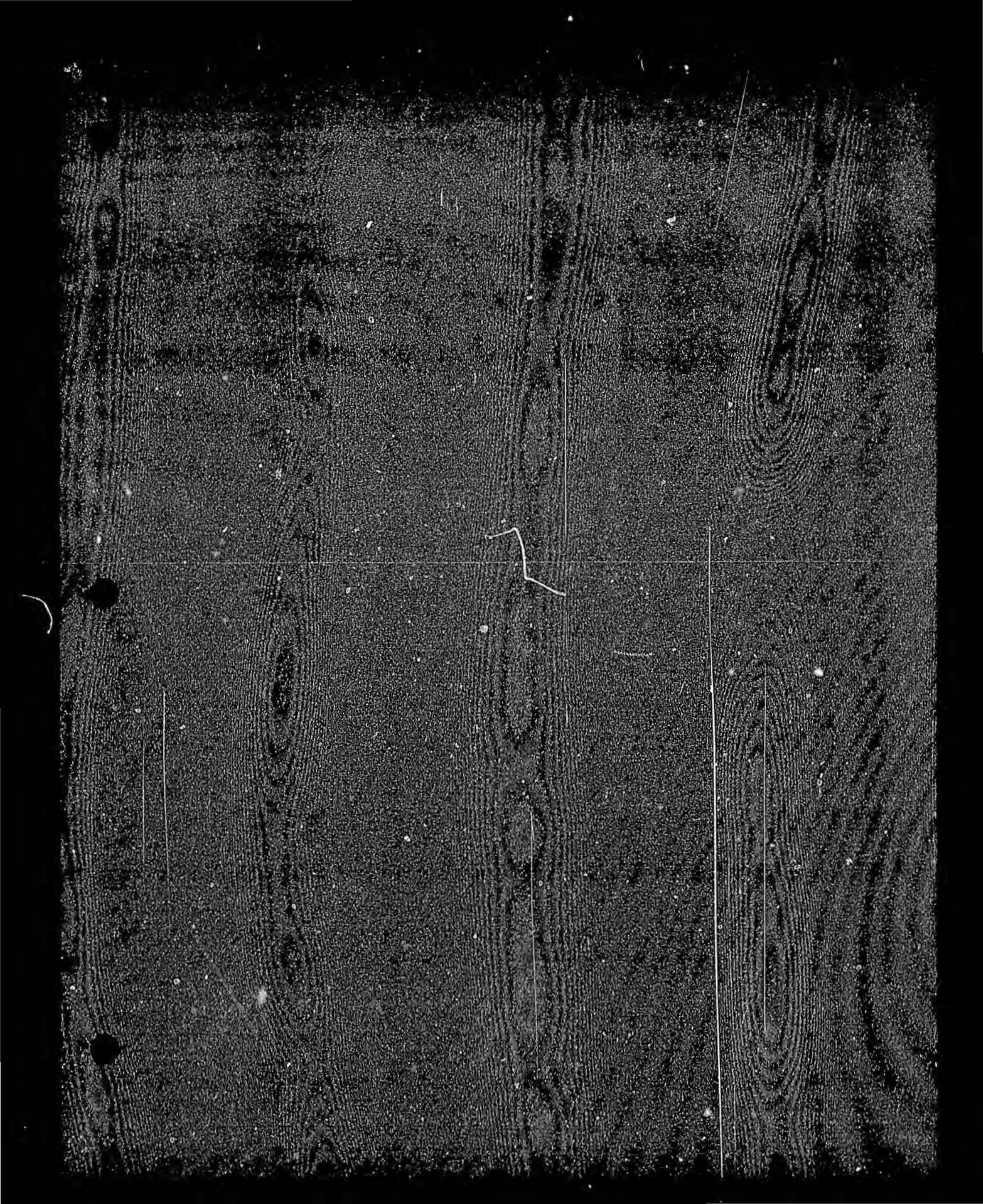
care. The United Auto Workers union Blue Cross coverage includes both residential and outpatient treatment.

- Many employee health insurance plans specifically include inpatient alcoholism treatment; far fewer cover outpatient treatment.

- State legislatures are concerned about the availability of insurance for alcoholism treatment. Twenty States have enacted legislation either mandating that alcoholism coverage be provided or requiring that it be available as an option.

- Preliminary findings from a California experimental project indicate that the average monthly nonalcoholism health care costs for both the alcoholic and the immediate family were reduced by 25 percent after the individual began treatment for alcoholism.

- Varied benefits are offered in the public sector. Current medicare provisions for alcoholism treatment to the aged and disabled are restrictive compared to benefits available for physical disease. Medicaid programs often ignore treatment for alcoholism. The Supplemental Security Income Program (title XVI of the Social Security Act) employs sanctions against the alcoholic who fails to stay in treatment. Alcoholism treatment is specifically provided for under the Social Services for Individuals and Families Program (title XX of the Social Security Act) in 10 States, and specific alcoholism services are reimbursed by 11 States.





Alcoholic Person's Right to Disability Aid Stressed

Disabled alcoholic persons have the same right as other disabled persons to receive social security disability payments if they meet the eligibility requirements, according to John A. Noble, deputy director of NIAAA's Division of Special Treatment and Rehabilitation.

However, says Mr. Noble, greater awareness of this right must be acquired both by disabled alcoholics and treatment personnel to ensure that eligible alcoholics receive their fair share of such payments.

The Institute is concerned over whether eligible alcoholics are receiving disability benefits—both for "humanitarian interest" and because "we would like to see as many funding sources as available made accessible to alcoholic people," Mr. Noble said at a recent meeting of the National Advisory Council on Alcohol Abuse and Alcoholism.

He noted that alcoholic persons who qualify for disability payments can receive fully paid treatment if selected as candidates for vocational rehabilitation. The Social Security Administration (SSA) pays all costs of rehabilitation for disabled persons when it can be shown that this will help remove such persons from the disability rolls.

Alcoholic persons who might be eligible to receive social security disability funds often fail to apply for this aid due to a widespread misunderstanding of the facts, Mr. Noble said. This probably stems from lack of knowledge by the public about changes in SSA regulations that have in recent years improved the prospect that an alcoholic person will qualify for the disability program, he suggested.

Under a 1956 criterion, alcoholism and drug abuse were viewed as personality disorders. There was some evidence that, as a result, a diagnosis of alcoholism or drug abuse "may have discouraged some examiners from giving further consideration" to a disability case, Social Security Administration officials said in discussing the subject in a top-level HEW conference in 1973. (They added at the time that "such cursory treatment of claims on the basis of diagnosis was not intended.")

Between 1968 and 1974, evidence of "irreversible organ damage" was used in disability determinations to demonstrate the presence of chronic alcoholism. Again, according to Social Security officials, the absence of such damage "was not infrequently a cause for rejection despite the presence of significant function psychopathology or organic pathology," Mr. Noble noted.

In 1974, Social Security dropped the language about irreversible organ damage and reemphasized that alcohol or drug abuse should be evaluated as a disability based on the symptoms, signs, and laboratory findings in each case, and not on the "diagnostic label" of alcoholism or drug addiction.

How does one qualify for disability payments?

Under SSA regulations, an individual is deemed to have a disability if unable to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of at least 12 months.

It is not known how many disabled alcoholics are receiving social security disability payments. As a possible indication of the number, 2 percent of a sample of applicants for disability had reference to severe alcohol problems in their records. Though this sounds like a small figure, 2 percent of the several million receiving these payments would amount to a significant total, Mr. Noble said.

Receiving payments under

(Mutual) INS Bulletin

the social security disability program are approximately 2.5 million disabled persons, plus 1.9 million dependents. An additional 2 million are receiving disability benefits under the newer Supplementary Security Income (SSI) program of the Social Security Administration. An estimated $12.4 billion is being paid out annually in the two programs.

The SSI program has complicated the picture since it was introduced in 1974, Mr. Noble said. Under this program, alcohol- and drug-dependent persons "are treated differently from other disabled persons" in that they must be in treatment for their disorder in order to be eligible for payments and, in addition, the payments are not sent directly to them but to a person designated as their payee.

SSA officials note that no special funds or facilities have been provided to treat such persons under the SSI program.

The Treatment and Rehabilitation Working Group of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism has taken a special interest in the SSI program, which falls under Title XVI. A resolution on the program initiated by the Working Group and sent by the Interagency Committee to SSA Commissioner James B. Cardwell requested that the SSA:

"1. Take the necessary steps to assure that disabled alcoholic persons receive the same consideration as any other applicant in the disability determination process in Title XVI, and that any indication of alcohol abuse or alcoholism manifested by an applicant be fully developed.

"2. Place greater emphasis in the Title XVI program on assuring that the maximum number of disabled alcoholic persons enter treatment services."

In reply, Elmer Smith, Associate Commissioner for Program Policy and Planning, SSA, wrote Dr. Ernest P. Noble, NIAAA Director expressing concern that applicants with alcohol addiction receive the same consideration as other applicants under SSI. He noted that the change in SSA regulations deleting reference to "irreversible organ damage" as a sign of alcoholism was made to aid in fully developing indications of alcoholism in disability applicants.

Mr. Smith also indicated that SSA's program goals are consistent with the Interagency Committee's resolution, and expressed an interest in receiving the Committee's suggestions on specific aspects of the SSI program. However, he stated that SSA was not prepared "to offer specific program changes at this time."

Persons interested in disability payments for alcoholic persons under either of the two SSA programs should contact their local Social Security office.

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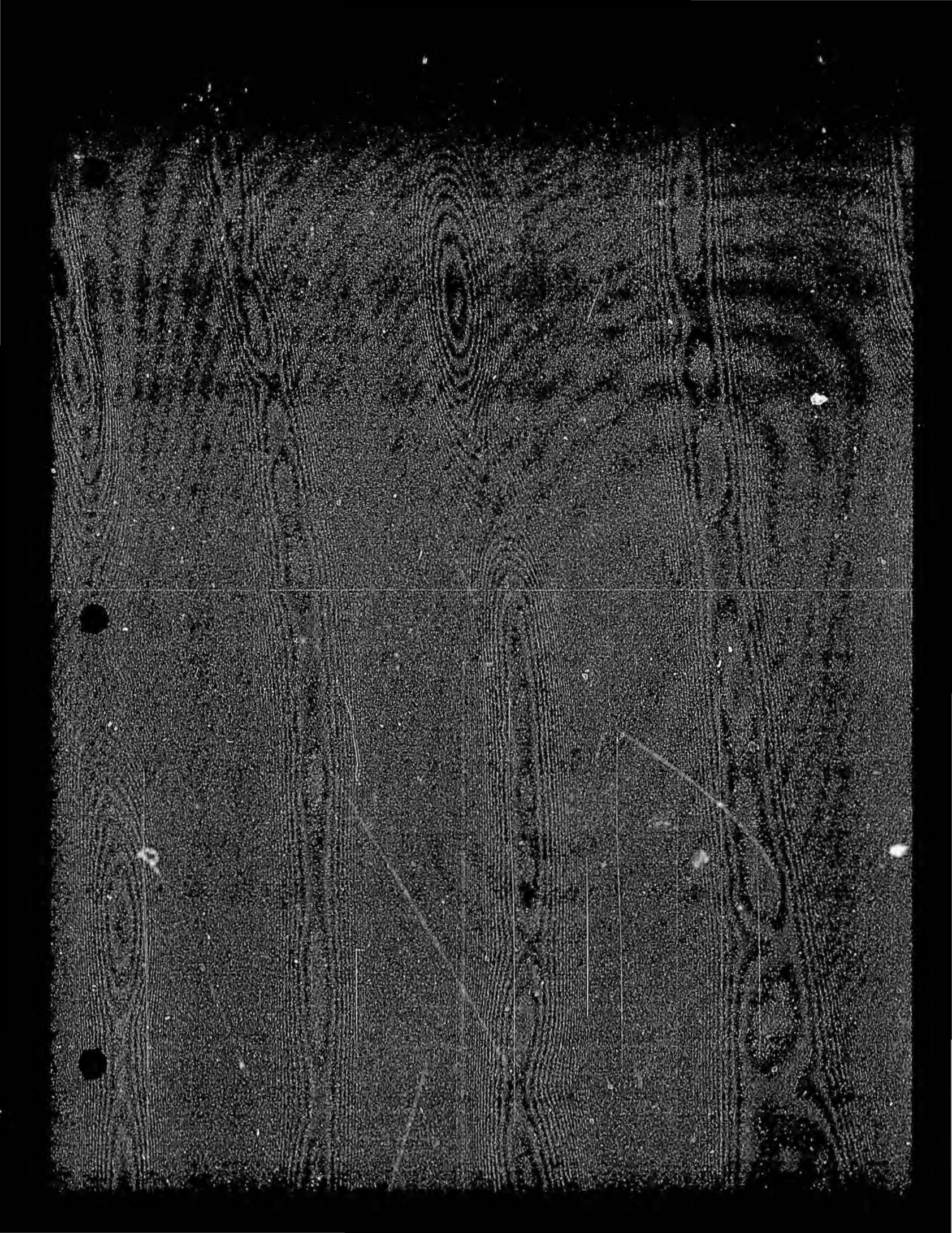
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LIQUOR LINKED TO ROAD DEATHS

About half the drivers killed in multiple fatality traffic accidents in Wisconsin in the latter part of 1977 had been drinking, Acting Gov. Martin Schreiber said.

Schreiber released the results of a study he commissioned after 27 persons died on Wisconsin's highways last Aug. 19-21, the highest non-holiday weekend traffic toll in state's history.

Of the 32 drivers killed in multiple fatality accidents in the next four months, 14 were legally drunk when they died, two had some alcohol in their blood, 15 tested negative and one was not tested, Schreiber said.

Twenty-five of the 66 drivers involved in the accidents had from one to five speeding convictions on their records, and four had been convicted of drunken driving, the study added.

It said only seven of the 118 drivers and passengers involved in the multiple fatal auto accidents were wearing seat belts. Three of the seven died. Schreiber's safety advisers estimated that another 10 of the victims would have survived had they been wearing safety belts.

The four persons killed on motorcycles in the accidents surveyed all were wearing helmets.

The team that conducted the study said three-fourths of the drivers of the motorcycles, compacts and subcompacts involved in the accidents were killed, but only two-fifths of the drivers of the intermediate and full-sized cars and trucks involved in the accidents were killed.

DRIVE-A-DRUNK

Is Wisconsin Next?

One of the fascinating things about life is people's ingenuity. Let a need arise — any need — and someone will start a business to fill it.

In California, in 1971, a need arose. That was the year the courts ruled that a bar owner is liable to civil suit if he serves a person who is obviously drunk. It took a while, but now an organization has been created to serve it. Drive-a-Drunk, it's called.

It is a simple, and ingenious, idea. If you are out drinking someplace, and you think you have had too much

(continued on page 16)

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SOCIAL DEMANDS TOO COSTLY

Americans, in their "headlong rush for social and economic progress," may be in danger of stifling the institutions that make progress possible, William B. Spann, Jr., president of the American Bar Association, said.

"Not only the disadvantaged but the entire population demand a wide variety of social benefits unknown and inconceivable a generation ago," he said.

This adds up to a psychology of entitlement, a belief that "what we want is what we have a right to," said Mr. Spann, and it gives him concern, he added, because "the world does not have unlimited resources to satisfy our every whim."

Mr. Spann said he believed government should draw up "balance sheets" for each new proposed program so that its social and economic costs "can be as easily perceived as its economic gains."

For their parts, business and the professions must make "critical choices," he said.

"How much justice can we afford? As lawyers we must participate in the answering of that question and then seek vigorously for solutions that will give us the fastest and fairest adjudication of disputes within those limits," he said.

"Can your industry insure against every risk? Can society afford the premiums? If not, rational boundaries must be established so that individuals will bear more responsibility for their own actions."

He said the time has come for the legal profession and the insurance business "to help society define the limits of the attainable and to exercise vigorous leadership in delivery within those limits."

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4E

(**Drive-A-Drunk** continued from page 7)

to be able to drive safely, you call Drive-a-Drunk. You tell them where you are, and where you want to go. They will quote you a fee ranging from $15 upward, depending on how far it is. If you go for it, they send out two people in a car. One drives you home in your car, and the other follows in their vehicle. They deposit you on your doorstep, and leave you to negotiate your way to your bedroom all by yourself.

The advantage to all this is that, unlike calling a taxi for safe transportation home, you don't have to face the hassle of getting your car the next day. And the service really doesn't cost much more than a cab anyway, depending on the distance involved.

(**Twenty Commandments** continued from page 12)

gets out of hand, advise the company why you referred it to an adjuster. If you "goofed" (and who doesn't) so advise the company.

8. Don't try to get your adjuster to color the facts to the company. If you want a favor in settlement, contact the production department of the company.
9. Remember that no one can sell everyone. If a serious difference of opinion exists between the insured and adjuster contact the adjuster. Get his story. If he is right, help him sell the insured.
10. Get well acquainted with your adjuster. Make him want to do a good job for you.

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TEENAGE DRINKING

Lowering the legal drinking age to 18 has had no effect on highway crashes in the state, but has resulted in more arrests of 13-17 year olds for liquor law violations, according to a report by the Wisconsin Council on Alcohol and Other Drug Abuse.

Although not yet formally released, the report said that while the number of liquor law violation arrests dropped by more than 60 percent for the 18-20 year olds, it increased by 120 percent for 13-17 year olds.

"It means that more kids are drinking younger, more liquor and more frequently, but those facts do not represent a significant difference in overall trends that have been going on since Prohibition," said one Department of Health and Social Services employee.

ALCOHOL AND AUTO DEATHS

About 70 percent of all drivers killed in Wisconsin highway crashes from 1968-77 were alcohol-involved (above the .05 percent legal evidence of intoxication level), yet just 65 percent — or five percent fewer — 18-20 year old driver deaths involved alcohol.

While nearly seven percent of all Wisconsin highway accidents involved drivers who "had been drinking," the 18-20 age group was no more represented than any other.

Other alcohol-related facts are:

• Wisconsin residents consumed 12 million gallons of absolute alcohol in 1975 — enough to give every resident, age 15 and older, 962 drinks per year.

• Nine percent of all high school students — nationwide — smoke marijuana daily while six percent say they daily consume alcohol.

• Approximately 80 percent of all 12th graders say they drink alcohol; 72 percent of all seventh graders say the same.

• An estimated 185,743 Wisconsin kids between 13-19 could be considered "problem drinkers" while 13,936 are considered "alcoholics."

Although about 92 percent of the 42,500-mile Interstate Highway System is open to traffic, more than 28,000 miles require safety and other improvements, according to the Department of Transportation.



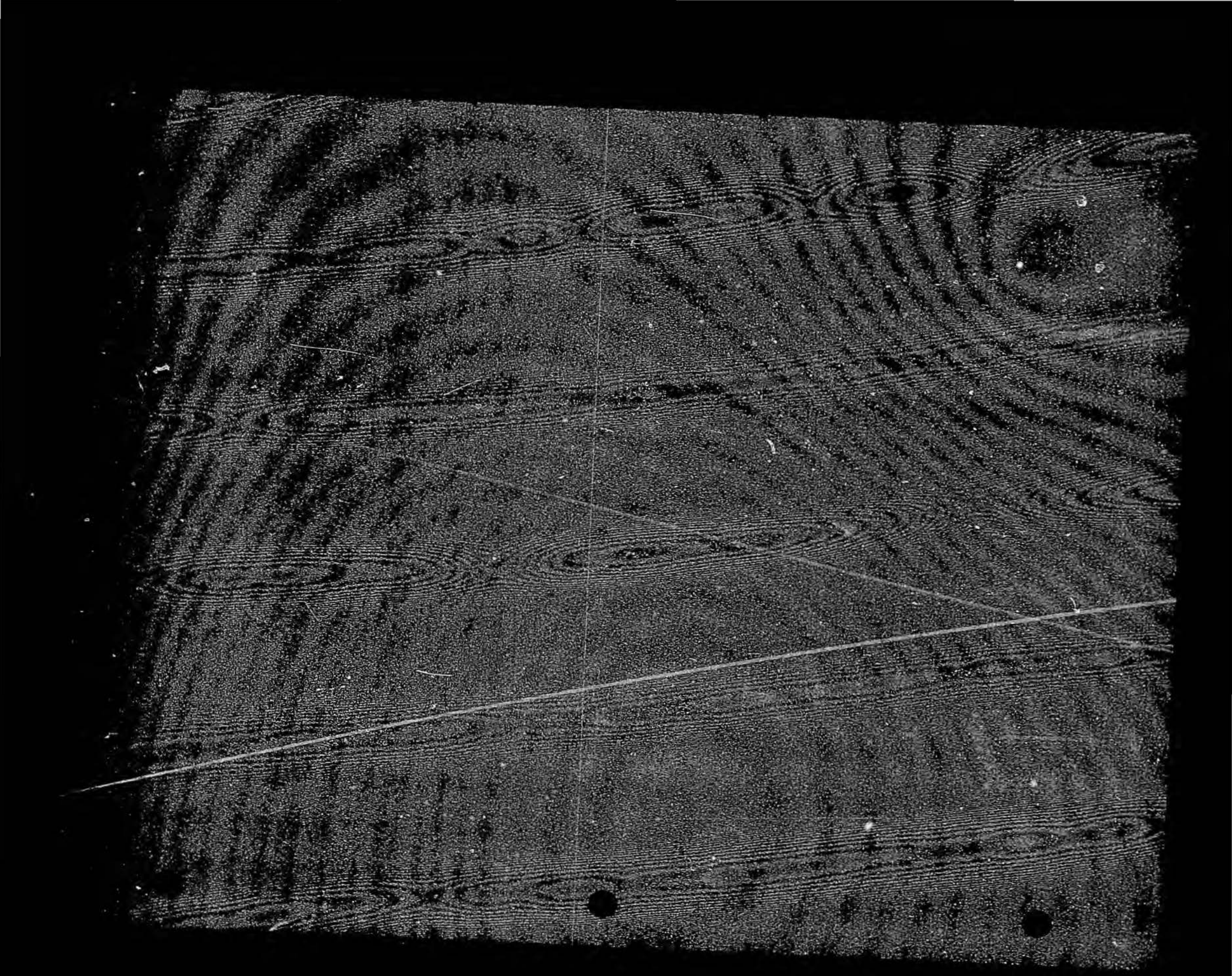


TABLE 1—MORTALITY FROM ALCOHOLIC DISORDERS

United States, 1963-64 and 1973-74

Sex and Age	Average Annual Death Rate per 100,000				Percent Increase† 1963-64 to 1973-74	
	1963-64		1973-74			
	White	Nonwhite	White	Nonwhite	White	Nonwhite
Male						
Ages 20 and over*	11.5	20.6	16.8	42.6	46	107
20-29	.6	4.9	1.1	7.3	83	49
30-39	4.9	23.1	7.0	39.7	43	72
40-49	15.2	33.4	22.9	70.6	51	111
50-59	25.1	29.2	34.9	76.0	39	160
60-69	25.9	24.3	40.0	48.7	54	100
70 and over	13.7	10.4	18.5	22.3	35	114
Female						
Ages 20 and over*	4.2	9.5	5.7	16.2	36	71
20-29	.2	2.6	.2	2.5	—	−4
30-39	2.4	12.9	2.3	15.2	−4	18
40-49	7.5	16.0	9.2	30.5	23	91
50-59	9.2	12.5	13.4	27.7	46	122
60-69	6.0	7.0	10.4	15.5	73	121
70 and over	2.5	‡	3.3	4.8	32	‡

*Adjusted on basis of age distribution of the United States total population, 1940.

†Minus sign (−) denotes decrease.

‡Fewer than 20 deaths.

Note: Disorders include Alcoholic psychosis (International Classification of Diseases, Adapted, 291), Alcoholism (ICDA 303), and Cirrhosis of liver, alcoholic (ICDA 571.0).

Source of basic data: Reports of the Division of Vital Statistics, National Center for Health Statistics.

Mortality from Alcoholism

Rising death rates from alcoholic disorders *(alcoholic psychosis, alcoholism,* and *alcoholic cirrhosis of the liver)* indicate that mortality from alcoholism in the United States is substantial. The true impact of the disease is hard to measure, however, because of considerable underreporting of alcoholism as a cause of death. The present system of tabulating mortality statistics by selecting the underlying cause of death excludes deaths in those cases where alcoholism is mentioned only as a contributory cause on the death certificate. In addition, many reporting physicians are reluctant to specify alcoholism as the underlying cause of death—when it is possible to assign another cause or complication—and may even omit mention of alcoholism as a contributory cause of death. Investigation of the causes of death indicates, however, that alcoholics are subject to excess mortality from all of the major diseases, as well as from accidents, suicide, and homicide.

Mortality from alcoholism rose alarmingly between 1963-64 and 1973-74, with a much steeper rise for nonwhites than for whites. As shown in Table 1, the death rate from alcoholic disorders doubled for nonwhite males at ages 20 and over, while the rate among white males rose by 46 percent. The disparity among females was not quite so great; nonwhite women experienced an increase of 71 percent, compared with a 36-percent increase among white women. The most substantial increase in mortality from alcoholism among nonwhite males (160 percent) occurred in their fifties, while the increase in mortality among nonwhite females reached about 120 percent at ages 50-69. Among whites, the increases were greatest for males at ages 20-29 (about 85 percent) and for females at ages 60-69 (about 75 percent).

The mortality rates from alcoholic disorders varied considerably by age. Death rates among white males in 1973-74 rose from 1.1 per 100,000 at ages 20-29 to 40.0 per 100,000 at ages 60-69, then dropped to 18.5 at ages 70 and over. Among nonwhite males death rates rose from 7.3 per 100,000 at ages 20-29 to a high of 76.0 at ages 50-59, before declining to 48.7 at ages 60-69 and to 22.3 at ages 70 and over. The rates among white females followed much the same pattern on a considerably lower scale, with a peak of 13.4 per 100,000 at ages 50-59. The mortality among nonwhite females reached its highest point at ages 40-49, with a rate of 30.5 per 100,000. Women of each race had uniformly lower death rates than did men in the same age group.

To determine the extent of alcoholism involvement in recently reported deaths, a special study of death claims has been conducted by the Statistical Bureau of the Metropolitan Life Insurance Company. All death claims paid during the 12-month period from June 1975 to June 1976 on Standard Ordinary policies issued by the Metropolitan were reviewed. Whenever an alcoholic disorder *(alcoholic psychosis, alcoholism,* or *alcoholic cirrhosis of the liver)* was mentioned anywhere on the death certificate, the available records were examined in detail. The 692 claims so selected were analyzed by age and sex and as to whether the alcoholic disorder had been reported as the underlying or contributory cause of death. (See Table 2.) Four out of five of these alcohol-related deaths occurred among males. Almost three-fifths of the deaths among men and about two-thirds of the deaths among women occurred in the age range 45-64. The proportion of alcohol-related deaths was also quite high among men aged 65 and over (about 30 percent) and among women at ages 25-44 (about 25 percent).

Of the 692 claims, alcoholic disorders were reported as the underlying cause of death in 536 cases; 462 of these deaths were assigned to *alcoholic cirrhosis of the liver,* 65 to *alcoholism,* and 9 to *alcoholic psychosis.* In the remaining 156 claims, alcoholic disorders were considered a contributory cause of death. It appears, there-

TABLE 2—MORTALITY FROM ALCOHOLIC DISORDERS*

Underlying and Contributory Causes

Metropolitan Life Insurance Company
Standard Ordinary Policyholders
Death Claims Paid June 1975-June 1976

Sex and Age	Number of Deaths		
	Total	Underlying Cause	Contributory Cause
Both Sexes	692	536	156
Male			
All Ages	553	415	138
Under 25	7	3	4
25-34	26	18	8
35-44	53	44	9
45-54	136	107	29
55-64	177	127	50
65-74	137	105	32
75 and over	17	11	6
Female			
All Ages	139	121	18
Under 25	—	—	—
25-34	8	7	1
35-44	25	23	2
45-54	51	44	7
55-64	38	34	4
65-74	13	10	3
75 and over	4	3	1

*Disorders include Alcoholic psychosis (International Classification of Diseases, Adapted, 291), Alcoholism (ICDA 303), and Cirrhosis of liver, alcoholic (ICDA 571.0).

fore, that underreporting of alcoholism as a cause of death could be as high as 25 percent.

The same death claims were then analyzed to determine which other causes of death were associated with alcoholism when it was either the underlying or the contributory cause; the results are presented in Table 3. In 319 claims alcoholism was considered the underlying cause of death, and one or more contributory causes were also mentioned on the death certificate. Diseases of the digestive system (gastrointestinal bleeding, ulcers, pancreatitis) were the most frequently reported contributory cause, occurring in 27 percent of the cases. Certain vascular diseases (mostly bleeding esophageal varices) accounted for 24 percent of the deaths, and diseases of the urinary system (renal failure, urinary infection) for 22 percent. Diseases of the respiratory system (bronchopneumonia, pulmonary edema, emphysema) and heart disease were reported somewhat less frequently (19 percent and 16 percent, respectively).

The second column in Table 3 gives the distribution of the underlying causes of death for the

TABLE 3—MORTALITY FROM ALCOHOLIC DISORDERS* ASSOCIATED WITH OTHER CONDITIONS

Metropolitan Life Insurance Company
Standard Ordinary Policyholders
Death Claims Paid June 1975–June 1976

Associated Cause of Death	Alcoholic Disorders as Underlying Cause Where Associated Cause is Contributory	Alcoholic Disorders as Contributory Cause Where Associated Cause is: Underlying	Contributory
	Number of Claims		
All Causes	319	156	68
	Percent Distribution of Claims		
Infective diseases (septicemia, etc.)	4	—	4
Malignant neoplasms	4	3	—
Diabetes mellitus	3	2	12
Anemia and malnutrition	7	—	4
Heart disease	16	30	22
Cerebrovascular diseases	3	9	1
Other vascular diseases	24	1	9
Diseases of respiratory system	19	8	29
Diseases of digestive system	27	8	9
Diseases of urinary system	22	—	12
Accidents	2	30	1
Suicide	—	6	—
All other causes	15	3	25

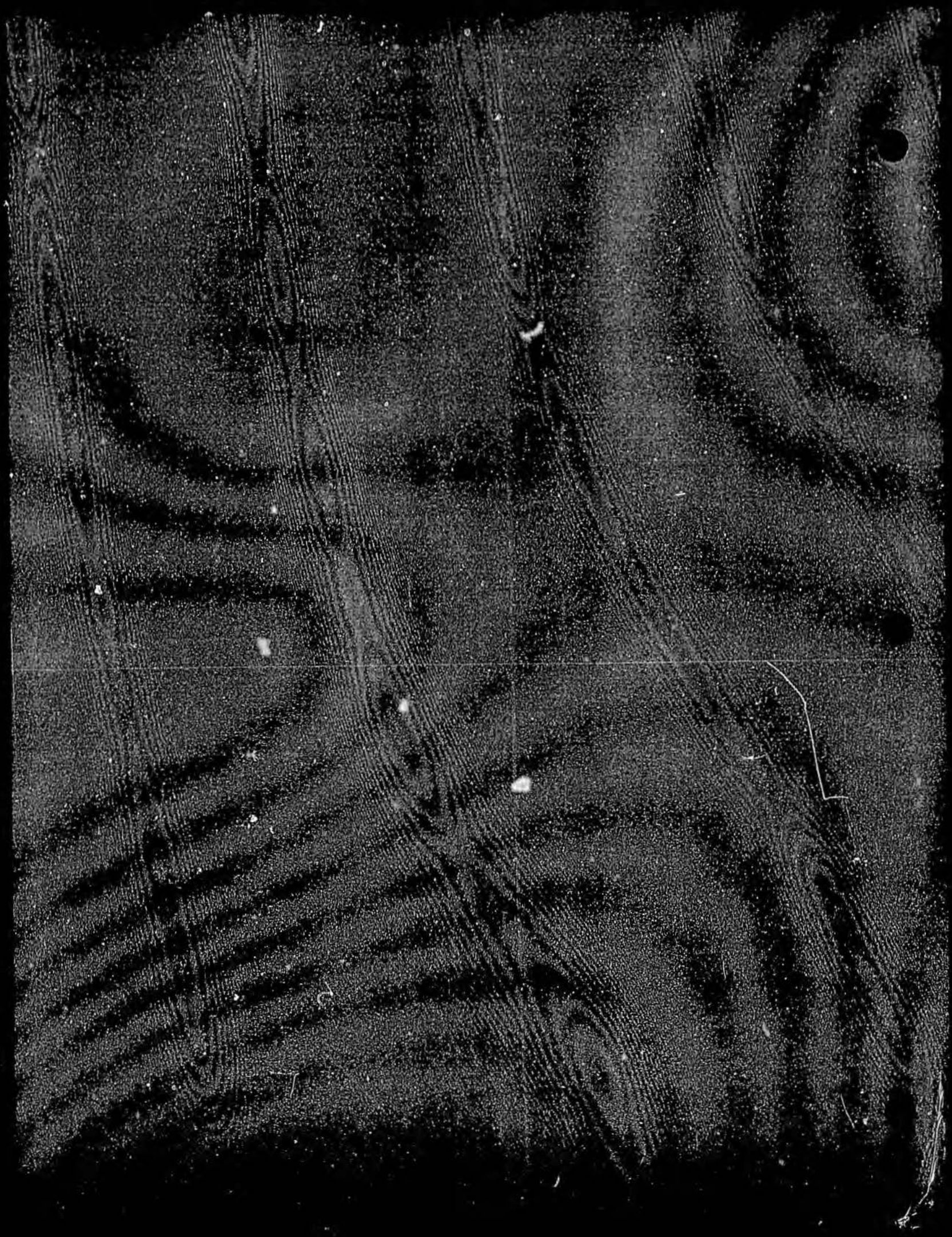
*Disorders include Alcoholic psychosis (International Classification of Diseases, Adapted, 291), Alcoholism (ICDA 303), and Cirrhosis of liver, alcoholic (ICDA 571.0).

Note: First and third columns total more than 100 percent due to recording of multiple contributory causes.

156 deaths in which alcoholism was considered a contributory cause. Thirty percent of these claims show heart disease as the underlying cause of death, while another 30 percent specify accidents. Respiratory, digestive, and cerebrovascular diseases each accounted for 8 or 9 percent of the total.

The third column in Table 3 relates to 68 claims in which other causes were reported as contributory to death in addition to alcoholism. In these cases, respiratory diseases were the most frequently mentioned, with heart disease a close second; both diabetes mellitus and disorders of the urinary system were reported to a lesser degree.

Additional research is needed to clarify the relationship between alcoholism and the increased risk of mortality. It is also important that, when applicable, alcoholism be mentioned on the death certificate along with other associated medical conditions. As the coding of multiple causes of death becomes more widespread, a more precise measure of the role of alcoholism in mortality will be obtained.



PUBLIC POLICY REPORT

NEW JERSEY ALCOHOLISM ASSOCIATION
212 West State St.
Trenton, N.J. 08618
(609) 392-0808

HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

The New Jersey Alcoholism Association supports the enactment of A-1718, A-1719, A-1720 and A-1722 which provide for the inclusion of treatment of the disease of alcoholism in health insurance policies in the State of New Jersey.

Alcoholism is a Distinct Primary Illness.

Alcoholism is a disease that can be as fatal as heart disease and cancer. This year 86,000 people will die as a result of acute alcoholism. Last year alcoholism and alcohol abuse was responsible for the arrest of two million public intoxicants that cost the judical system, the police and the corrections system one half billion dollars. An estimated 28,500 of the 50,000 motor vehicle fatalities were a direct result of alcohol abuse. The estimated impact on our economy is $25 billion in lost productivity and absenteeism.

Alcoholism is recognized as a distinct primary illness by the U.S. Department of HEW, State of New Jersey, ABA, AMA, and the industrial sector:

American Medical Association, 1956.

> "Alcoholic symptomatology and complications come within the scope of medical practice. Acute alcoholic intoxication can be and often is a medical emergency."

American Hospital Association, 1967.

> "Alcoholism is a serious health problem. It falls within the scope of medical practice and it is often a medical emergency. The alcoholic should not be denied the advantage of a thorough study of the cause or causes of his condition and should not be denied the advantage of the best possible management of his case."

American Psychiatric Association, 1965.

> "All prepayment plans for defraying the cost of medical care through insurance should cover the person presenting symptoms of alcohol problems who seeks treatment on the same basis as for other illnesses."

State of New Jersey.

> The New Jersey Alcoholism Treatment and Rehabilitation Act, recently enacted by the legislature, declares that "it is the policy of the State of New Jersey to afford alcoholics a continuum of treatment in order that

they may lead normal lives as productive members of society." P.L. 1975, Chapter 305.

New Jersey AFL-CIO.

"The disease of alcoholism has been recognized as a treatable illness and the third most serious health problem for the nation and the American worker... the New Jersey AFL-CIO encourages its affiliates to negotiate provisions in their contracts covering expenses incurred for the treatment of alcoholism whether the services are administered by a hospital or a non-hospital extended care facility." Res. #24, AFL-CIO.

The recognition of alcoholism as a chronic disease makes it as incumbent to provide quality care for the alcoholic as it is to provide care for the diabetic, the coronary patient, or any other sick person at the lowest appropriate cost setting consistent with patient needs and high quality care.

Alcoholism Coverage is Cost Effective.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recently released the results of a cost benefit study on 41 Alcoholism Treatment Centers (ATC's) funded by NIAAA in 1971. The study demonstrates that 70% of clients show a significant reduction in alcohol consumption rates, unemployment, and health impairment. Approximately three dollars will be returned to the economy for every treatment dollar expended in the next 10 years. The benefits realized from the operation of 41 ATC's will exceed $33 million primarily a result of reduction in health care cost, and increases in productivity, taxable earnings.

Experience in other states demonstrates that concerns of increased costs and over utilization of benefits by alcoholics are unfounded. In Washington, the legislature mandated alcoholism coverage in approved residential care facilities to the normal limits of the policy. Connecticut has mandated the inclusion of alcoholism with no premium increase.

In California, only $172,801 in benefits were paid in a one year period. The average annual premium required for the four major carriers amount to 26¢ per member. In Pennsylvania, Capital Blue Cross covered alcoholism in licensed residential care facilities with no premium increase. Pennsylvania found the increase in utilization to be gradual--the natural maturation of a new program. By virtue of receiving treatment, an alcoholic recovers from the disease, achieves better health and utilizes fewer or less costly medical services, permitting Capital Blue Cross to adopt a three day to one day per diem tradeoff.

Insurance providers that cover alcoholism such as Prudential, Kemper, Hartford and Employees Insurance of WAUSAU, recognized that they were already "paying" for alcoholism indirectly through claims paid to general hospitals for alcoholism related admissions under other diagnosis such as musculoskeletal disorders and cirrosis. Licensed residential care facilities demonstrate an average recovery rate of 70% and cost one-third the average hospital per diem.

Basic Element V. Optional Coverage

The experience of other states, insurance carriers, and industry document that concern of increased costs and over-utilization of benefits are unfounded. Alcoholism coverage as a basic element of an insurance policy is consistent with the basic principal of insurance to distribute the risks among a large number of subscribers, thereby minimizing the cost to individual subscribers.

Alcoholism is a stigmatized illness, basic denial is a part of the illness, and an alcoholic rarely recognizes the symptoms of the disease. Alcoholism is a primary illness and the recognition of alcoholism as a deadly and chronic disease makes it as incumbent to provide quality care for the alcoholic as a basic element of coverage as it is for the cancer or coronary patient.

Current methods of coverage restricted to a hospital setting encourage hospitalization under an inappropriate diagnosis, and contribute to increased health care costs due to late diagnosis and serious medical complications such as cirrosis and muscoskeletal disorders. The bulk of the alcoholic patient population is adequately insured and currently treated for complications in the later stages of chronic alcoholism at a hospital per diem rate three times the cost of a comprehensive treatment program.

The attached addenda outline the experience of major industries that have an alcoholism benefit. The experience of major insurance carriers document the cost effectiveness of alcoholism coverage. The experience of the following major insurance providers is outlined: Prudential, Kemper, Hartford, Employees Insurance of WAUSAU, Blue Cross of Michigan, Blue Cross of Maryland, and Capital Blue Cross of Pennsylvania. The actual experience of states that have adopted similar legislation, insurance carriers, and the industrial experience strongly support the conclusion that alcoholism should be a basic element of coverage in health insurance polices in New Jersey. It is for these reasons that the New Jersey Alcoholism Association strongly support the adoption of A-1718, A-1719, A-1720 and A-1722.

addendum I

EXPERIENCE OF MAJOR INSURANCE CARRIERS

Insurance carriers have instituted coverage in recognition that traditional limitations are actually counterproductive. Educators Mutual Life recognized that a benefit restricted to hospital treatment, tends to encourage repeated treatment and increased costs. According to Mr. A. W. Adee, Vice President of Educators Mutual Life:

> "it makes good economic sense from an insurance standpoint. We were already paying...for...detoxification in general hospitals and found that the situation tended to repeat itself and we were paying for more than one incident of detoxification. Why not take the claim money of the second incident...and spend it on rehabilitation and try to prevent the repetition? We think we can and that in the long run we will be making no more payments for alcoholism than we were already making."

Prudential Insurance Company.

October 1972, deleted from new policies their standard exclusion of treatment for alcoholism in "a facility for the care of alcoholics."

The Kemper Insurance Companies.

Medical and hospital expenses incurred in the treatment of alcoholism are covered, including income protection, in the same way as any other illness. There are benefits for hospital out-patient care as well as in-patient and out-patient services at licensed non-hospital alcoholism treatment centers. Kemper included these services effective June, 1973, without premium increase.

Hartford Insurance Company.

June 1974, offered coverage for alcoholism "on the same basis as any other disease" in group policies, coverage extended to alcoholism treatment facilities and out-patient programs.

Employees Insurance of WAUSAU.

September 1973, included benefits for both in-patient and out-patient treatment of alcoholism at treatment centers.

Blue Cross of Michigan.

The United Auto Workers has 2.5 million members enrolled in the plan. The cost for coverage of alcoholism treatment in residential care facilities is 36¢ per subscriber per year.

Blue Cross of Maryland.

January 1974, extended benefits to approved non-hospital residential facilities, in 1975, out-patient coverage was included.

Capital Blue Cross of Pennsylvania.

Effective August, 1974, Capital provided alcoholism coverage for alcoholism treatment in residential care facilities to their seven million subscribers as a basic benefit.

Capital Blue Cross cited major reasons for providing coverage for residential care facilities with no rate increase:

1. "Recognition of alcoholism as a chronic disease makes it incumbent on the third-party payor to provide appropriate benefits...obligation to provide care for the diabetic, coronary patient, or any other sick person. If the revolving door syndrome is to be avoided, the alcoholic patient cannot be deserted after (hospital) treatment for his acute illness..."

2. "...treat alcoholism as a distinct disease entity for purposes of third-party reimbursement consistent with policy to provide benefits...in the lowest appropriate cost setting consistent with patient needs and high quality care."

3. Capital Blue Cross recognized it has been "paying" for alcoholism indirectly, through claims paid in the general hospital for alcoholism or alcoholism-related admissions under other diagnosis such as muscoskeletal disorders or cirrosis. Limitation of benefits encourages admission under a disguised diagnosis contributing to the "revolving door"--the alcoholic is treated at a hospital and released without referral to appropriate treatment, only to return to drinking and ultimately the hospital.

4. Utilization: First year experience indicated a low volume of utilization, alcoholics did not "come out of the woodwork" at the availability of covered care, any increase should be gradual--the natural maturation of a new program.

5. Cost: Capital Blue Cross projected their cost in 1974 to be $600,000; it was $200,000. Capital estimates a savings to the plan from those subscribers who, by virtue of receiving treatment, maintain sobriety and thus better general health and utilize fewer or less costly medical services. Coverage is provided on a three-day to one-day tradeoff from regular hospital benefit days because the per diem cost for licensed alcoholism providers is significantly less than an in-patient hospital per diem. A recent report indicates that after a two year period, the cost of the benefit was $345,000 or 18¢ per subscriber per year. This does not take into account any savings as a result of reduced medical expenses.

addendum II

THE INDUSTRIAL EXPERIENCE

Problem drinkers use a disproportionately high portion of health benefits, contributing to high insurance cost. Statistics document that the mortality ratio for alcoholics is 3.22 times greater than non-alcoholics. The problem drinkers' overall accident rate is 3.6 times that of other persons. The benefit utilization rate of alcoholics is 3 times that of others for digestive and muscoskeletal disorders, and 2 times greater for respiratory infection. In industry, the average and total benefits paid to alcoholics cost employers three times that of other employees and absenteeism is 2½ times greater.

The actual findings of major industrial companies clearly document a high treatment success rate, a marked decrease in utilization of health benefits and an insurance cost savings due to an adequate alcoholism health benefit:

The Philadelphia Fire Department.

Established a referral program for its 3,410 employees in 1972. For those problem drinkers referred to out-patient care, sick leave was reduced by 55%. Injuries were reduced by 67%; both of these factors indicating a significant decrease in health insurance utilization.

Scovill Manufacturing Company in Waterbury, Connecticut.

Employs 6,500 employees. The Scovill program processed 180 employees over a three year period. They estimate their annual savings at $186,550. Importantly, 78% of those problem drinking employees referred for treatment arrested the disease.

Economics Laboratory, Inc. of St. Paul, Minnesota.

Has an employee population of 3,500 in the United States. They have a rehabilitation success rate of 80% for employees and 50% for dependents of the employees. In addition, the Company reduced treatment cost 60 to 65 percent by utilizing non-hospital facilities such as alcoholism treatment centers.

General Motors.

General Motors has saved millions of dollars in lost productivity, on-the-job accidents and sickness and accident benefits through alcoholism coverage. Over 8,000 employees have been referred and health insurance benefits declined 42% in a two year period.

The De Paul Industrial Alcoholism Project of Milwaukee, Wisconsin.

Receives referrals from 23 companies in the Milwaukee area. This population is composed primarily of blue-collar skilled and unskilled factory workers. In conducting a nine month follow-up study of problem drinkers treated, 46% reported total abstinence and 25% essential abstinence, for a total of 71% significantly improved.

Illinois Bell Telephone Company.

Studied 402 employees for five years prior to referral and for five years after. The job rehabilitation rate was 72%. In addition, these 402 employees had 602 cases of sickness disability before rehabilitation and 356 cases after rehabilitation. This is a reduction of 46% in sickness disability, indicating a tremendous decrease in utilization of insurance plans.

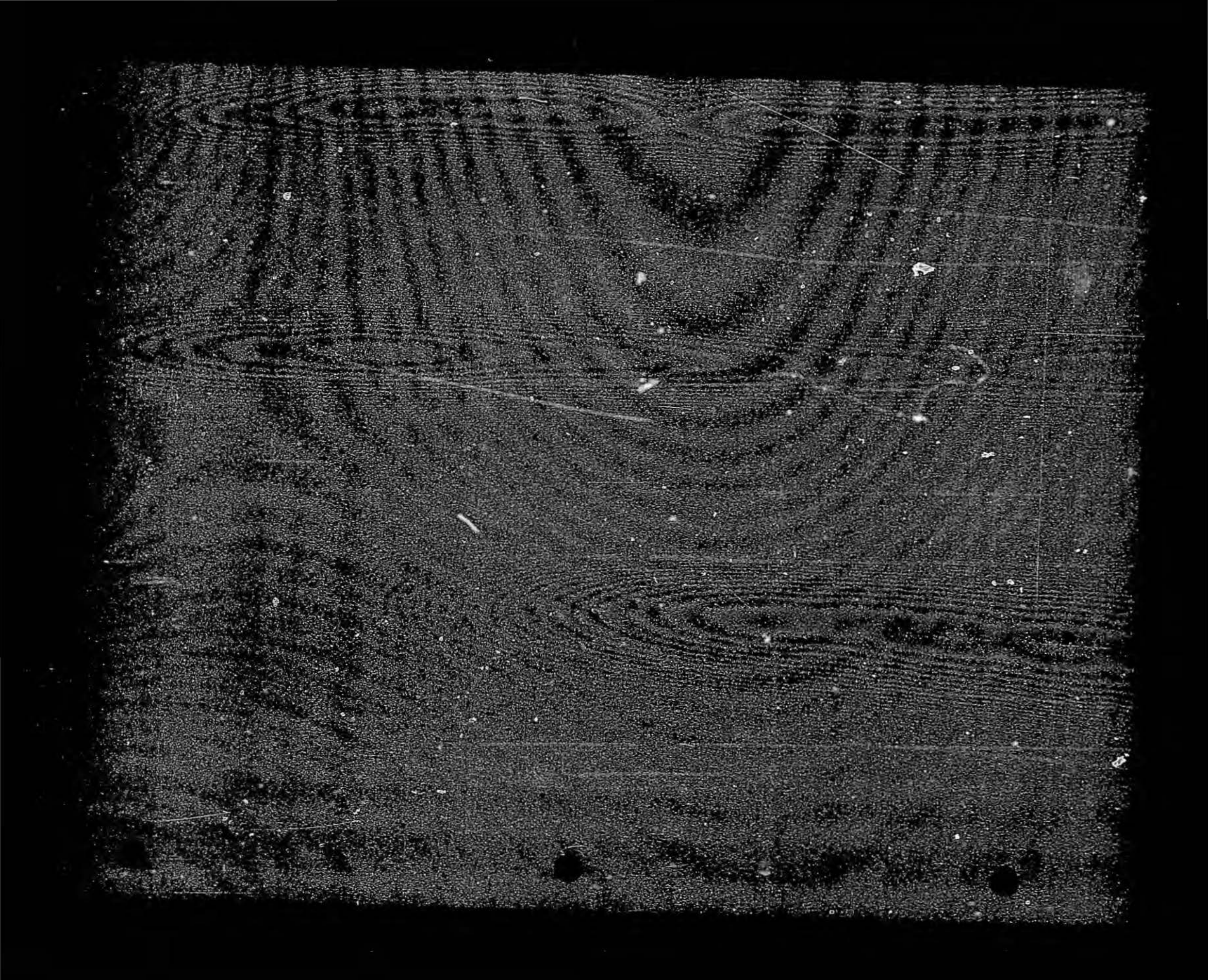
Kennecott Copper Company.

Found sickness and accident cost ratio for alcoholics compared with the non-alcoholic employee to be more than 5 to 1; hospital, medical and surgical costs were more than 3 to 1. Yet, after a 12½ month involvement in a treatment program, hospital, medical and surgical costs decreased 55.35%.

Problem drinkers utilize three dollars in health benefits to one dollar for the average person. In-patient treatment programs average a 70% success rate. If the recovery rate were only 20%, the impact on insurance would still effect a 2% cost savings in claims paid.

To cite specific examples, the following table represents cost savings in the industrial experience previously presented:

COMPANY	EMPLOYEE REHABILITATION SUCCESS RATE	PROBLEM DRINKERS REDUCTION IN CLAIMS PAYMENTS
SCOVILL	78%	-
ECONOMICS LAB, INC.	80%	65%
COMPANIES IN MILWAUKEE	71%	-
ILLINOIS BELL TELEPHONE CO.	72%	46%
PHILA.FIRE DEPARTMENT	-	55%
KENNECOTT COPPER COMPANY	-	55%



JANUARY 1976

THE STATE BAR OF CALIFORNIA

Reports:

IN THIS ISSUE...

- Alcohol Abuse Program
- Letterhead Rule Interpretation
- Conference Call

REC'D FEB 3 7 1976 DEPARTMENT OF & ECONOMIC DEVELOPMENT D.V. OF ASSISTANCE





Signing for WAPAC were Ms. Mary Rogers (top, left), and Arnold Townsend (below, left). John S. Malone (top, watching Ms. Rogers and Board member Richard C. Dinkelspiel (below) signed for the State Bar. In background (top) are John N. Doggett, III, and Kenneth B. Gillis.

BAR AND COMMUNITY REACH UNDERSTANDING

The State Bar and the Western Addition Project Area Committee signed a compact governing minority hiring by the Bar. The agreement may be the first of its kind. See story, p. 4.

Board Seeks Comment On Proposed Attorney Advertising Experiment

The Board of Governors is anxious to receive comments from all Bar members and other interested persons regarding the proposed pilot program of lawyer advertising approved for publication in December.

If the Board decides to proceed with the plan after reviewing those comments, it will ask the State Supreme Court to approve certain amendments to the Rules of Professional Conduct.

Those amendments would relax the present ban on advertising—at least with respect to yellow pages and legal directory listings—in order to provide the public with useful information on which to base the choice of an attorney.

As stated in December *Reports*, the Board stresses that in approving publication of the program for comment, no present relaxation of the Rules of Professional Conduct is implied.

The deadline for receiving comment is March 1, 1976.

In a December 12 letter to local bar association presidents, Bar President David S. Casey urged "active consideration, discussion and debate on the local bar level between now and that date."

He suggested that workshops, general meetings and plebiscites be conducted on the subject of lawyer advertising, and offered to send members of the Bar Board or staff to speak locally. Any comments or requests for speakers should be addressed to the Board Committee on Professional Responsi-

(Continued on page 4)

11th Annual Conference of Bar Presidents Will Focus On Advertising, Other Major Issues Facing Lawyers

Panels on attorney advertising and maintenance of professional competence will be among the highlights of the Eleventh Annual Conference of Bar Presidents, to be held February 27-29 at the Harbor Island Sheraton Inn in San Diego.

Additional presentations on major issues confronting the legal profession in 1976 will cover specialization, various types of legal services, legal malpractice insurance, public affairs and legislative advocacy, unauthorized practice of law and changes in disciplinary procedure.

All members of the Board of Governors will be present to answer questions and bring the conferees up to date on the work of the Board.

The Conference of Bar Presidents is not restricted to "bar presidents," Robert D. Raven, chairman of the Conference of Delegates, wrote the presidents of 102 local bar associations suggesting that not only they attend but also presidents-elect or vice-presidents, persons in charge of public affairs for the local bars, and executive directors and executive secretaries as well.

Bar President David S. Casey will speak at a luncheon Saturday, February 28, honoring local bar presidents and presidents-elect.

SPECIAL ELECTION RESULTS

Members of District II have elected Melvyn J. CoBen of Sacramento to represent them on the Bar's Board of Governors. Results of the balloting were announced Jan. 6. More information on the election and CoBen will appear in February Reports.

Bar Committee Opens New Front in War Against Alcoholism



While thousands of Americans make annual New Year resolutions, the Bar's Committee on Alcohol Abuse operates year-round to encourage troubled attorneys and judges to make one of the toughest resolutions of them all: the decision to confront and deal with the illness called alcoholism.

The committee's program, underway for barely a year, has already helped at least 40 attorneys and judges, and an estimated 85 are currently participating.

The committee's success may be partly due to the fact that a number of its members have been through the alcoholism mill and back.

One of them is Ted Cohen, a Los Angeles attorney. He did not request anonymity, saying instead, "Most of us were never anonymous when we were out there stumbling around, or getting in trouble with the law. I'm not ashamed of having straightened out."

Cohen works hard for the committee. "My profession gave me another chance. This is my way of repaying it."

Two aspects of Ted Cohen's case are typical of the estimated 4,000-7,500 California lawyers and judges who suffer from problem drinking.

"Difficult to Reach Attorneys . . ."

First, Cohen was unable to admit to himself that alcohol was a problem. He started drinking heavily after a personal tragedy in 1963 and, at the time, did not recognize drinking as a problem.

This is characteristic, according to Jack L. Sanow (occupational program consultant of the Alcoholism Council of Greater Los Angeles and consultant to the Bar committee). Sanow says it's extremely difficult to reach attorneys and doctors:

"Both professions are always giving advice to other people but resist taking it themselves. Generally, the more intelligent individuals are, the harder it is to work with them.

"When you're with attorneys, you're in court. Their alibi structure is strong. They can offer a thousand excuses why they drink. And people cover up for them in a way they would not for truck drivers or salesmen.

"The secretary will tell clients that the lawyer is studying a case, when in fact he passed out at lunch. Other lawyers in a firm will take over in court rather than admit that the senior partner blacks out during cross examination."

Alcohol & Discipline Problems

The second aspect of Cohen's case typifying the problem of the alcoholic attorney is that it led to commission of offenses resulting in disciplinary action by both the State Bar and the State Supreme Court. Judge Leon Emerson of Downey Municipal Court, chairman of the Committee on Alcohol Abuse, says alcoholism is responsible for "probably two-thirds of the disciplinary actions against California lawyers."

Lily Barry, assistant secretary in charge of the Bar's Los Angeles office, reports, "Often in the course of disciplinary proceedings we discover that the respondent attorney is a problem drinker.

"Whether drinking caused his problems or his problems caused the drinking, the fact remains that to become rehabilitated the attorney should first control his drinking. We tell him about the Committee on Alcohol Abuse and the consultants available, and suggest that he call and make an appointment and see if they can help."

While suffering from alcoholism, Cohen committed offenses in 1964 and 1965 which led to his conviction in 1968 of grand theft and conspiracy to commit grand theft and forgery.

"At the time of the offenses," Cohen says today, "I wasn't aware of my alcohol problem. It was the jolt of being sentenced to prison that did it.

"Actually that sentence was the best thing that ever happened to me. It woke me up to the fact that something was seriously wrong."

Again, Sanow says, the pattern is typical. "Most of the time, the full-blown alcoholic becomes a thief. He needs money for booze but can't function to earn it. Alcohol will take away wives, children, homes, law practices. Sometimes the alcoholic *must* hit bottom and lose all those things before he or she will admit there is a problem."

Cohen adds, "I don't want anyone to have to go through what I did. We want to reach people before they hit rock bottom."

Why a Bar Program?

Since organizations to help alcoholics already existed, why did the Bar feel it necessary to create a program of its own to help problem drinkers in the legal profession?

Bruce Bartlett, vice chairman of the committee, says "The advantage of working with other attorneys is the identification factor. Most attorneys and judges with the alcohol problem think they are unique, that no other attorney or judge has ever had that affliction. By talking with fellow-lawyers who have successfully corrected their drinking problems, the identification opens new vistas of motivation."

Cohen adds to this theory:

"Lawyers are independent souls—they feel more educated, more intelligent. We started a committee on alcohol abuse within the Bar so the attorneys and judges can share experiences with fellow lawyers. They relate better. I know of several lawyers and judges currently in the program who, if it weren't for this Bar-sponsored program, wouldn't be getting help anywhere."

There are exceptions. Vice chairman Bartlett points out, "Another type of attorney is very fearful of having his or her problem known. He or she can work best with the committee's consultant non-attorneys rather than with other attorneys."

(Continued on page 3)

Reports Editor: Jean Knightley
601 McAllister Street
San Francisco, CA 94102
415-922-1440

Legal Specialization Board Announces Time and Places Of Annual Examination for Certification of Specialists

The California Board of Legal Specialization has announced that the fourth annual written examination for attorneys seeking certification as legal specialists will be held August 29, 1976, 8:30 a.m.-5 p.m. at these locations:

Hastings College of the Law, 198 McAllister Street, San Francisco;

University of California, Los Angeles School of Law, 405 Hilgard Avenue, Los Angeles.

The filing deadline for applicants wishing to take the examination is July 15, 1976. Specialty experience and educational requirements must be completed before the filing deadline.

The specialization program includes criminal law, worker's compensation law and taxation law, and is open to active State Bar members who will have 5 years of law practice on or before November 1, 1976.

For applications and information, write: California Board of Legal Specialization, 633 Battery Street, Suite 510, San Francisco, CA 94111. (Indicate area of interest—criminal, worker's compensation or taxation field—and include State Bar membership number.)

The application packet costs $5. Please include a check or money order with written request. If an application is filed, the $5 will be credited against the application fee of $100.

FOR THE RECORD: The deadline for submitting counter-arguments to conference resolutions is May 15, 1976—not 1975 as printed in the December issue of Reports.

Alcohol Program

(Continued from page 2)

The Word Is Confidential

What can the troubled attorney or judge expect, after contacting the committee for help?

First of all, he or she can expect total confidentiality. The Committee on Alcohol Abuse is wholly separate from the profession's disciplinary arms—i.e., the Commission on Judicial Qualifications and the State Bar disciplinary committees. Bartlett explains: "We each pursue our separate but interrelated objectives. The Bar disciplinary agencies are bound to strict confidentiality under Rule 8. A similar rule applies to judges. They cannot reveal the identity of a person under disciplinary proceedings. We, in turn, don't divulge the identity of persons who seek our assistance.

"In those situations where our participants already face disciplinary proceedings, individual participants invariably request that we forward the results of our documentation and monitoring efforts to the involved disciplinary agency.

"Correction of the drinking problem is often a factor tending to mitigate the otherwise harsh consequences that would attach to the professional conduct violation. These are the *only instances* in which we reveal the identities and program involvements of our participants."

Ted Cohen's experience illustrates this point. After his conviction, and following hearings held before a Bar committee, the Bar's Disciplinary Board recommended disbarment. The State Supreme Court ordered continuation of suspension for five years, but stayed execution of that order and placed Cohen on probation for five years on specified conditions, including that he abstain from the use of alcoholic beverages.

Specifically concerning Cohen's problem drinking, the Court pointed out that although doubt existed that alcohol caused his problem it may have been a contributing factor.

The Court said it found mitigating circumstances, including the testimony of witnesses demonstrating Cohen's rehabilitation and expressing their belief in his present fitness.

Help: What Kind & Where?

Today, Cohen stresses, "Help exists. There is a number to call, a place to go. There are a number of fellow attorneys who've been there and want to help."

When a lawyer or judge contacts the committee, its members introduce him or her to several fellow attorneys who have fought the alcohol battle and won. These people are available to call whenever their colleague is tempted to take a drink or just wants to talk, and meet regularly with him or her. Professional alcoholism counselors such as Sanow also work with the attorneys and judges, and help steer them to whatever other sources of assistance might be appropriate for the individual case.

(Continued on page 8)

Board Announces Official Interpretation Of Letterheads Rule

LETTERHEADS. Rule 2-103(A)(4) of the Rules of Professional Conduct permits a lawyer to use a letterhead which sets forth the lawyer's name, his address(es) and telephone number(s), the name of his law firm, the names of his associates and, if he is a patent or trademark lawyer, such fact pursuant to Rule 2-106(1) of the Rules of Professional Conduct. The names of, and dates relating to, deceased and retired members of the law firm may also be listed on the letterhead. Rule 2-103(A)(4) further allows (and defines) "Of Counsel" designation on a letterhead, and the listing of predecessor law firms.

If a member of the State Bar devotes a substantial amount of time in the representation of a client, such client's letterhead may designate him as "General Counsel," provided such letterhead is used only for correspondence relating to the professional representation of that client. Readers are referred to the text of Rule 2-103(A)(4) for complete information and are cautioned to read Section (A) with subparagraph (4) to determine the scope of information permissible on a lawyer's letterhead.

In Rule 5-103, the word "associate" is defined to mean "an employee or fellow employee who is a member of the State Bar." "Associate" as used in Rule 2-103 is intended by the Board of Governors to refer only to members of the State Bar; the word is not intended to include employees or affiliates who are not members of the State Bar. It should also be noted that Rule 2-103(A)(4) specifies what may appear on a lawyer's letterhead and that which is not included in the Rule is deemed to be proscribed by the specific language of Section (A).

The above is intended to serve as notice to all members of the State Bar of the Board's official interpretation of Rule 2-103(A)(4). A willful breach of this Rule constitutes cause for discipline pursuant to Business and Professions Code § 6077.

COMMENTS INVITED

Members of the bar who are of the view that Rule 2-103(A)(4) should be revised to permit additional information on letterheads are requested to send their written comments to the State Bar of California, 601 McAllister Street, San Francisco, CA 94102, c/o Ronald W. Stovitz, by Feb. 10 for consideration by the Board of Governors.

Bar Office Expansion in Redevelopment Area Leads to Unique Minority Hiring Agreement

Cooperation rather than confrontation was the key to the Dec. 17 "Memo of Understanding" between the State Bar and San Francisco's Western Addition Project Area Committee (WAPAC).

Basically, this contract — perhaps the first of its kind in the country— provides that the State Bar call on WAPAC when newly-created jobs are to be filled or vacancies occur, when these fall under the Bar's affirmative action program. Preference will be given to the minority applicants who possess the necessary skills to fill the positions in question.

The History

The agreement is the result of protracted negotiations between the Bar and WAPAC, which began when the Bar staff and functions outgrew its present headquarters. A three-story building will be constructed just southeast of the Bar's existing structure on Franklin and McAllister Streets. The property is part of the Western Addition Area. WAPAC is the official community organization authorized under the Redevelopment Act of 1949 to advise the San Francisco Redevelopment Agency.

The Goal

The eventual goal is to have 47% of the Bar's staff be minority persons, reflecting the ethnic composition of San Francisco. The 47% includes persons already employed. Of the 123 people currently employed by the Bar's San Francisco headquarters, 23 are minority—about 19%.

Job openings eligible for WAPAC consideration will be determined by the composition of the employee classification level—i.e., professional, paraprofessional or clerical—in which the opening occurs.

Kenneth B. Gillis, director of the Bar's financial affairs, estimated that in the next several years, 100-125 jobs will be available due to Bar expansion and natural attrition.

The Significance

At the signing ceremony, John N. Doggett, III, the Bar's assistant director of the Office of Legal Services, noted that "To our knowledge this is the first agreement between a community organization authorized under the Redevelopment Act of 1949 and a corporation like the State Bar."

This agreement, Doggett says, "represents recognition by the State Bar that residents in the Western Addition community have the right to determine what's going to happen to their community."

Participating in the ceremony was Brent M. Abel, immediate past president of the State Bar. Abel stated that from the Bar's standpoint, "One of the major pluses of this agreement is that it enables the State Bar to stand tall for affirmative action, as an example to the 50,000 lawyers in the state.

"It shows that the organized bar stands for an open profession, for advancement of society, and I hope it will have a substantial inspirational effect on lawyers throughout the state—both in their own lives and in representing their clients."

Board members Richard C. Dinkelspiel and Kurt W. Melchior were instrumental in completing final negotiations with WAPAC. Dinkelspiel said that ". . . the exciting thing about this is the emergence of the Western Addition as a vital part of San Francisco.

"I hope this is the beginning and not the end of a great movement of government agencies and business out into this area.

"This could be a vital movement that would rehabilitate San Francisco, which has been suffering from all the ills that plague urban areas in the United States, and I see, out there, the city of the future. I'm very pleased to be part of that, pleased that the State Bar can contribute something to that important development."

The agreement was signed by John S. Malone (secretary, State Bar), Richard C. Dinkelspiel (Bar Board member), and, representing WAPAC, Ms. Mary Rogers (chairperson, WAPAC Board of Directors) and Arnold Townsend (WAPAC executive director).

Cooperation—Not Confrontation

Both Townsend and Rogers said it was important that the decision was made through discussion rather than forced by activism.

Ms. Rogers said that "three or four years ago, I would have been sitting here with a group of people fighting with the State Bar.

I'm happy that we've grown enough to sit down and negotiate this first step to bridge the gap that existed between the community and institutions for so many years."

(Continued on page 7)

Proposed Rule to be Reconsidered

The Bar's Board of Governors will reconsider a rule previously sent to the State Supreme Court for approval. The proposed rule would govern the conduct of lawyers running for judicial office.

Proposed Rule 9-101 (Rules of Professional Conduct: Bar Misc. 3849), now pending before the Court for approval, has been calendared for reconsideration by the Board of Governors at its January 22-24, 1976 meeting.

Board Approves Support For Determinate Sentence Bill

At their December meeting, the Bar's Board of Governors approved a report submitted by the Committee on Corrections recommending support of S.B. 42.

The bill would establish a determinate (fixed term) system of sentencing for all except capital crimes.

"Proof of Damages" Institute Set by ABA Litigation Section

The American Bar Association's Section of Litigation is presenting an institute on "Proof of Damages," Jan. 22-23, at the Fairmont Hotel in San Francisco.

Section chairman Robert F. Hanley, of Chicago, says the program will give litigators "practical insights and information in an area which is often overlooked."

For further information, call ABA National Institutes, 312-947-3950.

Advertising

(Continued from page 1)

bility, Suite 502, 633 Battery Street, San Francisco, CA 94111.

With his letter, President Casey enclosed a copy of the committee's report containing a description of the proposed pilot program, and two other attachments:

(1) A memo on lawyer advertising prepared by the ABA Young Lawyers Section, which analyzes developing case law and pertinent policy issues. The memo concludes in favor of a controlled advertising program similar to that being considered by the Bar's Board of Governors.

(2) A Discussion Draft of proposed amendments to the Ethical Considerations and Disciplinary Rules of Canon 2 of the Code of Professional Respon-

(Continued on page 5)

Board Seeks Local Bar Comment on Creating More Sections

The Board of Governors is studying the advisability of creating "sections" in various areas of the law.

The purposes would include: (1) permitting greater participation of individual members and local bars in State Bar activities; (2) giving Board members broader input on matters affecting certain areas of law; (3) keeping section members up to date in those areas of law of special interest to them; (4) giving broader-based support for Bar-sponsored legislation, insuring that Bar legislative activities represent the thinking of the Bar in general; and (5) permitting the Conference of Delegates to focus on the more important aspects of proposed legislative change.

A Taxation Section was created in 1974 on a pilot basis, and the Board has approved a Legal Services Section.

In a December 15 letter to all local bar presidents, however, Bar President David S. Casey wrote that the Board "does not want to create additional sections until assured the bar generally and the local bar associations in particular approve the concepts."

Included in Casey's letter were four questions, which he asked the local bar presidents to answer and return to the State Bar headquarters no later than January 26, 1976.

Briefly, the questions asked what local bar presidents thought about the concept of State Bar sections; whether creating such sections would adversely affect their local associations; whether those whose local bars had sections would favor or oppose State Bar sections in the same field; and specifically, whether the bar presidents favored State Bar sections on Patent, Trademark and Copyright Law, and on Family Law.

Advertising

(Continued from page 4)

sibility prepared by the ABA Standing Committee on Ethics and Professional Responsibility. This draft, which would permit advertising except for "a false, fraudulent, misleading, deceptive, or unfair statement or claim," will be discussed by the ABA House of Delegates at its midwinter meeting.

Earlier this month, Casey also sent out sample lay-outs of the type of advertisements envisioned in the pilot program, with an extensive bibliography of relevant cases and articles for those interested in acquiring a thorough understanding of the issues.

All of the above-mentioned material has been distributed to local law libraries and law schools so that it is accessible to concerned Bar members. Additional copies are available at cost from the State Bar.

In a very summarized form, the pilot program would permit the following for an experimental period of 18 months:

(1) Each law firm or sole practitioner could take out a Yellow Pages display ad in the local telephone directory. No ad could be larger than 1/16 of the page on which it's printed, and no artwork or photography would be allowed. (Phone company regulations prohibit listing fees, but the ad could contain a statement that a fee schedule is available on request.) The display could also contain, in addition to normal name-address-telephone data, the following information: number of attorneys and paralegals in the office—fields of law in which the lawyer practices—office hours—whether credit cards are accepted—languages other than English spoken by attorney—whether the attorney interviews clients away from the office—State Bar-approved specialties—whether the attorney would submit to binding arbitration in a fee dispute.

(Continued on page 8)

DISCIPLINE IMPOSED

December 31, 1975

Addresses appearing below are last addresses as shown by State Bar membership records.

Only certain matters which have become effective are shown.

The reader is referred to articles which will be appearing in the State Bar Journal for a summary of the facts found with respect to the following cases:

Discipline ordered by the Supreme Court following State Bar proceedings.

RICHARD B. BLYTHE, also known as Richard Barclay Blythe, 1250 Wilshire Boulevard, Suite 501, Los Angeles, California 90017, suspended from the practice of law for a period of one year and until he makes restitution and returns client's documents, November 20, 1975, effective December 19, 1975.

ROBERT H. McCOY, also known as Robert Hughes McCoy, 19730 Ventura Boulevard, Woodland Hills, California 91364, suspended from the practice of law for a period of three years and until he makes restitution, suspension to commence upon the reinstatement from his present suspension, November 20, 1975, effective December 21, 1975.

RICHARD R. MURPHY, 106 North McPherson Road, Orange, California 92668, suspended from the practice of law for a period of three years, execution stayed, placed on probation for said three year period upon condition that he be actually suspended for one year and that he comply with the conditions recommended by the Disciplinary Board, November 18, 1975, effective December 19, 1975.

ALEXANDER G. SHIROKOW-WALTERS, P.O. Box 1841, Monterey, California 93940, order of June 26, 1974, suspending Mr. Shirokow-Walters from the practice of law until further order of the Court terminated forthwith. (The Disciplinary Board had recommended that the period of suspension already served was sufficient discipline) November 25, 1975.

AVERY SEYMOURE WAISBREN, 4210 Bellingham, Studio City, California 91604, suspended from the practice of law for a period of four years, commencing on September 29, 1972, November 26, 1975, effective December 27, 1975.

FRED KEE WONG, 940 Mei Ling Way, Los Angeles, California 90012, disbarred, November 18, 1975, effective December 19, 1975.

In addition to the foregoing, the Court has entered an interim suspension order pursuant to Section 6101-6102 of the Business and Professions Code with respect to the following member of the Bar who has been convicted of a crime. The effective date of the order is shown.

RICHARD DOLWIG, also known as Richard Joseph Dolwig, 535 Wilhaggin Drive, Sacramento, California 95825, effective December 21, 1975.

RESIGNATION ACCEPTED WHILE DISCIPLINARY MATTER PENDING

December 31, 1975

Addresses appearing below are last addresses as shown by State Bar membership records. The Supreme Court has accepted the voluntary resignations of the following members of the State Bar without prejudice to further proceedings in any disciplinary matters pending against them should they thereafter seek reinstatement.

The dates of acceptance are shown.

JAMES H. BANKS, 16200 Ventura Boulevard, Encino, California 91316, accepted November 25, 1975.

ROBERT M. DERITIS, 14045 Milbank Street, Sherman Oaks, California 91403, accepted November 20, 1975.

Conference Call

JANUARY 1976

Vol. 76 No. 1

Co-editors Judith E. Ciani and Thomas W. Eres

OFFICERS AND DIRECTORS OF THE CALIFORNIA BARRISTERS ASSOCIATION

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President's Report—by Edward W. Poll

Our bicentennial year promises to be the dawning of a new era for the California Barristers Association. Barristers all over the State are preparing to enter the twenty-first century, both as individuals and as members of a professional association. To do this, we must master change.

Paraphrasing one recent writer, to master change, we shall need both a clarification of important long range goals *and* a democratization of the way in which we arrive at these goals.

The California Barristers Association has recently made large strides toward achieving greater participation of young lawyers in their professional destiny. The California Barristers Association is a changed organization because of this new involvement. The following is a brief list of some of the changes in your organization: (1) *Conference Call* is being forwarded to *every* Barrister in California. We now have the opportunity for frequent and direct communication with our constituency. (2) We have direct and frequent communication with the Board of Governors of the State Bar. Two CBA representatives sit with the Board of Governors at each of their meetings. Thus, the Barristers' voice is heard on every issue of our concern. If you need to say something on any given subject which may properly be brought before the Board of Governors, please contact me or the CBA director in your district. (3) A Barrister will sit as liaison to each of five committees of the Board of Governors. This most recent development will permit early consideration of Barristers' opinions. Barristers, for the first time, will have the opportunity to make important contributions in the beginning stages of a program's development rather than merely react to an accomplished fact. The five committees are: Unauthorized Practice of Law, Delivery of Legal Services, Professional Responsibility, Budget and Efficiency and Long Range Planning. We look forward in 1976 to continuing our good relations with the Board of Governors and improving the effectiveness of the communication of your wishes to the Board. (4) Creation of task forces on Employment Opportunities, Law Office Management and Ethics.

In the coming year, we will turn our attention to the "clarification of long-range goals". Our task forces will help in their respective areas; we anticipate the task forces will submit reports and/or have completed their tasks by September, 1976. In each of the three areas mentioned, exciting programs are planned. The response to these task forces has been fantastic!

However, for those to whom these areas have insufficient interest to have become involved, I ask you to let me know of your particular interests. We will move into any area where the CBA believes we can make a contribution and where Barristers have expressed a desire to become involved. We look forward to your comments and to your becoming participants in your organization.

One area in which your Board of Directors has become involved and which is of concern to all attorneys is that of advertising. Each president of a local barristers' organization has received a packet of materials discussing the various issues and arguments pertaining to advertising. Please be sure your organization discusses this very important topic. Send your comments to me at 9777 Wilshire Boulevard (Suite 718), Beverly Hills, California 90212 by February. The CBA wishes to reflect and report your attitudes to the Board of Governors. We need your support and responses to be able to do this.

In February, 1976, the State Bar will hold its annual mid-year meeting in San Diego. On Saturday afternoon of this meeting, the CBA will conduct its mid-year Conference of Barristers. All Barristers in attendance are urged

(Continued on page 7)

Barristers: Interested In Placement Service?

To determine barrister interest in establishing a placement service for California lawyers, the Employment Opportunity Task Force has prepared the following brief questionnaire. Please take a moment to complete the questionnaire and mail it to Toliver Besson, Paul, Hastings & Janofsky, 22nd floor, 555 South Flower Street, Los Angeles, CA 90071.

1. Are you in favor of establishing a lawyer placement service in California which would match lawyer applicants with job openings in California?
   yes_____ no_____
2. Would you use such a service if it were established?
   yes_____ no_____
3. Is there a 50-50 chance or better that you would need to use such a service within the next five years?
   yes_____ no_____
4. Would you use the service if there were a $25.00 application fee?
   yes_____ no_____
5. Please provide the following information:
   a) age: _____
   b) number of years in practice: _____
   c) type of practice: (check as appropriate)
      individual practitioner ____
      associate ____
      partner ____
      government service ____
      employed by private concern ____
   d) county in which you practice _____
6. Additional comments: _____

Barristers Attend ABA Young Lawyers' Regional Meeting

by Noel W. Nellis

California Barristers Clubs affiliated with the ABA Young Lawyers Section were recently invited to send representatives to attend a regional meeting of affiliated young lawyer organizations sponsored by the ABA Young Lawyers Section and held on December 6 at the Stanford Court Hotel in San Francisco. Invitations to the meeting were sent to affiliated organizations in eight western states. Attending from California were representatives of barristers clubs in Beverly Hills, Fresno, Long Beach, Los Angeles, Sacramento, San Francisco, Santa Barbara, Santa Clara County, and Shasta-Trinity Counties, as well as representatives of the California Barristers Association Board of Directors.

The main purpose of the meeting was to give the ABA Young Lawyers Section an opportunity to discuss with affiliated organizations various current projects and activities which the Young Lawyers Section has underway. The Young Lawyers Section distributed background materials dealing with such subjects as Mental Health Law Reform and Youth Education. In addition, the conference also served as a forum for an exchange of ideas among local young lawyer organizations concerning their activities and concerns. Among the subjects discussed was the pending proposal by the California State Bar Board of Governors and the American Bar Association for allowing limited advertising by lawyers.

President's Report

(Continued from page 6)

to attend this meeting. Further details will be mailed directly to the presidents of the local barristers' organizations.

The future of our profession can be very bright. However, the will of large members of hitherto unconsulted attorneys must be ascertained. To some, this appeal for a form of neo-populism may seem naive. Yet, nothing is more naive than the notion that the Bar Association can shape the destiny of the legal profession without the input and support of its members.

BIOSKETCH: Edward W. Poll, CBA President

(Editor's Note: Beginning with this issue, we will prepare a brief biographical sketch of Board members for the Conference Call in an effort to give Barristers more information on their representatives.)

Ed is a long-time Southern California resident now in private practice in Beverly Hills. He obtained his BS, cum laude and JD from UCLA. In 1973 he received an MBA from the University of Southern California.

Ed began his professional career in 1965 as a trial attorney for the City of Los Angeles. In 1966 he left public service to become vice president and general counsel for the Fairfax Food Corporation.

He remained in business practice until 1970 when he began his private practice with emphasis in general corporate matters, real estate, civil litigation, and tax and estate planning.

Ed is a former editor of *Conference Call* and is currently a member of the Board of Governors of both the Beverly Hills Bar Association and Beverly Hills Barristers. He is a member of the American Arbitration Association, American Bar Association, Los Angeles Bar Association and Association of Business Trial Lawyers. He is an associate editor of the "Journal of the Beverly Hills Bar Association" and is a Judge Pro Tempore of the Beverly Hills Municipal Court, Small Claims.

Community activities include liaison with the Department of Consumer Affairs, City of L.A. for the food industry, member of Palms Jr. High School Advisory Council, and vice president, Canfield-Crescent Heights Community School.

CBA Board to Confer with Presidents Of Local Barrister Associations

Members of the Board of Directors of the California Barristers Association will meet with presidents of barrister associations throughout the state on Saturday, Feb. 28, 1976, in San Diego.

The meeting will be held in conjunction with the Conference of Bar Presidents scheduled Feb. 27-29, also in San Diego.

On the agenda will be discussion of the new CBA Task Force concept, better ways of communicating barrister activities, concerns and problems on a statewide basis, and additionally, major current topics such as legal advertising, recertification, legal specialization, and the organization of the State Bar.

* Formal invitations and materials are now being sent to barrister presidents, and if you have topics of concern you would like voiced at this meeting you should contact your local association president.

WAPAC

(Continued from page 4)

Townsend said that while the agreement was not expected to solve the employment problems of the Western Addition area, it was nonetheless significant:

"A positive step has been made by two organizations to sit down and rationally work out an agreement—rather than having the State Bar say 'because this area in which our headquarters is located is going through some redevelopment and some problems, we're going to pack up and move down to Los Angeles.'

"The Bar has done what I think is the proper thing, in saying instead 'this is the situation at home; now what can we contribute?' "

Program Discusses Opening & Managing Small Law Offices

The ins and outs of "Opening and Managing a Small Law Office" will be covered in a program sponsored by the Barristers of Los Angeles County Bar Association. The program will be held Saturday, Feb. 7, in Department 1 of the Los Angeles Superior Court. The fee is $15. For more information, phone the Los Angeles County Bar Association: 213-624-8571.

Advertising

(Continued from page 5)

(2) Law lists and legal directories, now published under existing rules, would be permitted to contain additional information of interest to consumers of legal services. This might include any of the items listed above, as well as the cost of an initial half-hour or one-hour consultation fee.

In addition to comment on the basic program, the Board is especially interested in responses to these specific possibilities: experiment with placing law list information in the classified sections of newspapers once a week (or month) — limit experimentation with Yellow Page display advertising to specified geographic regions (perhaps only two or three counties)—increase efforts to assist local bars in engaging in institutional forms of advertising.

The Board would also like members' thoughts on whether any of the proposed forms of advertising should include information about paralegals.

To aid in consideration of this issue, Bar members are urged to examine the specific, proposed changes in the Rules of Professional Conduct. The proposed changes are printed in their entirety on pps. 20-27 of the Board committee's report describing the proposed pilot program. (Again, that report was sent, with other material mentioned above, to all local bar presidents by President Casey; it has been distributed to local law libraries and law schools; and it is available at cost from the State Bar.)

The deadline for receiving comment is March 1, 1976. Comments should be addressed to the Board Committee on Professional Responsibility, Suite 502, 633 Battery Street, San Francisco, CA 94111.

Alcohol Program

(Continued from page 3)

Any attorney or judge who wonders if he or she might benefit from contacting the committee can look in the November-December 1975 issue of the *California State Bar Journal*. On page 489, the Journal printed 20 questions prepared by the committee specifically geared to lawyers. A "yes" answer to any one of the questions indicates that alcohol might be a problem.

Vice chairman Bartlett says, "If you need a Bloody Mary, Screwdriver or similar concoction in order to make it to the office this morning, maybe you should give us a call."

In Northern California: Bruce Bartlett (vice chairman, Committee on Alcohol Abuse), 415-851-7248; Ed Spanier (consultant), 415-467-6688; Hal Cook (consultant), 408-293-4848.

In Southern California: Judge Leon Emerson (chairman, Committee on Alcohol Abuse), 213-923-1271; Jack L. Sanow (consultant), 213-413-4800.

February Brings 2 New CEB Programs Plus Repeat of Discovery Presentation

The CEB February line-up includes Remedies for Breach of Contract, the Law of Politics, and Repeat Discovery programs.

Remedies for Breach of Contract in California—a three-hour intermediate level program exploring techniques available to attorneys who handle contractual disputes. Experienced litigators discuss what contract remedies to pursue and how best to solve problems likely to be encountered. Topics covered: understanding statutory remedies; drafting and interpreting clauses providing specific remedies; avoiding litigation when a breach occurs or is threatened; deciding whether to seek declaratory relief; measuring and proving various types of damages; pleading and recovering punitive damages; handling materials shortages. The $35 fee includes an outline of statutes, cases and other authorities, and sample clauses.

The Law of Politics—a CEB conference on lobbying, corporate/union political activity, and campaign regulations, pertaining to both state and federal level activity. Conferees should be familiar with the basics of political campaign and lobbying regulations. Speakers will discuss: tax consequences to contributors and recipients; disclosure obligations; limitations on expenditures and contributions; lobbying and its restrictions; misrepresentation and defamation in campaigns; and current trends in regulation of political activity. Daniel H. Lowenstein (chairman, Fair Political Practices Commission) will give an insider's view of coping with the FPPC, speaking at a luncheon. The $90 fee includes the luncheon and two 75-page syllabi of excerpts from the coming CEB book on the law of elections and political activity.

Creating and Implementing Discovery Plans in California—a three-hour program (repeat of a June '75 presentation) for attorneys who need to learn the basics of discovery. Using hypothetical case situations, experienced trial attorneys and law and motion judges will discuss tactics and procedures of designing and implementing discovery plans: use of depositions; written interrogatories; requests for admissions, for production and inspection of documents, for inspection of land, and for physical examination; impact of amendments to the California Civil Discovery Act; use of objections; motions for protective orders; motions to compel discovery, and for sanctions. The $30 fee includes a chart analyzing California's civil discovery practices.

For program dates and locations, contact CEB, 2150 Shattuck Ave., Berkeley, CA 94704; 415-642-0223; in Los Angeles, 213-825-5301.

PLAN AHEAD FOR THESE CEB PROGRAMS

March—Organizing California Partnerships

March/April—Income Tax Consequences in Real Property Transactions • Problems in Criminal Law Practice: Search Warrants and Eye Witness Identification

April—2nd CEB Consumer Law Conference • California Federal Civil Practice Seminar

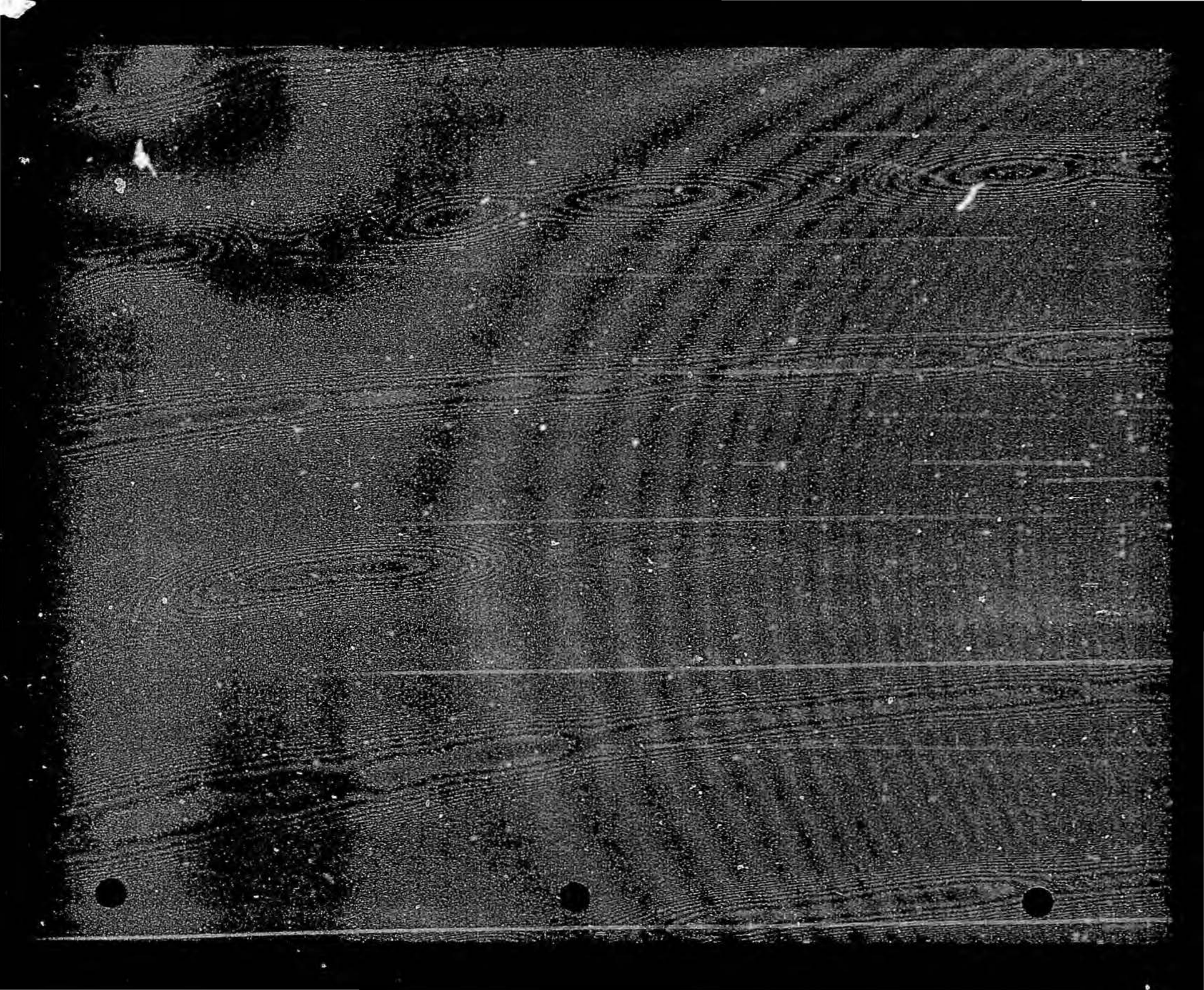
May—Probate Problems Seminar • Problems and Pitfalls of Attorneys' Opinion Letters and Recommendations • Dissolving California Businesses.

Reports: PUBLISHED MONTHLY BY THE STATE BAR OF CALIFORNIA
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INFORMATION FOR HEALTH CARE PROVIDERS CONCERNING MANDATED BENEFITS FOR THE TREATMENT OF ALCOHOLISM, DRUG ABUSE AND MENTAL AND NERVOUS DISORDERS



STATE OF WISCONSIN
OFFICE OF THE
COMMISSIONER OF INSURANCE
123 WEST WASHINGTON AVENUE
MADISON, WISCONSIN 53702

This guide has been prepared by the Office of the Commissioner of Insurance of the State of Wisconsin to assist health care providers (and insurers) in understanding and applying Wisconsin's mandated health care benefits law, as it relates to treatment of alcoholism, drug abuse and mental and nervous disorders.

The guide is not as easy reading as we would have liked, because it is addressing a complicated law, which presents many complex problems of administration. It is hoped that the guide will alleviate needless confusion and misunderstanding concerning this innovative law; but it should be kept in mind that in any particular fact situation, it will be that fact situation, and the law, which will determine the outcome. For that reason, whenever possible, footnotes have been used to tie statements in the guide to specific statutory provisions.

Revisions of the guide will be made in the future as necessary.

INFORMATION FOR HEALTH CARE PROVIDERS CONCERNING MANDATED BENEFITS FOR THE TREATMENT OF ALCOHOLISM, DRUG ABUSE AND MENTAL AND NERVOUS DISORDERS

Providers of health care services have asked the Department of Health and Social Services and the Office of the Commissioner of Insurance many questions about the provisions of section 632.89, Wisconsin Statutes, which mandates coverage in some circumstances for inpatient and outpatient hospital treatment of alcoholism, drug abuse and mental and nervous disorders.

The following questions and answers prepared by the Office of the Commissioner of Insurance should provide a better understanding of this legislation. All of the questions and answers should be read carefully as a guide to the interpretation of this statute and the insurance contracts to which it applies. The provisions of health insurance contracts vary greatly from one policy to another so that it is unlikely that all of the possible questions which can arise have been answered, but it is hoped that the most important ones have been included. Further questions can be referred to the Bureau of Alcohol and Other Drug Abuse, Department of Health and Social Services, 1 West Wilson Street, Room 523, Madison, WI 53702, (608) 266-0907, or the Office of the Commissioner of Insurance, 123 West Washington Avenue, Madison, WI 53702, (608) 266-3585.

Q. *Wisconsin insurance law (section 632.89, Wisconsin Statutes) requires that certain inpatient and outpatient benefits be paid by insurers for the treatment of: 1) alcoholism; 2) drug abuse; and 3) nervous and mental disorders.*

To what policies or plans does the law apply?

A. This law generally applies only to group insurance policies and contracts issued in Wisconsin which provide hospital treatment coverage, and to comparable policies issued to a group based in another state if more than 25% of the insured persons are Wisconsin residents.

These mandated benefits are not required (but may be included) in:

- individual insurance policies;[1]
- federal employee group plans (e.g. postal carriers' plans);[2]
- self-insured employer group plans falling within the terms of the Federal Employee Retirement Income Security Act of 1974 (ERISA limits or precludes state regulation of properly constituted plans, even when they are administered by an insurance company);
- most policies issued to a group based in another state in which fewer than 25% of the insured persons are Wisconsin residents.[2]

Q. *Must all plans and policies to which the law otherwise applies provide both in.tient and outpatient treatment?*

A. No. Inpatient hospital treatment benefits are required only under group plans which provide hospital treatment coverage.[3]

Generally outpatient treatment benefits are required only under group policies which provide both hospital treatment coverage and outpatient treatment coverage.[4] An exception to this is the requirement that "Blue Plans" (e.g. Blue Cross, Surgical Care, WPS) must provide outpatient hospital treatment benefits for alcoholism under any group contract or plan which provides either hospital or outpatient treatment.[5]

Q. *What types of coverage must be provided for in those plans subject to the law?*

A. Required coverages are as follows:

1) Alcoholism

-- a minimum of 30 days' confinement in any calendar year for inpatient hospital treatment.[6]
-- the first $500 in any calendar year for outpatient treatment services, including but not limited to partial hospitalization services, prescribed drugs and collateral interviews with patients' families.[4]

2) Drug Abuse

-- Coverages provided are identical to those provided for alcoholism.[4, 6]

3) Mental and Nervous Disorders

— a minimum of 30 days' confinement in any calendar year for inpatient hospital treatment.[6]
-- The first $500 in any calendar year for outpatient treatment services provided by or under contract for a board established under section 51.42 of the state statutes. (These are the county mental health boards.)[4]
— $500 in any calendar year for any other outpatient services for mental and nervous disorders.[4]

Q. *Do coinsurance requirements and deductibles apply to these mandated benefits?*

A. Section 632.89 (2) (b) specifies that exclusions and limitations which are generally applicable to other conditions covered in a policy may be applied to:

— inpatient hospital treatment for alcoholism, drug abuse and mental and nervous disorders.

— outpatient treatment for nervous and mental disorders — other than by or for a 51.42 board — as long as $500 per year in benefits are provided.

Deductibles and coinsurance may not be applied to coverage required for outpatient treatment of alcoholism and drug abuse, or outpatient treatment provided by or for a 51.42 board for nervous and mental disorders until the first $500 has been paid by the insurer.

Q. *What is an "outpatient treatment facility?"*

A. An outpatient treatment facility is a facility licensed or approved by the Wisconsin Department of Health and Social Services whose outpatient services meet the standards established in section 51.42 (12), Wis. Stats., and which provide those services, except inpatient services, enumerated in section 51.42 (5) (b) to (d), Wis. Stats., for the prevention and amelioration of mental disabilities, including but not limited to mental and nervous disorders, alcoholism and drug abuse.[7]

Q. What are "outpatient services"?

A. "Outpatient services" mean services, medications, equipment and supplies performed or furnished by or under the supervision of or on referral from a physician at a hospital or outpatient treatment facility to a patient who is not a bed patient of the hospital or outpatient treatment facility.[8]

Q. Are psychologists' or social worker's charges for outpatient treatment required to be covered?

A. This depends upon whether such services are provided under the supervision of or on referral from a physician. The definition of outpatient services in section 632.89 (1) (d) which insurers are required to provide does not include those of non-physicians unless furnished under the supervision of or on referral from a physician.

Referral and supervision are not further defined. Comparable psychotherapy programs seem to require that, at a minimum, initial referral will include written authorization from a physician and that any subsequent visits will involve periodic reporting to that physician.

Q. Some group policies set waiting periods for "pre existing conditions." How is the date of onset of the alcoholism or drug abuse condition to be determined, in order to judge whether the condition is a "pre-existing condition" for insurance purposes?

A. The applicable standards for judging pre-existing conditions are contained in Wisconsin Administrative Code section Ins 3.31 and read as follows:

> A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition, as distinguished from the cause of such disease or physical condition, had manifested itself prior to such date. Such manifestation may be established by evidence of medical diagnosis or treatment of such disease or physical condition prior to the effective date, or the existence of symptoms of such disease or physical conditions prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care or treatment. (Emphasis added)

The insurer must use these standards in determining if a condition is pre-existing. Health care providers can assist in proper settlement of claims involving questions of a pre-existing condition by providing complete information about medical diagnosis or treatment, including recorded symptoms, of the condition.

Q. *What if benefits could be paid under more than one plan?*

A. Benefits can be paid under more than one plan. However, most group plans contain a coordination (or non-duplication) of benefits provision which is intended to limit the payment of benefits under all coverage to the amount of the total expenses incurred.

Q. *Does the requirement of section 632.89 (2) (d) that coverage for the first $500 of outpatient treatment in a calendar year be provided prohibit any limitation on the amount of a charge to be co... for services of a provider, e.g., application of a "usual and customary fees" limitation that would be generally applicable to other covered conditions?*

A. No, if the basis an insurer uses to establish fee reimbursement ...els is reasonable, and equitably ...lied to all providers.

Q. *What level of coverage for outpatient treatment must a contract include in order for the coverage for outpatient services mandated by section 632.89 (2) (d) to be required?*

A. Coverage which provides any kind of benefit for health care service other than for a hospital inpatient is "coverage for outpatient treatment" even if this coverage is very limited. This means that a policy which provides any outpatient treatment must include the mandated benefits.

Q. *When did this law become effective? Does it apply to policies and contracts then in force or only to those issued after that date?*

A. The legislative chapters that included these mandated coverages became effective May 5, 1976. All group policies and contracts issued after that date or renewed or otherwise changed after that date must include these coverages. Thus, all group contracts presently in force in Wisconsin which are subject to the law in other respects must now include these coverages and benefits. Moreover, most of them should have been including some of the mandated benefits for a number of years.

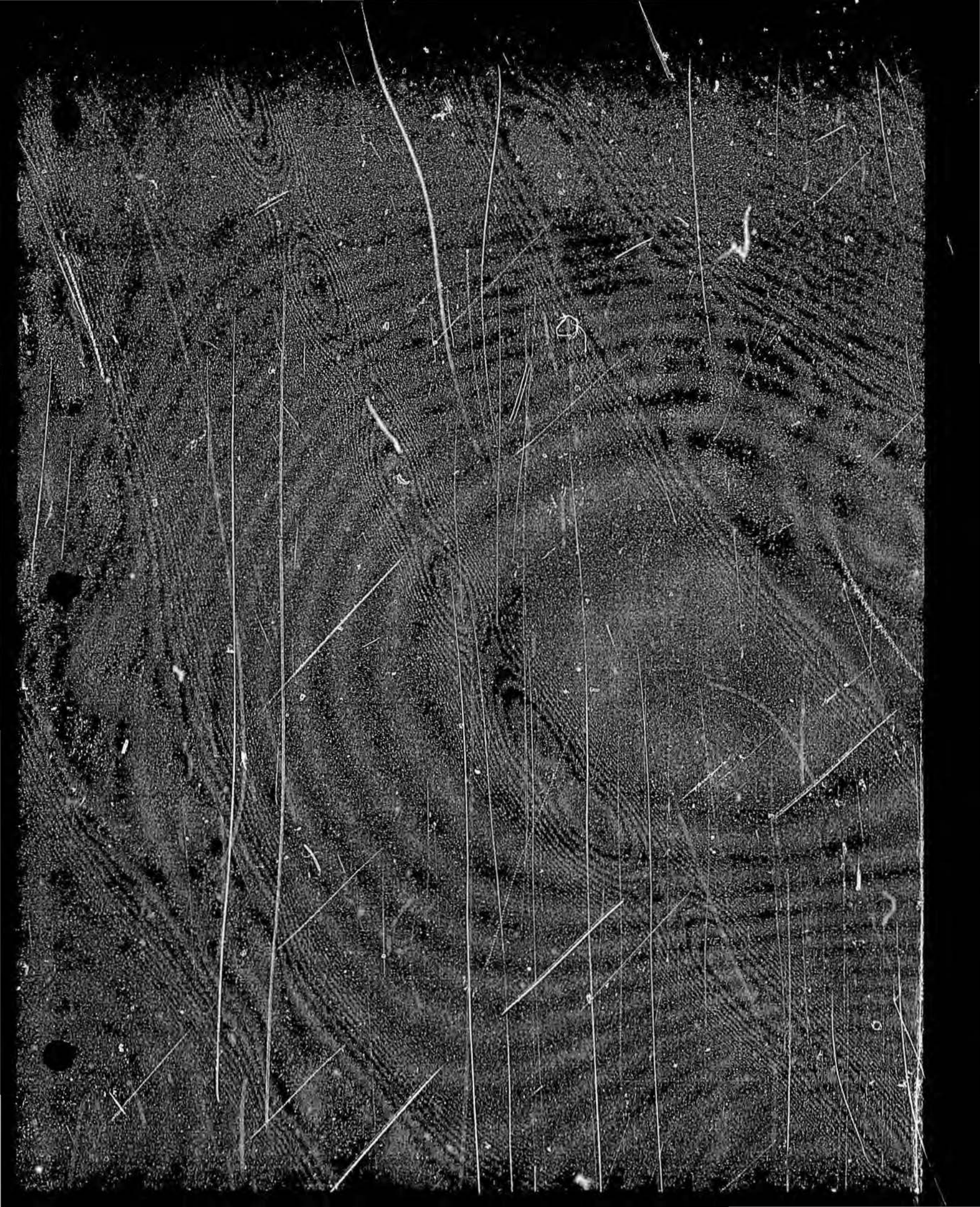
Q. *What should a provider or patient do if there is a question about whether a claim for insurance benefits has been properly handled?*

A. He or she should write to the Consumer Services Bureau of the Office of the Commissioner of Insurance describing the problem and including the name of the insurance company, the group policy number, and the subscriber or certificate number, if appropriate.

Consumer Services Bureau
Office of the
Commissioner of Insurance
123 West Washington Avenue
Madison, WI 53702
(608) 266-0103

Footnotes

1. 632.89 (2) (a), Wis. Stats.
2. 600.01 (1) (b) 3., Wis. Stats.
3. 632.89 (2) (a) 1., Wis. Stats.
4. 632.89 (2) (d), Wis. Stats.
5. 632.89 (3), Wis. Stats.
6. 632.89 (2) (c), Wis. Stats.
7. [illegible].89 (1) (a), Wis. Stats.
8. [illegible].89 (1) (d), Wis. Stats.



niaaa information & feature service

IFS No. 46
April 3, 1978

From the National Clearinghouse for Alcohol Information of the National Institute on Alcohol Abuse and Alcoholism

3rd Party Coverage Cuts Nonalcoholism Care Cost

A large-scale study in California has demonstrated that, when comprehensive insurance benefits for the treatment of alcoholism are provided, the cost of nonalcoholism health care may be reduced by some 25 percent per month for the alcoholic person.

In addition, figures from a 23-month pilot program for California State employees and their families showed that, when the alcoholic patient enters treatment, the frequency of inpatient care decreases and less expensive forms of care such as outpatient treatment are used more frequently.

The study project, which served about 337,000 beneficiaries and was funded by the State, also further confirmed the feasibility of providing a uniform and comprehensive model of insurance coverage for alcoholism treatment at a moderate increase in premium cost. The added cost for this coverage during the pilot program was figured at $2.05 per year or 17 cents per month.

This cost figure was based on a relatively low utilization of the alcoholism benefits, noted by Harold D. Holder and Jerome B. Hallan of H-2, Inc., a research firm in Raleigh, N.C., which was commissioned by the National Institute on Alcohol Abuse and Alcoholism to study the impact of the program. Utilization was especially low in the first 12 months of the 23-month period, but increased substantially the last 11 months, they said.

The project, which was under the supervision of the California Office of Alcoholism Program Management, provided a uniform set of alcoholism treatment benefits which included inpatient care of up to 17 days a year (including 6 days' detoxification), residential care of up to 30 days a year, and outpatient care of up to 45 visits a year.

Total benefits paid for the cost of treating the 766 patients served in the program were about $459,000. The insurance carriers' administrative costs of $94,000 brought the overall program cost to $553,000, or an average benefit cost of about $600 per patient.

The program paid for 422 inpatient admissions at an average cost of $1,392, representing about 83 percent of the total dollar benefits paid. Outpatient care services were utilized by 542 persons, with an average of 9.2 visits per patient at an average cost of $17 per visit, or 16 percent of the total benefits paid. Recovery home care was the least utilized service with 15 admissions at an average cost of $451.

General hospitals accounted for about 38 percent of the 422 admissions, alcohol treatment units in a general hospital for about 35 percent, and special alcoholism treatment hospitals for 21 percent.

The physician was the most frequent provider of outpatient care and the paraprofessional was the next most frequently used. The latter had the lowest average cost per visit—$15.

The estimate of a 25 percent drop in nonalcoholism care costs for a family after the alcoholic member began alcoholism treatment was based largely on a longitudinal study of the general health care experience of 240 families included in the pilot program coverage. Care was provided by the program to 462 alcoholic members of these families.

The cost of general health care for these 462 persons averaged $179.50 per person a month before alcoholism treatment began, but dropped to $133.22 after the start of treatment, Drs. Holder and Hallan reported. Thus, the saving was about $46 a month in nonalcohol related health care costs, or a total of about $370 per person for the time that care costs were followed.

Projecting this figure to embrace all of the 766 persons who used alcoholism benefits in the program, the researchers came up with a total cost savings of $283,297. Based on the ratio of this figure to total alcoholism care costs of $690,500 in the program, they found that for each $1 spent by the pilot program on alcoholism treatment, there was at least a 42-cent savings to the insurance carriers in the care of the alcoholic person.

The insurance coverage was provided through nine different carriers. However, more than 90 percent of the beneficiary population was covered by three carriers—Kaiser Foundation Group Plans, Blue Cross/Blue Shield, and California Western Occidental.

When the project ended in May 1976, the Kaiser Plans were the only carrier of the nine to continue providing alcoholism treatment benefits modeled after the pilot program, doing so at a small increase in the monthly premium. This carrier, which provides prepaid coverage, had the lowest per-visit charges among the nine.

For more information on the study, write: Jerome B. Hallan, Dr. P.H., H-2, Inc., 7334 Chapel Hill Rd., Raleigh, N.C. 27607.

Pamphlet Warns on Drinking in Pregnancy

The woman who is pregnant or plans to become pregnant is the target of a new pamphlet being distributed by the National Institute on Alcohol Abuse and Alcoholism.

The pamphlet, "Alcohol and Your Unborn Baby," states that drinking by the expectant mother could endanger the health of the fetus and suggests that, if she chooses to drink, she should limit her intake per day to no more than one ounce of absolute alcohol — the approximate equivalent of two mixed drinks, each containing one ounce of distilled spirits; or two five-ounce glasses of wine; or two 12-ounce cans of beer.

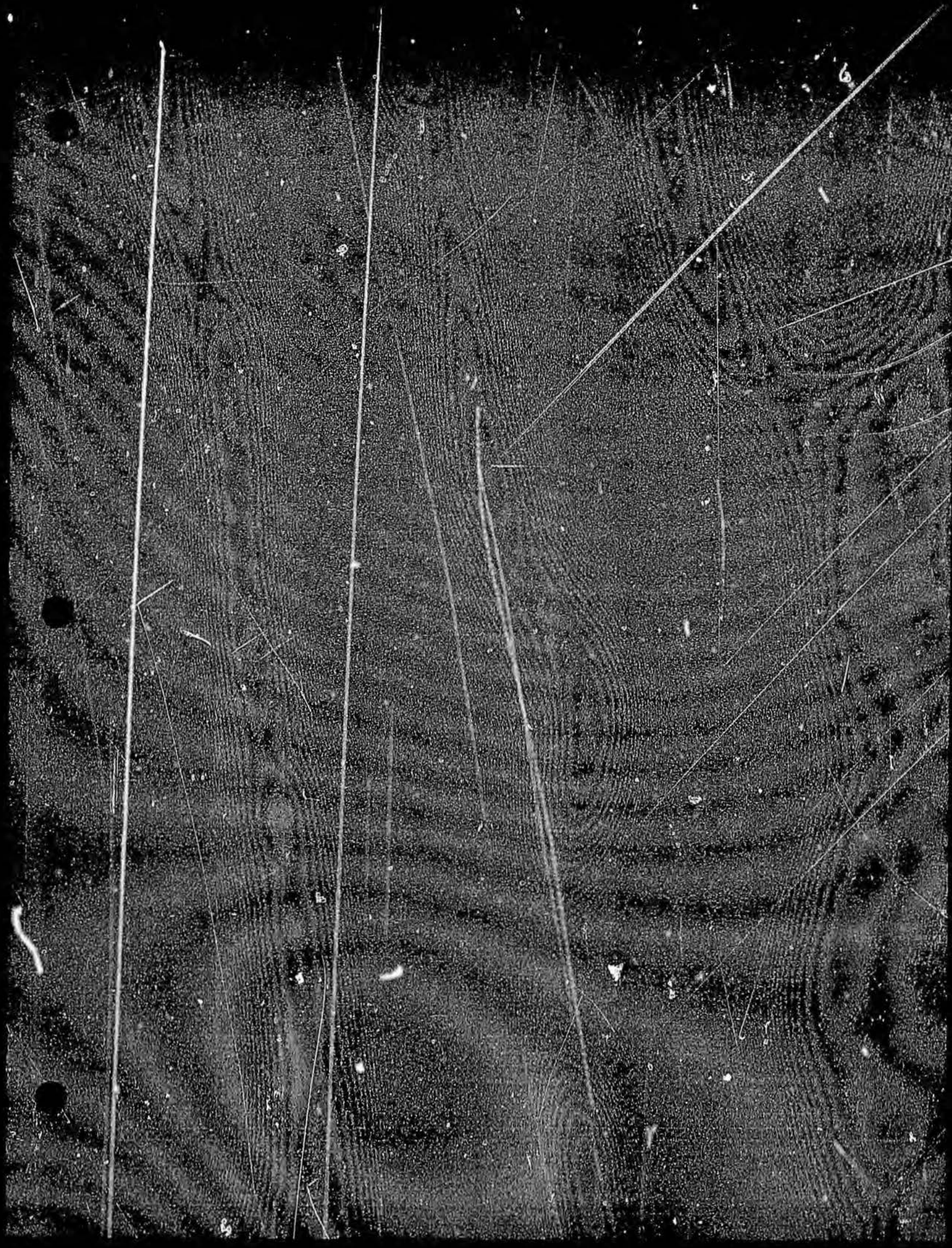
Publication of the pamphlet is part of a national effort by NIAAA to raise public awareness about the dangers posed to the fetus by drinking during pregnancy. The campaign particularly emphasizes the risk of developing the fetal alcohol syndrome (FAS)—a specific pattern of physical, mental and behavioral abnormalities that can occur in the offspring of women who drink heavily during pregnancy.

The possibility that even moderate drinking by the pregnant woman can harm the unborn baby is still being investigated, as is the effect of binge drinking, the pamphlet notes. Also being studied is the possible role of other risk factors, such as smoking and poor nutrition, in FAS.

The pamphlet tells where to get help for drinking problems and also touches on the use of other drugs during pregnancy, alternatives to drinking, and ways of coping with anxiety and depression.

"Alcohol and Your Unborn Baby" is being distributed through the National Clearinghouse for Alcohol Information to obstetrician-gynecologists' offices and for use in supermarket displays. Copies have also been sent to state alcoholism authorities, prevention coordinators, and program directors.

Single copies of the pamphlet are available by writing Dept. FAS, National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, Md. 20852.



CHAPTER XI. FINANCING ALCOHOLISM TREATMENT SERVICES

The magnitude of the alcohol problem in this country and the economic costs to society of alcohol-related problems have been discussed in chapter I of this report. It has been noted that health care costs directly attributable to alcohol-related problems are an estimated 12.1 percent of U.S. national health expenditures. There is a significant opportunity for reducing health care expenditures if effective alcoholism treatment services are supported. Recognition of this opportunity has led to funding by Federal, State, and local governments, as well as to modifying health insurance policies to cover alcoholism services. This chapter discusses these and other funding sources that currently are being used to finance alcoholism treatment services.

GOVERNMENT SUPPORT

Since its inception in 1970, the National Institute on Alcohol Abuse and Alcoholism has been helping to establish alcoholism programs by funding service projects directly and by making Federal formula grants available to States. An added source of Federal moneys became available from NIAAA in 1974 when incentive grants to the States were authorized to encourage the adoption of the Uniform Alcoholism Treatment and Intoxication Act. In addition, Federal support from other agencies (table 1) totaled approximately $207 million in 1976.

The financial base at the local level has expanded as States and other local governments either matched Federal funds or appropriated other sources of support. Federal, State, and local administrators consequently have sought to determine what resources are available for alcoholism programs and to identify what services these moneys are buying. This information is compiled in NIAAA's State Alcoholism Profile Information System (SAPIS), developed to discover the impact of formula grants within the States. According to a 1977 SAPIS report of 43 States providing information, average financial sources were formula grants, 13 percent; other NIAAA funds, 17 percent; local sources, 17 percent; and State and other Federal funds, 53 percent. An average of $7,322,000 per State was available to the States in FY 1976.

Information about resources undoubtedly will be improved by the SAPIS program, the impact of 1976 legislation requiring an accounting of States' public and private alcoholism service facilities in formula grant applications, and a recent NIAAA initiative to compile an annual report on all Federal activities related to alcohol problems.

Whatever the precise level of public funding of treatment services may be, nonpublic support clearly is required if adequate treatment resources are to be made available. Therefore, the extent of health insurance coverage for alcoholism treatment is of great concern. To illustrate the situation, table 2 shows the amount of insurance coverage of clients of selected NIAAA programs in 1976. The proportion of individuals with health insurance at all and with alcoholism coverage in particular varies

widely with the type of program. Health insurance coverage varies from 21 to 85 percent and alcoholism coverage from 10 to 45 percent. The proportion of individuals with health insurance who also have alcoholism coverage ranges from 18 percent to 53 percent.

HEALTH INSURANCE

Health insurance has been made available specifically for alcoholism only within the last decade. In the past, alcoholism was a hidden illness, and treatment usually took place in a State-supported institution because care in the private sector was either unavailable or prohibitively expensive. Little is known about the nature or extent of insurance coverage for alcoholism before the mid-1960's. However, it is safe to assume that many alcoholics received treatment under the mental health benefits of their insurance policies.

By the late 1960's it became clear that insurance carriers and providers were applying obvious sanctions to the treatment of alcoholics. Hospitals frequently blocked the admission of alcoholics, and health insurance policies limited coverage in many ways. With the dramatic surge of health care costs in this era and the increased recognition of the extent of alcoholism and alcohol abuse, the need to establish effective private third-party payment mechanisms was clear. NIAAA worked with representatives of health agencies and insurance carriers to study the status of alcoholism insurance coverage, to identify barriers to improved coverage, and to develop model benefit provisions.

PRIVATE SECTOR PLANS

The private sector has three major components: Blue Cross-Blue Shield plans, commercial insurance companies, and independent plans. Blue Cross-Blue Shield is a confederation of two private nonprofit corporations. Commercial companies include life and casualty insurance companies as well as other companies that provide health coverage. Finally, independent plans include employer- or employee-sponsored programs, health maintenance organizations, private group clinics, and dental service corporations.

Blue Cross-Blue Shield

An estimated 84 million subscribers are covered by the approximately 70 Blue Cross and Blue Shield associations operating in the United States and Puerto Rico. In 1976, the Blue Cross Association (BCA) and NIAAA initiated a nationwide study to determine the feasibility of offering comprehensive benefits for alcoholism treatment throughout the Blue Cross health insurance system. The study has produced a series of technical assistance documents designed to address the essential components needed in comprehensive alcoholism coverage. They were (1) a marketing package, including the benefit structure, a defined target population, rates, and a subscriber education program; (2) an administrative segment covering contracts with health care providers, legal constraints, and control of benefit utilization; (3) a guideline for test-site selection; and (4) a program for evaluating test-site results.

Some individual Blue Cross plans are offering increasingly comprehensive alcoholism benefits. In 1974, for instance, Capital Blue Cross in Pennsylvania introduced an alcoholism benefit that provided rehabilitation treatment immediately following detoxification in institutions specializing in alcoholism treatment. Premiums were not increased for this benefit because the plan's administrators realized that alcoholism treatment previously had been paid for under other diagnoses. Current data indicate that the benefit will reduce the number of claims and the total costs incurred by the carrier.

Blue Cross of Maryland provides alcoholism treatment benefits through one program in residential nonhospital settings and through another in outpatient care. Substance-abuse benefits--including alcohol and other drugs--were made available to the approximately 1 million members of the United Auto Workers Union, their spouses, and dependent children by Blue Cross and Blue Shield of Michigan.

Commercial Carriers

The trend among major commercial carriers is toward offering coverage for alcoholism treatment. The percentage of policies specifying exclusions or limitations on alcoholism coverage dropped from 16.5 percent in 1972 to 13 percent in 1975, according to one survey.

Independent Plans

Health Maintenance Organizations (HMO's). HMO's provide basic and supplemental health care on a prepaid basis to their membership. To qualify for Federal subsidies, an HMO must offer medical treatment and referral services for alcohol or other drug abuse. The Group Health Association of America, a national voluntary organization of group health plans, initiated an alcoholism treatment feasibility project to test the potential of comprehensive alcoholism treatment services in prepaid group practice plans. Although the data are too limited to be conclusive, indications are that there is a reduction in total health care use when alcoholism is identified and treated appropriately.

The Harvard Community Health Plan. This plan in Cambridge, Mass., which includes both inpatient and outpatient alcoholism benefits, reported a monthly cost for alcoholism treatment of only $0.05 per member. During the first year, no client used the inpatient treatment beyond the benefits provided.

Employee Benefit Plans. The industries sponsoring occupational alcoholism programs usually have policies that cover inpatient services, according to one survey. Considerably less coverage was provided for outpatient treatment.

Unions and Health Insurance Plans. The Nation's labor unions have participated actively in encouraging health insurance coverage for treating alcoholism and other drug abuse. Unions affiliated with the AFL-CIO and major independent unions such as the United Auto Workers, the United Mine Workers, and the Teamsters are implementing and expanding alcoholism treatment benefits.

PUBLIC SECTOR PROGRAMS

Several health insurance assistance programs are provided by law under Federal or State auspices and are financed through taxes. Benefits, fixed by law, are available to those who qualify under the plan. These publicly supported programs include medicare, medicaid, CHAMPUS (Civilian Health and Medical Care Program for the Uniformed Services), the Veterans' Administration program, and State temporary workers' compensation systems.

Medicare

Primarily, medicare pays medical expenses to individuals aged 65 or older who are entitled to retirement benefits under title II of the Social Security Act or under the Railroad Retirement System. Administered by the Social Security Administration, medicare's benefits and eligibility requirements are uniform for all participants and include hospital insurance and supplementary medical insurance for the aged and disabled. Medicare categorizes alcoholism and drug abuse treatment under psychiatric or mental health services, and the coverage is less than that available for physical illness.

Medicaid

Medicaid provides medical assistance to low-income individuals. Treatment cost is shared by the States and the Federal Government. A major limitation is that persons aged 21 to 64 cannot receive care in a psychiatric hospital under medicaid. In several States, however, medicaid plans provide reimbursement for treatment of problems associated with drug or alcohol abuse. Because services for alcohol or drug abuse problems are not mentioned in the medicaid statutes, the States determine whether treatment should be excluded or included.

A 1976 telephone survey revealed a wide range of practices. Most States reimburse for inpatient treatment of organic illnesses caused by or related to alcoholism, and 85 percent of the States reimburse for outpatient care for these illnesses. The proportion of States that reimburse for direct treatment of alcoholism is substantially lower. Approximately two-thirds reimburse for treatment at a community health center; nearly one-third pay for care at an alcoholism treatment center or from an alcoholism counselor; and about one-tenth absorb treatment costs at a halfway house or similar facility.

Title XVI

Under title XVI of the 1973 Social Security Act, supplemental security income (SSI) is granted by the Federal Government to those eligible for Aid to Families with Dependent Children, to the blind, to persons who are otherwise disabled, and to needy persons over the age of 65. The present social security law requires an alcoholic SSI recipient to designate a third party to receive his or her supplementary income. Often, this procedure undermines the self-confidence of recovering alcoholics. Pending legislation would enable the attending physician of the facility where an individual is undergoing treatment to certify that direct payment of SSI benefits

to the patient would be beneficial. The costs of alcoholism treatment generally are not covered by the SSI program.

Title XX

Title XX, a 1975 amendment to the Social Security Act, currently contributes $2.7 billion annually to the States for social services. The required State comprehensive plans may include alcoholism treatment services if they are defined explicitly. A 1976 analysis of services available for treatment of alcoholism and drug abuse under State title XX plans revealed that 10 States provide services specifically concerned with treatment of alcohol abuse; 11 pay for services related to both alcohol and drug abuse, and 16 reimburse for specific mental health services.

CHAMPUS and CHAMP-VA

This insurance program for dependents of military personnel covers inpatient and outpatient care for alcoholism. However, inpatient rehabilitative care beyond detoxification is limited to a lifetime maximum of three admissions, and outpatient treatment is limited to psychiatric services. A similar program, CHAMP-VA, is available to the dependents and survivors of some disabled veterans.

Disability Insurance

Public disability programs involving workers' compensation are available in all 50 States. Compensation is limited by 27 States if alcoholism or problem drinking is the cause of injury resulting in a claim.

OTHER FEDERAL INVOLVEMENT

National Health Insurance

In view of the tremendous health, social, and economic costs related to alcoholism, benefits for alcoholism and related health problems should be considered in the development of health insurance coverage. These should include a range of service components to assure a minimum level of continuity of care for alcoholism treatment.

A recent cost-benefit study of alcoholism treatment centers reinforces the argument for including coverage for alcoholism care in any health insurance package. The study found that the national economy will realize 10 years of benefits, estimated at close to $22 million, from the operation of 41 alcoholism treatment centers during the last half of 1974. However, half of the 20 legislative proposals for national health insurance introduced in the 94th Congress did not mention alcoholism specifically.

Civil Service Plans

The Federal Government offers 55 health insurance plans to its employees. Most of these include some benefits for alcoholism, although the extent

of the coverage varies widely. Some plans have a specific alcoholism benefit, but most alcoholism treatment is part of the mental health benefits or some other benefit category.

NIAAA Activities

NIAAA has sponsored a range of studies to plan increased health insurance coverage for alcoholism treatment and has developed experimental projects to demonstrate the feasibility of this type of insurance. The agency helped to develop standards for treatment facilities that, when implemented, lead to accreditation. When a facility is accredited by the Joint Commission on Accreditation of Hospitals (JCAH), more carriers are willing to insure the care provided there. More than 200 alcoholism programs nationwide have been accredited by JCAH.

One of the agency's feasibility studies resulted in a model alcoholism treatment package designed to provide insurance companies with a basis for projecting a range of costs in various alcoholism treatment settings. The model benefit package recommends 6 days of inpatient emergency care, 14 days of inpatient care, 30 days of outpatient care, 30 days of short-term intermediate care, and 60 to 90 days of long-term intermediate care. This package was tested for 2 years in the California State Employees' Insurance Alcoholism Program.

NIAAA is concerned with State and local service programs in several administrative areas, including training, cost accounting systems, and policy procedures, and is working with others in the field to develop certification standards for alcoholism counselors.

STATE INVOLVEMENT

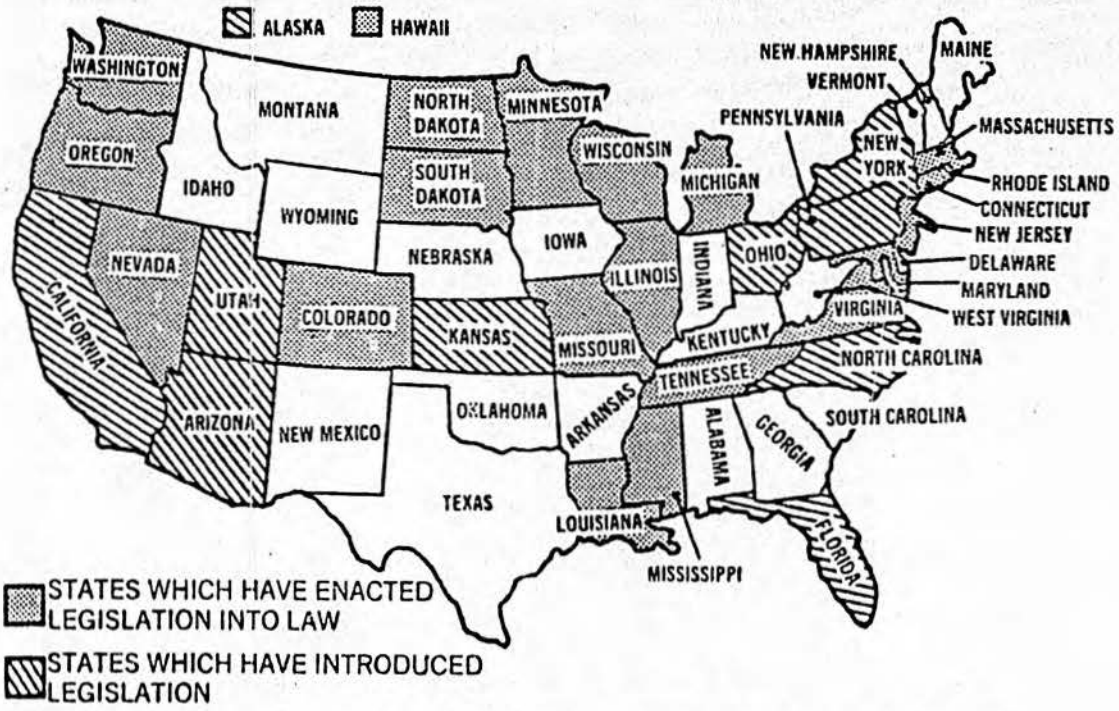
State Regulatory Agencies

Since State insurance departments are empowered by statute to regulate the extent and cost of insurance contracts and the conduct of insurance carriers, State legislative actions have become important in setting minimum standards for alcoholism treatment. A mid-1976 survey of State legislative activities showed that insurance coverage for alcoholism treatment had increased considerably since 1974. Unfortunately, the enacted legislation often emphasizes inpatient care and limits outpatient treatment, although recently some States have mandated more extensive outpatient benefits. By mid-1977, 20 States had enacted legislation into law, and 11 other States had introduced legislation related to health insurance coverage for alcoholism (figure 1).

California State Employees' Insurance Alcoholism Program

This 2-year pilot alcoholism program was based on the model benefit package described briefly above and more extensively in the Second Special Report on Alcohol and Health. It offered benefits for 158,000 State employees and more than 300,000 family members, through nine insurance carriers. The program involved no risk for the various moneys paid for both alcoholism treatment claims and carrier administrative expenses.

Figure 1. State legislative Activities Relating to Health Insurance Coverage for Alcoholism, 1971-77



SOURCE: Data from Jerome Hallan and Becky Hayward, Health insurance coverage for alcoholism: Current status. Unpublished report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0023. Raleigh: H-2, Inc. 1977.

The alcoholism benefit package provided

- inpatient care in a hospital or other licensed facility, including up to 6 days of detoxification services and 21 days of treatment a year;
- day or night residential care in a licensed recovery home for a maximum of 30 days annually; and
- outpatient care limited to 45 visits a year to a physician or to a licensed or certified professional or paraprofessional mental health worker.

For each of the 766 persons participating in the program, the average expenditure was approximately $600. Some 422 inpatient admissions were recorded at an average cost of $1,392. An estimated 540 persons each attended an average of nine outpatient sessions at an average cost of $17 a session. Outpatient care benefits represented approximately 16 percent of the total benefits paid. Recovery-home care was the least used service.

For one evaluation, data were collected on nonalcoholism health care for 2 years before treatment began and continued during treatment. Preliminary findings indicate that average monthly nonalcoholism treatment costs were reduced by approximately 25 percent after a person began treatment for alcoholism.

If the State of California had not paid for all costs of the pilot program, the additional average premium for each family enrolled in the State and public employees' program would have been only $2.05 a year, or $0.17 per month, to cover the cost of alcoholism treatment. However, these estimates are based on a relatively low utilization rate for the available services.

SUMMARY

- Federal, State, and local government funds constitute a significant proportion of the resources for alcoholism treatment. If adequate treatment coverage is to be provided to alcoholics, a major increase in the share of this support must be provided by health insurance.
- Lack of third-party reimbursement has limited the number of service providers. Until recently, insurance carriers were reluctant to cover treatment of alcoholism, but the trend is changing. For example, in 1972 approximately 25 percent of all Blue Cross plans specifically excluded alcoholism. By 1976, only 4 of 60 plans responding to a survey excluded alcoholism treatment.
- Although some private insurance carriers still exclude or limit alcoholism treatment, increasing numbers are providing coverage.
- Increasingly comprehensive alcoholism benefits are being offered by individual Blue Cross plans. Some offer alcoholism treatment in special inpatient centers and others provide innovative outpatient

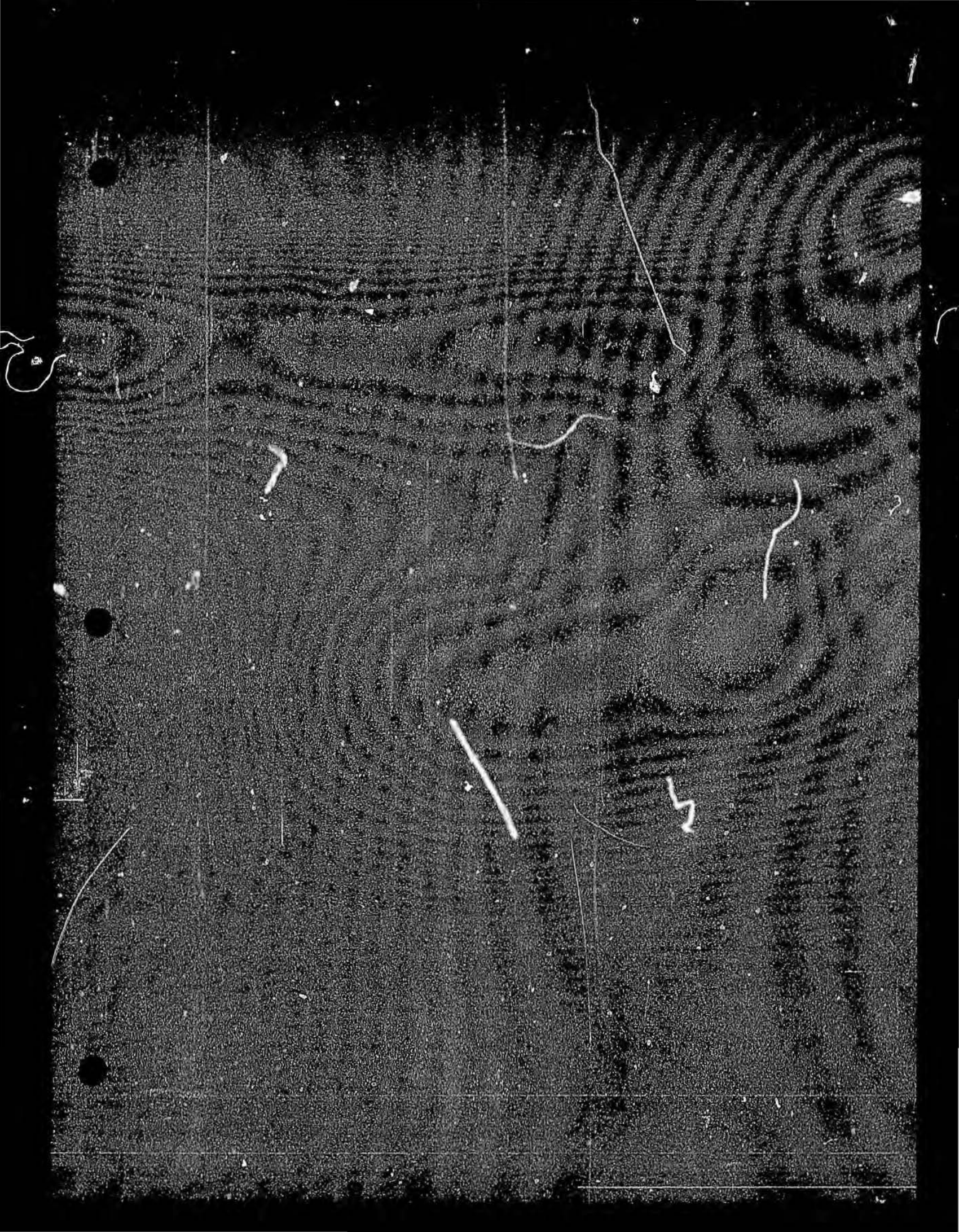
care. The United Auto Workers union Blue Cross coverage includes both residential and outpatient treatment.

- Many employee health insurance plans specifically include inpatient alcoholism treatment; far fewer cover outpatient treatment.

- State legislatures are concerned about the availability of insurance for alcoholism treatment. Twenty States have enacted legislation either mandating that alcoholism coverage be provided or requiring that it be available as an option.

- Preliminary findings from a California experimental project indicate that the average monthly nonalcoholism health care costs for both the alcoholic and the immediate family were reduced by 25 percent after the individual began treatment for alcoholism.

- Varied benefits are offered in the public sector. Current medicare provisions for alcoholism treatment to the aged and disabled are restrictive compared to benefits available for physical disease. Medicaid programs often ignore treatment for alcoholism. The Supplemental Security Income Program (title XVI of the Social Security Act) employs sanctions against the alcoholic who fails to stay in treatment. Alcoholism treatment is specifically provided for under the Social Services for Individuals and Families Program (title XX of the Social Security Act) in 10 States, and specific alcoholism services are reimbursed by 11 States.



A STUDY OF HEALTH INSURANCE COVERAGE FOR ALCOHOLISM FOR CALIFORNIA STATE EMPLOYEES

by

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ABSTRACT

A. INTRODUCTION

In 1974, the State of California undertook a pilot program to test the feasibility of providing model health insurance coverage for alcoholism for all the employees of the State as well as employees of certain public and county municipalities which contract with the State for employee health benefits (Ref. 1). The program was the result of specific action taken by the California Legislature which approved the Program and appropriated money from the State's general fund for its operation. About 337,000 beneficiaries (employees and family members) were covered by these benefits at the time of program initiation.

The California Office of Alcoholism Program Management was instrumental in the development of the Pilot Program and was responsible for its overall management. Another agency, the Public Employees Retirement System (PERS) was responsible for day-to-day administration.

The Program was based on provision of a uniform set of alcoholism treatment benefits, as follows:

1. Inpatient Care: (hospital or other medical or nonmedical facility licensed by the State)
   Acute: 6 days of detoxification services/year
   Intermediate: 21 days of treatment/year
2. Day or Night Controlled Residential Care: (recovery home licensed by the State)
   30 days of care/year
3. Outpatient Care: up to 45 visits per year to be provided by a:
   - licensed physician
   - licensed counselor
   - licensed clinical social worker
   - licensed psychologist
   - licensed or certified paraprofessional

The Program benefits were vendored by nine different insurance carriers, including four prepaid group practices, two service types, two indemnity type carriers, and one individual practice. Three of the carriers - Kaiser Foundation Group Plan (North and South), Blue Cross/Blue Shield, and California Western Occidental (California West) - provided coverage for more than 90 percent of the beneficiary population. The Program was established such that there was no risk involved for the various carriers; i.e., State monies paid for alcoholism treatment claims and carrier administrative expenses. The Program began in June 1974 and ended in May 1976. At that point the Kaiser Foundation Plans sought and received approval from the State to continue model insurance benefits for alcoholism treatment for their state and public employee population for a small increase in monthly premiums.

This report is the third in a series of evaluation reports concerning various aspects of the California Program. The first report was concerned with the historical development of the program and as a consequence it: (1) traced the legislative history of the program; (2) documented the efforts and activities of the several public agencies which were instrumental in establishing and operating the program; and (3) made a series of observations and conclusions regarding the program, its development and, importantly, how those experiences could be useful in other programs which emphasize health insurance coverage for alcoholism treatment.[1] The second report reported on program utilization and costs for the first 12 months of the program. Specifically it examined: utilization of the various services available under the Program; treatment deviations for the various services and average costs associated with these therewith; comparisons of service utilization and costs

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[1] J. B. Hallan, H. D. Holder, and M. J. Stucker, "Historical Development of the California Pilot Program to Provide Health Insurance Coverage for Alcoholism," Raleigh, NC: H-2, Inc., November, 1975.

among the various carriers; and projections concerning the annual premium costs necessary to underwrite the costs of treatment provided by the program.[2]

This report is presented in several chapters and appendices. The remainder of this introductory chapter summarizes important findings, while Chapter II provides a detailed description of utilization costs and carrier experiences during the lifetime of the program. Chapter III reports on certain characteristics or patterns of care received by the beneficiary population. A longitudinal study of nonalcoholic health care utilization by the alcoholic and his family is reported in Chapter IV. Finally, this report also contains several appendices including two (Appendices A and B) which present the various data collection instruments used in the utilization and cost study and in the longitudinal study respectively. Appendix C documents certain medical care indices used to adjust the variation in year to year health care costs.

B. SUMMARY OF FINDINGS

The following is a summary of findings and conclusions concerning the various studies made of health care utilization and costs derived from the California Pilot Program to provide alcoholism treatment insurance benefits to State personnel.

Summary of 23 Month Operational Data

A summary of data on inpatient, outpatient and recovery home care provided under the Pilot Program during its 23 months of operation is presented in Table I-1. The total benefits paid to claimants under the Pilot Program excluding administrative costs were about $459,000; total carrier administrative

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[2] J. B. Hallan, H. D. Holder, M. J. Stucker, "Alcoholism Care Utilization and Costs California Pilot Health Insurance Program - First Twelve Months," Raleigh, NC: H-2, Inc., March, 1976.

TABLE I-1

SUMMARY OF COSTS, BENEFIT PLANS AND CARE UTILIZATION UNDER THE CALIFORNIA PILOT PROGRAM

July 1, 1974 - May 31, 1976

	Total Persons	Total Admissions or Visits [1]	Average Charge Per Admission/Visit	Total Charges [2,3]	Total Benefits Paid [2,3]
1. Inpatient Care	339	422	$ 1,392	$587,341	$382,475
2. Outpatient Care	542	5,028	17	83,316	71,164
3. Recovery Home	15	15	461	6,920	5,478
Total	766[4]	N/A		$677,577	$459,117

N/A = Not Applicable

1 Source: Analysis of claims submitted by carriers and prepaid programs to PERS.

2 Source: California Public Employees Retirement System

3 Does not include benefits paid by Cal-West under its basic plan before the Pilot Program. Inpatient care benefits paid by Cal-West were $133,484 and outpatient care benefits were $3,844.

4 Adjusted for double counting in care utilization.

costs amount to some $94,000. Overall costs of the program amounted to about $553,000 or an average benefit cost of about $600 for each of the 766 persons who participated in the program.

The Program incurred 422 inpatient admissions at an average cost per admission of $1,392. Consequently inpatient benefits represented about 83 percent of the total dollar benefits paid. Allowing for readmissions by the same person, a total of 339 people utilized inpatient services during the Pilot Program. There were 542 persons who utilized outpatient care in the Program. Each of these incurred about 9.2 outpatient visits at an average cost per visit of $17. Outpatient care benefit payments represented about 16 percent of total benefits paid by the Program. Recovery home care was the least utilized service with 15 admissions at an average cost per admission of $451.

Details of inpatient and outpatient care provided under the Program are presented in Tables I-2 and I-3 respectively. General hospitals accounted for about 38 percent of the 422 Pilot Program admissions; a slightly smaller proportion (35 percent) of admissions was made to alcohol treatment units in a general hospital. Special alcoholism treatment hospitals accounted for only 21 percent of admissions. There was considerable variation in treatment facility charges varying from a low of about $600 per admission in a general hospital to a high of $1965 in a hospital with an alcohol treatment unit. Table I-3 reveals that the majority of persons received outpatient care from a physician. Paraprofessionals were used the next most frequently and had the least average cost per visit, $15. Psychologists and social workers were used at about the same frequency (i.e., each group incurred some 360 visits) by Pilot Program beneficiaries. Psychologists with average charge of $31 per visit were the most expensive form of outpatient providers.

TABLE I-2

SUMMARY OF INPATIENT ADMISSIONS AND CHARGES: CALIFORNIA PILOT PROGRAM

Facility Type[1]	Number of Admissions	Average Charge per Admission
General hospital	159	$ 598
Alcohol unit in a hospital	147	1965
Alcoholism hospital	87	1823
Other	29	1008
TOTAL	422	

[1]Definitions of facilities used in the California Pilot Program will be found in Chapter .

Source: California Public Employees Retirement System

TABLE I-3

SUMMARY OF OUTPATIENT UTILIZATION AND CHARGES: CALIFORNIA PILOT PROGRAM

Provider	Number of Visits		Average Charge per Visit
Physician	2,216		$25
Paraprofessional	1,972		15
Social worker	362		24
Psychologist	357		31
Counselor	121		15
TOTAL	5,028	Overall Average	$17

Examination was also made of the patterns of care incurred by the Pilot Program beneficiaries. First, it was found that a majority of persons utilizing hospital inpatient care incurred only a single visit during their course of treatment. Nearly equal proportions of all admissions incurred a stay of 20 days or more (40 percent) or less than 6 days (35 percent). Second, though the average person utilizing outpatient care incurred some 9 visits during the course of treatment, fully one third of all clients using this form of care incurred no more than 1-2 visits. Third, examination of uses of inpatient and outpatient care by a single client revealed that outpatient care is more frequently used among clients who have multiple inpatient admissions. Extreme users of inpatient care however (i.e., 4 or more admissions), tend not to use outpatient care. Finally, examination of treatment durations revealed that the majority of clients tend to complete their treatment within 3 months with only a small fraction (about 10 percent) still in treatment after one year.

While the Pilot Program benefits were available through nine different carriers, the majority (over 90 percent) of beneficiaries were covered by Cal-West (a State-wide indemnity plan), Kaiser Foundation Health Plan - North and South (a prepaid group practice Plan), and Blue Cross/Blue Shield (a non-profit service plan). Table I-4 shows selected comparative information about health care utilization, charges and benefits paid by the major carriers operating under the Program. The average cost per inpatient admission varied from $905 for Blue Cross/Blue Shield subscribers up to $1,567 for Cal-West subscribers. Together these two carriers incurred the majority (63 percent) of Pilot Program inpatient admissions. Correspondingly, Kaiser-North and Kaiser-South incurred the majority of outpatient visits with an average cost per outpatient visit of $20 for Kaiser-North and $7 for Kaiser-South. Outpatient costs reported by the other carriers were more expensive, i.e., the

TABLE I-4

UTILIZATION AND COSTS BY CARRIER - CALIFORNIA PILOT PROGRAM

July 1, 1974 - May 31, 1976

Carrier	Inpatient		Outpatient		Recovery Home	
	Admissions [1]	Average Paid Per Admission [2]	Visits [1]	Average Paid Per Visit [2]	Admission [1]	Average Paid Per Day [2]
Cal-West	139	$1,567	659	$24	7	$10
Kaiser-North	91	1,119	1,338	20	2	24
Kaiser-South	49	1,278	2,139	7	1	17
Blue Cross/Blue Shield	127	905	874	29	4	18

[1] Source: Analysis of claims submitted by carriers and prepaid programs to PERS.

[2] Source: California Public Employees Retirement System

Cal-West average was $24, Blue Cross/Blue Shield was the most expensive at $29. While recovery home visits were reported by all four carriers or plans, nearly one-half of all such visits were reported by Cal-West--which had the lowest average daily recovery home costs of $10. Kaiser-North recovery home costs were the most expensive at $24 per day.

The projected annual premium addition to pay for the total program was $2.05 annually or 17¢ per month additional to the average cost for a policy under the PERS system. This projection is based on full 23 months of experience for the Pilot Program which had a low utilization of provisions for alcoholism treatment during the first 12 months but substantially increased utilization the last 11 months.

Finally, projections were made of the annual premium addition which would have been necessary to cover the costs of alcoholism treatment experienced by the program. Based on the full 23 months experience, average premium increases of $2.05 annually (17¢ per month) per policy would have covered all costs of care. Note, however, that these premium beneficiary addition estimates are based on a relatively low program utilization, i.e., only a small proportion of the target population utilized available benefits.

Summary of Longitudinal Study Findings

The longitudinal study consisted of analysis of utilization and costs for the alcoholic and his family during the 12 month period prior to the first treatment contact under the Program (the "pre" period) and during the period following the first treatment contact (the post period). The study examined the health care experiences of 240 families which had at least one member participating in the Pilot Program. As such, at least one family member was diagnosed an alcoholic and received treatment under provisions of

the Program. The study examined the utilization of general health care and its cost (not including any alcoholism treatment provided under the Pilot Program).

(1) Inpatient Care

Survey data revealed that the frequency of inpatient care for the total family and its alcoholic member decreases following initial treatment of the problem drinking member for alcoholism. The average length of inpatient stay decreases for the family primarily as a result of decreased length of stay for the nonalcoholic family members. On the average the alcoholic member's stay in the hospital increased by one day and, as a result, average costs per admission are higher. While the lengths of stay and average costs per inpatient admission are higher, the overall average monthly costs for inpatient care of the alcoholic are less. Average monthly costs for the family increase as a result in increased costs for nonalcoholic family members.

Generalizing from this study, as the alcoholic family member enters treatment for alcoholism, his/her frequency of inpatient care and total costs for such care could be expected to decrease. The alcoholic will enter the hospital less often but stay longer. He will utilize hospital care less often than other family members who also use such care. This suggests that either previous inpatient treatment was increased by a result of undiagnosed and untreated alcoholism or specific treatment for alcoholism replaces previous inpatient care under secondary diagnoses.

(2) Outpatient Care

While the alcoholic member utilizes hospital care less often for general health care after entering treatment for alcoholism, outpatient care tends to increase. Costs for outpatient care were found, however, to remain

about the same or slightly higher. This increase in outpatient care, with a corresponding decrease in hospital care, suggests that the alcoholic's illnesses are less acute and can be more frequently handled on an outpatient basis. The alcoholic member's frequency of outpatient care is comparable with other members who use such care.

(3) Care Patterns for Health Insurance Carriers and Prepaid Programs

The families in the longitudinal study were grouped according to the program or health insurance company with which they were enrolled. Blue Cross/Blue Shield, which before the Pilot Program provided no coverage for treatment of alcoholism when diagnosed as sucy, of all carriers and providers experienced the most marked changes in general health utilization and costs as alcoholic family members received alcoholism treatment. Families with Blue Cross/Blue Shield had a marked drop in inpatient care frequency and costs. Costs alone decreased 50 percent. While the outpatient care of the alcoholic member decreased, other family members' utilization of outpatient care increased. In like manner, the average lengths of stay and average costs per admission decreased.

Cal-West, as a carrier which provided coverage for some alcoholism treatment before the Pilot Program, had an overall increased incidence of care (inpatient and outpatient). Cal-West experienced higher inpatient costs for alcoholic family members than for other family members; this resulted from a few exceptionally high claims during the period of the longitudinal study. While incidents of care were increasing, the length of inpatient stay decreased as a result of an average drop of almost two days per stay for the alcoholic family member.

Kaiser-South, the only prepaid program participating in the longitudinal study, experienced a marked (around 50 percent) decrease in the

monthly incidence of care (inpatient and outpatient). However, average inpatient costs per admission increased, primarily as a result of a three-fold increase in the length of inpatient admission for alcoholic family members. Outpatient care frequency decreased with costs varying only slightly.

Overall, families grouped by the carriers and the prepaid program follow the trends shown for the total population with some exceptions. The more restrictive the coverage for alcoholism treatment provided under health insurance policies or a prepaid program, the more dramatic the decreases in general health care costs and utilization will be when alcoholism treatment as such is covered or expanded.

(4) Diagnosis and Care

An examination was made of the various diagnoses used while treating the families in the survey before alcoholism treatment and following its initiation. A clear decrease was observed in the number of diagnoses which are identified as surrogate or substitute for a primary diagnosis of alcoholism following initiation of treatment. This would be expected to result when a diagnosis of alcoholism entitles a patient to a comprehensive treatment program for the condition. The diagnoses most affected were in "mental disorder" categories and the utilization rates and costs for care with these diagnoses decreased when the Pilot Program began.

(5) Cost Reduction

For the months that health care costs for the alcoholic were tracked, there was an average monthly cost of $179.50 for inpatient, outpatient and other care before beginning treatment for alcoholism and $133.22 after treatment began. This produces an estimated savings of $369.84 per person for the time that care costs were followed or a total estimated savings of

$283,297 for the 766 persons receiving care during the period of the Pilot Program. See details in Appendix D. In short, for each $1.00 spent on alcoholism treatment by the Pilot Program, there was at least a 42¢ projected savings to the insurance carriers and prepaid plans in health care costs of the alcoholic, i.e., the ratio of the total alcoholism care costs of $690,500 (Pilot Program, $553,173, plus Cal-West Basic Plan, $137,327) to the total estimated savings in health care (other than alcoholism) of $283,297.

C. CONCLUSIONS

Conclusions which may be drawn from the study include the following:

(1) The California Pilot Program experienced a relatively low utilization of health insurance benefits for alcoholism treatment relative to the accepted estimates of treatment needs in the worker population.

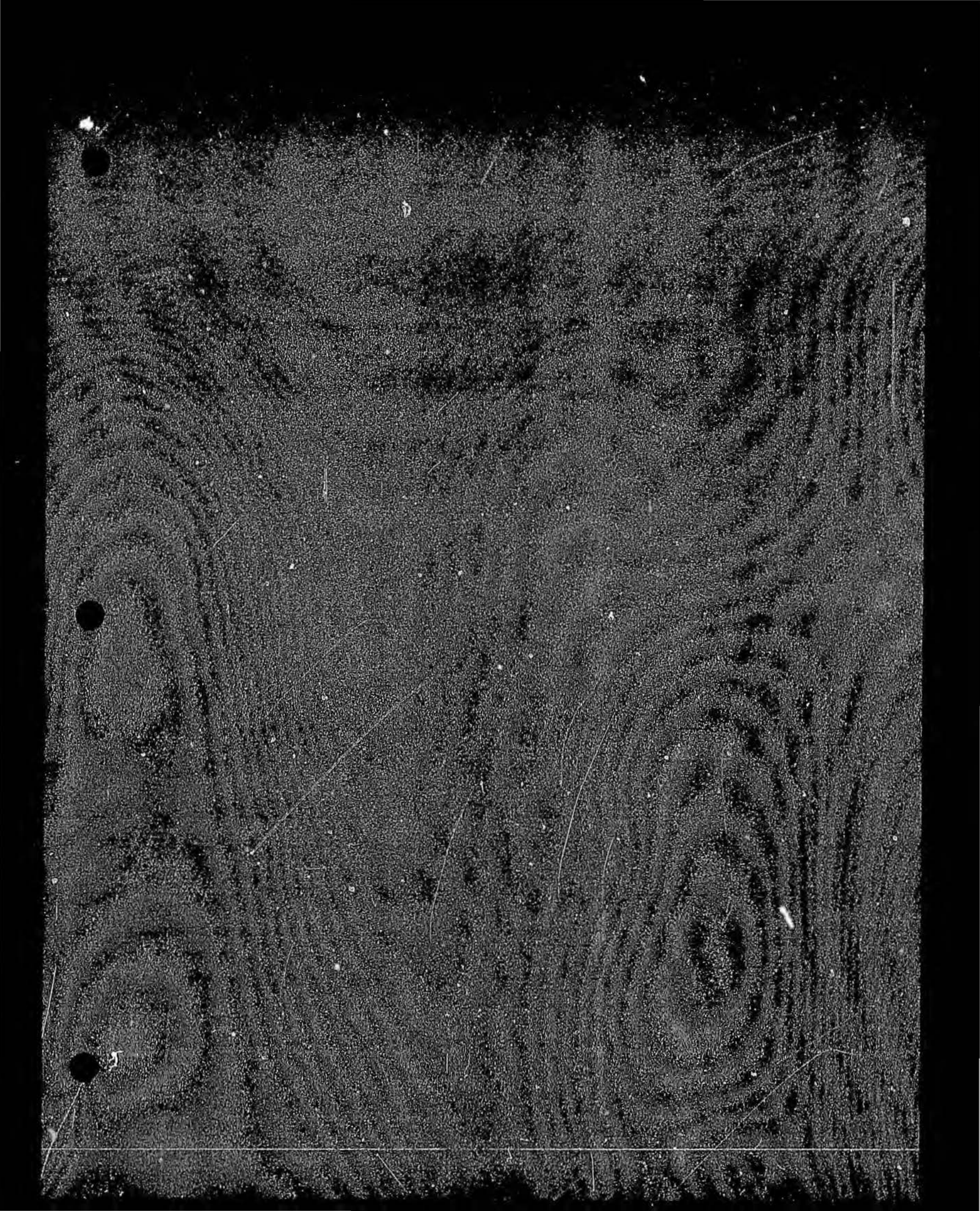
(2) The program demonstrated the feasibility of providing a uniform and comprehensive set of insurance benefits for treatment of alcoholism. Utilization was well within the limits established by the Program benefit provisions and projections of insurance premiums necessary to finance such a program indicate only moderate increases above usual insurance costs.

(3) Some variation found in utilization and costs between the types of carriers involved in the program were not significant. Part of the variation may be explained by the existence of alcoholism treatment benefits in place before the Pilot Program began.

(4) When alcoholism is treated under an explicit diagnosis, utilization and costs for health care (other than alcoholism) decrease. This decrease is a result of (a) direct treatment of alcoholism and (b) the use of a primary diagnosis of alcoholism instead of a proxy or substitute diagnosis which has historically been acceptable for claims purposes.

(5) Inpatient treatment utilization and costs decreased when the alcoholic began participation in the Pilot Program. Other less expensive forms of care such as outpatient treatment were used more frequently.

(6) The Program demonstrated that following implementation of the comprehensive benefit program other health care costs were substantially reduced for the alcoholic population. Though the data are preliminary indeed there is indication that nonalcoholism treatment costs may be reduced by some 30 percent per month upon initiation of treatment for alcoholism.



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A REPORT ON HEALTH INSURANCE COVERAGE OF ALCOHOLISM AND DRUG ABUSE TREATMENT IN ALASKA

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IV. THE RESULTS OF A SELECTED SAMPLE OF THE ALASKAN HEALTH INSURANCE INDUSTRY

I. THE SURVEY

This survey of health insurance coverage of alcoholism and drug abuse treatment available in Alaska, was conducted to establish the current "state of affairs" of such coverage. In addition, a short history of health insurance coverage and a discussion of the attitudes and philosophy of "third-party" payors (both public and private) are presented and examined.

Since the health insurance "industry" is subject to state regulation, we have included pertinent aspects of law and regulation applying to the state's regulating entity, the Department of Commerce and Economic Development, Division of Insurance. The Division of Insurance also was reviewed for its general philosophy regarding health insurance regulation.

In summary, we feel that the report shows:

1. That private carriers and quasi private (e.g., Blue Cross) carriers are providing more and better coverage than ever before.

2. That "public" carriers, such as Medicaid, General Relief-Medical, etc., provide little or no coverage.

3. That alcoholism and drug abuse treatment programs can increasingly qualify for third-party payment and make the transition from grant to private funding.

4. Finally, that treatment programs need to pursue:
   a. funding by "public" carriers
   b. additional coverage and benefits from the private sector, perhaps through insurance regulation.

II. THE HEALTH INSURANCE "INDUSTRY"

A. Definitions

The Health insurance "industry" is the collection of economic entities, public and private, which offer to reduce or remove the cost of treatment for physical or mental illnesses (with important exceptions) for covered individuals.

Further definitions of "illnesses" and "covered individuals" are in order.

For practical reasons, "illnesses" are those disorders of the body or mind that are accepted by the medical community as such. Where the medical community has wavered, insurance interests have often reduced or removed coverage. Even where the medical community has defined a specific illness, insurance interests have often reduced or removed coverage to suit their experience factors or profit motives.

"Covered individuals" are those subscribers to health insurance who meet criteria set by the insurance company. Being a policy-holder is not enough. Certain illnesses may be subject to limited coverage. The coverage may be subject to conditions: treatment approval by the insuror; who treats the illness; where it's treated, the length of treatment, etc.

The "covered individuals" clause in insurance policies can dramatically affect the actual coverage available to the insured. It is also the major concern to those who feel that the generally accepted definition of health illness should include alcoholism and drug abuse treatment.

B. A Short History

Insurance against illness can take many forms, perhaps even dramatic ones. The Chinese (Circa 2,000 B.C.) are often given the credit for the first "insurance" against illness. It was perhaps the simplest of coverages. Wealthy Chinese employed physicians to keep them well. If the person paying got ill, payments stopped. If the patient died, the physician was summarily killed. Perhaps society has never gone further from that model than today, where physicians are often criticized (and sued) for doubtful treatment, patients do die, and the major process of paying for physicians' services is still controlled by the physician.

The ancient Greeks had benevolent societies, some of which provided medical coverage (such as it was) in return for regular payment to the society.

The English added limited physician and general health coverage to its marine and life insurance coverages. This occurred in

the middle of the 17th century, but the philosophy remains the same as today's coverage. Health insurance was then and is still today considered a hard to manage, unprofitable business by the private insurance companies. It is generally carried as an added inducement to attract buyers of life and casualty coverage.

C. Private Carriers

Recent years have seen a change in attitude among commercial insurance carriers. That change, toward more coverage for ambulatory care, appears closely paralleled to the rise in demand for national health insurance. While the interests of private-sector insurers have never been high in regards to health insurance, as stated previously, one can see that nationalization of the health insurance industry could lead to nationalization of the more profitable lines of coverage offered by insurance carriers. This appears to be sufficient motivation for the increasingly flexible coverage of health services, particularly alcoholism treatment. Moreover, such coverage, while available, can still be controlled by specified limits set at arbitrary levels that may, in effect, give little or no practical coverage. This is the case of private insurance coverage of alcoholism and drug abuse treatments. Part IV to this report, and Attachment A, expand on this further.

D. Quasi-Private Carriers

The most substantial insurance carriers in the quasi-private (non-profit) sector of the health insurance field are the Blue Cross/Blue Shield plans. With a nationwide subscription of approximately 85 million, Blue Cross has 50% of all institutional health care coverage.

Blue Cross is a loose confederation of individual plans of health insurance coverage which provide coverage of institutional charges for services. Several features are required of member plans to the national association. The most prominent are:

1. That each plan be a non-profit community organization with governing boards composed of both the general public and providers of service.

2. That each plan "substantially" cover hospitalization costs.

3. That each plan pay out at least 85 percent of subscribers' premiums as benefits.

4. That each plan provide for its continued financial solvency, and provide reasonable accounting and statistical records.

5. That each plan cooperate with other member plans.

In return for agreeing to the terms of the association, the following are the significant benefits of national membership:

1. National advertising

2. Use of the Blue Cross emblem, and the general franchise for the sale of Blue Cross benefits within a designated territory

3. Use of association facilities for coordinating accounts involving treatment and payment where such activity involves two or more Blue Cross plans

4. Easy provision for the transfer of subscribers

5. Use of the extensive lobbying efforts of Blue Cross in Washington, D.C.

Blue Cross plans have been subject to considerable criticism in recent years for affiliations with the various hospital associations. More pointed has been the criticism of the national Blue Cross Association's affiliation with the American Hospital Association. While private health carriers have always main-

tained a natural "arm's-length" relationship with the institutional providers of paid health care, Blue Cross (BCA) was formed by the American Hospital Association (AHA) in the 1930-40 period. Those close ties have lately made BCA and the AHA the objects of much public concern. In a period of exponentially rising health costs (and compensating rises in health insurance premiums), it is only natural that public attitudes about control of the rise in the cost of health treatment would focus on a group of organizations which both provide health care and control the payment for the same care. In response to this criticism, BCA and the AHA have moved farther apart organizationally since 1972, when they split the joint board of directors of BCA and AHA into separate directorships.

The 1940's saw the American Medical Association sponsor Blue Shield's predecessor organizations to both provide insurance coverage for physician's fees and to certify and control physicians eligible to receive payment. Blue Shield has member plans, a national association (National Association of Blue Shield Plans (NABSP)), and is subject to the same criticisms made of Blue Cross: that the provider-insuror relationship is too close to be cost-effective; that NABSP, like BCA, is too provider-dominated to play a leading role in containing the rapid escalation of health care costs; and that neither BCA nor NABSP offer any real incentive for preventive medicine.

Health Maintenance Organizations (HMO's) are an alternative to traditional third party payors. They date back to the late 1920's where they began achieving a slow but steady following on both the West Coast (Ross-Loos, Kaiser-Permanente, etc.) and East Coast (Health Insurance Plan of Greater New York, etc.). The passage of Public Law 93-222, the Health Maintenance Organization Act of 1973, has served as an impetus to the growth of HMO's by providing funding and other benefits. That impetus has been somewhat blunted by a requirement that HMO's obtaining federal development funds under P.L. 93-222 have open enrollment periods in which all applicants desiring coverage be admitted both in order of application and irrespective of previous medical conditions. Since all insurance relies on the spread of risk across a large enough base of subscribers to be cost-effective, this may prove to be a permanent hindrance to any but the largest of HMO plans.

E. Public Carriers

The only "public carrier" of health benefits are the federal/ state agencies involved with the Medicare or Medicaid programs. IHS? VA?

Medicare is a program for people 65 and older, and certain disabled people under 65, which provides some coverage for traditional hospital treatment under Part A of Medicare and some coverage of physician treatment under Part B. of Medicare.

Medicare is provided by the federal government and administered by the Social Security Administration.

Medicaid is a program, for certain eligible people, where the federal and state governments share the cost of medical treatment. Eligibility generally means "needy," as defined by Aid to Families with Dependent Children (AFDC) requirements and other programs of a welfare nature. Each state has a considerable number of options in choosing under which programs they wish to elect coverage.

General-Relief Medical is a State of Alaska program where the State agency administering the Medicaid program also can pay for health benefits to certain persons not otherwise eligible for Medicaid coverage. This is frequently used to pay for drugs used in treatment.

F. Other Possible Coverages

Since basic charges for institutional care often have a custodial element, e.g., a portion of a daily charge for inpatient hospital care would include a "room and board" charge, it is possible to charge non-medical agencies for that portion of institutional care. Examples in Alaska include the Veteran's Administration and the Bureau of Indian Affairs.

Another potential source for health treatment coverage would be the State of Alaska's program of vocational rehabilitation. That program, administered by the Department of Education's Division of Vocational Rehabilitation, can provide reimbursement of the cost of health benefits given to clients of that division. If the disabled person can be rehabilitated from a certified disability, and other minor requirements are met, benefits are generally available. Alcoholism abuse and drug abuse, however, are administratively excluded "due to poor results." Only after a certain abuse-free period has been attained are clients accepted for rehabilitation.

III. STATE REGULATION OF HEALTH INSURANCE IN ALASKA

The State of Alaska's Department of Commerce and Economic Development is the state agency responsible for applying the State laws on the insurance industry. Within that Department, the Division of Insurance administers the State's mandates on insurance. Within the Division of Insurance, there is no sub-entity to handle health insurance separate from any other line of insurance.

A review of Alaska Statutes (A.S.) showed that Title 21 governed insurance per se. A few chapters under A.S. 21 applied to health insurance. Important chapters are:

1. Chapter 6 -- The commissioner has certain duties, powers, etc. These do not include the power to prescribe coverage, limits of coverage, or other benefits to be paid.

2. Chapter 36 -- States that certain trade practices in marketing must be followed. This chapter also protects against frauds.

3. Chapter 42 -- Prescribes that annual reports be filed and provides for the timing of such filings.

4. Chapter 51 -- Disability coverage (including health) is described. This chapter only notes the State's approval of a clause in policies to preclude coverage of health ailments in existence before the date of coverage.

5. Chapter 54 -- describes group disability coverage. No specifics on health.

There are no regulations based on the statutes. Further, discussions with officials of the division disclose a policy of not interfering with the free-enterprise process of "caveat emptor," let the buyer beware. This has its roots in the division's belief that since most coverage is via group policies, and since most group policies affecting are negotiated, those negotiations permit the buyers of group plans to protect their own interests in regard to what services are covered, limits of coverage, covered individuals, etc.

In summary, the State of Alaska's agency involved in insurance company regulation, the Division of Insurance, does not feel that it should regulate health insurance beyond basic prohibitions against fraud and some miscellaneous requirements for filing annual reports of financial condition and economic stability.

IV. THE RESULTS OF A SELECTED SAMPLE OF THE ALASKAN HEALTH INSURANCE INDUSTRY

A. Overview

The health insurance industry, as mentioned in previous sections of this report, is an assortment of diverse entities. Those entities range from private, for-profit carriers to purely "public" carriers such as Medicare and Medicaid. All are different in degrees of coverage of health benefits in general, and alcoholism and drug abuse treatments in particular. This section deals with alcoholism or drug abuse treatment benefits exclusively.

This survey of available coverage began with an added dimension. Originally, it was hoped that negotiations could be started with the major carriers to produce an agreement on methods of cost-finding and rate-setting. This proved impossible, since none had detailed requirements for cost-finding and rate-setting nor had any ever prescribed any to their health providers. This attempt was abandoned in favor of surveying the current provisions and coverages available to the majority of Alaskans.

B. The Sample

As seen on Attachment A to this report, the major carriers are listed, along with the general provisions of coverage of alcoholism and drug abuse treatments. It was felt that the sample was broad in terms of effect on alcoholism and drug abuse benefits since the estimated number of Alaskans covered (225,239) equals 53.6% of the current estimated population of 420,000. Possible reduction of the above figures for duplication of coverage (where a spouse might also be employed and therefore double-counted), is offset by the Aetna survey. Since no figures were available for Aetna, that company's total coverage isn't listed. Since Aetna has major employers, as shown on Attachment A, their coverage should neutralize any reduction for double-counting of the other carriers. Also note that no coverage for state/federal programs was counted.

In reviewing the coverage note that all information was obtained from the companies themselves and should be quite current. Excerpts of limits of coverage, the narrative of coverage and requirements for coverage, all were taken from summaries of current policies in force during 1978.

C. The Results

The results were both impressive and sobering. The impressive portion was the private insurance industry. Having often been

cast as totally non-responsive to the non-hospital model of care, the results instead show that basic coverage is offered by the private insurance carriers in non-hospital settings. This fact, along with a trend toward ambulatory care coverage, presents bright prospects for reimbursement where free-standing programs can present the following credentials:

1. Community viability (acceptance)

2. An organization composed of dedicated professionals and paraprofessionals who are results-oriented.

3. An adequate financial organization, geared to collect, assimilate, and analyze cost-finding and rate-setting data.

The sobering thoughts are two-fold:

1. While the coverage is there, treatment is generally limited in dollar amount of benefits and days of treatment allowed. In the future, with greater acceptance of viable treatment programs, health benefits for alcoholism and drug abuse programs should equal those offered hospitals for basic and major medical coverages.

2. A second sobering thought involves the rather dismal record of the federal and state governments in providing non-grant funds for alcoholism and drug abuse treatment. With federal Medicare of little consequence due to the minimal number of alcoholics/drug abusers over age 65, we see the following for other federal/state programs:

a. Medicaid-alcoholism/drug abuse services would be covered if the state had elected coverage of "clinic services" as a Medicaid option. The State, even with federal shared funding available, has not opted for such coverage for Medicaid-eligible Alaskans.

b. State General Relief-Medical: alcoholism/drug abuse treatments are specifically excluded by 7 AAC 47.210, under authority of AS 47.05.010 and AS 47.25.120.

c. Federal Social Security (excluding Medicare): as described above, the Social Security Administration can provide disability benefits for those under age 65. Those disability benefits only apply to the disabled individual, not the institution which may provide rehabilitation

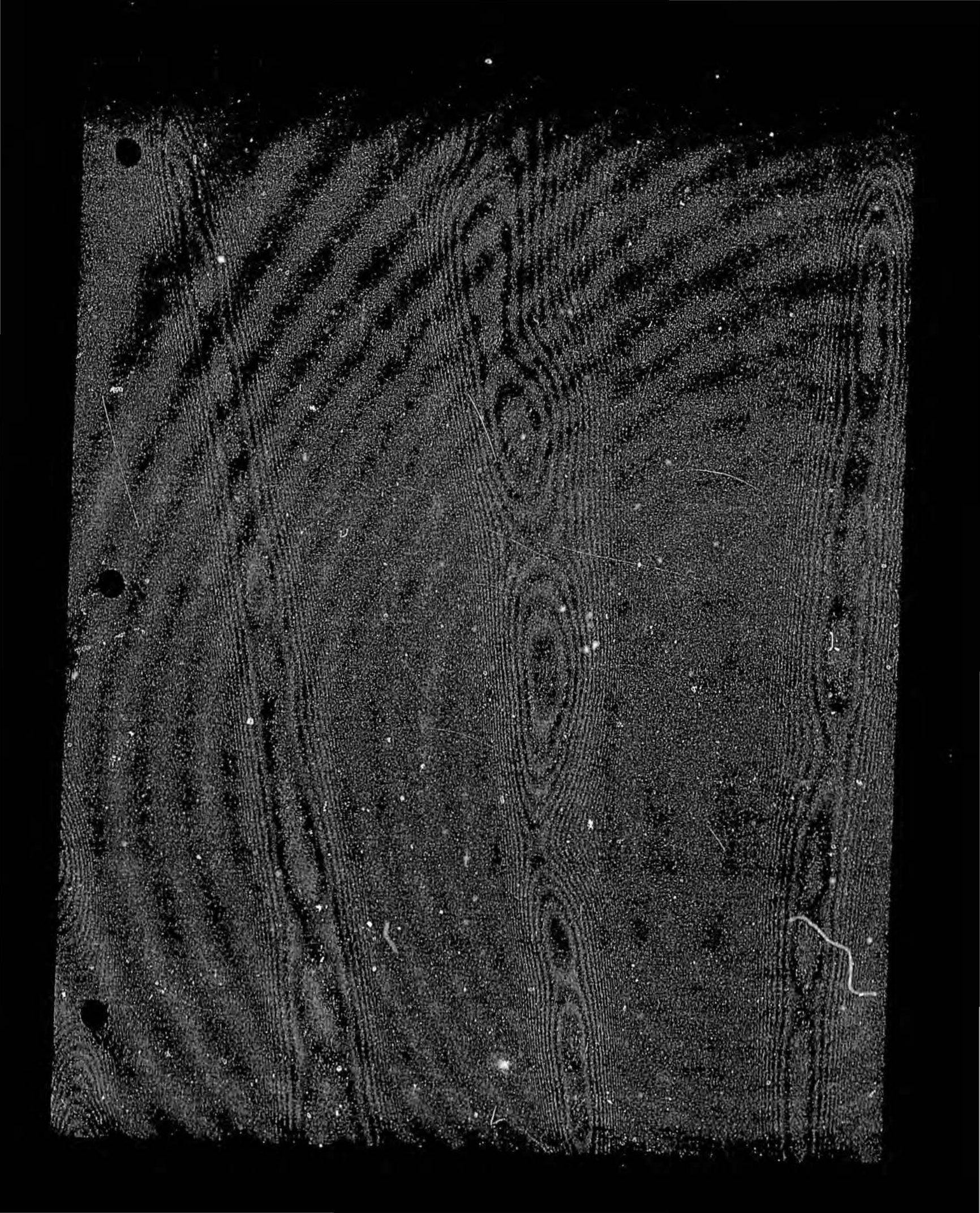
through treatment. Surprisingly, Social Security regulations (Regulations No. 16, Subpart Q, Section 416.1710) require treatment as a condition of Supplemental Security Income (SSI) payments to the disabled, but provide no benefits toward payment for such treatment.

d. State Department of Education, Division of Vocational Rehabilitation (DVR), has the state authority and responsibility for evaluating, planning, and implementing rehabilitation services for those who can benefit from them. That authority includes paying for medical treatment of a rehabilitative nature for clients. By administrative directive, however, DVR will not deal with an alcoholic or drug abuser until six months after the applicant is drug or alcohol-free.

Carrier	Covered?	Brief Description of Coverage: Basic Plan	Maj. Med.	Limits: Year	Limits: Lifetime	Brief Narrative of Sample Plan	Alaskans Covered: Company	Employees	Total Covered* (Employee X 3.5 factor) (Blue Cross x 2.7 factor)
AETNA									
Alcohol Abuse	Yes	Same Coverage		45 days $500 deductible	No days limit $ Limit	M.D. Referral or diagnosis M.D. provided or M.D. "directi "Effective" Program - DETOX ALONE DISQUALIFIES. "LICENSED BY THE STATE, INPATIENT COVERA 24HR RN coverage.	Alyeska Pipeline Service Co. ARCO (Alaska) Alaska Painters Union Southern Baptist Convention	No Data	No Data
Drug Abuse	No	N/A	N/A						
BLUE CROSS									
Alcohol Abuse	Yes	Same Coverage		$1,000 80% Co-Insurance	$250,000	M.D. Supervision "State Approv Facility	Statewide Alaska	39,784	108,556
Drug Abuse	Yes	Same Coverage		$1,000 80% co-insurance	$250,000				
TEAMSTER #959									
Alcohol Abuse	Yes-if recog. by 959	Same Coverage		70 days per incident No year or lifetime per se		Not well defined, but definitel medical model. Licensed. JCAH accredited	Teamster Local 959	25,000 members	87,500
Drug Abuse	Only Emergency and emergency inpatient	N/A	N/A						
TRAVELERS INSURANCE									
Alcohol Abuse	Yes	Same Coverage		120 days per incident (inpatient) 50 visits outpatient deductible, then 80% to $2,000, then 100%.		M.D. "orders for care" and diagnosis, state license, JCAH accredited	Alaska Carpenters (all locals)	2,500	8,750
Drug Abuse	Yes	Same Coverage					Parker Drilling	500	1,750
							All others including Honeywell, Methodist Ministers, Burroughs Corp., Servomation Conf.	1,250	4,375
METROPOLITAN LIFE									
Alcohol Abuse	Yes	Same Coverage		120 days per year	$250,000 lifetime	"Licensed" by State, "Diagnosis or recommended by Doctor of Medicine"	University of Alaska	2,376	8,316
							Municipality of Anchorage (Part of)	1,712	5,992
Drug Abuse	Yes	Same Coverage		80% co-insurance to $1,000					

* Factor based on industry norms

MEDICAID	
Alcohol Abuse	No State Coverage
Drug Abuse	No State Coverage
STATE GR-MEDICAL	
Alcohol Abuse	No State Coverage
Drug Abuse	No State Coverage
SOCIAL SECURITY	
SSI - Alc-Drug	No Coverage for Institution
SSDI - Alc-Drug	No Coverage for Institution
STATE VOC. REHABILITATION	
Alcohol Abuse Drug Abuse	No Coverage for Institution nor for Alcoholic or Drug Abuser until six months "sobriety"



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AN OUTLINE OF A UNIFORM ACCOUNTING AND FINANCIAL REPORTING SYSTEM FOR ALCOHOLISM AND/OR DRUG ABUSE TREATMENT PROGRAMS IN ALASKA

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I. INTRODUCTION

The methods and means used to generate third-party payments are often as diverse as the institutions which use them. In this report we will outline and discuss generally accepted processes that the average program (or institution) should find adaptable to their administrative capacity, necessary for management reporting, as well as acceptable to third-party payors' reporting needs.

In undertaking to make their program flexible enough to meet the demands for information posed by third-party payors, each provider will need to assess their organization's strengths and weaknesses in respect to this definition of a health provider:

> An organization, practicing the healing arts, which recognizes the constraints of cost versus benefits in rendering the maximum service to the greatest number of people.

This definition, well recognized by the private sector, will need special attention by provider organizations which often began operations with a general statement that "help is needed...we should provide services" rather than the question "help is needed...can we provide effective services at a reasonable cost?"

With the above in mind, here is an outline of a viable provider organization; from Board of Directors and Management, on down to the cost-finding and rate-setting which support the organization.

II. OUTLINE OF THE UNIFORM ACCOUNTING AND FINANCIAL REPORTING SYSTEMS (UAFRS)

A. The Board of Directors, Management and the Budgeting Process.

In its corporate form (profit or non-profit), each provider must have a viable Board of Directors. Without going into great detail, each Board should:

1. Be representative of the community being served.

2. Provide guidance and direction to Management in:

   a. setting priorities for the delivery of new services or programs,
   b. setting the philosophy for rate-setting,
   c. setting the philosophy for bad-debt and indigent write-off policies,
   d. setting the standards for reduction of existing services, where necessary,
   e. review and approve the annual budget offered by Management.

Of the above, no item represents more time, effort, and importance to both Management and the Board than the budgeting process. "The Budget" is not only a way to make concrete the goals and objectives for the organization, but also the financial plan supporting the attainment of those goals and objectives.

Through the planning process, an organization states what it would like to achieve. Through budgeting, it states realistically what it can achieve. In effect, the budget takes the planning process and fits it to the artificial time-frame of single (fiscal) year and multiple periods (e.g., 3-year plan) that present goals and objectives reasonable for the organization to achieve within the given time. While multiple year budgets are not discussed further in this report, they can be used with an extension of the principles discussed herein.

A systematic process of budgeting should provide 1) a means to both define and quantify expected output toward meeting goals and objectives; 2) a means of recording, summarizing, and accumulating data to evaluate the results of operations; and 3) a means of controlling the expenditure of resources toward meeting the goals and objectives.

Since a budget provides a means to both state and quantify expected output toward meeting goals and objectives, what should it consist of? In general, a budget should include:

1. Statistical information that measures intake, treatment (including follow-up), discharge, and recidivism figures.

   Statistical information should begin with the client encounter, duly recorded, and a track through the treatment system. It should include:

   a. Admission data for inpatient/outpatient treatment such as (a) name and identifying number (e.g., social security number); (b) specific symptoms of illness stated; (c) day, date, and by whom admitted; (d) third-party insurance coverage, if any.

   b. Treatment given (including follow-up) with (a) physician named; (b) type of treatment (by incidence-coded); (c) length of treatment; (d) third-party carrier index; (e) self-pay index, if any; and (f) referral, if made.

c. Discharge data, to include (a) carrier billing status; (b) self-pay billing status; (c) follow-up for recidivism review.

While the above are important examples of statistical information, each provider organization should develop its own statistical base, not only to enable the billing of third-parties and others, but to provide internal reports to management on the cost/efficiency of provider departments.

2. The budget should also consist of information expressed as a measure of the cost of operations of each discrete service category. These service categories represent cost centers. They can include and be expressed as follows:

For Alcoholism Treatment Programs:

a. Emergency care
b. Inpatient care
c. Intermediate care
d. Outpatient care
e. Outreach
f. Aftercare

g. Consultation and education

h. General administration/support services.

For Drug Abuse Programs:

a. Outpatient drug-free care

b. Residential drug-free care

c. Outpatient Methadone Treatment

d. General administration/support services.

3. The budget should also have a narrative combining statements of goals and objectives with the necessary statistical and cost information (including projections) that represent a sound plan of action for the budget period.

B. The Accounting Structure.

It should be emphasized that one of the most significant aspects of designing a successful financial reporting system (to include budgeting), is the design of the accounting classification system. This system begins with the following basic categories:

1. Assets
2. Liabilities
3. Surplus or Reserves
4. Revenues
5. Expenses

The cateogries of accounting we will be dealing with are expenses and revenues. These are where cost finding and rate setting impact the financial reporting system. Cost finding is a discipline of the expense classification system, while adequate revenues are a result of rate setting policies, including the results of cost finding.

Classification of Expenses

Since the accounting classification of expenses are of paramount importance to any program, they should be designed with special care. Most organizations can design (or already have available) a "chart of accounts" that displays the natural

classification of expenses such as "personal services," "supplies," "equipment," etc. Most programs also include a numeric designator as an "account number," e.g. "713" is "supplies" displayed as follows:

	Chart of Accounts
XXX	Telephone Expenses
XXX	Utilities Expenses
713	Supplies Expenses
XXX	Interest Expenses

With the above already in place, one can easily add sub-account numbers by cost center, e.g.:

	Chart of Accounts
713.00	Supplies Expense-Control Total
713.01	Supplies Expense-Outpatient Drug-Free
713.02	Supplies Expense-Residential Drug-Free
713.03	Supplies Expense-Outpatient Methadone Treatment
713.04	Supplies Expense-Administration/Support Services

The above will enable not only the recording, summarizing and classifying of the natural expense elements, but also the same treatment for cost centers. By breaking the natural expenses up into predetermined cost centers, according to usage or other good service measure, we can accumulate the normal categories

of expenses one step further. This treatment provides for 1) a way to accumulate direct costs on both cost centered and traditional methods of accumulation, so as to not disturb the traditional reporting of agencies, and 2) a way to maintain cost-center expenses for control purposes and as a base for rate-setting.

Having identified and recorded traditional expense categories into cost centers, the agency should maintain subsidiary ledgers of each expense category. By adding all sub-account (cost-center) transactions together, the total of the subsidiary postings should always equal the postings total of the account entitled, as in our example, "Account 713.00 Supplies Expense-Control Total." By maintaining the separate but related elements of general accounting and cost-finding, we can gather the cost-finding data as a supplement to the existing accounting system. This should ease the transition from a "general" to a "general and cost-finding" accounting structure.

C. The Cost-Finding System

The common accounting treatment, used to analyze and schedule costs of operations, is to define direct and indirect costs of operations, accumulate costs on a direct and indirect basis, and allocate such costs to the cost centers on a reasonable basis. As is well-known, the proper cost of any activity includes all goods and services utilized during a period, whether received from sources outside or from within. Cost centers, in turn, should correspond to the services rendered (e.g., "Intermediate Care Department") rather than to a physical facility (e.g., "Building A").

Total costs may be accumulated for any department. Each department will have its own total costs, parts of which have been received from other departments. As a result, the total cost of operating can be determined by listing the direct costs of each department along with some general costs, such as interest and depreciation. When all indirect costs have been allocated, and the program has completed its cost-finding procedure, the total cost of operating may be established by summing the total costs of the various departments.

Some Departments may not receive their total costs because of methods used in a cost allocation procedure. Since the method of allocation used is basically a managerial decision governed

by the economy of gathering the data, and the purposes for which it is gathered, such factors may make total allocation impractical. It is possible to make a special study to obtain the total cost of a department not receiving its total costs under the cost finding method used by the management.

It can be seen that, where possible, the total cost of operating a department should properly include costs of all assets and services used in a period. The basic chart of accounts, however, provides for the accumulation of only the direct costs of the responsibility centers. In order to arrive at the total cost, it is necessary to use a cost allocation proced re, or a special cost study which assigns indirect costs to an activity. Even in these cases, total costs would be specially defined for the cases where contractual agreement, custom, or tradition make it necessary to exclude certain costs in reports. In some cases, other cost analyses may be more appropriate.

Allocating Costs

In general cost finding, the direct costs recorded in the accounts are entered on a worksheet. The unassigned expenses (depreciation and interest, for example) then are allocated to the various departments. Then, the adjusted costs of the non-revenue producing departments are allocated to each other and to the revenue producing centers. The occurrence of the results produced depends to a great degree on the bases of allocations used and the order of their distribution.

The costs attributable to various departments are allocated to other departments and cost centers on a basis related to the amount of services rendered to each. When a department's costs are being allocated among the departments and cost centers which have received its services, the basis for apportioning costs should be determined by whether the use of that basis will effect an equitable cost allocation. The bases generally used to distribute costs are: Quantity of service and actual dollar amount of service. On Attachment A, examples of allocation bases are presented for the reader's review.

Quantity of service bases are those that make use of actual counts, or reasonably reliable estimates, of the amount of service rendered by a department or cost center. Some of these are costs that measure the main service of a department, such as patients served. Others are counts that may be used to represent a measure of the relative provision of service that may be applied when the real measure of service is difficult to define. An example is the number of administrative hours spent and the allocation of administrative staff cost to other cost centers. The possibilities of using weighting factors for the quantitative estimates should always be examined.

The actual dollar amount of service is often used where the services rendered by a department or activity involve distribution of supplies or other items for which either the purchase

price or the amount charged to clients is known or can be determined. The cost of items purchased can be kept and, as the items are drawn by departments, the costs of the supplies requisitioned can be tabulated by each cost center, or a charge basis can be used. General supplies and expenses are familiar examples. Here, certain supplies are distributed to other departments and cost centers, usually by requisitions. The cost of supplies requisitioned may be used or, as discussed later, a price schedule may be established that will permit the determination of a dollar amount for the items sent to each department or cost center served. These amounts may then be used as the basis for distributing the costs of general supplies and expenses.

Special analyses of cost or time could also be used to determine the proportions of service that a department normally renders to other cost centers. From the studies, percentages or proportions could be established to be applied to costs when a cost apportionment procedure is used. As long as the routine services to departments are fairly consistent from period to period, this method would be reasonable. If special studies are used, care should be taken to review the situation periodically, particularly when there has been a change in procedure or a relatively significant change in costs.

Outline of the Cost-Finding Procedure

An outline of the general cost-finding procedure is given below.

The setting up of the procedure, which will be designed for management purposes and needs, can be outlined as follows:

1. Select the cost centers from which and to which costs will be distributed.
2. Determine the basis for distributing the costs.
3. Establish the mechanics for obtaining the necessary periodic accounting and statistical data.
4. Select the method to be used in the cost apportionment.

Mechanics of the Procedure

1. Collect the necessary accounting and statistical data from the general ledger and statistical reports, and put them in appropriate columns of schedules and worksheets, by cost center.

2. Adjust and reclassify the accounting data for certain direct costs that were not treated as departmental costs in the routine process of accounting.

3. Allocate the costs according to the bases established. (This will require computations on separate worksheets and allocations on a master schedule. In addition, deductions often must be made for cost recovery items.)

4. Report the data by cost centers and/or departments.

The first step in cost finding is to collect the necessary accounting and statistical data from departmental statistical reports, and put them in the appropriate columns of schedules and worksheets. The cost-finding procedure begins with the placement of the summarized statistical data for the period in the Statistical Data column of a schedule supporting the lead schedule (see Attachment D). In addition, cost and other data taken from the accounts in the general ledger are listed in the same schedule.

The second step in general cost finding is to make preliminary reclassifications and adjustments, if necessary, to direct expenses (this is a "fail-safe" review to catch those direct costs which may have slipped through the original procedure described above).

Step three in the cost finding procedure is to allocate general service cost centers to revenue producing centers (see

Attachment E). In cost finding, the principle is to first allocate the accumulated costs of those departments or cost centers that render the most service to others and receive the least service in return (Attachments B & C). Where this determination cannot be made, first allocate the indirect costs to the department having the greatest amount of accumulated costs.

Step four, it is now necessary to summarize the cost data in a formal report for use by management. The form of such a report will vary depending on the type and amount of information desired. It is this report that combines the non-cost statistics with the aforementioned costs. The combination should produce unit costing. Such unit costs then become the basis for rate setting, discussed in the next section of this report.

Unit Costing

Generally, cost centers record only one type of service, e.g., counseling. Where the program determines that cost centers include several separate sub-cost components (or services), then unit costing becomes refined to:

1. Unit cost per direct labor hour
2. Unit cost per other direct costs
3. Unit cost per ancillary and other indirect costs.

Where such refinement is needed, the worksheets merely separate direct labor (time rendered directly to or on behalf of a patient) from indirect labor (the remainder of patient time) and direct non-labor costs from ancillary and other indirect costs.

This analysis (displayed at Attachment F) can be valuable in measuring efficiency and effectiveness of services delivered and is recommended for inclusion in the Uniform System. The time sheet displayed at Attachment G provides for the accumulation of time by:

1. Day and date of treatment/service
2. The person rendering treatment/service
3. The type of treatment/service rendered
4. Whether the service was direct or indirect, to the patient.

The final feature of cost finding is the summarizing of patient encounter data into the cost-finding system. The application of cost-finding with the patient encounter figures will produce unit costs showing:

1. Total units of service by cost center
2. Unit costs of such units of service

See Attachment H for a sample unit cost report.

The utility of unit cost analysis, one should remember, serves as 1) an efficiency and effectiveness evaluation; 2) a means to measure budgeted units of service vs. planned; and 3) other management uses such as cost control, as well as the basis for rate-setting.

A final series of uses for unit costing involve:

1. Permitting management a review of the allocation bases used in the cost-finding technique
2. Permitting management to analyze the need for special cost studies, where needed.

Questions on Allocation Bases

Since cost finding utilizes statistics in making the distribution of indirect costs to revenue producing departments, the quality of the allocations and, in fact, the entire cost finding process is dependent on the quality of the statistics. In considering the allocation bases suggested in the cost finding procedures, it is important that the statistics used are appropriate for each individual situation. If they are not, more appropriate bases should be used. The basis chosen in each situation should be the one that most accurately measures the proportionate amount of benefits received by departments to which allocations are to be made.

After having made decisions as to the propriety of the various allocation bases, there are several questions that must be considered in connection with the gathering of statistics:

1. Is the effort expended in gathering the statistics commensurate with the magnitude of the cost to be distributed?
2. Is there some way to simplify the process of accumulating statistics, such as by testing, sampling, or estimating?
3. How frequently must the data be accumulated?

Special Costs Studies

A special cost study may be defined as a cost analysis supplemental to the routine accounting process and to the general cost-finding procedure. Its purpose is to provide information for specific managerial uses.

The most important application of the results of such studies is in the solution of financial management problems; however, studies may also be used for public relations purposes.

The major use of special cost studies, however, is in providing information that will aid management in making decisions and in establishing policies concerning certain phases of the department's operations. Studies of particular activities are valuable

because they may provide detailed information ordinarily not reported, yet necessary for full analysis of an administrative problem. It is possible to obtain cost and statistical figures for almost any purpose desired by management. The administrator should consider the need for studies of cost and statistics, as well as studies of other relevant factors, when seeking a solution to a management problem.

Another general use to be made of the data from a special cost study is the presentation of information to the public. The results of a general cost finding procedure can be used for the same purposes, but frequently there is a need for presenting total costs information on general service activities, information not provided by the cost finding procedure.

Some of the areas of administrative action in which these studies would be most appropriate are:

1. Judging the operational efficiency of an activity in terms of total cost,
2. Determining the cost of adopting new technical procedures,
3. Determining whether equipment should be replaced,
4. Evaluating the cost of alternative choices in: purchasing equipment, utilizing technical or non-technical personnel, utilizing equipment or personnel,

conducting an activity or contracting with outsiders for the service, and utilizing equipment centrally or in departments.

5. Determining costs for allocation purposes, and
6. Determining costs of specific activities within a department.

Special studies may be prepared whenever management desires information for specific situations.

D. The Rate Setting System

The discussions in this report are based on a rate philosophy of equity among patients. Equity dictates that rates should reflect the cost of the specific services rendered to each individual patient, plus an appropriate provision for such additional amounts as are needed for capital purposes, contingencies, and so on.

Despite the objective of relating rates to cost, rates do not usually reflect all of the differences in cost that can apply to each service the patient receives. A practical alternative is to evaluate the average cost of specific medical services and calculate rates based on such averages. This is what has been outlined in the previous sections of this report.

Basic Policy Decisions

Before specific rates can be calculated, there are certain broad policy decisions which each provider must make. These policy decisions relate to the level of income the provider requires in order to meet its financial needs.

The first of these considerations deals with the problems of inflation and technological improvements. Because of inflation, the purchasing power of today's dollar received from a patient is not the equivalent of the purchasing power of a dollar spent

twenty years, or even two years ago. Because depreciation provisions today are computed on the basis of the original cost, an institution that includes only amounts equivalent to depreciation provisions in its rate structure is permitting the purchasing power of its capital to be eroded. Depreciation provisions (and, consequently, rates) which are based on historical cost are almost certain to be inadequate when the institution faces the problem of replacement of obsolete or worn-out facilities at a later date. In addition, the factors of innovative and technological change can influence the amount of working capital needed to finance current operations. Therefore, consideration must be given to these factors in setting the rates of the institution.

Another significant rate consideration, which must be dealt with at the policy level, is the cost of free services, including charity service and bad debts. One of the considerations that clouds all discussion of the rate implications of free care is the question of whether it is a cost or merely a reduction of income. From a bookkeeping standpoint, it is generally recommended that free care be shown as a reduction of income. However, from a rate-making standpoint, and in order to cover the subsequent or concurrent reduction of income, the cost of free care must either be included in rates charged to paying patients or be recovered in some other way. For example, if

bad debts and charity represent 10% of amounts billed to patients, then rates must be set at about 111% of cost in order to collect 100% of cost.

The policy consideration with respect to free care relates to the question of how free care should be financed. For example, should the charity element of free care be paid for by philanthropy, by government (using government as a broad term to indicate all kinds of government agencies), by the paying patients, or by some combination of these sources? This issue is extremely complex and will not be discussed in detail. However, certain of the factors pertinent to a policy resolution of these questions are:

1. Is the free service a result of a legal (and moral) responsibility of the institution, such as emergency admittances?

2. Is the free service attributable to the community service responsibilities voluntarily assumed by the institution?

3. Are acceptable alternative facilities available for the medically indigent? What is considered acceptable?

Policy decisions with respect to other types of free service are less complex. Bad debts, for example, pose no complex problems, and there is almost universal acceptance of the inclusion of the cost of bad debts in the rates charged to paying patients.

Policy consideration also must be given to the necessity for the retirement of loans and reserve funds. Certainly loans must be retired, and funds must be made available for this purpose. Also, it is nearly impossible to operate at an exact, break-even level, and it would appear prudent to provide some margin over and above debt and other requirements to ensure that operations will continue on a sound financial basis.

To summarize, in addition to regular operating expenses, rates must be set to cover:

1. Replacement of facilities, taking into account inflation and other change factors,
2. Working capital requirements,
3. All service and other costs (e.g., free care) not otherwise reimbursed,
4. Debt requirements,
5. As much excess as necessary to provide for sound financial operations, and
6. New or expanded plant facilities.

At the risk of overcomplicating the matter of rate policy decisions, it is important to consider the impact of one additional factor on rate structures: the third-party purchaser. In principle, third-party purchasers should pay essentially the same rate as any other user. In practice, however, they often do not pay on the same basis. Accordingly, to the extent that some third-party purchasers pay less than or more than other patients, rate structures applicable to other patients must be adjusted to absorb the difference. Prime examples are Medicare and Medicaid, which reimburse at "cost" (by their definition of cost).

The Process

Once the costs are accumulated, inflation considered and a philosophical stance assumed, all total estimated costs can be spread to the cost centers.

Since we have accumulated units of service from past activity and projected the next year's activity through a proper planning process, we can now reduce our units of service indicators as follows:

Total Units of Service
Less
Nonbillable Units of Service
Less
Uncollected Bills Expressed as Units of Service
Equals
Net Units of Service to be Scheduled

By applying net units of service to total costs, each service unit then becomes scheduled for client billing.

Important Comments

1. Regarding Costs. Cost are to be adjusted with the "plus factors" of "funded depreciation," etc.

2. Those adjusted costs are priced out via the net units of chargeable service.

3. Philosophies of billing do change. Unless precluded from certain activities by third party payors, "reasonable charges" include all monies necessary to make an effective, or reasonably effective program stand on its own.

4. Some form of utilization review and/or efficiency studies should be used to preclude runaway costs.

5. Controls must be manitained over a) intake to screen out clients who should not be in the system, and b) that all potential third-party reimbursement is discovered.

6. Controls must be rigorously followed on client billing to: a) request payment immediately from clients, or b) make timely billings and follow-up of third-party payments.

E. Other Important Considerations

Assignment of Interest

Under commercial insurance company plans (including Blue Cross), it is the responsibility of the insurer company to reimburse the insured client for the costs of covered services, up to the policy limits, less deductibles and co-insurance amounts. Payment to the client, however, is independent from payment to the program -- that is, the client may present either a paid or an unpaid bill to the insurance company in order to receive reimbursement; the program is left to conclude all financial business directly with the client. If the client does not pay his bill, even though he has been reimbursed by the insurance company, there is little the program can do short of taking legal action which, in turn, may prove to be both costly and non-rewarding. In this situation, the fact that the client may or may not have insurance is irrelevant, other than as a factor in deciding whether to extend credit to the client for services or to make him pay an estimated bill, or substantial portion thereof, as a deposit in advance.

A partial alternative to reliance on direct patient payment is for the program to accept an assignment of insurance benefits. Under this arrangement the client assigns his rights to reimbursement to the program which, in turn, serves as the client's agent in making the claim for, and collecting, the benefit

payments from the third-party payor. Assignment of benefits is commonly used to reduce reliance on the patient for payment and guarantee that the program will receive all payment for services made by the client's insurance company. Assuming that it properly estimates this payment, the program's only financial concern will be to collect, either as an advance deposit, or after services are rendered, the portion of the patient's bill not covered by the insurance company's payments.

Accounts Receivable and Payment Mechanisms

Each provider will need to extend its receivables management system to include the expected increase in managing patient payments and third-party billings. Since this report has been written to address cost-finding and rate setting in alcohol and drug abuse programs that are on-going operations, some degree of familiarity with receivables management has been assumed. It may be well worth the time if the following are added or reemphasized in your program:

1. Maintain a discrete carrier index for each insurance company you deal with.

2. Maintain a discrete cross-tracking system, by patient:
   a. A discrete number for each patient. We suggest a "month-incidence" number. This number, e.g.,

03-113, represents a patient seen initially in March ("03"-third month), and is the 113th patient admitted for some treatment in the system in March. Add a ".1" to the number if a second episode occurs the same month. Subsequent incidences should note the previous patient number.

b. An alpha cross-reference should correlate the patient name with the discrete number listed in "a." above. Nothing may be more embarrassing than having a former patient or insurance carrier call to find out treatment information and having the program find out that it has "lost" a patient.

3. Bill patients/carriers with a statement showing at least:

   a. day/date(s) of treatment

   b. treatment rendered

   c. professional staff or treatment mode.

   Copies of commonly used carrier claims forms are included as Attachment I to this report.

4. Maintain proper controls over billings to include:

   a. when billed

   b. "aging" of receivables by patient and by carrier

c. an agressive collection policy

d. complete monthly reconciliations to the general ledger control totals for receivables.

5. Maintain a file of carrier "acceptances." These "acceptances" show that a carrier has examined or had a chance to examine your program. Maintain a copy of all correspondence showing that the carrier has agreed to pay for patient services. A sample application for "acceptance" is included as Attachment J.

6. Maintain and improve the existing accounting system. A sample flow of accounting functions is included as Attachment K.

ATTACHMENT A

Acceptable Allocations

Allocation	Bases for Allocation
Provider Accounting	1. Hours of service 2. Number of employees served 3. Other acceptable method
Heat, light, Power, etc.	1. Utilization, e.g., wattage 2. Square footage 3. Repairs needed
Physician & Nursing (Administrative)	1. Number of patients 2. Estimated time spent
Employee Benefits	1. Ratio of benefits/general payroll 2. Average number of employees 3. Other acceptable method
Depreciation	1. Square footage 2. Formula basis
Telephone	1. Direct for long-distance, common charges by number of telephones 2. Direct for long-distance, common charges by number of patients 3. Other acceptable method
Etc.	Etc.

ATTACHMENT B

	Initials	Date
Prepared By		
Approved By		

WORKSHEET A
Schedule of Total Costs
All Cost Centers

	(1) Cost Center	(2)	(3)	(4) Direct Costs	(5) Departmental General Overhead Allocation	(6) Allocated Indirect Costs	(7) Final Costs
1							
2							
3	Outpatient Methadone			$ 9,500	$ 800	$ 525	$10,825
4							
5	Outpatient Drug-Free			~~~	~~~	~~~	~~~
6	Residential Drug-Free			~~~	~~~	~~~	~~~
7							
8	General Administrative			900	325	(1,225)	-0-
9				$20,000	$5,000	-0-	$25,000
10							
11				From AA	From AA	From BB	
12							
13							
14							
15							
16							
17							
18							
19							
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Form 1557 Buff - Form G557 Green

ATTACHMENT C

	Initials	Date
Prepared By		
Approved By		

WORKSHEET AA
Direct Costs
Outpatient Methadone Cost Center

(1) Expense	(2) A/C No.	(3) Direct Costs From G/L	(4)	(5) From General Allocation	(6) Total Direct Costs
Salaries & Wages	400	$3,000			$ 3,000
Employee Benefits	401	300			300
Heat	501	200		100	300
Lighting	502	150			150
General Electricity	503	100		50	150
Medical Supplies	504.01	300			300
Food Supplies	504.02	700			700
Methadone	504.03	400			400
Office Supplies	504.04	500		50	550
Travel	505	200			200
Telephone	506	75			75
Depreciation	703			200	200
Totals		$9,500		$800	$10,300
		To A		To A	

Form 1557 Buff - Form G557 Green

ATTACHMENT D

	Initials	Date
Prepared By		
Approved By		

WORKSHEET BB
Indirect Allocation
Outpatient Methadone Cost Center

	(1) Expense Category	(2) FYE	(3) Amount	(4) Allocation Basic	(5)	(6) Indirect Allocation	(7)
1							
2	Heat		XXX	Patient Ratio		200	
3	General Electricity		XXX	Patient Ratio		150	
4	Office Supplies		XXX	Usage Ratio		75	
5	Depreciation		XXX	Sq. Footage		100	
6	Payroll Administrative Salaries		XXX	Supervisory Time		700	
7							
8						$1,225	
9						To A	
10							
11							
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Form H557 Buff - Form C557 Green

ATTACHMENT E

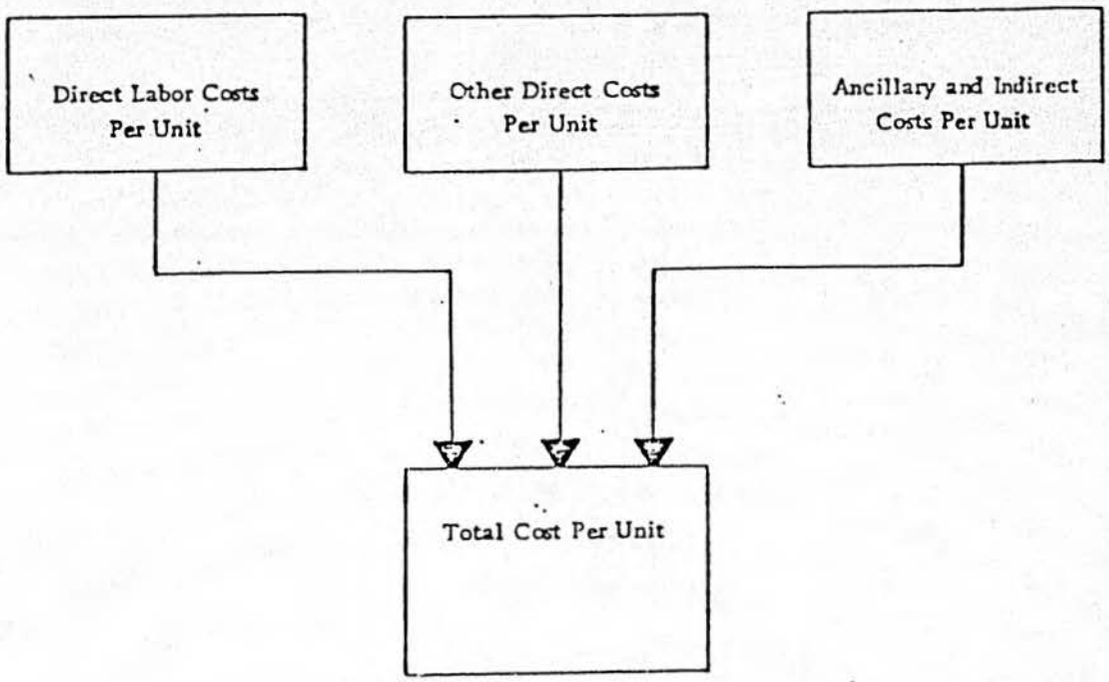
	Initials	Date
Prepared By		
Approved By		

WORKSHEET CC
Schedule of Direct Labor Costs
X Program

(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Name of Employee	Direct Labor Cost: Outpatient Methadone		Outpatient Drug-Free		Residential Drug-Free	
1							
2	Calhoun-Salary		800		XXX		X
3	Benefits	75					
4	Jones-Salary		700		XXX		XXX
5	Benefits	65					
6	Trent-Salary		600		XXX		XXX
7	Benefits	60					
8	Purvis Salary		900		XXX		XXX
9	Benefits	100					
10							
11		300	3000	X	X	X	X
12		To AA	To AA				
13							
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Form H557 Buff - Form G557 Green

ATTACHMENT F



ATTACHMENT G

X TREATMENT PROGRAM

EMPLOYEE NAME _____ EMPLOYEE NUMBER _____ PAY PERIOD ENDING _____

		DATE																
SERVICE GROUP	SERVICE CODE	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

EMPLOYEE SIGNATURE/DATE _____ SUPERVISOR SIGNATURE/DATE _____

NOTES: Employee number contains employee job classification, e.g. Physician, Counselor, etc.
Service Group contains the treatment service mode, e.g. inpatient, intermediate care, etc.
Service Code contains the treatment itself, e.g. individual counseling, detox, etc., and the designation of direct service or indirect.

BANK OF TIME SHEET CONTAINS ALL RELEVANT CODES TO BE USED ABOVE

ATTACHMENT H

X Program
Sample Unit Cost Report

May XX, 19XX

Cost Center	Patient Census or Service Count	Cost Per Unit of Service
Outpatient Methadone:		
Individual Counseling	337 units	$42.17
Group Counseling	187 units	33.14
Medical Review	40 units	45.18

ATTACHMENT I-1

HOSPITAL INSURANCE FORM

HIF (69)

GROUP OR INDIVIDUAL

Spaced for Typewriter – Marks for Tabulator Appear on this Line

'ENT'S NAME AND ADDRESS	DATE OF BIRTH
INSURED'S NAME IF PATIENT IS A DEPENDENT	INSURED'S SOC. SEC. NUMBER
NAME OF INSURANCE COMPANY	POLICY NUMBER

IF GROUP INSURANCE, NAME OF POLICYHOLDER (i.e. Employer, Union or Association through whom insured)

I HEREBY AUTHORIZE PAYMENT directly to the below named hospital of the hospital insurance benefits otherwise payable to me but not to exceed the balance due of the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this authorization.

SIGNED (INSURED PERSON)

DATE

I HEREBY AUTHORIZE RELEASE OF INFORMATION, requested on this form, by the below named hospital.

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE

DATE ADMITTED	TIME ADMITTED AM PM	DATE DISCHARGED	TIME DISCHARGED AM PM

COMPLAINT

DATE OF FIRST SYMPTOMS

DIAGNOSIS FROM RECORDS (IF INJURY GIVE DATE, PLACE OF ACCIDENT)

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? Yes ☐ No ☐

OPERATIONS OR OBSTETRICAL PROCEDURES PERFORMED (NATURE AND DATE)

OTHER HOSPITAL COVERAGE: YES ☐ NO ☐ (IF "YES" NAME OF CARRIER)

IF PATIENT HAD OTHER THAN SEMI-PRIVATE ROOM, INDICATE MOST COMMON SEMI-PRIVATE DAILY RATE $.....

HOSPITAL CHARGES: (COMPLETE THIS SECTION OR ATTACH COPY OF BILL WITH A DETAILED BREAKDOWN OF CHARGES)

ROOM AND BOARD	Ward _____ Days at $ _____ Total	$
	Semi-Private _____ Days at $ _____ Total	
	Private _____ Days at $ _____ Total	
	Intensive Care Unit _____ Days at $ _____ Total	
	Extended Care Facility _____ Days at $ _____ Total	
CHARGES	Operating or Delivery Room	
	Anesthesia	
	X-Ray	
	Laboratory	
	EKG BMR	
	Physical Therapy	
	Medical and Surgical Supplies	
	Pharmacy (Except Take-Home Drugs)	
	Inhalation Therapy	
	Intravenous Solutions	
	TOTAL	$

TOTAL CHARGES $ _____
PAYMENT CREDITS–PATIENT $ _____
PAYMENT CREDITS–OTHER CARRIER (S) $ _____
BALANCE DUE $ _____

THIS FORM APPROVED BY THE HEALTH INSURANCE COUNCIL AND ACCEPTED FOR USE BY HOSPITALS BY THE AMERICAN HOSPITAL ASSOCIATION.

HEALTH INSURANCE COUNCIL

HOSPITAL

ADDRESS

TAKEN FROM RECORDS ON: 19

SIGNED BY

MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE

Most insurance companies provide their insured persons with simplified and standardized claim forms approved by the American Hospital Association and the Health Insurance Council. Such forms can be identified by the HIC symbol:

The HOSPITAL INSURANCE FORM – GROUP OR INDIVIDUAL – HIF (69), may be stocked and used by hospitals in those instances when other approved forms are not submitted by insured patients. When the HIF (69) form is completed instead of an insurance company form, the two should be attached together inasmuch as parts of the company form may have already been completed by the insured person and/or the employer. This will facilitate the handling of the patient's claim.

The Health Insurance Council is a division of the Health Insurance Association of America. As such it represents the member companies of the Association which provide a majority of the protection against the costs of health care in the United States. Additionally, representatives of other insurance organizations act in advisory capacities and their member companies may and do participate in Council programs. In this way, the Health Insurance Council is representative of the business as a whole in its endeavors to maintain and strengthen relationships between providers of health care and the business which helps finance its costs.

FORM C-646 (REVISED 1971) PHYSICIANS' RECORD CO., BERWYN, ILLINOIS PRINTED IN U.S.A.

ATTACHMENT I-2

Blue Cross
of Washington and Alaska

P.O. Box 327
Seattle, Washington 98111
206/461-3232

Hospital Outpatient Service Billing Form

Please fill out Parts 1 and 2 below and send to the Blue Cross Plan Claims Department. Please type or print.

PART 1 / PATIENT INFORMATION

PATIENT'S NAME First / Initial / Last

BIRTHDATE Mo / Day / Year

IS THIS CLAIM DUE TO AN ACCIDENT OR INJURY? YES ☐ NO ☐

DATE _____ TIME _____ AM ☐ PM ☐

AT WORK ☐ AT HOME ☐ AUTO ☐ OTHER ☐

EXPLANATION:

RELATION TO SUBSCRIBER: SELF ☐ SPOUSE ☐ CHILD ☐

GROUP NUMBER

MEMBERSHIP NUMBER

SUBSCRIBER'S NAME, ADDRESS, CITY, STATE, ZIP

IF ACCIDENT OCCURRED AT WORK, IS CASE COVERED UNDER WORKMEN'S COMPENSATION? YES ☐ NO ☐

WAS ANOTHER PARTY RESPONSIBLE FOR THIS ACCIDENT? YES ☐ NO ☐

PLEASE INDICATE IF ADDRESS IS: TEMPORARY ☐ PERMANENT ☐

IS THE PATIENT OR OTHER FAMILY MEMBERS COVERED UNDER ANOTHER GROUP MEDICAL PROGRAM? YES ☐ NO ☐

NAME AND ADDRESS OF OTHER CARRIER

SUBSCRIBER'S EMPLOYER

OTHER GROUP COVERS: PATIENT ☐ SPOUSE ☐ CHILD(REN) ☐

ID NUMBER

GROUP NUMBER

PART 2 / MEDICAL INFORMATION

NAME OF HOSPITAL: [redacted]

HOSPITAL NUMBER: [redacted]

HOSPITAL CASE NUMBER

DATE(S) OF SERVICE

TIME OF SERVICE ____ AM ☐ PM ☐

DIAGNOSIS (INCLUDE TYPE OF OPERATION IF APPLICABLE) If treatment is for a medical condition, please attach a copy of hospital outpatient lab report

ICDA CODE

HCFA/CPT CODE

DESCRIPTION OF SERVICES	TYPE OF SERVICES	CHARGE
Please itemize bill or itemize below Lab, X-Ray, Physical Therapy and X-Ray Therapy.	EMERGENCY ROOM CHARGE	
	MINOR SURGERY	
	HOSPITAL EXTRAS (Room, Board, Lab, X-Ray, Physical Therapy, Etc.)	
	TAKE HOME PRESCRIPTION DRUGS	
	Total Charge	

FOR BLUE CROSS PLAN USE ONLY

VALIDATE	TRUST ELIGIBILITY CODING	GROUP NUMBER	WAITING PERIOD WAIVED YES ☐ NO ☐	PAID TO DATE	EMPLOYEE NUMBER	APP. DATE

1						A	2				ACCD 0												
2						A	2																
3						A	2																
						A	2																

BALANCE OF CHARGES

NON ALLOW CODE AND CHARGE

AMOUNT TO APPLY MAJOR MED THIS CLAIM

MAJOR MEDICAL DEDUCTIBLE ($ only) .00

AMOUNT OF DEDUCTIBLE PREVIOUSLY SATISFIED

REMAINING DEDUCTIBLE

BALANCE APPLICABLE TO MAJOR MEDICAL

% OF C

ACCUMULATIVE MAJOR MEDICAL PAYMENTS ($ only) CURRENT YEAR / LIFETIME

MAJOR MEDICAL AGGREGATE $ (only)

FAMILY OR AGGREGATE DEDUCTIBLE SATISFIED? (If yes, Code F)

	SERVICE DATES FROM & TO MO – DAY / MO – DAY – YEAR	GROUP NUMBER	CLASS	PRE	REJECT CODE	CLAIM NO	AGE	SEX	W.I.C
1									

	F C	DI	M O	D A	S N	P O S	I N T	T Y P E	M O D	M O D	PROCEDURE CODE	STANDARDIZED REMARKS & PROVIDER'S NAME	P A I D	PROVIDER NO.	PAYMENT AMOUNT	S P E C	F S	R O	C O B
1																			
2																			
3																			

FOR F.E.P. USE ONLY

F E P	D I V	D S	ADMISSION DATE M M D D Y	A S E	P R E	P O S	D P C G	I M C	A C C	HOSP INITIALS	DAYS PAID	I N P	C O B	GOVT AGENCY	TOTAL CHARGES	V.S.R.	PAYMENT BLANK	Q F
	2								0		0 0 0							

FOR INCREASE ADJUSTMENTS 2

ATTACHMENT I-3

Blue Cross
of Washington and Alaska

P.O. Box 327
Seattle, Washington 98111
206/361-3232

Provider's Service Billing Form

Please fill out Parts 1 and 2 below and send to the Blue Cross Plan Claims Department. Please type or print. See reverse side for complete instructions on how to submit to the Blue Cross Plan.

PART 1/PATIENT INFORMATION

PATIENT'S NAME
First Initial Last

BIRTHDATE
Mo Day Year

RELATION TO SUBSCRIBER
SELF SPOUSE CHILD

GROUP NUMBER

SUBSCRIBER'S IDENTIFICATION NUMBER

SUBSCRIBER'S NAME, ADDRESS, CITY, STATE, ZIP

ZIP CODE

PLEASE INDICATE IF ADDRESS IS TEMPORARY PERMANENT

SUBSCRIBER'S EMPLOYER

IS THIS CLAIM DUE TO AN ACCIDENT OR INJURY? YES NO

DATE _____ TIME _____ AM PM

AT WORK AT HOME AUTO OTHER

EXPLANATION

IF ACCIDENT OCCURRED AT WORK IS CASE COVERED UNDER WORKMEN'S COMPENSATION? YES NO

WAS ANOTHER PARTY RESPONSIBLE FOR THIS ACCIDENT? YES NO

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER GROUP MEDICAL OR DENTAL COVERAGE? (THIS INCLUDES OTHER BLUE CROSS COVERAGE) YES NO

NAME AND ADDRESS OF OTHER CARRIER

COVERAGE IS FOR:
PATIENT SPOUSE CHILDREN

I.D. NUMBER

GROUP NUMBER

PART 2/MEDICAL INFORMATION

PROVIDER'S NAME, ADDRESS, CITY, STATE, ZIP

PROVIDER'S I.R.S. TAX NUMBER

HAVE THESE CHARGES BEEN PAID?
YES NO

THIS ILLNESS
MEN WOMEN

DATE OF ONSET

PREGNANCY RELATED?
YES NO

NAME OF HOSPITAL (If hospitalized)

ADMISSION DATE

DISCHARGE DATE

DIAGNOSIS (including complications)

ICDA CODE

TYPE OF OPERATION? (If unusual or complicated attach operative report)

DATE OF SERVICE	RVS OR CPT CODE	DESCRIPTION OF SERVICES	CHARGE
		Total Charge	

FOR BLUE CROSS PLAN USE ONLY

SERVICE DATES FROM & TO MO – DAY MO – DAY – YEAR

GROUP NUMBER | CLASS | REL | DESIG | REJECT CODE | CLAIM NO | AGE | SPEC | ALLC

	FC	OL		DED	BEN	DISP	AOT	TYPE	IMC	MISC	PROCEDURE CODE	STANDARDIZED REMARKS OR PROVIDER'S NAME	PAYE		PAYMENT AMOUNT	CGV CHG ONLY	TS	ROV	COB
2															.				
3															.				
4															.				
5															.				
6															.				

OTHER MEDICAL INFORMATION

CHARGE(S) . | MAJOR MEDICAL DEDUCTIBLE ($ only) .00 | BALANCE APPLICABLE TO MAJOR MEDICAL . | | |

ALLOWABLE CHARGE . | AMOUNT OF DEDUCTIBLE PREVIOUSLY SATISFIED . | % OF C . | | |

AMOUNT FORWARD MAJOR MED THIS CLAIM . | REMAINING DEDUCTIBLE . | ACCUMULATIVE MAJOR MEDICAL PAYMENTS ($ only) CURRENT YEAR | | MAJOR MEDICAL AGGREGATE ($ only)

LIFETIME | FAMILY OR AGGREGATE DEDUCTIBLE SATISFIED (If less than full)

TRUST ELIGIBILITY CODING	WAITING PERIOD WAIVED YES NO	PAID TO DATE	EMPLOYER NUMBER	APP. DATE
	GROUP NUMBER / CLASS / RELATION	EFFECTIVE DATE		

400-009 (12-77)

How To Submit This Billing Form*

The Blue Cross Plan claims processing system allows for direct payment for covered services to the provider of services. This system operates at greatest efficiency when the Blue Cross Plan is billed directly by the provider. When payment is made directly to the provider, the subscriber will receive an Explanation of Benefits which describes how the claim was processed.

To The Provider Submitting This Form:
In order to speed payment to you, please complete Part 1 (Patient Information) and Part 2 (Medical Information). Please be sure to enter your correct IRS Tax Number in box 11. The IRS Tax Number is essential for correct and timely payment to you.

To The Subscriber Submitting This Form:
Payment for covered services can be made faster when your provider of services bills the Plan directly on this form. *Please encourage your provider to bill the Plan directly.*

Should your provider not bill direct, please complete Part 1 and attach the itemized bill received from your provider.

Please note:

- Please submit a separate form for each patient.
- Please submit a separate form for each calendar year.
- If the provider has already been paid, please be sure that box 12, "Have these charges been paid?" is completed.
- If the subscriber has coverage under more than one Blue Cross group program, please submit a billing form for each group.
- All completed forms must be sent to the Blue Cross Plan home office in Seattle, Washington:

Blue Cross of Washington and Alaska
P.O. Box 327
Seattle, Washington 98111

If you need additional forms, please contact your Blue Cross Plan office.

*The Provider's Service Billing Form is to be used for Doctor, Vision, Nursing, Appliance, Ambulance and other special bills as explained in your Blue Cross benefit booklet. This billing form replaces the Physician's Service Report (form #9).

THE TRAVELERS INTEROFFICE MEMORANDUM

TO Examiner Smith, LAG/RAM Div., LAG Unit, 7 PB

FROM

SUBJECT Hospital Survey *(Personal visit required. If not possible, explain under comments)*

Name of Institution _____

Address _____

Check mark and/or fill in ' cks

1. Date institution began operation _____.

2. Is this institution *primarily* engaged in treating sick or injured persons on an in-patient basis?
   Yes ____ *No* ____

3. Does this institution provide room and board confinements extending at least 24 hours? *Yes* _____ *No* ____

4. Is room and board provided at patient's expense? *For example, are patients who do not have insurance required to pay some portion of the bill?* *Yes* _____ *No* _____

5. How many in-patient beds? _____

6. Are orders for care written by physicians? *Yes* _____ *No* _____

7. What is the primary or most appropriate classification of this institution?

   ____ Short-Term General Hospital
   ____ Long-Term General Hospital
   ____ Children's General Hospital
   ____ Chronic Disease Hospital
   ____ TB or Respiratory Disease Hospital
   ____ Short Stay Psychiatric Hospital
   ____ Long Stay Psychiatric Hospital
   ____ Children's Psychiatric Hospital
   ____ Alcoholism Treatment Facility
   Residential Treatment Facility
   ____ a. For Emotionally Disturbed Adults
   ____ b. For Emotionally Disturbed Children or Adolescents
   ____ c. Other, *Explain* _____
   _____
   ____ Drug Addiction Treatment Center
   ____ Extended Care Facility
   ____ Skilled Nursing Facility
   ____ School
   ____ Convalescent Facility
   ____ Other, *Explain (e.g., part of a hospital)* _____
   _____

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8. Diagnostic X-Ray and Laboratory Facilities

____ None Provided or Readily Available
____ On the Premises
____ Arrangement with Another Facility, *Explain* _____

_____

9. Therapeutic Facilities for Medical and Surgical Treatment of In-Patients, *e.g., Drugs, Medicines, Surgical Dressings, Equipment for Administering Oxygen and Other Durable Equipment for Therapeutic Treatment.*

____ None Provided or Readily Available
____ On the Premises
____ Arrangement with Another Facility, *Explain* _____

_____

____ Other, *Explain* _____

10. Nursing Services

____ 24 Hour Nursing by or Under the *Direct Supervision** of Registered Graduate Nurses (**Registered Nurse on Premises at all times)*
____ Nursing Rendered by LPN's, LVN's, and/or Nurses Aids with no Registered Nurse on Premises at all times
____ Other, *Explain* _____

_____

11. Surgical Facilities

____ Major Operative Surgery *(One or More Operating Rooms and a Post-Op Recovery Room)*
____ Minor Surgery Only
____ Emergency Facilities Only
____ No Surgical Facilities on Premises, Arrangement with _____

_____

____ Other, *Explain* _____

_____

12. Medicare

____ Institution Does Not Participate in Medicare
____ Applied for Medicare Participation – Date _____
____ Participates in Medicare
a. Provided Number__ __ – __ __ __ __
b. Effective Date of Participation _____
____ Other, *Explain* _____

_____

SI-49599A (BACK)

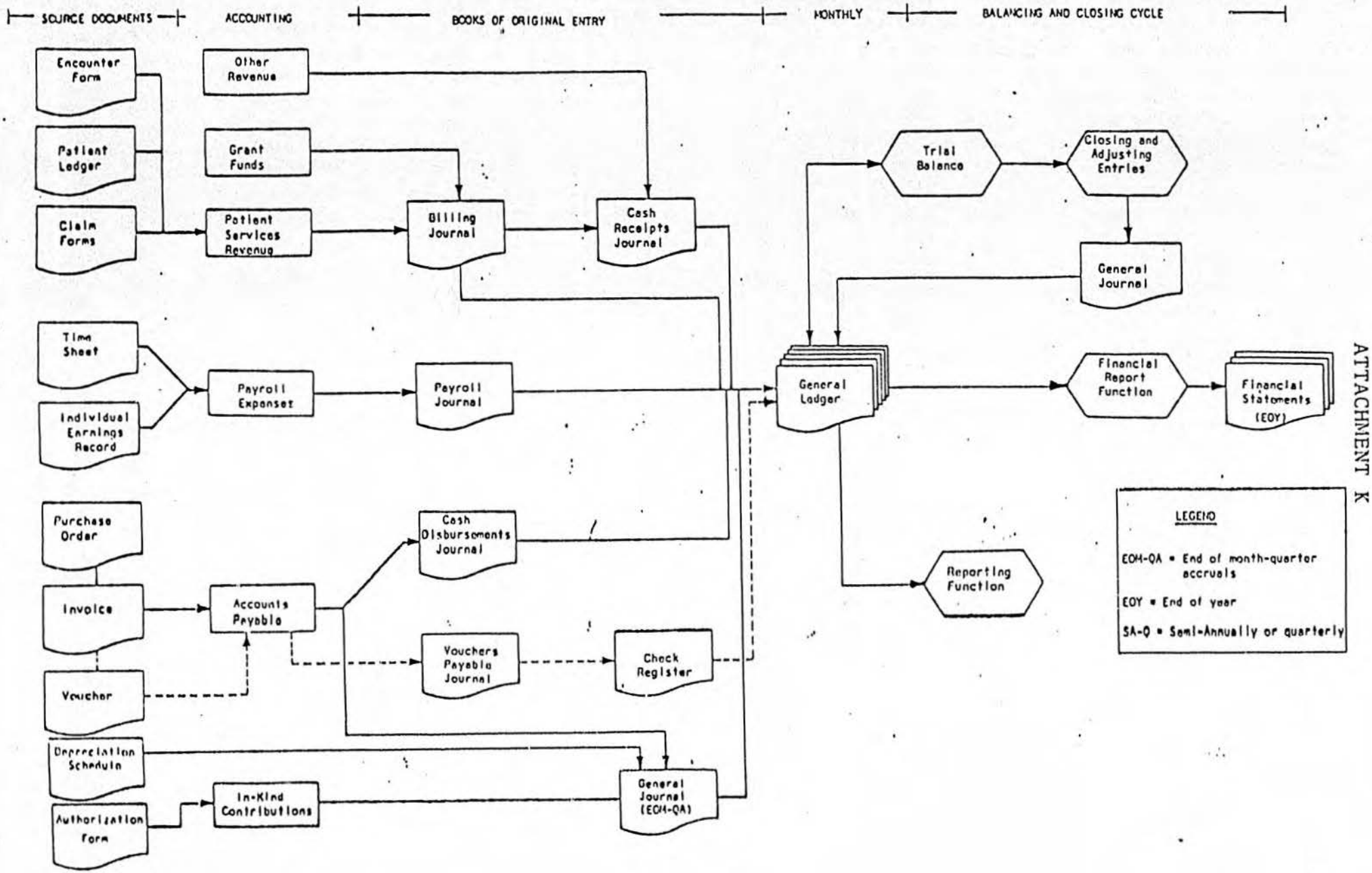
13. JCAH Accreditation

____ No Accreditation – No Application Made
____ Applied for Under Psychiatric Facilities Program
(Attach copy of Application for Survey)
____ Applied for Under Hospital Accreditation Program
(Attach copy of Application for Survey)
____ Accredited as Psychiatric Facility
(Attach copy of Accreditation Letter)
____ Accredited as a Hospital
(Attach copy of Accreditation Letter)
____ Other, *Explain* _____

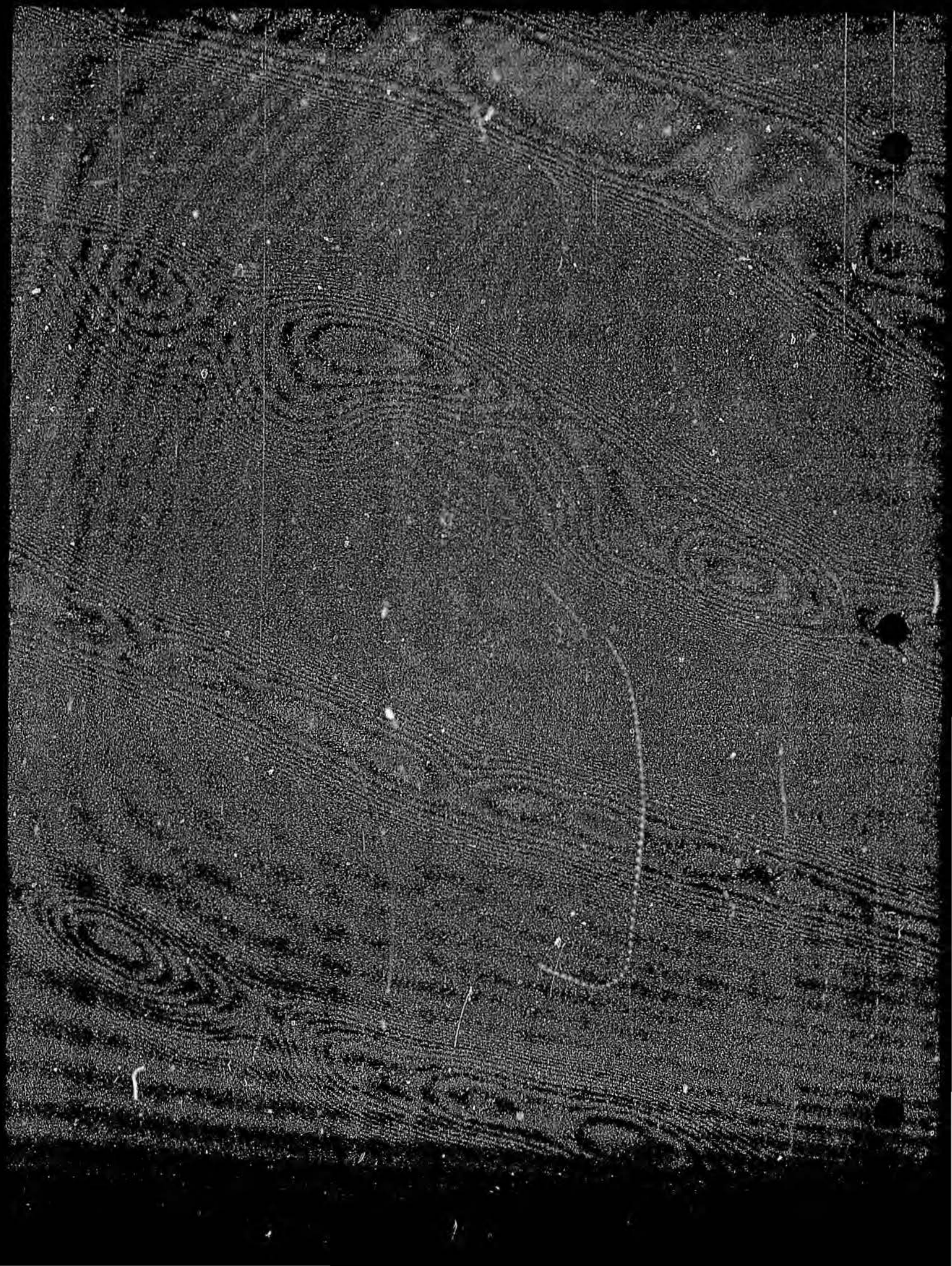
14. Additional Comments _____

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ACCOUNTING SYSTEM FLOW



ATTACHMENT K



Lawn & Associates
CERTIFIED PUBLIC ACCOUNTANTS
P.O. BOX 1586
JUNEAU, ALASKA 99802



REPORT ON A DEMONSTRATION PROJECT:

A STUDY TO DETERMINE COST COMPONENTS AND DEVELOP FEE SCHEDULES (INCLUDING PAYMENT MECHANISMS) IN THE FAIRBANKS NATIVE ASSOCIATION'S COMPREHENSIVE ALCOHOLISM PROGRAM AND FAIRBANKS DRUG TREATMENT CENTER

Prepared for:

Robert L. Cole, Coordinator
State Office of Alcoholism
and Drug Abuse
Department of Health and
Social Services

Spring 1978

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I. INTRODUCTION

II. COST COMPONENTS FOR THE FAIRBANKS NATIVE ASSOCIATION'S COMPREHENSIVE ALCOHOLISM PROGRAM (FNACAP) AND IN THE FAIRBANKS DRUG TREATMENT CENTER (FDTC)

III. FEE SCHEDULES IN THE FNACAP AND FDTC PROGRAMS

IV. CONCLUSION

I. INTRODUCTION

This Demonstration Project, commissioned by the State Office of Alcoholism and Drug Abuse (SOADA), was designed to explore the potential for funding alternative sources of revenue (beyond grants) for alcoholism and drug abuse programs in Alaska. This project recognizes the following facts:

1. That alcoholism and drug abuse programs, extensively grant-funded in the past, are facing a leveling off of grant funds for programs. This leveling off means that, in a period of rising costs and increasing demand, alcoholism and drug abuse programs are experiencing a shortfall of the revenues needed to operate their programs at adequate levels.

2. That a major source of revenue, previously ignored, needs to be pursued as an essential and feasible part of paying for alcoholism and drug abuse treatment. That source is the "third party payor," whether private (insurance companies) or "public carriers" (Medicaid, etc.).

With the premise that alcoholism and drug abuse are now accepted as an illness, more and more insurance companies are being

billed for their treatment. There has been considerable resistance to this from these third-party payors. The National Institutes on Alcohol Abuse and Alcoholism (NIAAA) has published excerpts from a study by the National Underwriters group showing that of 278 insurance policies studied, over 80% either exclude or limit payment benefits for alcoholism treatment (NIAAA publication "Alcohol Topics in Brief," Volume 1, Number 2). A study of the insurance coverage available to Alaskans, a companion to this report (Exhibit A) shows the same situation for both alcoholism and drug abuse treatment in Alaska ("A Report on Health Insurance Coverage of Alcoholism and Drug Abuse Treatment in Alaska," Lawn and Associates, Spring 1978).

The rationale for non-coverage of alcoholism and drug abuse treatment ranges from the emotional to the very practical. For example, the emotional reaction: "It can't be cured, so why treat and pay for it" can almost be heard from the executive board rooms of insurance carriers whose business is to "pay for it." The practical resistance is two-fold: 1) standards of practice, utilization (peer) review, certification or licensure of counselors, etc., are just beginning to be defined; 2) fiscal management, budgeting, cost accounting, rate setting, etc., have not been emphasized to respond to the requirements for accounting data to support billings to third party payors. It is the fiscal part of the above that will be addressed in this paper.

With the completion of an outline of a uniform accounting and financial reporting system completed (Exhibit B, Lawn and Associates, Spring 1978), the following questions need answered:

1. Can cost components, by treatement service, be produced from the fiscal records of two typical Alaska programs, one treating alcoholism and one treating drug abuse?

2. Can these programs generate fee schedules (and payment mechanisms) to provide the basis for establishing reimbursement from third-party payors?

II. COST COMPONENTS FOR THE FAIRBANKS NATIVE ASSOCIATION'S COMPREHENSIVE ALCOHOLISM PROGRAM AND THE FAIRBANKS DRUG TREATMENT CENTER

A. Financial Controls Review

The subject programs were examined for their ability to meet certain standards of financial controls. Those standards are accepted in the general business community and form the basis for the extent of testing that an auditor (generally a Certified Public Accountant (C.P.A.)) would perform in rendering an opinion on the "fairness of presentation" of financial statements issued to third parties. These standards are often called internal controls.

The potential of third-party payment is predicated on acceptance, by those payors, of the competency of the treatment organization to control its operations and to produce high quality care at a reasonable cost. Where third party reimbursement is available, those payors reserve the right, among other rights, to assess the adequacy of the program's fee schedules and the financial reporting system are the elements or characteristics which comprise internal controls. These elements are:

1. The proper functioning of competent personnel, performing duties in an atmosphere where clear lines of authority and responsibility are established;

2. The adequate segregation of duties;
3. The presence of proper procedures for authorizations;
4. The presence of adequate documents and records;
5. The presence of proper procedures for recordkeeping;
6. Physical control over the assets and records; and,
7. Independent checks on performance.

The results, summarized below, are by agency (a complete report on the study is on file with the SOADA):

1. Comprehensive Alcoholism Program: The examination disclosed that the CAP had adequate controls to produce financial reports, unit costing of services, and be able to support fees charged for services. Current personnel appear adequate to supervise the reporting and control systems. One additional coordinating accountant position, mid-level range, will be required to amass and code transactions into a unit of service mode. Also recommended is a financial audit of records and a separate specific program audit. Such program audits should produce a statement of assurance that the chargeability provisions of major third party payors have been reasonably attained, giving due recognition to such items as pre-cost charges and other items funded for future replacement or utilization.

2. The Fairbanks Drug Treatment Center: The examination disclosed that, similar to any small operation, there tends to be a dramatic overlapping of program management, program services delivery, and program accountability and reporting. In this report, we recommend the addition of an independent recording and record keeping entity, although still under the general approval and control of the Program Director. Also recommended is a financial audit and program audit as suggested for the FNACAP.

B. Producing Cost components.

Concurrent with the review of controls discussed in the previous section, the availability of baseline data for unit of service charges was explored. The general results were as anticipated: There is no current reporting on a cost center approach, nor are records directed toward patient flow.

A review of the existing programs can, however, produce information according to these generally acceptable service categories:

1. For Alcoholism Services:

   Joint Commission on Accreditation of Hospitals (JCAH)

   a. Emergency care
   b. Inpatient care
   c. Intermediate care

d. Outpatient care

e. Outreach

f. Aftercare

g. Consultation and education

h. General administration/support services

2. For Drug Treatment Services:

a. Methadone Program Treatment

b. Outpatient Counseling

Since we had available general service categories but no way to produce cost components directly from the accounting records, we decided on the following indirect method, using estimations:

1. Using the principles outlined in Exhibit B, an estimate of the distribution of expenses (expired costs) was used to produce the cost components.

2. Based on "1", then the services rendered, by cost component, were applied to available statistics on patient services. This produced an interim unit cost for each service.

The results were the cost-findings shown as Exhibits C and D for the FNACAP and FDTC programs respectively.

These analyses (Exhibits C and D), are actually listed as an "interim rate" for the services listed. The fact that they represent both the cost and the rate per service unit is explained in the next section.

III. ESTABLISHING FEE SCHEDULES IN THE FNACAP AND FDTC PROGRAMS

A. Philosophical Considerations in Fee Scheduling

Concurrent with or before establishing cost components, the program assembles data on program requirements above pure accounting cost. Toward this, certain philosophical questions must be addressed. For example:

1. What is to be the position of the program in regards to indigents, especially those marginal indigents who do not fully, or perhaps even partially, have economic means to pay for services. Are they accepted for treatment? Must they be treated under contractual requirements with a funding source, e.g., the Federal Government?

2. "Funded replacement" costs are generally those future costs of constructing or purchasing major assets. Should they be funded in advance (according to a plan) to meet the cash requirements of an asset purchase, or should long-term financing be obtained, with the finance costs included in the rate structure?

3. What offset to costs can be expected of private philanthropy or of grants from government? What special costs are required to maintain these funding sources? Is it worth the money received?

4. What is the position of the "good" program in regards to "bad debts" write-offs? How liberal a position on bad debts is acceptable to the program?

Neither the FNACAP nor FDTC programs have addressed these issues (Since philosophical issues are explored in more detail in Exhibit B, they are not discussed further in this section).

B. Fee Scheduling for FNACAP and FDTC

Since the subject programs have no defensible adjustment to cost at this time, their cost-finding becomes rate-setting at this point, as noted in Exhibits C and D.

C. Other Comments

The analysis of cost-finding and rate setting, while under-developed at FNACAP and FDTC, can offer several insights into the programs:

1. The question can be asked why "Transportation Services" (per trip) are so relatively expensive at FNACAP. Since transportation is not in an emergency vehicle, fully staffed with paramedics, etc., and involving expensive equipment, the figures point out the need for a review of this service. Perhaps the program can provide acceptable contract transportation services at a lower cost.

2. At FNACAP, the question can be asked why "Emergency Detoxification" (per day) appears so relatively high cost. Since our review showed that detoxification services were not on the same critical plane as those found in a general hospital setting, perhaps contracting for this service, as an alternative to in-house detox, may prove acceptable to the program and less expensive to the patient.

IV. CONCLUSION

This report shows the subject programs as capable of a transition (whole or in part) to free-standing programs capable of managing third-party payment systems. As outlined in Exhibit B, both programs need accounting and financial reporting systems more sophisticated than currently available. Also noted are the necessary philosophical stands to be taken by program management and boards of directors toward setting rates.

Given that the subject programs are representative of alcoholism or drug abuse programs statewide, the various statewide programs should be capable of third-party payment as a source of revenue.

The keys to success are commitment and training.

EXHIBIT A (SEE INDEX FOR FULL COPY)

Laux & Associates
CERTIFIED PUBLIC ACCOUNTANTS
P.O. BOX 1586
JUNEAU, ALASKA 99802



A REPORT ON HEALTH INSURANCE COVERAGE OF ALCOHOLISM AND DRUG ABUSE TREATMENT IN ALASKA

Prepared for:

Robert L. Cole, Coordinator
State Office of Alcoholism
and Drug Abuse
Department of Health and
Social Services
State of Alaska

EXHIBIT B (SEE INDEX FOR FULL COPY)

Lawn & Associates
CERTIFIED PUBLIC ACCOUNTANTS
P.O. BOX 1586
JUNEAU, ALASKA 99802



AN OUTLINE OF A UNIFORM ACCOUNTING AND FINANCIAL REPORTING SYSTEM FOR ALCOHOLISM AND/OR DRUG ABUSE TREATMENT PROGRAMS IN ALASKA

Prepared for:

Robert L. Cole, Coordinator
State Office of Alcoholism
and Drug Abuse
Department of Health and
Social Services
State of Alaska

FNA - CAP

Interim Rate

3/31/78

EXHIBIT C

	Name	Date
Prepared By		
Approved By		

Component / Subcomponent	Basis for Charge	Charge	Comment
Emergency Services:			
Transportation Services	Occasion of Service	$212	Per trip
Emergency Detox	Patient Days	556	Per Day
Consultation/Education	Occasion of Service	91	Per Visit
Intermediate Care:			
Short Term Facility	Patient Day	30	Per Pat. Da
Long-Term Facility	Patient Day	25	Per Pat. Da
Outpatient Care	Patient Visits	49	Per Visit
Aftercare	Patient Visits	68	Per Visit

Form 6557 Buff - Form 6557 Green

FDTC

EXHIBIT D

Interim Rate
3/31/78

	Initials	Date
Prepared By		
Approved By		

Component / Subcomponent	Basis for Charge	Charge	Comment
Outpatient Care:			
Methadone Program:			
Medical Diagnosis	Occasion of Service	$496	Per Diagnos
Methadone Dispensing	Occasion of Service	5	Per Visit
Outpatient Counseling	Occasion of Service	48	Per Session

Form HSS7 Buff - Form G557 Green