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Alcohol-related traffic accidents represent a major adverse consequence associated with underage drinking. The rate of accidents involving underage drinking drivers decreased consistently between 1990 and 1993 with a less significant decrease in 1994. The rates were mixed between 1994 and 1998 varying up and down, but varying little between 1994 and 1998. The trend for accidents involving drinking drivers of all ages (39.5% decrease) was similar to that for underage drinking drivers (38.1% decrease). The investigators could find no conclusive information supporting an explanation for the trends. National studies have suggested that similar declines on a national level occurring between 1976 and 1987 are, at least partially, a result of the increase in legal drinking age across the country to 21.¹⁴

4. Alaska Division of Alcoholism and Drug Abuse – Substance Abuse Treatment Utilization. The Division of Alcoholism and Drug Abuse funds and coordinates an extensive substance abuse treatment system serving Alaskans. As a part of their management of this system, they collect data from each funded program that provides information on client characteristics as well as service information. The graph below presents the rate of utilization for youth 17 years of age and younger and for youth 18 to 20 years old. The following table in this sub-section presents the raw numbers of individuals served in each component of care during the period 1992-1998. The nature of this latter analysis prevents using unduplicated clients since individuals may receive treatment in more than one component of care. Since 1992 there has been a slow but steady increase in clients 18 to 20 years old with a more marked increase in those under 18 years of age, both in raw numbers and as a rate per 100,000 population. The treatment capacity of the adolescent residential treatment facilities has remained static through the 1990s.

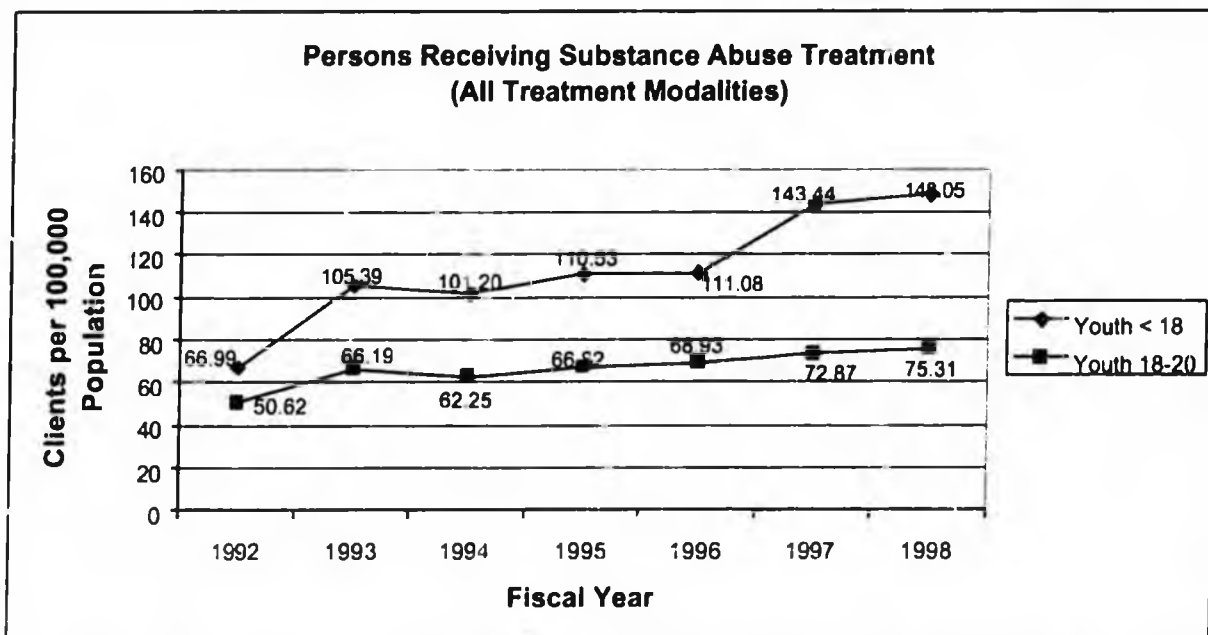


Figure 6 – Youth Receiving Substance Abuse Treatment (includes only programs funded through the division grant process or by direct Budget Request Unit (BRU)); Data Source: Treatment Data – Alaska Division of Alcoholism and Drug Abuse; Population Data – Alaska Department of Labor and Workforce Development

¹⁴ O'Malley, J.L. and Wagenaar, A.C., "Effects of minimum drinking age laws on alcohol use, related behaviors, and traffic crash involvement among American youth: 1976 – 1987." *Journal of Alcohol Studies*, 52 (5): 478-491, 1991

**Substance Abuse Treatment to Adolescents by Component
1992 – 1998
(Actual Numbers – Duplicated Clients)**

Year	Detox	Inpatient (Hospital)*	Short Term Residential*	Long Term Residential**	Outpatient	Intensive Outpatient	Continuing Care
1992	19/57	1/3	12/17	92/85	199/121	70/58	34/25
1993	37/40	1/0	38/24	188/108	245/168	147/101	69/23
1994	27/61	2/10	6/34	153/101	243/136	113/106	134/32
1995	18/63	3/17	10/30	164/101	306/161	80/114	158/46
1996	11/55	1/8	14/25	160/101	345/173	93/106	110/47
1997	13/56	2/12	7/25	150/109	385/176	218/139	179/53
1998	20/54	5/10	3/16	159/101	422/193	288/138	149/51

Table 3 – Substance Abuse Treatment to Adolescents by Component; Data Source: Alaska Division of Alcoholism and Drug Abuse

Number Reporting Format: Ages 17 & Younger / Ages 18 – 20

Notes: * Inpatient (Hospital) and Short-Term Residential length of stay 10 – 30 days.

** Long-Term Residential length of stay – greater than 30 days

- ?? Increases in long-term residential adolescent treatment data are supported by key informant interviews indicating average lengths of stay between three and six months. Increased intensive outpatient services of 311% can be partially attributed to an increase in programs offering that service, as well as third party payors who favor treatment settings less restrictive than residential.
- ?? Continuing care utilization increased by over 300% for youth ages 17 and younger and by just over 100% for youth ages 18 through 20. Increases in utilization of continuing care reflects the importance attached to continuing care by the Division of Alcoholism and Drug Abuse and the addictions field in general.

J. Conclusions. Based on national and state surveys, alcohol consumption by youth in Alaska is comparable to consumption by youth nationally. When considering trends in consumption of alcohol by youth, there are mixed indicators that preclude the development of conclusions. The 1998 and 1999 National Household Surveys on Substance Abuse sponsored by SAMHSA concluded that the trend in consumption of alcohol by youth during the 1990s was relatively flat.¹⁵ This is supported somewhat by trends in per capita alcohol consumption in Alaska and nationally through the 1990s¹⁶ as well as by the rate of motor vehicle accidents in Alaska and nationally involving underage drinking drivers. Countering this, however, is the Alaska Court System and Alaska Division of Juvenile Justice data that shows a marked and consistent increase in MCA cases beginning in the early 1990s and continuing through 1999. There is no evidence to indicate any marked increase or focus in law enforcement that might explain this increase. Additionally, there has been an increase between 1991 and 1998 in the number of alcohol-related injuries among youth.

There are a variety of adverse consequences that occur as a result of underage drinking. The specific consequences identified and quantified in this inquiry were alcohol-related injuries requiring hospitalization among youth, including those resulting from suicide attempts and those resulting in death and traffic accidents involving underage drinking drivers. Other adverse consequences for which data was not gathered in this report include school performance, criminal activity, and overall health. In addition to consequences that can be quantified through data collection, there are other, more subjective consequences such as the deterioration of families, alienation of friends, and general disenfranchisement from society.

In the data collected for this inquiry, the rate of alcohol-related hospitalizations for youth increased from 1991 through 1998 by 66.5%. The trend for injuries attributable to suicide attempts was mixed with a 43.3% increase between 1993 and 1996 followed by a 14.3% decrease from 1996 to 1998. The trend in deaths resulting from alcohol-related accidents among youth is clouded by the small numbers of events occurring, with 24 occurring between 1991 and 1998. Motor vehicle accidents involving underage drinking drivers decreased by 38.1% between 1990 and 1998. The decrease in the rate for underage drinking drivers is comparable to the decrease in accidents involving drinking drivers of all ages, 39.5% between 1990 and 1998.

Efforts to address underage drinking in Alaska are ongoing in various domains.

1. **Statutory Effort.** The primary statutory action involving underage drinking over the past ten years has been the transfer of jurisdiction over MCA cases from the juvenile justice system to district court in 1995. There have been some adjustments since that time, primarily dealing with revocation of drivers' licenses and the length of time for which they can be revoked. In examining data from the period 1991 through 1998 and 1999, the number of MCA cases has increased steadily through the period. When examining the trends for youth ages 17 and younger for both the juvenile justice system prior to 1995 and the Alaska Court System after that, there appears to be a consistent increase that began in 1993 and continued across the two jurisdictions.

¹⁵ Substance Abuse and Mental Health Services Administration (SAMHSA). Summary of Findings: 1999 National Household Survey on Substance Abuse. Rockville, MD, August 2000

¹⁶ Advisory Board on Alcoholism and Drug Abuse. Results within our Reach: Plan for Delivery of Substance Abuse Services 1999 - 2003. Juneau, AK, January 1999

When examining adverse consequences, there were no major shifts in numbers/rates that corresponded with the change in jurisdiction. While law enforcement, judges and magistrates may believe the new statute to be ineffective or limiting, the investigators found no evidence that the change in statute itself was the sole contributor to the increase in arrests indicated by the increased number of MCA cases. Neither can we say that the statutory change caused any identifiable change in adverse consequences.

2. Law Enforcement Effort. Investigators found no evidence of heightened law enforcement effort or focus with regard to underage drinking between 1993 and 1999, with the exception of a consistent increase in MCA cases. Key informants indicated that law enforcement pursued reactive strategies in most communities with underage drinking violations competing with every other law enforcement issue. An exception to this observation is the coordinated effort taking place in five communities in Alaska, coordinated by the ABC Board, using Enforcement of Underage Drinking Laws (EUDL) grant funds from the Division of Juvenile Justice. This effort is taking the form of intensified scrutiny of licensed establishments using supervised youth attempting to make purchases and the concentration on identifying and intervening in large drinking parties.

3. Court System Effort. The Alaska Court System has experienced a consistent increase in MCA cases from 1995 through 1999. The major trends observed within these cases are that the fines have increased steadily by 121% during the period and that the disposition of cases has changed, with fewer cases being dismissed and more cases having default judgments (where the offender does not show up for court). The vast majority of offenders (72.1%) are one-time offenders, however, 54.7% of the total cases are attributable to individuals with multiple cases (27.9% of unduplicated individuals). Judges and magistrates are using graduated increases in fines to deal with repeat offenders. Because there are no conclusions on whether prevalence of underage drinking is increasing or decreasing, investigators are unable to draw conclusions about the impact of court efforts on the underage drinking problem.

4. Substance Abuse Treatment Effort. Utilization of substance abuse treatment services by youth has increased through the 1990s most significantly in the outpatient, intensive outpatient, and continuing care modalities. There was a marked increase in utilization of long-term residential services between 1992 and 1993; however, the utilization rates for that modality have remained somewhat static over the remainder of the period. The increase in utilization of intensive outpatient services is most likely connected to the emergence of this modality in the 1990s as a step between regular outpatient and residential. The increase in continuing care utilization reflects, at least in part, the growing emphasis placed on this service by the Division of Alcoholism and Drug Abuse and the addictions field in general. Another complicating factor in analyzing the treatment data, particularly for residential care, is that the state's limited public residential programs tend to operate at capacity all the time. This does not allow investigators to use treatment utilization data as a gauge of the need for residential treatment. Key informants indicate that there is a waiting list of between three and six months for youth residential treatment. There are, however, two proposed residential treatment expansion projects in the development process that, if approved, will help to alleviate this backlog.

5. Prevention, Education, and Advocacy Efforts. There is considerable prevention activity in Alaska, however, results from these types of efforts manifest themselves on a population basis over long periods of time, and many of these efforts have only recently been implemented. The investigators, therefore, draw no conclusions regarding their effectiveness at reducing underage drinking. The Division of Alcoholism and Drug Abuse has, as a part of its current emphasis on prevention, developed a comprehensive prevention evaluation component being conducted by the Institute for Circumpolar Health Studies. If successful, this evaluation effort should provide valuable information on the efficacy of various approaches to dealing with substance abuse by youth and play a vital role in future program planning.

Key informants in this project suggested that community norms and values play a key role in underage drinking trends. This reflects current thinking among substance abuse prevention professionals nationally as well as many of the best practices in prevention adopted by SAMHSA. Given the importance attached to environmental strategies, and the role that key informants believe that community norms and values play in underage drinking in communities, advocacy and environmental prevention efforts may have great potential to impact the problem.

The data systems described in this report all collect data to serve the unique needs of the respective organizations. There are, in addition, other emerging data sources that could prove valuable in the future. One such data set will be maintained by the Department of Education and Early Development and will contain data on school suspensions and expulsions due to alcohol or drug use. Another database worth exploring is maintained by the Alaska Bureau of Vital Statistics. That database contains information on deaths that could prove useful if a method could be devised to clearly identify which of those deaths were attributable to alcohol. There is currently information in the database that relates to some instances of alcohol-related deaths, but it is inconsistent and does not cover the range of possibilities where alcohol can contribute to a death. While these two data sources provide additional insight into adverse consequences of underage drinking, one of the major gaps in data/information relates to actual prevalence of underage drinking. A data collection effort that could prove useful if successfully implemented is the YRBS. As previously noted, identifying prevalence of underage drinking is an important task and YRBS, which surveys students, could be one of the most reliable tools. The state will need to address barriers to participation to gain a response rate sufficient to generalize the samples to the population statewide.

The promise of such diverse and robust databases is that they can provide glimpses of the problem from different perspectives. With each different perspective comes a greater understanding of the breadth and depth of the problem. The difficulty with these databases is that they are all proprietary and accessible only through special effort by the maintaining organization, they are designed in terms of structure and format to meet the needs of the maintaining organization and are, most often, not well-suited to integration without a great deal of intervention. Using all of this potential data together in an integrated effort to describe the problem and/or progress in addressing the problem will require that it be gathered and analyzed, preferably by a central organization requiring an ongoing dedication of resources.

Finally, the failure to intervene in underage drinking represents a lost opportunity to address future problems. Magistrates, judges, prosecutors, and law enforcement officials agree that

alcohol is involved in most violent crimes against persons and property crimes committed by young adults. While it cannot be said with certainty that every one of these young adult offenders began drinking as a teen, youth with multiple MCA violations seem to be good candidates for future alcohol-related problems. Future studies that examine court data, Division of Juvenile Justice data, and public safety data could well provide more solid evidence of correlation between underage drinking and young adults who commit more serious crimes under the influence of alcohol.

K. Recommendations.

1. Increased law enforcement efforts have been made possible through the ABC Board and new funding. Evaluation of these efforts in coming years will be an important source of information that should be reviewed.

2. Case disposition for MCA's under existing statute disallows assessments or other treatment interventions. This was cause for concern for law enforcement, court personnel and treatment providers. Statutes should be reviewed for possible changes and/or improvements to allow for a broader range of sentencing alternatives.

3. One treatment component lacking in Alaska is that of assessment and referral for youth similar to the adult Alcohol Safety Action Program (ASAP). This may be an area worth further exploration, given the increase in the number of MCA cases shown by the court system data.

4. Alaska has recently undertaken a number of prevention efforts, many of which are research-based. The state may wish to consider a statewide approach to prevention strategies and funding for such. Additionally, the existing evaluation effort funded by Division of Alcoholism and Drug Abuse through the Institute for Circumpolar Health Studies holds promise as a potential source of policy information in this arena.

5. Environmental prevention strategies may play an important role in the state's efforts to address underage drinking, given the emphasis placed by key informants on community norms and values. This area deserves further exploration.

6. The YRBS survey represents a potentially data rich resource for prevalence information within Alaska. Efforts should be continued to ensure that this source of information is obtained in a manner that will ensure valid data.

7. Given the complexity and diversity of data on this issue, the state may wish to consider the feasibility of having a centralized entity collect information on the issue of underage drinking.



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Teen Tipplers: America's Underage Drinking Epidemic

Revised February 2003

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Accompanying Statement by Joseph A. Califano, Jr., Chairman and President

Alcohol is far and away the top drug of abuse by America's teens. Children under the age of 21 drink 19.7 percent of the alcohol consumed in the U.S. More than five million high school students (31.5 percent) admit to binge drinking at least once a month. The age at which children begin drinking is dropping: since 1975, the proportion of children who begin drinking in the eighth grade or earlier has jumped by almost a third, from 27 to 36 percent. And the gender gap that for generations separated alcohol consumption by girls and boys has evaporated: male and female ninth graders are just as likely to drink (40.2 percent and 41 percent) and binge drink (21.7 percent and 20.2 percent).

By any public health standard, America has an epidemic of underage drinking that germinates in elementary and middle schools with children nine to 13-years old and erupts on college campuses where 44 percent of students binge drink and alcohol is the number one substance of abuse--implicated in date rape, sexual harassment, racial disturbances, drop outs, overdose deaths from alcohol poisoning and suicides. Teenagers who drink are seven times likelier to engage in sex and twice as likely to have sex with four or more partners than those who do not. Such behavior can lead to unprotected sex with the increased risk of AIDS, other sexually transmitted diseases and pregnancy. Preliminary studies have shown that alcohol damages young minds, limiting mental and social development. High schoolers who drink are five times likelier to drop out of school.

No other substance threatens as many of the nation's children. Eighty percent of high school students have tried alcohol, while 70 percent have smoked cigarettes and 47 percent have used marijuana. Twenty-nine percent of high school seniors have used some other illegal drug such as Ecstasy.

Drinking is teen America's fatal attraction. Beer and other alcohol are implicated in the three top causes of teen deaths: accidents (including traffic fatalities and drowning), homicide and suicide. The financial costs of underage drinking approach \$53 billion in accidents, drowning, burns, violent crime, suicide attempts, fetal alcohol syndrome, alcohol poisoning and emergency medical care.

Teens who experiment with alcohol are virtually certain to continue using it. Among high school seniors who have ever tried alcohol--even once--91.3 percent are still drinking in twelfth grade. Most troubling, of high school students who have ever been drunk, 83.3 percent--more than two million teens--are still getting drunk in twelfth grade.

This report makes clear: the time and place to deal with binge drinking in college is in elementary and high school.

Teen drinking is the number one source of adult alcoholism. Children who begin drinking before age 21 are more than twice as likely to develop alcohol-related problems. Those who begin drinking before age 15 are four times likelier to become alcoholics than those who do not drink before age 21.

Underage drinkers are at greater risk of nicotine and illegal drug addiction. Teens who are heavy drinkers (consume at least five drinks on at least five occasions over 30 days) are more than 12 times likelier to use illegal drugs than those who do not drink.

How did we get here?

We have to point the finger at ourselves.

Parents tend to see drinking and occasional bingeing as a rite of passage, rather than a deadly round of Russian roulette. Home--a child's or a child's friend's--is a major source of alcohol for children, especially for younger children. A third of sixth and ninth graders obtain alcohol from their own homes. Children cite other people's houses as the most common setting for drinking. In our schools, middle and

high school teachers have been reluctant to inform parents or intervene when they suspect a child or teen of drinking. College administrators and alumni have played Pontius Pilate, washing their hands and looking away, as students made beer, alcohol and binge drinking a central part of their college experience. The pervasive influence of the entertainment media has glamorized and sexualized alcohol and rarely shown the ill effects of abuse. A review of 81 G-rated animated films found that in 34 percent of them alcohol use was associated with wealth or luxury and 19 percent associated alcohol with sexual activity.

Television runs ads glorifying beer on sports programs watched by millions of children and teens. With a big push from alcohol lobbyists, the Congress has denied the White House Office of National Drug Control Policy authority to include alcohol--the number one drug of abuse by children and teens--in its media campaign and other activities to prevent drug abuse.

The interest of the alcohol industry--especially those who sell beer--in underage drinking is understandable, if appalling. Underage drinkers are a critical segment of the alcohol beverage market. Underage drinkers consume 19.7 percent of the alcohol--most often beer--sold in this country. In 1999, they accounted for approximately \$22.5 billion of the \$116.2 billion spent on alcohol, including as much as \$17.2 billion on beer. Without underage drinkers, the alcohol industry, and the beer industry in particular, would suffer severe economic declines and dramatic loss of profits.

Drawn from CASA's innovative *National Underage Drinking Survey* of adults, this report calls for a national mobilization to curb underage drinking. It sets out actions for parents, law enforcement, legislators, the entertainment industry and for a measure of self control by the beer, wine and liquor industries. It will take all of that to save millions of teens from destroying their lives through alcohol abuse. Our children are our future and, for adults, the future is now in mounting a national effort to curb teen drinking. This survey provides a road map of citizens' attitudes to

guide federal, state and local officials interested in promoting public policies to reduce teen use of alcohol and binge drinking.

The prevention message is more difficult to convey with regard to alcohol. For smoking and illegal drug use, the message is, "No!" for children and adults. For alcohol, the message is "No!" for children under 21 (except for certain family and cultural occasions), but for most adults (those who are not alcoholics or alcohol abusers) the message is moderation, not prohibition.

This report continues CASA's ongoing analysis of the impact of substance abuse on America's systems and populations. We wish to thank Douglas L. Piper, Ph.D., Senior Researcher at the Pacific Institute for Research and Evaluation who conducted focus groups and managed our survey, and Thomas K. Greenfield, Ph.D., Senior Scientist and Center Director of the Alcohol Research Group for consultation on our analysis of the financial interests of the alcohol industry.¹

Susan E. Foster, M.S.W., CASA's Vice President and Director of Policy Research and Analysis, directed this effort. Linda Richter, Ph.D., senior research associate, was the Principal Investigator. Other CASA staff who contributed to the research were: Monica Anzaldi, M.A., research associate; Patrick Johnson, Ph.D., CASA Fellow; David Man, Ph.D., CASA's librarian; Ivy Truong, library research associate; Barbara Kurzweil, library research specialist; and Elizabeth Johnson, M.P.A., intern and research assistant. Tisha Hooks helped edit the report. Jane Carlson handled the administrative responsibilities.

While many individuals and institutions contributed to this effort, the findings and opinions expressed herein are the sole responsibility of CASA.

¹ Dr. Greenfield's assistance was not in any way related to the inadvertent error in the first printing of this report where CASA stated that underage drinkers account for 25 percent of alcohol consumption rather than 19.7 as corrected herein.



Chapter I

Introduction and Executive Summary

Alcohol is the number one drug of choice among America's teens and underage drinking is a problem of epidemic proportion. Those under the age of 21 drink 19.7 percent of the alcohol consumed in the U.S. Underage drinkers accounted for up to \$22.5 billion of the \$116.2 billion spent on alcohol in 1999, including as much as \$17.2 billion on beer. More than five million high schoolers (31.5 percent) admit to binge drinking* at least once a month. Contrary to popular belief, girls are equally at risk as boys. The gender gap that once existed in adolescent alcohol use has closed, especially among younger teens.

Underage drinking and alcohol abuse can be catastrophic to young lives and the lives of those around them. Teenagers who drink are more likely than those who do not to have sex, to have sex at an earlier age and to have sex with multiple partners. Alcohol damages the young brain, interferes with mental and social development and interrupts academic progress. It is a major contributing factor in the three leading causes of teen death--accidents, homicide and suicide--and increases the chances of juvenile delinquency and crime.

Teens who use alcohol can pay the ultimate price if they mix drinking and driving or if they simply drink too much. The earlier young people drink and the more they drink, the more likely they are to become alcohol dependent and move on to other drugs. And there are other victims as well: the families of teen drinkers, those who have lost property and life to underage drinking and society that pays the bill.

* The most frequently cited national surveys define binge drinking as having five or more drinks in a row at least once in the past 30 days. More recent research defines binge drinking as four or more drinks in a row for women and five or more drinks in a row for men.

In contrast, America's adults are at best ambivalent about underage drinking. More than 90 percent of adults say that they are concerned about the issue; yet they are a primary source of alcohol for teens and too often implicitly accept teen drinking. That is not the end of the problem:

- Alcohol ads continue to appeal to children and portrayals of alcohol use in the entertainment media are extensive and often presented glamorously and without consequence.
- The alcohol industry has a financial stake in underage drinking.
- Enforcement of existing underage drinking laws is spotty.
- Congress has restricted the U.S. Office of National Drug Control Policy from taking on America's number one drug: alcohol.

America's ambivalence toward alcohol use is understandable. Alcohol use has been a part of the world's cultural and social landscape since the beginning of time. Despite the enormous social, health and economic toll underage drinking extracts, adults' alcohol use in moderation is acceptable and relatively safe. However, prevention programs for underage drinkers all too frequently are ineffective and treatment for children with alcohol problems is sorely lacking.

In preparing this report, CASA conducted a unique *National Underage Drinking Survey*, and carried out a series of focus groups, of adults with and without children under the legal drinking age. The *National Underage Drinking Survey* sought to determine the attitudes, views and thoughts of 900 adults regarding the

* The governing authority for ONDCP gives the term "drug" the meaning given the term "controlled substance" in the Control and Enforcement subchapter of Title 21 of the U.S. Code. 21 U.S.C. § 1701(3). "Controlled substance" specifically excludes "distilled spirits, wine, malt beverages, or tobacco...." 21 U.S.C. § 802(6).

problem of underage drinking and potential solutions. The survey was designed to identify opportunities for civic engagement on the issue of underage drinking and more effective marketing strategies for policies aimed at preventing and controlling underage drinking.

For the past two years, CASA has conducted special analyses of the underlying data in five national data sets[†] on the prevalence of underage drinking and attitudes about it. It has examined a wide variety of current strategies to reduce underage drinking and the state of prevention and treatment. CASA also reviewed some 500 articles and publications on the subject of underage drinking.

This report is the most ambitious assessment of the extent and consequences of underage drinking in America and documents the pathways to use and abuse of alcohol by children and teens. It identifies obstacles that hamper efforts to prevent underage drinking, including the economic interests of the alcohol industry in teen beer and other alcohol consumption, the ready availability of alcohol to minors, parental attitudes and the influence of the media and advertising.

Key Findings

Alcohol Is the #1 Drug for Children and Teens in America

- Each year approximately 3.3 million students between the ages of 12 and 17 start drinking. Alcohol use increases dramatically with age. Forty-one percent of ninth graders (1.6 million) currently use alcohol compared to 49.7 percent of tenth graders (2.0 million), 50.9 percent of eleventh graders (2.0 million) and 61.7 percent of twelfth graders (2.4 million).

[†] Monitoring the Future (MTF), Youth Risk Behavior Survey (YRBS), National Household Survey on Drug Abuse (NHSDA), American Drug and Alcohol Survey (ADAS) and CASA's Annual National Survey of American Attitudes on Substance Abuse (See Appendix A).

Combined, eight million high school students currently use alcohol.

- The age when young people begin to use alcohol has declined. While 27 percent of the high school graduating class of 1975 began using alcohol in eighth grade or earlier, approximately 36 percent of the class of 1999 had done so.
- Eighty-one percent of high school students have drunk alcohol compared to 70 percent who have smoked cigarettes and 47 percent who have used marijuana. Among twelfth graders, 79 percent have used another illegal drug such as Ecstasy.
- Almost all teens who experiment with alcohol continue its use. Among high school seniors who have ever tried alcohol--even once--91.3 percent are still drinking in the twelfth grade--compared to 85.7 percent who have ever smoked, 76.4 percent who have ever tried marijuana and 61.3 percent who have ever tried cocaine. Of those students who had ever been drunk, 83.3 percent (approximately 2.1 million each year) are still getting drunk in the twelfth grade.
- In 1999, 41.6 percent of twelfth graders admitted binge drinking in the past 30 days. More than five million teenagers admit binge drinking at least once a month.
- The gender gap that once existed in adolescent alcohol use has closed, particularly among younger teens. Current alcohol use is nearly identical among male and female ninth graders (40.2 percent vs. 41 percent) as is binge drinking (21.7 percent vs. 20.2 percent).
- Current alcohol use is comparable among white (52.5 percent) and Latino (52.8 percent) teens and lower among African-American teens (39.9 percent).
- Younger teens (eighth graders) in rural areas are 29 percent more likely than their urban

counterparts to have used alcohol in the last month and 70 percent more likely to have been drunk.

Underage Drinking Poses Enormous Threats to Children and Society

- The costs of underage drinking approach \$53 billion each year in alcohol-related traffic accidents, violent crime, burns, drowning, suicide attempts, alcohol poisonings, fetal alcohol syndrome and treatment for alcohol abuse. In comparison, the federal government spent only two billion in FY 2000 on the prevention of underage drinking and drug abuse combined.
- Alcohol is a contributing factor in the three leading causes of death among children ages 12 to 18: accidents (including motor vehicle traffic fatalities and drowning), homicide and suicide.
- Thirty percent of 15- to 20-year old drivers who were killed in automobile accidents had been drinking and 21 percent of drivers in this age group who were killed in automobile accidents were legally intoxicated.
- Teen heavy drinkers* and binge drinkers are more than twice as likely as nondrinkers to say they deliberately try to hurt or kill themselves (14.9 percent of heavy drinkers and 11.7 of binge drinkers vs. 4.4 percent of nondrinkers); and more than twice as likely to say they think about killing themselves (19.3 percent, 18.6 percent and 7.9 percent, respectively).
- Adolescents who drink give significantly lower ratings of their own general health and frequent drinkers report more overnight hospital stays than those who do not.

* Defined as having consumed five or more drinks on the same occasion on at least five different days in the 30 days prior to the interview.

- Teens who use alcohol are seven times likelier than teens who do not to have sex and twice as likely to have sex with four or more partners. Alcohol-using teens also are more likely to have sexual intercourse at an earlier age.
- Teen heavy drinkers are almost twice as likely as nondrinkers to say their schoolwork is poor (49.2 percent vs. 27.5 percent) and more than five times likelier to cut classes or skip school (54.7 percent vs. 9.9 percent).
- High school students who use alcohol are five times more likely than nonusers to drop out of school.
- The younger the drinker, the greater the risk to their cognitive development. After three drinks, learning among very young adults was found to be impaired 25 percent more than among adults in their late 20s who had had the same number of drinks.
- Alcohol-dependent youth fare worse than their nondependent peers on language and attention tests. Preliminary research suggests that because their brains are still developing, teens who abuse alcohol may be destroying a significant amount of their mental capacity.
- Teen heavy drinkers are more than 12 times likelier to be on juvenile probation than teens who do not drink (19 percent vs. 1.5 percent), and more than seven times likelier to have been arrested and booked for breaking the law (27.7 percent vs. 3.7 percent).
- The younger and more often a teen drinks, the higher the risk of developing alcohol-related problems: 21.2 percent of people who begin drinking before they reach the legal drinking age report having alcohol-related problems compared to only 7.4 percent of those who begin drinking only after they reach the legal drinking age. Children who begin drinking before the age of 15 are four times likelier than those who do not drink before 21 to become alcoholics.
- Underage drinkers are at a greater risk for nicotine addiction and for the use of illicit drugs. Two-thirds (66.7 percent) of teens who are heavy drinkers also use illicit drugs compared to 5.5 percent of teens who do not drink.
- An overwhelming majority of teens (84 percent) and adults (83 percent) favor keeping or raising the legal drinking age of 21.

The Alcohol Industry Has a Financial Interest in Underage Drinking

- Underage drinking accounts for 19.7 percent of all the alcohol consumed in the U.S. and for \$22.5 billion of the \$116.2 billion in consumer expenditures for alcoholic beverages in the U.S. in 1999.
- With such a significant amount attributable to underage drinking, the alcohol industry shares with the tobacco industry an economic interest in selling to minors. Those who drink before age 21 are more than twice as likely to develop alcohol related problems such as being unable to stop or cut down on drinking or spending a great deal of time getting or drinking alcohol or getting over its effects, compared to those who began drinking at age 21 or over. Those who begin drinking before age 15 are four times likelier to become alcohol dependent than those who do not drink before age 21.
- Without sales to underage drinkers, consumer expenditures for beer alone would drop by \$17.2 billion. For the alcohol industry, eliminating underage drinking represents an inherent conflict of interest between public health and profit.

The Media Normalizes the Problem

- Ubiquitous messages of alcohol use in the media normalize and legitimize teen alcohol use and promote positive attitudes and expectations about alcohol. Alcohol manufacturers spend over one billion dollars each year on television, radio, print and outdoor advertising alone. However, the industry's total expenditures to promote their products may be three or more times this amount once other forms of alcohol promotion, including sponsorship of events, Internet advertising, distribution of branded items, product placements in movies and TV shows and price promotions are taken into account. In comparison, the entire 2001 budget of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was only \$342 million.
- A recent study of 81 G-rated animated films found that nearly half showed characters using or abusing alcohol or tobacco, and that a significant proportion did not portray the long-term consequences of such use. In 34 percent of the movies, alcohol use was associated with wealth and luxury and in 19 percent of the movies, alcohol use was associated with sexual activity.
- Research suggests that drinking beliefs, knowledge and intentions to drink are positively influenced by awareness of the content of alcohol advertisements on television. For example, children with greater knowledge of beer brands and slogans have more positive beliefs about drinking and more frequently report intending to drink than adults. With greater exposure to beer advertising, children have higher recall of brand cartoon characters and hold more positive beliefs about the social and ritual uses of beer.
- Despite industry protestations that alcohol is not marketed to children, particular alcoholic beverages on the market have strong appeal to children and teens and are heavily promoted. Examples include the use

of animation (e.g., Budweiser's talking lizards), animal characters (e.g., Budweiser's Spuds MacKenzie dog), humor (e.g., Budweiser's "Whassup!" commercial) and rock music, all commonly used in beer advertising campaigns and all of which have been shown to have wide appeal to young people.

- A new breed of sweet-tasting and colorfully packaged alcoholic beverages known as "malternatives" or "alcopops" has been added to the product line of the alcohol beverage industry. In the first six months of 2001, 217 labels for these specialty drinks (e.g., Rick's Spiked Lemonade, Tequila, Hooper's Hooch, Smirnoff Ice, Skyy Blue) were approved by the Bureau of Alcohol, Tobacco and Firearms. Forty-one percent of teens, ages 14 to 18, have tried these sweet-tasting and colorfully packaged beverages. Teens are three times more likely than adults to be familiar with them and twice as many 14- to 16-year olds prefer them to beer or mixed drinks.

Parents are Unwitting Co-conspirators

- Among parents, permissive attitudes, ambivalence toward underage drinking, provision of alcohol to minors and limited awareness of children's use of alcohol contribute to underage drinking. When parents are tolerant of underage drinking on occasions other than when it is a basic component of a particular cultural event or religious ritual, children learn that it is acceptable.
- Home--a child's or a child's friend's--is a common source of alcohol for children, especially for younger children. One-third of sixth and ninth graders obtain alcohol from their own homes. Children cite other people's homes as the most common setting for drinking.
- A family history of alcoholism is a strong risk factor for a child's alcohol use, both

because of the genetic link and because of environmental exposure to alcoholism.

- The nature of the parent-child relationship also is a major determinant of underage alcohol use. Failure to provide a caring and supportive family environment, set high expectations, monitor children's behaviors, spend time with children and maintain open communication all hike the risk of underage drinking.

Pathways to Alcohol Use and Abuse

The pathways for children and teens leading to underage drinking emerge from genetic, family and social factors. Personality traits such as lack of empathy for others, easy and frequent lying, insensitivity to punishment, aggression, impulsivity, depression, anxiety, low religious commitment and low self-esteem may be precursors of future alcohol use. Extroversion and novelty seeking, particularly among boys, are linked to higher rates of alcohol use, while good social skills like flexibility, empathy, caring, ability to communicate and a sense of humor have been identified in children resilient to the pressures of alcohol use. Teens who have higher self-esteem, self-discipline and impulse control and have a sense of purpose with regard to their futures are more likely to resist alcohol use.

Children reared in supportive and enriching home environments with engaged parents and clear boundaries are less likely to use alcohol. Children learn by example and the children of parents who display permissive attitudes towards drinking (e.g., allowing young children to fix their drinks) or model drinking as a way to relax or cope with problems are at greater risk to begin drinking early.

Peer groups play an important role in teen use but family and school can moderate the negative influence of peers. Schools and community environments that are caring and supportive, hold high expectations for achievement and encourage children and teens to participate in

positive social events protect against underage drinking.

Prevention Programs

Strategies designed to reduce a child's demand for alcohol usually take the form of prevention programs primarily implemented in schools. Most prevention programs address substance abuse in general and focus less on alcohol use in particular. While few programs have achieved documented successes, the most effective programs appear to be those that are comprehensive and target many aspects of a child's life by involving the family and the larger community.

Adolescent Alcohol Treatment

Programs specifically aimed at adolescent alcohol abuse, particularly those that are accessible and affordable, are rare. Existing treatment programs primarily are based on adult models and do not conform to research-based evidence regarding what works best for treating young people. Even when appropriate treatment is available, many families either are unwilling to seek help for a child or are unaware of how to get the treatment they need. In 1997-1998, less than one in six of 12- to 17-year olds diagnosed as alcohol-dependent received treatment.

CASA's National Underage Drinking Survey

CASA's unique survey of 900 adults age 21 and over reveals that the vast majority of adults (92 percent) are personally concerned about underage drinking; 84 percent think that it is a problem in their own communities. Half of all adults (50.4 percent) hold parents primarily responsible for underage drinking and its associated problems. Half (52.2 percent) feel that the lack of parental involvement in a teen's life is the primary barrier to reducing underage drinking.

To address the problem, 76.1 percent of adults believe that parents should be held legally responsible for teen drinking. Other strategies preferred by adults include:

- Restricting home delivery of alcohol (85.2 percent),
- Creating nationally uniform zero-tolerance laws that consider drivers under the age of 21 with *any* blood alcohol content (BAC) to be driving while intoxicated or driving under the influence of alcohol (77.6 percent),
- Restricting alcohol advertising (74.1 percent),
- Requiring registration of kegs, in which beer kegs are marked with a unique identification number that is recorded by retailers along with the name, address and driver's license number of the keg buyer (71.2 percent),
- Undercover enforcement of existing laws (72.6 percent),
- Limiting teen access to commercial alcohol establishments (64.8 percent),
- Restricting teen access to alcohol in public places (63.5 percent), and
- Increasing alcohol taxes (54.1 percent). The most recent increase in the federal excise tax on alcohol took place in 1991. Following this increase, overall per capita alcohol consumption dropped by 6.1 percent.

Almost half of all adults (49.9 percent) prefer better enforcement of existing laws and regulations compared to enacting new ones (25.4 percent) or imposing more severe penalties for violating existing laws or regulations (24.7 percent).

For failure to comply with underage drinking laws or regulations, adults support the following penalties:

- Fines for underage drinkers (67 percent) or for parents of underage drinkers (60 percent)

and community service for underage drinkers (100 percent) or for parents of underage drinkers (85 percent).

- Sanctions against adults lending their ID (96.3 percent), providing alcohol to underage friends (95 percent) or providing alcohol to younger siblings (83.9 percent),

- Suspension of licenses (88.5 percent), civil liability (83 percent) or criminal liability (82 percent) for commercial establishments that sell alcohol to minors.

Opportunities and Next Steps

CASA has identified key issues and opportunities for parents and children, policymakers, educators, prevention specialists, treatment providers and the alcohol industry that appear to hold the greatest promise for reducing underage drinking:

Be "Hands-On" Parents by being involved in children's day-to-day activities, talking with them about alcohol use and its consequences and modeling healthy behavior.

Hold Parents Legally Responsible for their children's alcohol use through fines and community service requirements.

Engage Children and Young Adults in efforts to reduce underage drinking among their peers. Educate them about the effects and consequences of underage drinking and teach them to recognize and understand the persuasive appeal of alcohol advertising. Inform teens of their importance to alcohol industry profits. Engage them in positive future planning and provide more recreational activities and facilities for children.

Step Up Enforcement of Underage Drinking Laws for children and young adults who drink alcohol and the individuals and commercial establishments that provide it to them. Impose fines and community service requirements on underage drinkers and adults providing alcohol or lending their IDs to children. Penalize commercial establishments that sell alcohol to minors through suspended licenses and civil and criminal liability, and increase undercover enforcement of underage drinking restrictions.

A Checklist for Parents

- ✓ Set rules and expectations and enforce consequences.
- ✓ Eat dinner together.
- ✓ Monitor TV and Internet use and CD purchases.
- ✓ Know your children's friends and where they go.
- ✓ Send clear messages about alcohol use.
- ✓ Discuss negative consequences of drinking.
- ✓ Give your children perspective on media messages.
- ✓ Don't show your children that it takes a drink to relax.
- ✓ Don't accept underage drinking as a rite of passage.
- ✓ When your child needs help, get treatment--fast!

Restrict Social and Commercial Availability of Alcohol to Minors by restricting home delivery of alcohol to minors, requiring keg registration, regulating the distance of commercial alcohol establishments from schools and other places where children congregate and prohibiting sales of alcohol in public places such as beaches and parks.

Ban Alcohol Advertising on Television for beer, wine and distilled spirits. Promote responsible messages in the media (e.g., on-line, print and radio) and the entertainment industry about underage alcohol use (including its connection to dangerous sexual practices by teens).

Require Prominent Warning Labels in all alcohol advertising and product labels of the dangers of underage drinking, including federal dietary guidelines regarding consumption, and

require clear labeling of all alcohol beverages of the nutritional, including caloric, content. Currently, the U.S. federal government, through the Alcohol Beverage Labeling Act, only requires limited warnings to appear on all alcohol beverage container labels.

End Alcohol Sponsorship of child-oriented activities such as athletic leagues and events.

Expand the Authority of the Office of National Drug Control Policy to include alcohol. Congress should require the ONDCP to address alcohol (and tobacco) in addition to illegal drugs. The ONDCP should expand their national "Anti-drug" campaign to include alcohol.

Fund Additional Treatment Services to close the adolescent treatment gap.

Step Up Research for effective alcohol prevention and treatment for children. Examine the link between alcohol use and the use of nicotine and illicit substances, and develop effective anti-drinking messages for media campaigns. Researchers should continue to explore the relationship between the media and advertising and children's alcohol consumption.

Create an Independent Foundation endowed by the alcohol industry (modeled after the American Legacy Foundation) to develop ads and other methods to discourage underage drinking.

Increase Alcohol Taxes and dedicate revenues to prevention and treatment of alcohol abuse and alcoholism.

HB

121



ICICLE.

February 19, 2007

Representative Kurt Olson, Chair
House Labor & Commerce Committee
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Dear Chairman Olson and Committee Members,

On behalf of Icicle Seafoods, Inc., I want to express our strong support for HB 121, "An Act relating to release of information in individual workers' compensation records".

It has come to our attention, thanks in large part to one of our employees, that a private party outside of Alaska has been soliciting Alaska worker compensation claimants by obtaining personal information about them from the Alaska Dept. of Labor. After obtaining the names and addresses of injured workers, they use this private information for direct marketing purposes.

We find this practice incredibly disturbing and believe this information should not be made available without the consent of the person the information is about.

House Bill 121 would stop this objectionable practice and we fully support its adoption. Thank you for your consideration.

Sincerely,

Kris Norosz
Government Affairs
Icicle Seafoods, Inc.

PETERSBURG FISHERIES

A DIVISION OF ICICLE SEAFOODS, INC.

P.O. Box 1147 • Petersburg, AK 99833 • Tel: 907-772-4294 • Fax: 907-772-4472

February 15, 2007

Representative Peggy Wilson
Alaska State Legislature
State Capitol (MS 3100)
Juneau, Alaska 99801-1182

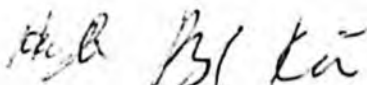
Dear Representative Wilson,

Thank you for sponsoring House Bill 121. I am in full support of this bill that will put an end to the release of personal information of worker compensation claimants by the State of Alaska, Dept. of Labor, and the Workers Compensation Board without the consent of the claimants.

I have attached a letter that I wrote last year in support of a similar measure. As a worker compensation claimant, I had my personal information released to a third party commercial operator (a Michigan law firm) who then used the information to solicit business from me. I did not appreciate this type of contact and do not feel personal information should be released in this situation without my personal consent.

Thank you for working to end this unpleasant practice. Please feel free to provide my letter to other legislators as the bill moves through the legislative process.

Sincerely,


Hyo R. Kim
P.O. Box 705
Petersburg, Alaska 99833

April 15, 2005

Senator Con Bunde, Chair,
Senate Labor & Commerce Committee
Alaska State Legislature
State Capitol (MS 3100)
Juneau, Alaska 99801-1182

Dear Senator Bunde and Committee Members,

My name is Hyo R. Kim and I have been an Alaska resident for over 27 years. Approximately 5 months ago, I received a letter from an out of state attorney that somehow learned of an injury I had at work. He indicated in his letter that if I contacted his firm, they could possibly get me more money for my injury.

I called the attorney to find out what this was about and how he had access to my personal information. During our conversation, the attorney asked me many questions about how I was injured, what the injury was, etc. After talking, the attorney indicated that he could not do anything for me since the injury was not substantial. I got the feeling he thought there was not enough money for him to get involved.

I asked him how he was able to get my personal information and he basically said he had his sources in the State of Alaska. This really bothered me since I really don't want people other than those that I approve of having access to my personal and private information. This especially concerns me the most now that there are so many cases in the news of identity theft and fraud.

After discussing with my friends the conversation I had with this attorney, I learned that he most likely got my personal information from the Workers Compensation Board and the Alaska Dept. of Labor. If this is the case, it irritates me a lot as I do not want people to have access to my private information and I assumed that what I filled out on the Alaska Workers Compensation forms was confidential.

I am very surprised the State of Alaska would allow this information to be released about its residents. My injury is my private concern and should only involve me, my employer, my doctor, my family and not an out of state attorney. I ask you to please take the appropriate steps to make sure this does not happen again in the future.

Sincerely,



Hyo R. Kim
P.O. Box 705
Petersburg, Alaska 99833



TRIDENT SEAFOODS CORPORATION

5303 Shilshole Ave NW, Seattle, WA 98107-4000 • (206) 783-3818 • Fax: (206) 782-7195
Domestic Sales: (206) 783-3474 • Fax: (206) 782-7246
Export Sales: (206) 783-3818 • Fax: (206) 782-7195

February 21, 2006

The Honorable Kurt Olson, Chairman
Labor and Commerce Committee
Alaska State Legislature
State Capital
Juneau, Alaska 99801

Dear Representative Olson:

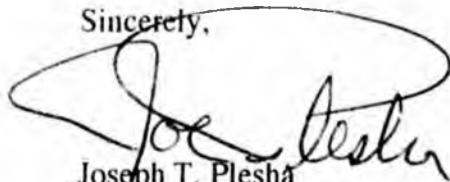
I am writing on behalf of Trident Seafoods Corporation to express our strong support for HB 121. Our employees have been surprised to learn that the Alaska Department of Labor's Division of Workers' Compensation is disclosing the names and addresses of all individuals who are injured in the seafood processing industry. We believe the law should be changed so that this information is released only with the employee's consent.

This issue has come to our attention because a law firm from Michigan has been requesting information from the State about all the individuals in the seafood industry who have filed workers' compensation claims. This firm then solicits business from these individuals, seeking to bring claims under maritime law instead of under the State's workers' compensation system. This has resulted in some unusual maritime claims, including one lawsuit filed against the "vessel" Sand Point. Sand Point, of course, is not a vessel. It is a community in the Aleutians East Borough where Trident has a shorebased processing plant.

More importantly, many of the people at Trident who file workers' compensation claims do not want their personal information released to the public. They are upset about lawyers contacting them about their injury. Those employees who do not object to having personal information disclosed should be free to consent to having such information released. Without such authorization, however, we believe this type of information should remain private.

Thank you for considering our views on this legislation.

Sincerely,



Joseph T. Plesha
General Counsel

Alaska

★ *The American Connection*

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Akutan • Anchorage • Chignik • Clarks Point • Cordova • Dillingham • Dutch Harbor
Ketchikan • Kodiak • Naknek • Petersburg • Sand Point • South Naknek • St. Paul



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Newport, OR • Ucluelet, B.C.

February 19, 2007

The Honorable Kurt Olson
Chairman, Labor & Commerce Committee
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Chairman Olsen:

I have been told that you are chairing a hearing on a bill that would keep confidential the personal information of people who file worker's compensation claims. I am writing in strong support of this legislation. I do not want any of my personal information made available to the public merely because I have filed a worker's compensation claim and respectfully ask that you enact the bill during this session of the legislature.

My husband, Gene, and I have both had minor injuries while we were working at Trident Seafoods Corporation shoreplant in Sand Point, Alaska. We each received unwelcomed solicitations from some lawyers back East asking if we were injured on a floating processing vessel! I do not want my personal information made available to the public and wondered how these lawyers got my name in the first place. I do not believe it is appropriate for the State of Alaska to release this information without my consent.

To be blunt, the fact I have suffered an injury in the workplace and filed a claim under worker's compensation should not entitle the public to my home address and other personal information. I certainly do not want some ambulance-chasing lawyer soliciting me because of my claim. If I had wanted to hire a lawyer to represent me, there are plenty of local attorney's available. They advertise in the Alaska Airlines magazine and every fishing magazine published.

I urge you to pass this legislation and appreciate you listening to my concerns.

Sincerely,



Gloria J. Copenspire



Alaska State Legislature

Representative Peggy Wilson

House District 2

Putting Alaska's Families First

MEMORANDUM

DATE: February 16, 2007

TO: Representative Kurt Olson, Chair
House Labor and Commerce Committee

FROM: Representative Peggy Wilson, Chair (PW)
House Health Education and Social Services Committee

SUBJ: House Bill 121 – Committee Substitute Explanation

Thank you for scheduling House Bill 121 before the House Labor and Commerce Committee. I have attached a blank CS intended for HB 121 and would appreciate the committee's due consideration. This work draft is numbered as: 25-LS0501\C (Drafter:Bailey)

In the process of reviewing each section of this bill as originally drafted, we ascertained that the addition of electronic mail addresses to this legislation as a specific item to be excluded from disclosure was in keeping with the intent of the bill. Although email addresses are not specifically collected by the Division of Workers' Compensation, the employee often provides them anyway on their records. This additional language will prevent someone from obtaining email addresses, thereby further protecting the employee's privacy.

The Department of Labor and Workforce Development also examined HB 121. As a result, another small change was recommended to clarify who within the department cannot release this type of information. Since a Workers' Compensation Appeals Commission was recently established within the framework of Title 23, the addition of the word commission was necessary to prevent this body from releasing the personal information as described in the bill.

I have also provided an updated sponsor statement and sectional analysis to cover the modest changes in this committee substitute.

If you or any members of the committee have any questions, please contact me or my staff.

25-LS0501\C
Bailey
2/15/07

CS FOR HOUSE BILL NO. 121()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVE WILSON

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to release of information in individual workers' compensation records;**
2 **and providing for an effective date."**

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

4 *** Section 1. AS 23.30.107(b) is amended to read:**

5 (b) Medical or rehabilitation records, and the employee's name, address,
6 social security number, electronic mail address, and telephone number contained
7 on any record, in an employee's file maintained by the division or held by the board
8 or the commission are not public records subject to public inspection and copying
9 under AS 40.25. This subsection does not prohibit

10 (1) the reemployment benefits administrator, the division, the board,
11 the commission, or the department from releasing medical or rehabilitation records in
12 an employee's file, without the employee's consent, to a physician providing medical
13 services under AS 23.30.095(k) or 23.30.110(g), a party to a claim filed by the
14 employee, or a governmental agency; or

1 (2) the quoting or discussing of medical or rehabilitation records
2 contained in an employee's file during a hearing on a claim for compensation or in a
3 decision or [AND] order of the board or commission.

4 * **Sec. 2.** AS 23.30.107 is amended by adding a new subsection to read:

5 (d) An employee may elect to authorize the disclosure of the employee's
6 name, address, social security number, electronic mail address, and telephone number
7 contained in a record described in (b) of this section by signing a declaration on a form
8 provided by the division.

9 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).



Alaska State Legislature

Representative Peggy Wilson

House District 2

Putting Alaska's Families First

SPONSOR STATEMENT

Committee Substitute House Bill 121

“An Act relating to release of information in individual workers’ compensation records; and providing for an effective date.”

With the call for more transparency in government, it is equally important to protect personal information from falling into the wrong hands. In this day and age of computers and extensive databases, government agencies have the potential to accumulate a tremendous amount of information on their employees.

Under the Alaska Division of Workers’ Compensation, some personal information is considered public record since it is not specifically prohibited by state statute. CSHB 121 will correct this oversight by prohibiting the release of the employee’s name, address, social security number, electronic mail address, and telephone number contained on any of the divisions’ files, the Workmen’s Compensation Board’s files, and the Workers’ Compensation Appeals Commission.

Currently, some of this personal information regarding employees who file workers’ compensation claims can be and has been released for public inspection. For example, a private company outside of Alaska has been requesting the names and addresses of injured workers. They have then used that information for direct marketing purposes of one kind or another.

This practice is very disturbing considering that identity theft is on the rise and a scourge on our society. It should be the right of any individual to keep personal information as cited above confidential. This data should not be revealed without the consent of that individual. This bill does add a provision to allow such disclosure, but only after the employee signs an affidavit to that effect.



Alaska State Legislature

Representative Peggy Wilson
House District 2
Putting Alaska's Families First

SECTIONAL ANALYSIS **Committee Substitute House Bill 121**

“An Act relating to release of information in individual workers’ compensation records; and providing for an effective date.”

CSHB 121 amends Title 23 under the Labor and Workers’ Compensation Act. It deals specifically with the section for release of information.

Section 1. Amends AS 23.30.107(b) with language specifying that an employee’s name, address, social security number, electronic mail address, and telephone number contained within the employee’s file under the Division of Workers’ Compensation or held by the Workmen’s Compensation Board or held by the Workers’ Compensation Appeals Commission are not public records subject to public inspection.

Section 2. Amends the statute reference above by adding a subsection (d). This provision allows for an employee to authorize the Division of Workers’ Compensation, the Board, or the Commission to disclose his or her personal information as described above. This will be accomplished by the employee signing a declaration on a form provided by the division.

Section 3. This bill has an immediate effective date. In effect, the bill becomes law the day after it is signed by the governor.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note: HB121-DOLWD-WC-02-16-07

Bill Version: HB 121

() Publish Date: _____

Revision Date/Time (Note if correction):
 Title: Workers' Compensation Records

Department: Labor and Workforce Development

RDU: Workers' Compensation

Component: Workers' Compensation

Sponsor: Representative Wilson

Requester: House L&C

Component Number: 344

Expenditures/Revenues

(Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: None

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

There is no anticipated financial impact to the department as a result of this legislation.

Prepared by: Paul Lisankle, Director

Division: Division of Worker's Compensation

Approved by: Click Bishop, Commissioner

Agency: Department of Labor and Workforce Development

Phone: 465-2790

Date/Time: 2/16/07 1:16 PM

Date: 2/16/2007

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB121-DOA-RM-2-15-07
 Bill Version: HB 121
 () Publish Date: _____

Revision Date/Time (Note if correction): 2/15/2007
 Title An act relating to release of individual
information in workers' compensation records
 Sponsor Representative Wilson
 Requester House Labor and Commerce

Dept. Affected: Administration
 RDU Risk Management
 Component Risk Management
 Component No. 71

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Risk Management is not affected by this legislation.

Prepared by: J. Brad Thompson, Director
 Division: Risk Management
 Approved by: Kevin Brooks, Deputy Commissioner
 Agency: Department of Administration

Phone 465-5723
 Date/Time 2/15/07 8:00 AM
 Date 2/19/2007

Alaska State Legislature

Representative Peggy Wilson

House District 2

Putting Alaska's Families First

MEMORANDUM

DATE: February 9, 2007

TO: Representative Kurt Olson, Chair
House Labor and Commerce Committee

FROM: Representative Peggy Wilson, Chair *PW*
House Health Education and Social Services Committee

SUBJ: House Bill 121 – Request for Hearing

I am requesting a hearing for House Bill 121 at your earliest convenience. Attached you will find a copy of HB 121, relative sponsor statement, and a sectional analysis. I will provide additional backup when it becomes available.

Please let Cliff Stone of my staff know if there is anything else we can provide. Thank you for your consideration.

Alaska State Legislature

Representative Peggy Wilson

House District 2

Putting Alaska's Families First

SPONSOR STATEMENT

House Bill 121

“An Act relating to release of information in individual workers’ compensation records; and providing for an effective date.”

With the call for more transparency in government, it is equally important to protect personal information from falling into the wrong hands. In this day and age of computers and extensive databases, government agencies have the potential to accumulate a tremendous amount of information on their employees.

Under the Alaska Division of Workers’ Compensation, some personal information is considered public record since it is not specifically prohibited by state statute. HB 121 will correct this oversight by prohibiting the release of the employee’s name, address, social security number, and telephone number contained on any of the divisions’ or Workmen’s Compensation Board’s files.

Currently, some of this personal information regarding employees who file workers’ compensation claims can be and has been released for public inspection. For example, a private company outside of Alaska has been requesting the names and addresses of injured workers. They have then used that information for direct marketing purposes of one kind or another.

This practice is very disturbing considering that identity theft is on the rise and a scourge on our society. It should be the right of any individual to keep personal information as cited above confidential. This data should not be revealed without the consent of that individual. This bill does add a provision to allow such disclosure, but only after the employee signs an affidavit to that effect.

Alaska State Legislature

Representative Peggy Wilson

House District 2

Putting Alaska's Families First

SECTIONAL ANALYSIS

House Bill 121

“An Act relating to release of information in individual workers’ compensation records; and providing for an effective date.”

HR 121 amends Title 23 under the Labor and Workers’ Compensation Proceedings. It deals specifically with the section for release of information.

Section 1. Amends AS 23.30.107(b) with language specifying that an employee’s name, address, social security number, and telephone number contained within the employee’s file under the Division of Workers’ Compensation or held by the Workmen’s Compensation Board are not public records subject to public inspection.

Section 2. Amends the statute reference above by adding a subsection (d). This provision allows for an employee to authorize the Division of Workers’ Compensation to disclose his or her personal information as described above. This will be accomplished by the employee signing a declaration on a form provided by the division.

Section 3. This bill has an immediate effective date. In effect, the bill becomes law the day after it is signed by the governor.

HB

136

ALASKA STATE LEGISLATURE

Vice Chair:
House Finance Committee

Chair:
House Finance Subcommittees for,
Department of Public Safety
Department of Law



Session:
Alaska State Capitol
Juneau, AK 99801-1182
Phone: (907) 465-4958
Fax: (907) 465-4928

Interim:
PO Box 464
Chugiak, AK 99567

BILL STOLTZE
State Representative

Representative_Bill_Stoltze@legis.state.ak.us

House Bill 136

Dental Hygienists

"An Act relating to dental hygienists."

Good oral health is essential to improving overall health and well being. However, many factors exacerbate the oral health disparity across Alaska's population, including the current structure of the oral healthcare delivery system, geographic and educational barriers, and the cost of care.

Dental Hygienists are licensed oral care health professionals who focus on preventing and treating oral diseases. They have graduated from nationally accredited dental hygiene education programs in colleges and universities, and have successfully passed a national written and state clinical examination. Given their comprehensive education and clinical preparation, dental hygienists are well prepared to deliver preventative oral health care services to the public, safely and effectively.

The provisions of House Bill 136 follow the expanded functions of dental hygienists in other states to improve access to preventative oral health care. Specifically, HB 136:

1. Allows a licensed dental hygienist to place "fillings" into a cavity prepared by a licensed dentist.
2. Authorizes a licensed dental hygienist to administer local anesthetic agents under the general supervision of a licensed dentist.
3. Permits a licensed dental hygienist to enter into a collaborative agreement with a licensed dentist in which the dentist authorizes the dental hygienist to perform certain duties stipulated under HB 136 without the supervision of the dentist.

I ask for your consideration and support of HB 136 to help improve access to oral health care in Alaska.

DISTRICT 16

BIRCHWOOD • BUTTE • CHUGIAK • EKLUTNA • FAIRVIEW LOOP
KNIK RIVER ROAD • LAZY MOUNTAIN • PALMER • PETERS CREEK

ALASKA STATE LEGISLATURE

Vice Chair:
House Finance Committee

Chair:
House Finance Subcommittees for;
Department of Public Safety
Department of Law



Session:
Alaska State Capitol, Rm 501
Juneau, AK 99801-1182
Phone: (907) 465-4958
Fax: (907) 465-4928

District:
600 E. Railroad Ave.
Wasilla, AK 99654

BILL STOLTZE
STATE REPRESENTATIVE
Representative_Bill_Stoltze@legis.state.ak.us

House Bill 136 (Version M) Sectional Analysis

Section 1 authorizes the Board of Dental Examiners to issue a restorative function endorsement to a licensed dental hygienist if the hygienist has successfully completed an accredited program and has passed the required restorative function examination(s).

A restorative function endorsement will allow a licensed dental hygienist to place restorations, i.e. fillings, into a cavity prepared by a licensed dentist and thereafter carve, contour and adjust contacts and occlusion of the restoration under the direct supervision of a licensed dentist.

Section 2 authorizes a licensed dental hygienist to administer local anesthetic agents under the general supervision of a licensed dentist.

Local anesthesia renders a small part of the body, such as a tooth, insensitive to pain without affecting consciousness. Licensed dental hygienists in the state who are certified by the Board have been administering local anesthesia under "direct" or "indirect" supervision of a licensed dentist since 1981. Adding "general" supervision would allow a licensed, Board-certified dental hygienist to administer local anesthetic agents without the requirement for a licensed dentist being present in the dental facility.

Section 3 includes under dental hygienists' scope of practice the ability to place restorations (section 1) and perform the activities authorized under a collaborative agreement with a licensed dentist (section 4).

Section 4 authorizes the Board to approve a collaborative agreement between a licensed dentist and a licensed dental hygienist and specifies the services and procedures allowed under a collaborative agreement.

Working under a collaborative agreement with a licensed dentist, a dental hygienist would be able to initiate treatment within their scope of practice based on his or her assessment of a patient's needs without the specific authorization of a dentist.

Section 5 applies supervision requirements to a dental hygienist operating in conjunction with a licensed dentist under a collaborative agreement.

DISTRICT 16

BIRCHWOOD • BUTTE • CHUGIAK • EKLUTNA • FAIRVIEW LOOP
KNIK RIVER ROAD • LAZY MOUNTAIN • PALMER • PETERS CREEK

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB136-COM-OL-03-05-07

Bill Version: HB 136

() Publish Date: _____

Revision Date/Time (Note if correction): _____

Dept. Affected: Commerce

Title Dental Hygienists

RDU Occupational Licensing (117)

Component Occupational Licensing

Sponsor Stoltze

Requester House HES

Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()	*	*	*	*	*	*
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services	*	*	*	*	*	*
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation amends AS 08.32 relating to Dental Hygienists to provide for a restorative function license endorsement, to amend supervision requirements, and to provide for collaborative agreements for certain dental hygienists to provide certain services.

Typically license endorsement fees are \$50 and do not include the costs of additional accredited programs requested or approved by the Alaska State Dental Board. There are over 500 licensed Dental Hygienist in the State. At this time the Division of Corporations, Business, and Professional Licensing does not know how many licensees will request a restorative function endorsement and therefore, is unable to estimate costs and revenue.

All Occupational Licensing programs are required to cover costs with licensing fees under AS 08.01.065. Licensees requesting the endorsement will cover the additional fees.

Prepared by: Chris Wyatt, Administrative Manager
 Division: Corporations, Business, and Professional Licensing
 Approved by: Emil Notti, Commissioner
 Agency: Commerce, Community, and Economic Development

Phone: (907) 465-2572
 Date/Time: 3/5/07 2:00 PM
 Date: 3/5/2007

HB 136 – “An act relating to Dental Hygienists”

Fact Sheet: Local Anesthesia

<p>What is Local Anesthesia?</p>	<ul style="list-style-type: none"> Local Anesthesia renders a small part of the body, such as a tooth, insensitive to pain without affecting consciousness. It reduces stress and allows a client to be comfortable while being treated by a hygienist for moderate to advanced gum disease.
<p>Statute Change</p>	<ul style="list-style-type: none"> AS 08.32.110(a) is amended to read: ... (6) if certified by the board and under the direct, [OR] indirect, <u>or general</u> supervision of a licensed dentist, administer local anesthetic agents.
<p>Definitions</p>	<ul style="list-style-type: none"> “Direct supervision” means the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before dismissal of the patient evaluates the performance of the dental hygienist. “Indirect supervision” means a licensed dentist is in the dental facility, authorizes the procedures, and remains in the dental facility while the procedures are being performed by the dental hygienist. “General supervision” means the dentist has authorized the procedures and they are being carried out in accordance with the dentist’s diagnosis and treatment plan.
<p>Dental Hygienists Can Help</p>	<ul style="list-style-type: none"> Education – The dental hygiene curriculum is established and competency requirements are enforced by the American Dental Association. Numerous hours of didactic and clinical experience, as well as written and clinical testing are required before a dental hygienist is licensed to administer local anesthetic agents. Additionally, in Alaska, a separate written and clinical exam administered by WREB, a National Dental and Dental Hygiene testing agency, is required prior to obtaining a license for administering local anesthesia. 25 years of experience – Dental hygienists in Alaska have been delivering local anesthesia under direct or indirect supervision since July 20, 1981. Record of safety – An Alaskan dental hygienist has <u>never</u> had disciplinary action taken against his/her license due to the administration of local anesthesia under the current statutes. Liability insurance – A dental hygienist’s liability insurance cost is the same whether they have a license to deliver local anesthesia or not. Therefore, it can be assumed that insurance companies do not see local anesthesia as an increased risk. Emergency training – Dental hygienists are required to maintain current CPR certification and are capable of responding appropriately in emergency situations. Dentist discretion – The administration of local anesthesia under general supervision remains at the discretion of the supervising dentist (i.e. a dentist’s authorization would still be required) Other states – The states of <i>Idaho</i> and <i>Oregon</i> allow local anesthesia under General Supervision. There have been no disciplinary cases against a dental hygienist as related to the administration of local anesthesia.



March 19, 2007

The Honorable Kurt Olson, Chair
House Labor and Commerce Committee
Alaska State Capitol, Room 408
Juneau, Alaska 99801-1182

HB 136 (Stoltze)—Support

Dear Chair Olson:

On behalf of the AARP members in Alaska, we encourage you and your colleagues on the House Labor and Commerce Committee to support HB 136, authored by Representative Bill Stoltze.

As you and your Committee colleagues know, Alaska has a shortage of all health professionals, particularly in our remote communities. We will never be able to find a sufficient number of physicians but we use physician assistants and nurse practitioners very effectively. We will never have enough dentists and Alaska uses dental hygienists effectively. We could use them even more effectively and HB 136 would help us accomplish this.

Dental hygienists are not independent practitioners. They work under licensed dentists and focus on preventing and treating oral diseases. HB 136 does not break new ground for their scope of practice. Other states already allow dental hygienists to:

- Place fillings into a cavity already prepared by a dentist
- Administer a local anesthetic under the general supervision of a dentist
- Enter into an agreement with a dentist in which the dentist authorizes the hygienist to work on specified tasks

We recognize that any change in a scope of practice may make other professionals concerned. We want to make certain that all Alaskans have access to high quality, affordable health care, including oral health.

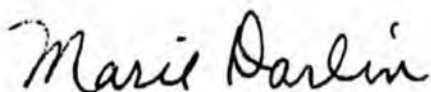
Many oral health problems can be prevented or treated by professional dental hygienists and this care may turn out to be less expensive and more accessible. Our dental costs are high. Dental procedures in Alaska cost 37.7% more than in the rest of the United States. We believe HB 1. will help reduce those costs as well as improve accessibility. Since all of these issues are under the supervision of a dentist or by agreement with a dentist, we also do not believe quality will suffer. Indeed, it may very well improve significantly since hygienists will serve as a "force multiplier" for the dentists we do have.

AARP recommends an "AYE" vote on HB 136.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,



Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Mark Neuman
Representative Carl Gatto
Representative Gabrielle LeDoux
Representative Jay Ramras
Representative Bob Buch
Representative Berta Gardner
Representative Bill Stoltze

Number of Dentists and Dental Hygienists by Region

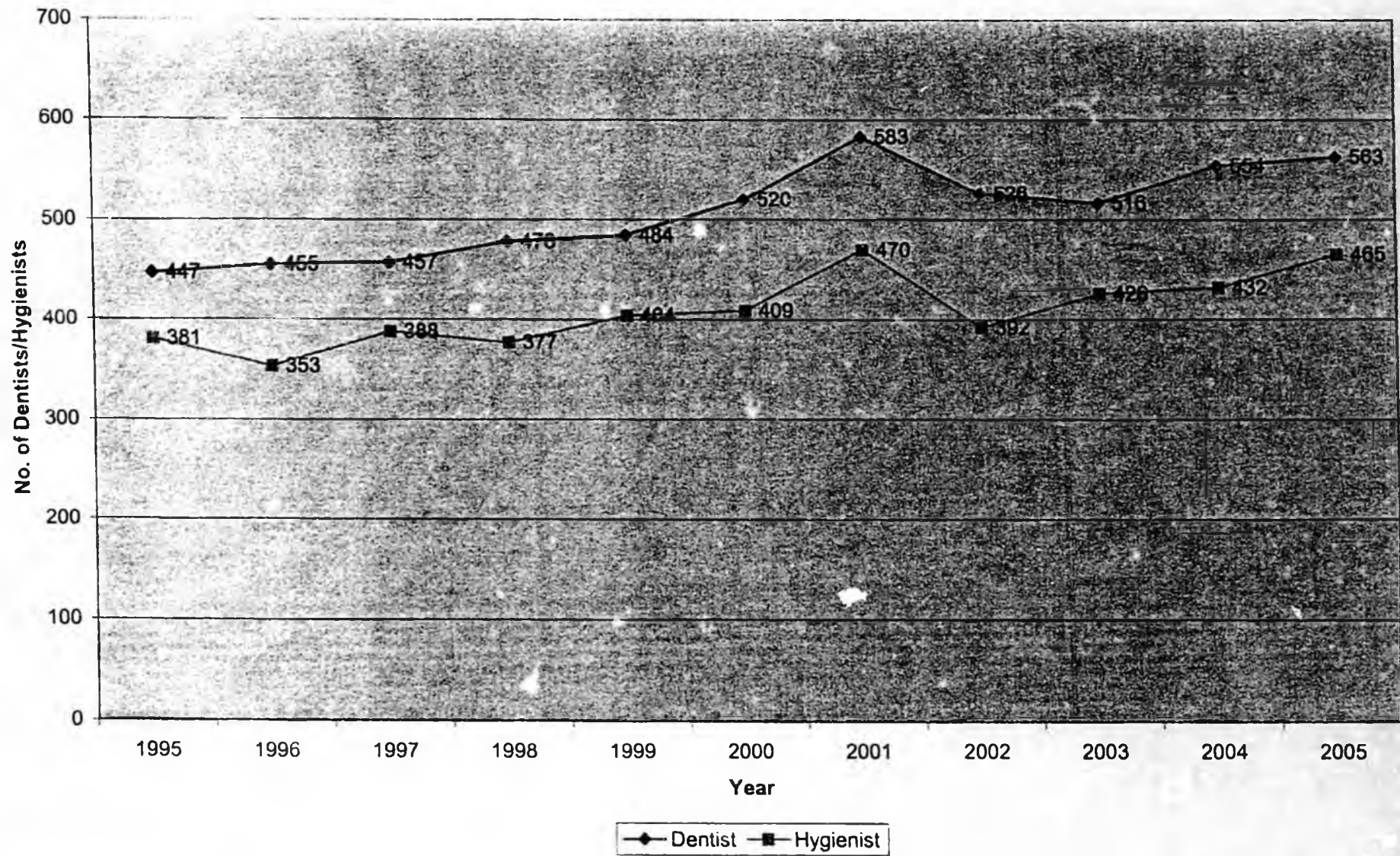
Region	Population	No. of Dentists	No. of Hygienists	No. of Hyg/Den	No. of Hyg/10,000
New England			13,118	1.4	9.4
Middle Atlantic			25,976	0.9	6.6
East North Central			31,851	1.3	7.1
West North Central			9,481	1	4.9
South Atlantic			27,484	1.1	5.3
East South Central			7,998	1.1	4.7
West South Central			12,287	0.9	3.9
Mountain			10,422	1.2	5.7
Pacific			31,149	1.1	6.9
U.S. Total			169,149	1.1	6.0
Alaska	663,661	497	496	1.0	7.47
Anchorage Mat-Su Region	352,282	226	270	1.2	7.66
Anchorage Municipality	278,241	197	216	1.1	7.76
Matanuska-Susitna Borough	74,041	29	54	1.9	7.29
Gulf Coast Region	74,904	37	42	1.1	5.61
Kenai Peninsula Borough	51,224	27	29	1.1	5.66
Kodiak Island Borough	13,638	7	9	1.3	6.60
Valdez-Cordova Census Area	10,042	3	4	1.3	3.98
Interior Region	102,005	50	45	0.9	4.41
Denali Borough	1,823	0	0	-	-
Fairbanks North Star Borough	87,650	47	45	1.0	5.13
Southeast Fairbanks Census Area	6,471	3	0	-	-
Yukon Koyukuk Census Area	6,061	0	0	-	-
Northern Region	23,669	8	2	0.3	0.84
Nome Census Area	9,452	5	1	0.2	1.06
North Slope Borough	6,894	2	1	0.5	1.45
Northwest Arctic Borough	7,323	1	0	-	-
Southeast Region	70,822	41	48	1.2	6.78
Haines Borough	2,207	1	2	2.0	9.06
Juneau City and Borough	31,193	22	26	1.2	8.34
Ketchikan Gateway Borough	13,125	7	9	1.3	6.86
Prince of Wales-Outer Ketchikan C.A.	5,497	1	2	2.0	3.64
Sitka City and Borough	8,947	6	5	0.8	5.59
Skagway-Hoonah-Angoon C.A.	3,062	0	0	-	-
Wrangell-Petersburg Census Area	6,172	4	4	1.0	6.48
Yakutat City and Borough	619	0	0	-	-
Southwest Region	39,979	13	5	0.4	1.25
Aleutians East Borough	2,659	0	0	-	-
Aleutians West Census Area	5,249	2	1	0.5	1.91
Bethel Census Area	17,085	9	2	0.2	1.17
Bristol Bay Borough	1,073	0	0	-	-
Dillingham Census Area	4,792	2	2	1.0	4.17
Lake and Peninsula Borough	1,620	0	0	-	-
Wade Hampton Census Area	7,501	0	0	-	-
Out-of State		122	84		

Source: National data calculated using ICR, 2000 and U.S. Census Bureau

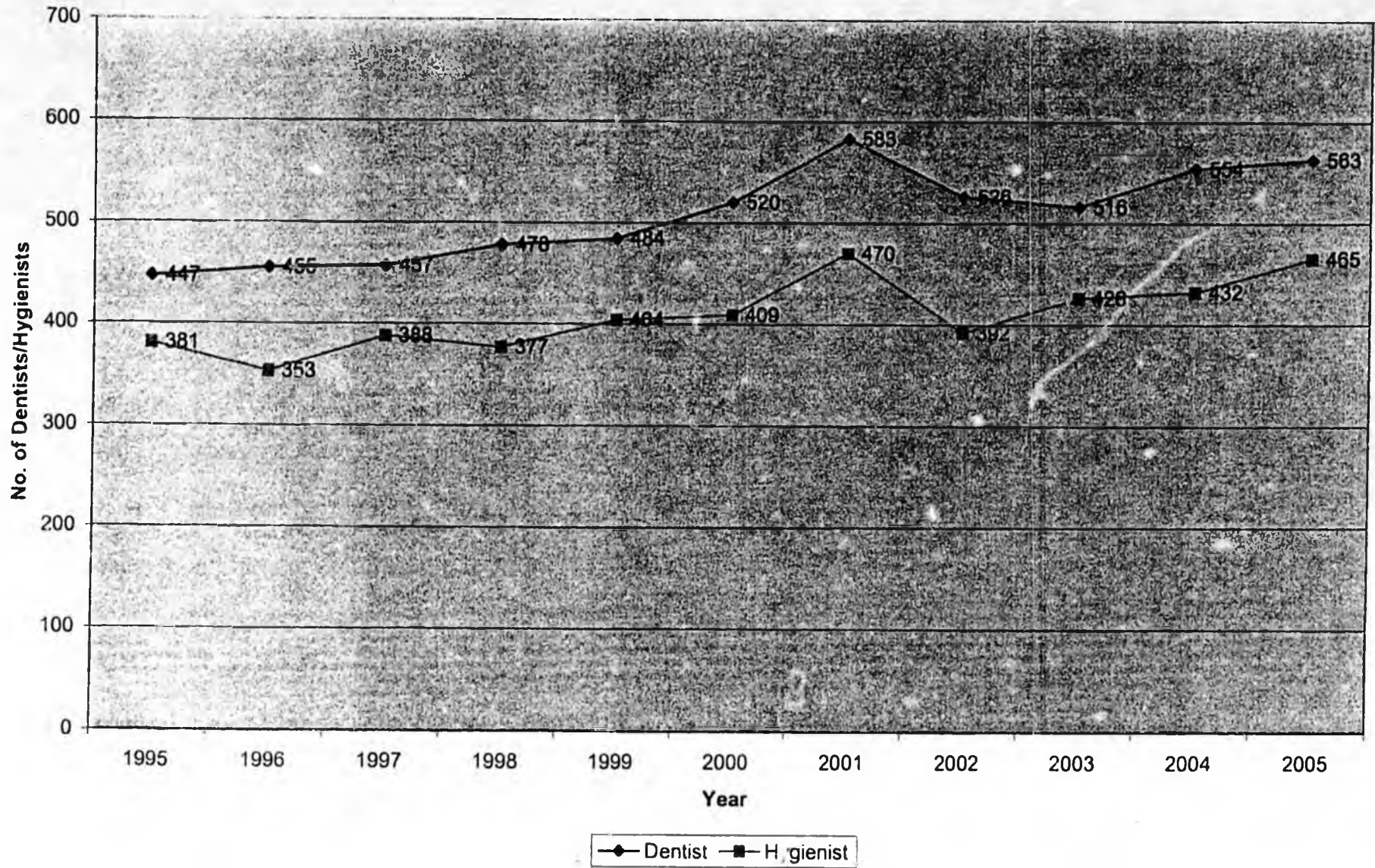
Source: State population data from ADOL&WD, 2005

Source: Dentist/Hygienist data from AK Div of Occupational Licensing, Jan 2007

Dentist & Hygienists in AK (1995 - 2005)



Dentist & Hygienists in AK (1995 - 2005)



DIRECT ACCESS STATES

For purposes of this document, direct access means that the dental hygienist can initiate treatment based on his or her assessment of patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and can maintain a provider-patient relationship.

Arizona 2004

Sec 32-1289

A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

California 1998 (*California has two different provisions for unsupervised practice)

Sec. 1774, 1775

Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas if the patient has a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.


Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.

Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

California 2002

Sec 1763 (a) 2002 Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

- In 2006, more than 100 RDHAP's registered.
- A dental hygienist mobile practice treats 25/35 disabled patients per week.
- Direct Medicaid reimbursement allowed.




Colorado - 1987
Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services--remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**



Connecticut 1999
Section 20-126l.

Dental hygienists with 2 years experience may practice without supervision in institutions, public health facilities, group homes and schools.

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophys/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs. As of 2005, 15 hygienists held public health permits.

Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.
- Preliminary estimates for 2004: Over 3,100 clients received sealants, over 11,000 received screenings, 1,600 received fluoride applications, over 150 received prophylaxis, and over 5,000 received education.
- In 2006, 24 public health RDHs.

Kansas 2003

Sec. 65-1456

Dental hygienist with 1800 hours experience can obtain an extended care permit to treat patients in schools, headstart programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice. Services permitted are the oral prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist.

- As of April 2006, there were 41 extended care permit dental hygienists.

Maine 2001

Rule 02 313 Chap. 1. Sec. 4

A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision.

The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

Special Requirements: A dental hygienist must apply to the board to practice providing such information the board deems necessary. The board must take into consideration whether the program will fulfill an unmet need, whether a supervising dentist is available and that the appropriate public health guidelines and standards of care can be met and followed.

Services: All services that can be provided under general supervision. Dentist's diagnosis for sealants not needed in public health or school sealant programs.

- From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.
- Direct Medicaid reimbursement allowed.

Michigan 1991

Sec. 333.16625

A dental hygienist may apply to the Department of Community Health to become designated as a "grantee health agency" for a 2 year period, during which time hygienist can administer dental hygiene services to patients not assigned to a dentist as part of a program in dentally underserved populations. Dental hygienists practicing as grantee health agencies must work under the supervision of a licensed dentist for a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Dental hygienists interested in attaining grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.



Minnesota 2001

Section 150A. 10, subd. 1a

A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.

A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing. A dental hygienist can provide sealants and fluoride varnishes without the patient first being examined by a licensed dentist.

Restorative Services: a licensed dental hygienist or a registered dental assistant may perform the following restorative procedures:

- Place, contour, and adjust amalgam restorations;
- Place, contour, and adjust glass ionomer;
- Adapt and cement stainless steel crowns; and
- Place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel.

The restorative procedures may be performed only if:

- The licensed dental hygienist or the registered dental assistant has completed board-approved courses on the specific procedures which include a course that sufficiently prepares the dental hygienist or registered dental assistant to adjust the occlusion on the newly placed restoration.

- A licensed dentist has authorized the procedure to be performed.
- There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.
- Direct Medicaid reimbursement allowed.

Missouri 2001

Statute 332.311.2

Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.
- Direct Medicaid reimbursement allowed.
- In 2006, were 12 registered providers.

Montana 2003

Sec. 37-4-405

Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, headstart programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- Program took effect in September of '04, 6 applicants so f

New Hampshire 1993

Rule 101.11(d)

Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

Services: Instruction in oral hygiene, topical fluorides, oral prophylaxis, assess medical/dental history, periodontal probing/charting.

New Mexico 1999

Sec 61-5A-4D

Rule 16.5.17

Collaborative practice permits based on a written agreement between the dental hygienist and one or more consulting dentist(s), dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

Special Requirements: 2400 hours active practice in past 18 months or 3000 hours in 2 of past 3 years.

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x-rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- One collaborative practice arrangement that started in 2002, serves a patient base of 4,000 people- 1/3 of which are Medicaid eligible.
- Direct Medicaid reimbursement allowed.
- In 2006, there were 35 collaborative practice RDHs.



Nevada 1998

Statute 631.287

Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **20 RDH's have gained board approval Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**



New York 2005

Rules Sec. 61.9

That a supervising dentist, be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances." A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened almost 800 children & sealed over 1500 teeth.**
- **Thousands of New York children have been treated by dental hygienists' in school based programs under general supervision.**



Oklahoma 2003

Sec. 328.34 C

A dentist may authorize in writing a dental hygienist with 2 years experience to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.



Oregon 1997

Sec. 680.200

Rule 818-035-0065

Dental hygienists who have obtained a limited access permit (LAP'S) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.

12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

Services--All dental hygiene services, except that some (local anesthesia, pit and fissure sealants, denture relines, temporary restorations, radiographs and nitrous oxide) must be preauthorized by a dentist.

- In 2006, there was 70 LAP's.
- In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Headstart, Early Headstart, WIC a public health settings.
- Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.
- Direct Medicaid reimbursement allowed.



Rhode Island 2006

Sec. 5-31.1-6.1

Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.



Texas 2001

Statute 262.1515

A dentist may delegate services without seeing the patient first to a dental hygienist practicing in a nursing facility or school based health center. The hygienist must refer the patient to a dentist following treatment. The hygienist may not perform a second set of services until the patient has been examined by a dentist.

Special Requirements: 2 years practice experience.

Services: No limitations.



Washington 1984 (*Washington has two different provisions for unsupervised practice)
Sec. 18.29.056

Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails, and public health facilities provided the hygienist refers patient to a dentist for dental treatment and needed care.

Special requirements: Two years clinical experience within the last five years.

Services -- removal of deposits and stains, application of topical preventive or prophylactic agents, polishing and smoothing restorations, root planing, curettage and local anesthesia. (The dental board has ruled that sealants are not included, but require general supervision).

Washington 2001

Statute 18.29.220

Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.
- Direct Medicaid reimbursement allowed.

House Bill 136 – “An act relating to dental hygienists”

The Problem

- Preventable oral diseases can cause life threatening emergencies.
- Many Alaskans cannot afford oral healthcare.
- There are geographic and educational barriers preventing access to oral health care.
- The structure of Alaska's current oral healthcare delivery system contains barriers that prevent access to oral health care.

Dental Hygienists Can Help

Dental hygienists are well-prepared to deliver preventative oral health care services to the public safely and effectively.

- Dental hygienists focus on preventing and treating oral diseases.
- Dental hygienists graduate from nationally accredited dental hygiene education programs in universities, and must pass a national written and state clinical examination in order to practice.
- Dental hygienists are state-licensed oral healthcare professionals.
- Dental hygienists are key to cost-effective early intervention and education.

Provisions under HB 136

1. Anesthesia under *general* supervision

Allows a licensed dental hygienist to perform local anesthesia under general supervision. A licensed dentist would still be required to diagnose the condition to be treated prior to the hygienist performing treatment.

2. Expanded restorative function

Allows a licensed dental hygienist to place “fillings” into a cavity prepared by a licensed dentist.

3. Collaborative agreement

Allows a licensed dental hygienist to enter into a written agreement with a licensed dentist who would authorize the services to be performed by the dental hygienist without the supervision of the dentist.



February 26, 2007

Representative Bill Stoltze
State Capitol, Room 501
Juneau, AK 99801-1182

Dear Representative Stoltze:

The Alaska State Dental Hygienists' Association (ASDHA) strongly supports House Bill 136 which represents many years of discussion, debate, research and reflection upon the oral health needs of Alaskans. As dental hygienists, we are a community of professionals devoted to the prevention of disease and the promotion and improvement of the public's health. We are preventive oral health professionals who provide education, clinical, and therapeutic services to the public.

In Alaska, the Board of Dental Examiners regulates the professions of dentistry and dental hygiene. Before a license is issued in the state, dentists and hygienists are required to meet specific guidelines. Dental hygienists must graduate from an American Dental Association accredited program and pass a national written and state clinical examination before they are allowed to practice. There are dental hygiene programs in nearly every state and the U.S. Bureau of Labor Statistics states that the profession of dental hygiene is expected to be one of the fastest growing occupations through the year 2012. In comparison, the number of dentists that graduate each year continues to decline as the population continues to grow. The needs of the public cannot be met by dentists alone.

Currently, there are legal barriers that prevent dental hygienists from providing oral health care to the public. State law and regulation limit access by imposing restrictive supervision requirements on dental hygienists. By virtue of our comprehensive education and clinical preparation, dental hygienists are well prepared to deliver preventive oral health care services to the public, safely and effectively, independent of dental supervision. The nation's more progressive states, such as Minnesota and Washington, which have already expanded the role of dental hygienists, have recognized that the traditional oral health delivery system does not work for many segments of the population.

ASDHA supports the statutory changes in HB 136 as it will help address access to oral health care in all Alaskan communities; most notably, in areas with little or no access to traditional dental services. Each statute change shows a continued professional commitment to working collaboratively with dentists in order to meet the needs of the public, and provide these services in a safe and effective manner.

A landmark report by the Surgeon General in 2000, *Oral Health in America*, highlighted the barriers to oral health and the importance and effectiveness of prevention. Most importantly, it calls upon "policymakers, community leaders, private industry, health professionals, the media, and the public" to take action and make necessary changes that will improve the oral health of the nation. ASDHA strongly encourages the Alaska Legislature to help break down the barriers keeping Alaskans from the oral health they deserve.

Thank you,

Ivonne Millea, RDH

Ivonne Millea
ASDHA President

P.O. Box 240247 Anchorage, AK 99524 www.asdha.com

Ben Mulligan

From: Dorrie Wallis [dwallis@svt.org]
Sent: Tuesday, February 27, 2007 9:52 AM
To: Rep. Bill Stoltze
Subject: *****SPAM***** HB 136

Dear Rep. Stoltze:

Thank you for sponsoring HB 136. I am a practicing dental hygienist with 14 yrs experience in Alaska providing treatment in many "Bush" communities. Alaska has over 400 hygienist, who are considered mid-level practitioners - if the Bill is approved, our profession can have a significant impact on improving the oral health of those most in need. Please let me know if I can be of any assistance in assisting you or your staff.

Thank you,
Dorrie Wallis, RDH
Homer, AK
(907)235-0626(h)
(907)399-3991(c)

2/27/2007

Southcentral Foundation

Date: February 22, 2007

From: Kevin Gottlieb, Chief of Staff

RE: House Bill No. 136

Dear Representative Bill Stoltze

Southcentral Foundation would like to state our support for the passage of changing the Statutes for Dental Hygienists in Alaska. These changes allow for local anesthesia under general supervision, restorative functions, and collaborative practice with a dentist. This expanded utilization of a licensed dental hygienist will help to address the inadequacy of access to dental care in Alaska.

It has been documented that Alaska is a State in need of increased access to dental services, especially in the rural areas. These expanded functions would increase the number of people that could be treated while working with a dentist. The collaborative agreement statute would provide increased access to care not only for rural areas but also for individuals in nursing homes, home bound disabled patients and low-income school programs. These individuals whether urban or rural have significant oral health needs and lack easy access to dental care.

The U.S. Surgeon General in May of 2000 made a landmark call to action upon *"policymakers, community leaders, private industry, health professionals, the media, and the public to affirm that oral health is essential to general health and well-being and to take action."* Furthermore, in the Surgeon General's Report: Oral Health in America, it was reported that no less than a *"silent epidemic of oral diseases is affecting our most vulnerable citizens"* and that *"no one should suffer from oral diseases or conditions that can be effectively prevented and treated."*

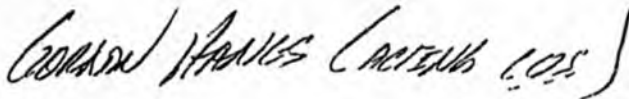
4501 Diplomacy Drive • Anchorage, Alaska 99508
(907) 729-4955 • Fax (907) 729-5000



Southcentral Foundation is confident that expanding the scope of practice for dental hygienists will result in improved access to care and improved overall health for Alaskans. These expanded functions are practiced in several other States throughout the country. Dental hygienists are licensed preventive oral health professionals. They have the capability and educational background to provide these services to the public in a safe and effective manner. Please support HB 136.

Sincerely,

SOUTHCENTRAL FOUNDATION

A handwritten signature in black ink, appearing to read "Kevin Gottlieb (Chief of Staff)", written over the printed name.

Kevin Gottlieb
Chief of Staff

House Bill 136 – “An act relating to dental hygienists”

The Problem

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- Dental hygienists are key to cost-effective early intervention and education.

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3. Collaborative agreement

Allows a licensed dental hygienist to enter into a written agreement with a licensed dentist who would authorize the services to be performed by the dental hygienist without the supervision of the dentist.

Number of Dentists and Dental Hygienists by Region

Region	Population	No. of Dentists	No. of Hygienists	No. of Hyg/Den	No. of Hyg/10,000
New England			13,118	1.4	9.4
Middle Atlantic			25,976	0.9	6.6
East North Central			31,851	1.3	7.1
West North Central			9,481	1	4.9
South Atlantic			27,484	1.1	5.3
East South Central			7,998	1.1	4.7
West South Central			12,287	0.9	3.9
Mountain			10,422	1.2	5.7
Pacific			31,149	1.1	6.9
U.S. Total			169,149	1.1	6.0
Alaska	663,861	497	496	1.0	7.47
Anchorage Mat-Su Region	352,282	226	270	1.2	7.66
Anchorage Municipality	278,241	197	216	1.1	7.76
Matanuska-Susitna Borough	74,041	29	54	1.9	7.29
Gulf Coast Region	74,904	37	42	1.1	5.61
Kenai Peninsula Borough	51,224	27	29	1.1	5.66
Kodiak Island Borough	13,638	7	9	1.3	6.60
Valdez-Cordova Census Area	10,042	3	4	1.3	3.98
Interior Region	102,005	50	45	0.9	4.41
Denali Borough	1,823	0	0	-	-
Fairbanks North Star Borough	87,650	47	45	1.0	5.13
Southeast Fairbanks Census Area	6,471	3	0	-	-
Yukon Koyukuk Census Area	6,061	0	0	-	-
Northern Region	23,669	8	2	0.3	0.84
Nome Census Area	9,452	5	1	0.2	1.06
North Slope Borough	6,894	2	1	0.5	1.45
Northwest Arctic Borough	7,323	1	0	-	-
Southeast Region	70,822	41	48	1.2	6.78
Haines Borough	2,207	1	2	2.0	9.06
Juneau City and Borough	31,193	22	26	1.2	8.34
Ketchikan Gateway Borough	13,125	7	9	1.3	6.86
Prince of Wales-Outer Ketchikan C.A.	5,497	1	2	2.0	3.64
Sitka City and Borough	8,947	6	5	0.8	5.59
Skagway-Hoonah-Angoon C.A.	3,062	0	0	-	-
Wrangell-Petersburg Census Area	6,172	4	4	1.0	6.48
Yakutat City and Borough	619	0	0	-	-
Southwest Region	39,979	13	5	0.4	1.25
Aleutians East Borough	2,659	0	0	-	-
Aleutians West Census Area	5,249	2	1	0.5	1.91
Bethel Census Area	17,085	9	2	0.2	1.17
Bristol Bay Borough	1,073	0	0	-	-
Dillingham Census Area	4,792	2	2	1.0	4.17
Lake and Peninsula Borough	1,620	0	0	-	-
Wade Hampton Census Area	7,501	0	0	-	-
Out-of State		122	84		

Source: National data calculated using ICR, 2000 and U.S. Census Bureau

Source: State population data from ADOL&WD, 2005

Source: Dentist/Hygienist data from AK Div of Occupational Licensing, Jan 2007

March 16, 2007

Representative Kurt Olson
State Capitol, Room 408
Juneau, AK 99801-1182

Dear Representative Olson,

My name is Betty L. Smith and I am a licensed dental hygienist from your district. I am writing to ask you to support House Bill 136 sponsored by Representative Bill Stoltze. This legislation would enable properly qualified and licensed dental hygienists to provide local anesthesia under general supervision, attain licensure to provide restorative services, and provide dental hygiene services under a collaborative agreement with a dentist approved by the Board of Dental Examiners.

Dental hygienists are licensed in the state of Alaska after graduating from an American Dental Association accredited dental hygiene college program and passing written, clinical and jurisprudence examinations. We are preventive oral health professionals who provide a wide range of services and treat one of the most common oral diseases—gum disease. We also provide treatments like fluorides and sealants to prevent tooth decay. We have the skill and educational background to provide these services to the public.

Dental hygienists in the state of Alaska have been providing pain control with local anesthesia since 1981 in a safe and effective manner. Dental hygienists frequently use local anesthesia when they perform deep scaling treatments (root planing) and gingival curettage, services for the treatment of gum disease. While most dental hygiene services can be provided under general supervision (meaning the dentist has authorized a hygienist to perform procedures but need not be present in the treatment facility during the performance of those procedures), a dentist must currently be present in the facility in order for a hygienist to provide local anesthesia. This limits dental hygienists from providing patients the comfort and stress reduction needed for root planing.

This bill also establishes a dental hygiene Restorative Function License Endorsement which would allow a dental hygienist who has successfully completed a restorative program and passed a clinical examination to work with a dentist under direct supervision to place, carve, contour, and adjust a restoration for teeth prepared by the dentist. If the dentist can begin the restoration of a tooth and delegate completion to a licensed dental hygienist, many more patients could be treated each day.

The final proposed change would create the option for dentists and dental hygienists to practice collaboratively according to a Board approved written Collaborative Agreement between them that authorizes the dental hygienist to perform specified services as outlined in the agreement. Hygienists would be able to then provide services in nursing homes, schools, and rural communities that lack access to these services. Currently under state law a dentist has to see the client prior to each treatment series, effectively preventing many people who are unable to visit the private office from obtaining even the most routine preventive care like fluorides and cleanings.

House Bill 136 is one step forward in addressing the oral health disparities in Alaskan communities. As a dental hygienist from your district, I ask for your support of HB 136. Please let me know if you would like additional information.

Sincerely,

Betty L. Smith RDH BS
Dena'Ina Dental Clinic, 412 Frontage Road, Suite 20, Kenai, AK 99611
907-335-2142; lsmith@kenaiakze.org

Ben Mulligan

From: Dorrie Wallis [dwallis@svt.org]
Sent: Tuesday, February 27, 2007 9:52 AM
To: Rep. Bill Stoltze
Subject: *****SPAM***** HB 136

Dear Rep. Stoltze:

Thank you for sponsoring HB 136. I am a practicing dental hygienist with 14 yrs experience in Alaska providing treatment in many "Bush" communities. Alaska has over 400 hygienist, who are considered mid-level practitioners - if the Bill is approved, our profession can have a significant impact on improving the oral health of those most in need. Please let me know if I can be of any assistance in assisting you or your staff.

Thank you,
Dorrie Wallis, RDH
Homer, AK
(907)235-0626(h)
(907)399-3991(c)



STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sarah Palin, Governor
Emil Notti, Commissioner
Rick Urion, Director

Division of Corporations, Business and Professional Licensing

March 6, 2007

The Honorable Peggy Wilson, Chair
Health, Education and Social Services Committee
House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Dear Representative Wilson:

RE: HB 136

The Board of Dental Examiners is in support of HB 136, "An Act relating to dental hygienists".

This legislation will be beneficial in providing more dental services to the citizens of the State of Alaska.

Please contact me at (907) 561-6262 or by email at geracedds@pci.net if you have questions regarding our support of this bill.

Sincerely,

William Gerace (Signature)

William Gerace, DDS, Acting-Chair
Alaska Board of Dental Examiners

THE EFFECTS OF STATE DENTAL PRACTICE LAWS ALLOWING ALTERNATIVE MODELS OF PREVENTIVE ORAL HEALTH CARE DELIVERY TO LOW-INCOME CHILDREN

EXECUTIVE SUMMARY

January 17, 2003

Lea Nolan, MA^{*}, Brian Kamoie, JD, MPH^{*}, Jennel Harvey, MHSA[‡],
Lissette Vaquerano[†], Sarah Blake, MA[¶], Satvinder Chawla[£], Jeffrey Levi,
PhD[§], Sara Rosenbaum, JD[¶]

The Center for Health Services Research and Policy (CHSRP) was funded by the Centers for Disease Control and Prevention's (CDC) Public Health Practice Program Office to examine state dental practice laws that permit alternative models of delivering preventive oral health care to low-income children¹.

BACKGROUND

Although the incidence of tooth decay has decreased considerably over the past two decades, the prevalence of caries among children and adolescents remains high. Minorities and low-income populations experience more dental decay than those with higher incomes, and they are also more likely to have a higher proportion of untreated decayed teeth.² Low oral health care utilization is the primary reason for higher tooth decay among low-income and minority populations. Low use of

^{*} Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University; [‡] Doctoral student, School of Public Administration and Policy, Eller College of Business and Public Administration, University of Arizona; [†] Department of Health Policy and Management, Rollins School of Public Health, Emory University; [£] JD/MPH Candidate, The George Washington University Law School/School of Public Health and Health Services, The George Washington University.

¹ This project was funded under the grant "Research on the Impact of Laws and Policies on Public Health" (grant number R06/CCR318771) from the CDC Public Health Law Program. The contents of this report are solely the responsibility of the authors and do not necessarily represent the official views of CDC, or the Public Health Law Program. The George Washington University Institutional Review Board (non-Medical) approved this study and provisions regarding informed consent in approval number 100026ER."

² U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, page 63.

dental services among low-income and minority children is related to several factors that reduce their access to such services, which include low dentist Medicaid participation, shortage of dentists, mal-distribution of dentists, restrictive state laws, patients' lack of health insurance, and families' lack of understanding and awareness of the need for preventive oral health care.

PROJECT OVERVIEW

Project Purpose

The purpose of this project was to examine state dental practice laws and the extent to which they encourage alternative models of delivering preventive oral health care. This project encompassed two distinct study components: 1) an analysis of existing state dental statutes and regulations; and 2) case studies to examine the enactment of public health-oriented provisions encouraging alternative models of delivering preventive oral health care to low-income children; and the development and implementation of such alternative models.

METHODS

Review State Dental and Medical Practice Laws

We reviewed state dental practice acts for the 50 states and the District of Columbia to determine how they address the delivery of preventive oral health care services by dentists and dental hygienists.³ We also examined any applicable exemptions for physicians and nurses to deliver oral health care. In addition, we reviewed the statutes for supervision requirements for dental hygienists consultation between dentists and hygienists when delivery of oral health services is unsupervised or independent, and the educational and competency requirements for dental hygienists.

Case Studies

We opted to study six states that had: 1) enacted a statute that permitted/encouraged an alternative model; and/or 2) had or had not yet implemented the alternative model. We chose to examine two types of

³ We reviewed state dental and medical practice laws during 2000-2001. The full report contains a full description of the scope of our review.

alternative models: 1) a model that uses dental hygienists working under either general supervision or without a dentist's supervision (but not independent practice) to provide preventive services; and 2) a model that uses physicians to provide screening, education, and in some cases, topical fluoride application to very young children. Our study states included Connecticut, Iowa, New Mexico, North Carolina, South Carolina, and Washington.

FINDINGS

Analysis of State Health Professions Laws

The licensing of dentists, as with other health professionals, is governed by state law. Health professions licensing statutes are implemented by boards dominated by the relevant professionals themselves.⁴ In the case of dental practice, definitions and scope of practice provisions become important when considering the role of dental hygienists. Generally, dental hygienists are subject to governance by boards of dentistry, which define and in many jurisdictions limit the scope of permissible practice.

The licensing system and self-regulation by the dental and medical professions have profound implications for low-income children. In many jurisdictions, state laws restrict the delivery of preventive oral health care to dentists. In other jurisdictions, restrictive licensing laws restrict the scope of practice of dental hygienists. These legal restrictions operate as a barrier to the provision of preventive oral health services to low-income children by limiting the number of individuals who can provide such services.

Although some states have begun to loosen their practice acts to allow dental auxiliaries to perform more preventive oral health services, these focus primarily on hygienists. Many jurisdictions require a dentist to be on-site and sign-off on preventive oral health services provided by dental auxiliaries. Although many state dental licensing laws provide exemptions for the delivery of preventive oral health care by physicians, other obstacles limit such delivery (e.g., training and equipment).

⁴ See Furrow et al., *Health Law*. 2000. St. Paul, Minnesota: West Group Publishing, at 59. See also Orentlicher D, "The Role of Professional Self Regulation" in *Regulation of the Healthcare Professions* at 129 (Timothy S. Jost, ed. 1997).

State Options

Our analysis revealed that states have elected to use one of three options in changing existing laws to allow for alternative models of oral health care delivery: 1) a state legislature can pass a new statute that explicitly permits an alternative model; 2) a state agency or dental/medical board can establish new regulations or rules (based on existing law) allowing an alternative model; and 3) a state agency, dental/medical board, or group of providers can reinterpret an old law or set of regulations/rules, usually with a broader interpretation, and implement an alternative model.

Supervision Requirements for Dental Hygienists

Two key issues stand out in the design of alternative delivery models for the delivery of preventive health services to low-income children: 1) whether a dentist has to be on the premises when services are provided; or 2) whether a dentist has to sign-off on the work performed prior to patient discharge.

The review of the dental practice laws demonstrates that for the four identified preventive oral health services, most state dental practice laws require supervision of a dentist at some level (direct, indirect, general) for the delivery of preventive oral health services by dental hygienists. Colorado has an independent practice law that allows dental hygienists to provide oral health services without the supervision of a dentist, and Washington state allows independent practice under certain conditions. The more restrictive the supervisory requirements are, the less flexibility states will have in designing alternate models of preventive oral health delivery by dental hygienists. The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision and approval. This confusion, in itself, is a deterrent to designing alternate delivery models.

Case Studies

Our findings reveal that making a change in the law does not result in an *immediate* change to the oral health care delivery system. In fact, in three of the cases (IA, NC, and WA) the alternative model could be developed *without* the creation of a new public health-oriented law. In

these states, existing dental and medical practice laws, accompanied by changes to rules, regulations, or administrative policies, were sufficient to permit a new model. In the remaining cases the alternative model could not be pursued unless the law was changed. Where laws are changed, it may take a substantial amount of time for the dental profession and the market to respond to such changes. However, in all cases we learned that the success of the alternative oral health care models lay not merely in the laws themselves, but in certain factors essential to their implementation.

Our findings suggest that a combination of essential factors is required for the implementation of an alternative oral health care delivery model, whether or not a new public health-oriented law has been enacted. The factors that facilitated the implementation of alternative models for delivering preventive oral health care are summarized below:

- Gaining the **support of dentists**, either through their organizational representatives or through the leadership of individual dentists is perhaps the most important factor in the success of an alternative model.
- Creating a **reimbursement mechanisms** for providers in the alternative model.
- Gaining **state Medicaid agency support** is essential.
- The **lack of a formal referral mechanism** severely hindered the successful implementation of most of the alternative models.
- The **type of alternative model** may predetermine how easily it is implemented in a state.
- Alternative models that utilize an **incremental approach** seem to have more success.
- **Outreach and training** are necessary.
- **Professional recognition and acceptance of the need** for the alternative model.

CONCLUSION

The alternative models we studied have had little impact on the preventive oral health care delivery systems in our study states. In states with dental hygienist alternative models (CT, NM, and SC), the law and models have not yet significantly changed the way that dental hygienists work. In all three states, dental hygienists provide the same services they did before the law or model was enacted or implemented (e.g., treatment planning, prophylaxis, and care coordination). Prior to the law, dental hygienists worked under some degree of supervision by a dentist, and they continue to do so currently. Until a reimbursement mechanism can be instituted, thus creating a provider number to allow for direct billing, dental hygienists will be forced to maintain their ties to a dentist of record. As we have seen, this can encourage the old models of general supervision (or indirect supervision), and discourage increased access since dental hygienists interested in the alternative model will have to rely on a dentist to bill for their services.

Given the arduous task of implementing an alternative oral health care model, and the slow progress that accompanies such an endeavor, we conclude that states planning to undertake such an effort should be mindful of several factors: 1) it is difficult to make changes in the scope of practice of one class of professionals who are overseen by a different group of professionals; 2) action should be taken at deliberate speed, and incremental steps should be made; 3) preventive oral health care providers operating within the model must have the ability to self-regulate; 4) viable funding mechanisms must be set up prior to implementing the program; and 5) careful consideration should be given to the type of model the state seeks to implement, the types of providers it will include, and the political viability of such a model.

RECOMMENDATIONS

This study did not focus on dentist workforce training and supply issues, and, therefore, our recommendations do not address these factors. Instead we focus on those elements that facilitate the development and implementation of alternative models of delivering preventive oral health care services.

- Public health leadership is needed to create a greater awareness of the need for oral health among poor children.

- Public health and dental professional leadership is needed to destigmatize the services provided by non-dentists. Disseminating the results of recent studies indicating that dental hygienists provide safe care may facilitate these efforts.
- Federal and state Medicaid officials can be effective leaders in implementation and reimbursement issues. In particular, officials can follow the example of the North Carolina Medicaid agency and its leadership in promoting the alternative oral health care model.
- Federal government and professional societies should address outreach and training issues associated with implementation of these models.
- Even without legal changes, Medicaid and public health officials can encourage the role of pediatricians regarding applying fluoride varnish. In most states physicians are already permitted to provide such services.
- Further study is needed on successfully implemented preventive oral health care models. Study should be undertaken at the individual provider level to learn exactly what elements are necessary to make a particular model successful.

March 3, 2007

*you are hearing this
Bill in HESS
tomorrow*

Representative Peggy Wilson
State Capitol, Room 403
Juneau, AK 99801-1182

Dear Representative Wilson, *Sitka*

My name is Rebecca Bender and I am a licensed dental hygienist from your district. I am writing to ask you to support House Bill 136 sponsored by Representative Bill Stoltze. This legislation would enable properly qualified and licensed dental hygienists to provide local anesthesia under general supervision, attain licensure to provide restorative services, and provide dental hygiene services under a collaborative agreement with a dentist approved by the Board of Dental Examiners.

Dental hygienists are licensed in the state of Alaska after graduating from an American Dental Association accredited dental hygiene college program and passing written, clinical and jurisprudence examinations. We are preventive oral health professionals who provide a wide range of services and treat one of the most common oral diseases—gum disease. We also provide treatments like fluorides and sealants to prevent tooth decay. We have the skill and educational background to provide these services to the public.

Dental hygienists in the state of Alaska have been providing pain control with local anesthesia since 1981 in a safe and effective manner. Dental hygienists frequently use local anesthesia when they perform deep scaling treatments (root planing) and gingival curettage, services for the treatment of gum disease. While most dental hygiene services can be provided under general supervision (meaning the dentist has authorized a hygienist to perform procedures but need not be present in the treatment facility during the performance of those procedures), a dentist must currently be present in the facility in order for a hygienist to provide local anesthesia. This limits dental hygienists from providing patients the comfort and stress reduction needed for root planing.

This bill also established a dental hygiene Restorative Function License Endorsement which would allow a dental hygienist who has successfully completed a restorative program and passed a clinical examination to work with a dentist under direct supervision to place, carve, contour, and adjust a restoration for teeth prepared by the dentist. If the dentist can begin the restoration of a tooth and delegate completion to a licensed dental hygienist, many more patients could be treated each day.

The final proposed change would create the option for dentists and dental hygienists to practice collaboratively according to a Board approved written Collaborative Agreement between them that authorizes the dental hygienist to perform specified services as outline in the agreement. Hygienists would be able to then provide services in nursing homes, schools, and rural communities that lack access to these services. Currently under state law a dentist has to see the client prior to each treatment series, effectively preventing many people who are unable to visit the private office from obtaining even the most routine preventive care like fluorides and cleanings.

House Bill 136 is one step forward in addressing the oral health disparities in Alaskan communities. As a dental hygienist from your district, I ask for your support of HB 136. Please let me know if you would like additional information about oral health, dental hygiene services or barriers to oral health care and I will arrange to have it provided.

Sincerely,
Rebecca Bender

HB

155

There are some concerns about the ABC on our side of the building. It is our understanding that the third floor will be contacting you shortly and assure you that they too are aware of the issues .

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: HB 155
 (H) Publish Date: 3/29/07

Revision Date/Time: Corrected 3/16/2007 10:25 a.m. Dept. Affected: Public Safety
 Title: Extend Alcoholic Beverage Control Board RDU: Statewide Support
 Component: ABC Board
 Sponsor: House Labor & Commerce Committee
 Requester: House Labor & Commerce Committee Component No.: 2690

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	932.5	932.5	932.5	932.5	932.5	932.5
Travel	28.3	28.3	28.3	28.3	28.3	28.3
Contractual	399.0	399.0	399.0	399.0	399.0	399.0
Supplies	6.6	6.6	6.6	6.6	6.6	6.6
Equipment	13.3	13.3	13.3	13.3	13.3	13.3
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	1,379.7	1,379.7	1,379.7	1,379.7	1,379.7	1,379.7

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	1.7	1.7	1.7	1.7	1.7	1.7
1005 GF/Program Receipts	1,220.5	1,220.5	1,220.5	1,220.5	1,220.5	1,220.5
1037 GF/Mental Health						
Other Interagency Receipts	157.5	157.5	157.5	157.5	157.5	157.5
TOTAL	1,379.7	1,379.7	1,379.7	1,379.7	1,379.7	1,379.7

Estimate of any current year (FY2007) cost: 0.0
 Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time	9	9	9	9	9	9
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

The funding shown represents the Governor's request for FY2008 and is continued through the six year sunset extension.

Prepared by: Douglas B. Griffin Phone 269-0351
 Division: Alcoholic Beverage Control Board Date/Time 3/16/07 10:30 AM
 Approved by: Commissioner Walt Monegan Date 3/16/2007
 Agency: Department of Public Safety



ALASKA STATE LEGISLATURE

HOUSE LABOR & COMMERCE COMMITTEE

REP. KURT OLSON

Chairman
State Capitol, Room 17
Juneau, AK 99801-1182
(907) 465-2693 FAX 465-3835

Rep Mark Neuman, V-Chair Rep. Carl Gatto
Rep. Jay Ramras Rep. Berta Gardner
Rep. Gabrielle LeDoux Rep. Bob Buch

Sponsor Statement CS HB 155 (FIN)

The House Labor & Commerce Committee introduced this bill at the request of the Alcoholic Beverage Control Board.

Although the audit recommended extending the Board until 2013 the House Finance Committee changed the date to 2010 to provide oversight by the legislature of the Board's progress in adopting the audit recommendations.

When this bill was introduced we were assured by the Dept. of Public Safety that the needed statutory changes would be forthcoming in a separate piece of legislation. To my knowledge this has not occurred. Obviously, we would prefer a clean sunset extension bill.

We ask for your support of this legislation.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 2
 Bill Version: CSHB 155(FIN)
 (H) Publish Date: 4/13/2007

Revision Date/Time (Note if correction): _____ Dept. Affected: Public Safety
 Title Extend Alcoholic Beverage Control Board RDU Statewide Support
 Component ABC Board
 Sponsor House Labor and Commerce Committee
 Requester _____ Component No. 2690

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services		932.5	932.5	932.5		
Travel		28.3	28.3	28.3		
Contractual		399.0	399.0	399.0		
Supplies		6.6	6.6	6.6		
Equipment		13.3	13.3	13.3		
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	1,379.7	1,379.7	1,379.7		

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF		1.7	1.7	1.7		
1005 GF/Program Receipts		1,220.5	1,220.5	1,220.5		
1037 GF/Mental Health						
Other Interagency Receipts		157.5	157.5	157.5		
TOTAL	0.0	1,379.7	1,379.7	1,379.7		

Estimate of any current year (FY2007) cost: 0.0
 Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time		9	9	9	9	9
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
 HB 155 extends the sunset date for the Alcohol Beverage Control Board to June 30, 2010. The amount represented in this fiscal note is based on the Governor's FY 08 budget request. No new funds will be needed to implement HB 155 in FY 08.

 Funding is included in FY 2011 for the sunset year and close-out of the ABC Board.

Prepared by: House Finance Committee Phone 465-4945
 Division: _____ Date/Time 4/11/07 4:04 PM
 Approved by: Representative Meyer Date _____
Representative Chenault



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SUMMARY OF: A Sunset Review of the Department of Public Safety, Alcoholic Beverage Control Board, August 31, 2006.

PURPOSE OF THE REPORT

In accordance with Titles 24 and 44 of the Alaska Statutes (sunset legislation), we have reviewed the activities of the Alcoholic Beverage Control Board (ABC Board or the board) to determine if there is a demonstrated public need for its continued existence and if it has been operating in an efficient and effective manner. As required by AS 44.66.050(a), this report shall be considered by the committee of reference during the legislative oversight process in determining whether the ABC Board should be reestablished. Currently, under AS 44.66.010(a)(1), the board will terminate on June 30, 2007 and will have one year from that date to conclude its administrative operations. Our report objectives were as follows:

1. To determine whether there is a public need for the board and if its existence should be extended.
2. To review the board's major functions of licensing, inspections, and investigations for effectiveness in meeting public need and for efficiency of operation

REPORT CONCLUSIONS

In our opinion, the termination date of the ABC Board should be extended. The board should continue to regulate the manufacture, sale, barter, and possession of alcoholic beverages within the State of Alaska in order to protect the public's health, safety, and welfare. The board has demonstrated a need for its continued existence by providing protection to the general public through the issuance, renewal, revocation, and suspension of liquor licenses. Protection has also been provided through active investigation of suspected licensing violations and enforcement of the state's alcoholic beverage control laws and regulations.

As indicated in the Analysis of Public Need section of this report, the ABC Board has met the various statutory sunset criteria. With the exceptions noted in the Findings and Recommendations section of this report, the board is effectively and efficiently meeting its statutory responsibilities and is operating in the public interest. Beginning FY 04, the board was reorganized under the Department of Public Safety and improvements have been made in the regulatory aspect of the board's operations. However, the board lacks an overall strategy for accomplishing its enforcement goals. In addition, certain operational improvements are needed to allow for greater public participation and to improve the overall efficiency with which the board performs its administrative functions.

We recommend that Alaska Statute 44.66.010(a)(1) be amended to extend the termination date of the Alcoholic Beverage Control Board to June 30, 2013.

FINDINGS AND RECOMMENDATIONS

1. The ABC Board and director should strengthen the control environment over alcohol regulatory functions. Internal controls at the ABC offices are weak in a number of areas including the licensing and permitting functions, revenue sharing payments, licensee fee collection activities (including wholesaler fee collections), and the licensing database. Weaknesses are due to the lack of well-designed controls and/or the circumvention and neglect of established controls.
2. The ABC Board and director should develop and implement an overall plan for enforcement activities to ensure the effective allocation of their resources. The ABC Board lacks a systematic strategy for scheduling inspections and compliance checks to ensure effective enforcement. Increase in the number of regulatory inspections has not resulted in a significantly greater percentage of licensees being inspected.
3. The ABC Board director should ensure compliance with public notice requirements and establish procedures to ensure board meeting records are complete and accurate. Board meetings were not consistently advertised, affected parties were not promptly notified of statutory and regulatory changes, and the board minutes were inadequately documented.
4. The legislature should consider amending Title IV to remove the voting ability of the board's director. To ensure an appropriate balance of government, the legislature should amend AS 04.06.060 to remove the director's voting ability.

AUDITOR COMMENTS

The legislature may want to reevaluate the general wholesales license fee structure. The ABC Board could assist by proposing new volume fee brackets that take into consideration the current and projected future sales. The statutory structure for general wholesale license fees is based on a progressive tax rate; however, because of the increase in the sales volumes of the wholesalers, the licensee fee structure is actually regressive. Wholesale volume fees have not changed since 1980. Alcohol sales are increasing at a much faster rate than the volume fees collected. The current structure has a regressive effect and puts low-volume wholesalers at a competitive disadvantage.



* Requires Acrobat Reader 

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



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October 21, 2006

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF PUBLIC SAFETY ALCOHOLIC BEVERAGE CONTROL BOARD SUNSET REVIEW

August 31, 2006

Audit Control Number

12-20047-06

This review examines the activities of the Alcoholic Beverage Control Board (ABC Board) to determine if there is a demonstrated public need for its continued existence and if it has been operating in an efficient and effective manner. Alaska Statute 44.66.010 specifies that the ABC Board will terminate on June 30, 2007 and will have one year from that date to conclude its administrative operations. We recommend that the legislature extend the ABC Board's termination date until June 30, 2013.

The audit was conducted in accordance with generally accepted government auditing standards. Field work procedures utilized in the course of developing the findings and discussion presented in this report are outlined in the Objectives, Scope, and Methodology section. Audit results may be found in the Report Conclusions, Findings and Recommendations, and Analysis of Public Need sections of the report.

A handwritten signature in black ink that reads "Pat Davidson".

Pat Davidson, CPA
Legislative Auditor