SENATE
COMMERCE & LABOR
COMMITTEE

Minutes of Meeting
Wednesday, March 9, 1977

The meeting of the Commerce and Labor Committee was held on March 9, 1977, at 1:30 P.M. in Room 213.

Senator Thomas Wilson was in the chair.

PRESENT: Senator Wilson
Senator Blakemore
Senator Young
Senator Close
Senator Bryan
Senator Ashworth
Senator Hernstadt

ALSO PRESENT: See attached list

The committee considered the following:

S. B. 182 REQUIRES HEALTH INSURANCE TO COVER TREATMENT FOR ALCOHOLISM AND DRUG ADDICTION (BDR 57-495)

The first witness was SENATOR GOJACK who appeared in favor of the bill. Her statement is attached as Exhibit A.

The second witness was SENATOR RAGGIO. He stated that in the Senate Committee on Education, Health and Welfare, and State Institutions, as well as in the Assembly companion committee, two measures have been deliberated which would make appropriations - one for 1 1/2 million dollars for enhancement of detoxification centers - and one to appropriate an amount equivalent to about 10% of the tax on hard liquor. He stated this would not increase the tax, but appropriate an amount for the operation of the program once detoxification centers are enhanced in their ability to provide treatment.

He stated that as a District Attorney for eighteen years he had witnessed the effects of alcoholism upon the citizenry of the State.

It has been documented that alcohol abuse costs Nevada about 68 1/2 million dollars a year, not only the cost of alcoholism programs and research which is limited, but 25 million dollars in lost production, 22 million dollars in health and medical costs.

The Rand Report recognized this program-Nevada decriminalized alcoholics. We have put civil protective custody around those people who are arrested. However, that is all we did. We didn't provide detoxification and treatment facilities to deal with these problems.

He stated he is in support of the bill.

The next witness was Mr. Paul Cohen, Chief, Bureau of Alcohol and Drug Abuse. Please see Exhibits B, C, and D.

Supported the bill and stated that if this bill is passed the program service provider, either in a hospital or non-hospital setting, would really benefit from this bill without any monies flowing directly through the Bureau of Alcohol and Drug Abuse.

Mr. Cohen indicated there is a stigma about going to an insurance company and asking for insurance coverage in this regard and therefore, the optional choice has not worked, and Nevadans have not taken advantage of it. He indicated an increase of 14-20¢ on group plans.

He was unable to answer SENATOR HERNSTADT'S question as to why the unions have not adopted this plan.

Stated they have services that are available for those that would possibly have insurance coverage. Their figures cover approximately 20%. This bill is not going to force people to come forth. Further, - that is not the intention - it is a way as an alternative to generate funds directly to the service provider in this field of alcoholism and drug addiction.

SENATOR YOUNG asked out of the indicated 55,000 abusers how many were getting treatment and how many would get treatment if the bill was passed. Mr. Cohen referred the Senator to his exhibits with a breakout of information. Stated these are only his figures from the Bureau's Data Collection System. He does not have any figures compiled from hospitals other than Sunrise, Raleigh Hills, and Comp Care which are private service providers.

Mr. Cohen indicated they are caring for approximately 1/10 of the 55,000. The cost of the programs that they run range anywhere (non-medical services) from $84.00 per week, per client, up to $1,000 which gets into your hospital for medical coverage. Last year they gave out, through the Bureau, 1.1 million dollars to treat the people. Approximately another 1.1 to 1.5 million dollars was generated from other sources (Title 20, Food Stamps, United Way, client fees).

If this bill were passed he has projected that about 1,000 people - 20% would initially be served.

The next witness was Dennis G. Campton, M.D., from Sunrise Hospital in Las Vegas. See Exhibit E for his testimony.

At the end of his report Dr. Campton stated that as a functioning emergency department physician probably the most frustrating experience that physicians are faced with is to be presented with a patient who is in the emergency dept. for some minor problem but during his visit it becomes obvious to the physician that the person's basic problem is alcoholism, and in the attempt to render the patient into treatment at that time, is blocked by his inability to pay for hospitalization, secondary to the fact that his insurance carrier does not cover this disease. For these reasons, the patient is sent out of the emergency only to return 2-3 weeks later with multiple injuries requiring expensive and extensive hospitalization, and often bringing many other patients in with him as the result of an automobile accident. In his opinion, and in the view of emergency department physicians, this may have been prevented if they been able to treat the basic problem that the patient was presented with initially.

Dr. Campton gave the committee a composite profile of a potential alcoholic: 42 years of age, male, white, Irish, Catholic, and professional.

SENATOR BRYAN asked about the treatment given. The doctor responded the alcoholic drinks because he has to, not because he wants to. They have to get him in a situation where they can relieve his pain and discomfort of withdrawal to be able to render him chemically free so that they can deal with him. Involves 72 hour period. Once chemically free they can deal with his intelligence, then they begin to institute long term treatment, which is basically

based on education about what the disease is, what the causes are, and once the person is able to identify what his problem is, he becomes easily treatable. In case of hospitalization that requires non-acute or non-critical hospitalization this usually involves, for most effective programs in the country, in the area from 7 days to 21 days.

The reason that most alcoholic and drug abusing people are resistive to treatment is because they have the concept they are somehow responsible for being what they are. They feel remorse and guilt. Have a poor ego structure. They feel they are drunks because they made themselves that way. Once they get the information through to the person that he is no more responsible for being in the state than a diabetic would be who is having a diabetic coma, then he begins to recognize that maybe he is not a no good individual.

Costs involvement is as follows:

72 hours in hospital = $400.00

After care costs depend on the patient's identification with the problem, his willingness to cooperate, and desire to try to do something about the problem. A person who requires a great deal of help (21 day program) will have the cost run somewhat less than $100.00 per day.

Alcoholism, Dr. Campton testified, is not a symptom of mental illness. People with mental illness can develop alcoholism.

Next was Mr. George Evans of Mass. Mutual Life Insurance Company. Stated he is in support of the Legislation. Believes that group medical benefits are the most efficient and least expensive way to pay for this treatment. Seems to him that the standardization of the Legislation, so that the benefits would be provided equally by all companies, would not only strengthen the program, but would separate the cooperative from the uncooperative insurance companies. Believes all of them could conform to a good standardized program.

Indicated he had a case of a client who had the option of taking alcoholic coverage and it would cost him $10.40 per quarter for each adult in the family and $7.20 for all children.

Mr. Evans stated they put this benefit under the mental and nervous disorders. This is a double limitation. You normally have your deductable in front of any expenses paid on a comprehensive plan. Then you have your benefit. In this, you have a reduction in benefits - your mental and nervous disorders do not provide 80-20, they provide 50% up to a limit-so much per out-patient. He stated this was fairly standard.

Mr. Carlton Naugel of E.G.&G. Inc. provided the committee with a benefit booklet from his firm (Exhibit F). He stated he is the industrial relations manager. He is concerned with the contract group. They have 900 people in Las Vegas with an annual payroll of approximately 13 million dollars.

He stated the employees did not come forward because the insurance they had in the past would not cover them. The employee may be paid through his sick leave plan while he is getting treatment. They are a self-insured company. They cover treatment as long as it is performed in any licensed hospital.

Mr. Michael Grover of Titanium Metals, informed the committee he was not speaking for or against the bill. Regarding costs,he stated that for the past 2 years they have had the basic type of coverage that this legislation would provide. During that period approximately 2% of the employees have taken advantage of the insurance program and the cost has averaged about $31.25 per employee per year. That is the direct cost of the insurance that is attributable for direct alcohol treatment.

Mr. Fred Hillerby of Nevada Hospital Assn. testified that many patients were admitted under a false or secondary diagnosis in order to have insurance coverage. Therefore, the patient is regularly being admitted to acute care facilities (alcoholic) under various diagnosis intended to assure his coverage. Therefore,he is in the wrong place, being served at a cost far greater than if he had been able to honestly and openly seek treatment. Seems unreasonable to select one particular illness and say that it is not covered.

Mr. Hillerby submitted a report on a alcoholic pilot program conducted in California for California employees from July, 1974, through May, 1976. (Exhibit G) There were 140,757 people treated during this 23 months. Total treatment cost was $677,577.23. Rate per enrolled member was $4.82 - average monthly rate was $0.21 per member.

Benefits paid were (not 100% benefits) in the neighborhood of $596,000.00 - average benefit paid per enrollee a month was $0.18.

Martha W. Coon, Member of Governor's Advisory Board, as well as a member of the Legislative Committee, stated that this board is in support of the mandatory coverage of alcohol and drug abuse in health insurance. Voted unanimous approval of S.B. 182 at their last meeting.

Mr. Robert Whiton of Raleigh Hills Hospitals submitted a report for the committee's consideration. He read directly from pages 11-20 for the record (see Exhibit H).

Mr. Larry Sullivan, Director of the New Frontier Treatment Center in Fallon, Nevada, testified before the committee. The service providers in the State of Nevada and the State agency involved have "legitimized" their services, he said. He had a list of 13 companies he has done business with in the last 18 months and only 3 have refused to pay the benefits, under the optional coverage bill.

Next was Mr. Milos Terzich, representing the Health Insurance Assn. of America. The bill really provides that each individual and group insurance policy issued or delivered in this state must provide benefit for the treatment of alcohol and drug abuse. Also, each policy must provide (bottom page 2) at least 20 days care in a health and care facility. A health and care facility includes a hospital. Further, they must pay for all the expenses required during the stay, not just within the normal policy limits. It has no cap on it. Additionally, the policies must provide in-patient care in a health and care facility or a treatment facility certified by the Bureau of Alcohol and Drug Abuse.

He referred the committee to Subsection 2, page 3, lines 1-5. There is an additional 30 days in a health and care facility with absolutely no limits. The maximum of $1,000 has been lifted. Further, it does not say that it is limited within normal policy coverages of perhaps 80-20.

He had obtained rates from various companies. The figures rate from 1.5 to 4% increase of annual premium. Another figure he offered was $0.25 per month per person. (See Exhibit H-1) He stated one of the impacts of the cost figures is that the bill should have a local and state government impact fiscal note.

He stated he had been informed it takes approximately 5 years for a program such as this to be in effect before they can come down with any proper actuarial experience in order to base a reasonable fee. Mr. Terzich stated none of the states offered as examples has had 5 years experience as yet. Many of these states have restricted coverages. Wisconsin, for example, has coverage only for groups - not individual. The limitation is 30 days confinement in any calendar year and not less than the first $500.

Cal Western participated in the pilot study in California. They handled alcoholics only and had a total of 35,000 people. The benefits provided 6 days of detoxification - 160 dollars per day, with one year maximum of $960.00. You were allowed 21 of additional in-patient care days with a maximum of $450.00. Out-patient care for 45 visits during any one year, $25.00 per visit. The utilization for the first was calculated to be between 10-20 persons; the second year between 15-30 persons. The calculated cost was $0.14 per member per month. The utilization increased during the second year. As the utilization increased the cost would also increase, even under these limited provisions.

A misunderstanding in the hearing has been that medical policies do not cover alcoholism. They do, he said, on a in-patient basis, unless it is specifically excluded in the policy. The policy for State employees does not exclude it, and alcoholism is covered....it is treated as any other illness.

Next to testify was Mr. Frank Parks of Mutual of Omaha, second vice president of the Policy Approval Department. He stated that benefits for hospital in-patient care are, in the majority of cases, already provided under both group and individual basic hospital policies. Some insurers do provide additional out of hospital benefits, but he did not consider that to be typical.

In January, 1977, his company was asked by a large group policy holder to extend the benefits of their comprehensive major medical plan to cover only alcoholism on the same basis as any other sickness. In effect that meant they extended the plan's benefits to facilities other than in-hospital benefits. The policy provided no maximum upper limits. It provided a variable deductable based on the class of insured. It ranges from $250 up to $2,000.....based primarily on the salary level of the person.

Mutual of Omaha asked a premium of $1.15 per month for the individual employee and $3.15 per month for the employee and all insured dependents. This group employer has over 5,000 employees.

The benefits in the states already mandating coverage extends coverage to both in-patient and out-patient treatment at facilities other than hospitals. The in-patient benefit is the reasonable and customary charge in the area of residence of the policy holder. The benefit is payable for 30 days in any 2 yr. period and is limited to 2 such confinements over the insured's life time.

The out-patient benefit is limited to the usual and customary charges up to $500 in any 12 consecutive month period. There is no recurrent limit on the out-patient benefit. This particular benefit is at a cost of $0.42 per month for the insured employee and $.67 per month if dependents are included.

Group insurance does have a facility of experience rating. Therefore, if this going in rate should prove to be wrong, either plus or minus, at a given point in time, when experience can be determined to be credible, there will be adjustments made.

Stated on an individual basis it will be considerably higher. They have related it to the mandated benefits of the proposed Nevada bill. They have figured that the average cost, based on their experience in other areas, is about $2,000. That consists of 30 days treatment at approximately $70.00 per day. Based on the $2,000 cost, they would project, on an individual basis, a premium of $21.00 annually for each insured adult and $5.00 annually for each minor dependent.

Since this bill does not contain limits this might be slightly understated. He proposed a benefit limit as stated in the above paragraph -two such benefits payable over the life time of the insured.

Mr. Daryl Capurro, Managing Director of Nevada Motor Transport Assn. & Nev. Franchised Auto Dealers Assn. stated the bill is open ended. Asked about page 2, lines 33-35, as to what the new language means. Offered a letter to the committee (Exhibit I).

He was advised that at the absolute minimum the provisions of this bill would add 5% to the cost. Mr. Dasher at Universe Life indicated to him that the figure would probably be significantly higher than that if they were to rate it today. The reason being there is not enough information available with which to rate this coverage.

Next was Mr. Richard Garrod, Farmers Insurance Group, who stated he concurred with the statements made by the preceding witnesses who represent the employer and insurance industry. Stated he did not think it fair that religious sects who do not drink or use drugs should be forced to provide health and accident coverage to the abusers.

Mr. Clarence Heckethorn, Executive Director of Nevada Blue Shield, stated they strongly opposed the bill because it is mandatory. Stated they offer a rider to their policy for drug and alcohol conditions. It approximates between 4 and 5% increase in the premium.

He estimated a dollar figure would be $4.00 per month per family. For an individual it would be $1.50.

Mr. Don Heath (Registration 77-300) representing the Nevada State Assn. of Life Underwriters stated he is the Northern Nevada Chairman. He stated basically they are not opposed to treatment, only the mandated nature they read in the bill.

Concerned about the cost and agrees with previous testimony on that.

Sees this discouraging employer groups from continuing group insurance as we know it today. Also, they are concerned that carriers (some 1800 in this country) with this kind of legislation may very well withdraw from a jurisdiction like Nevada. Concerned about it being a defacto kind of tax- wants to go on record opposing this bill.

S. B. 257 — CHANGES STRUCTURE OF NEVADA INDUSTRIAL COMMISSION (BDR 53-687)

Mr. Jack Kenney, Southern Nevada Home Builders Assn., informed the committee that people in his industry have been unhappy with parts of the Nevada Industrial Commission as it presently is structured. He proposes in the bill an executive officer that reports to a board. The board would be made up of 7 people. Members of the board should come from different walks of life. Proposes that when Legislature is not in session, that 3 senators and 3 assemblymen during the interim period would be the ones that would review what the N.I.C. committee does.

Stated the executive officer must have experience, in this bill. Open to discussion on that matter.

In regard to the commissioners they would like to amend the phrase "one person affiliated with the Nevada Resort Assn. or its legal successor". Should be changed to say "someone who is affiliated with the gaming industry",or whatever the proper phrasing might be.

Thinks the bill would improve the current system.

Next was Mr. Glen Taylor, representing Basic Management from Henderson, Nevada. Referred committee to page 2 - note there is no one represented from industrial plants, mining industry. Also, would

point out the Nevada League of Cities and stated neithe the counties nor school districts belong to that organization and he thinks it should be a governmental agency - certainly should not be limited to just the cities.

Under the fiscal impact - thinks it would be something different than the $2,000 as shown.

Mr. Michael Grover, Titanium Metal, had a question regarding the bill. Stated that if the 7 member committee is going to replace the 3 member commission it had been his experience that the 3 member commmission meets at least weekly if not twice a week. He asked how you are going to get responsible citizens to meet on that kind of a schedule for $40.00 per day plus expenses.

Mr. Lou Paley, A.F.L.&C.Y.O., stated N.I.C. is a complex law and to ask senators and assemblymen to come in and try to operate it would not suffice as you would have individuals entering and leaving office and never the same people. - Further, he stated that no one in agriculture is covered by N.I.C. and they are listed as having a representative. Asked who would handle the claims.

Mr. Kenney stated the ultimate review board would be the legislators who would review the decisions of the commission in response to a question by SENATOR CLOSE. Stated he sees the executive board meeting once a month handling the business the executive officer brings to them. Does not prevent the executive officer from adding to the N.I.C. staff.

Mr. Kenney stated there would be no objection to taking out agriculture and putting in mining or something similar.

S. B. 246 — PROVIDES FOR TRANSITION OF WORKMAN'S COMPENSATION INSURANCE FROM NEVADA INDUSTRIAL COMMISSION TO PRIVATE INSURANCE CARRIERS AND SELF-INSURED EMPLOYERS (BDR 53-500)

The first witness was Mr. Richard Garrod, Farmers Insurance Group. He stated they support the theory of competitive workman's compensation coverage.

Next was Mr. Bob Alkire, Kennecott Copper Corp. People in his corporation have no quarrel with this concept but suspect that it is premature by perhaps

a couple of years...primarily because this is such a new field and there isn't really experience available yet to determine what is going to happen. Stated there is a state comparable to Nevada in size and employment structure (Arizona) and one company he knows took advantage of the private carrier in the State of Arizona and has at this point had some favorable experience.

SENATOR HERNSTADT testified that S.B. 246 is an act which will phase out N.I.C. and put workman's compensation into the province of private enterprise. Asked that the bill be patterned after the basic procedures followed in New York and Connecticut for workman's compensation and had to provide a transitional means of effecting it.

Informed Committee that N.I.C. makes no experience adjustment unless you are paying more than $3,000 in premiums, and very few employers qualify. Further, the N.I.C. law eliminates the tort system. ..no lawyer will take a case in this State to sue an employer for negligence in connection with a work related accident because they can't.

Stated N.I.C. is working inefficiently and costing employers increased premiums, and they may also be creating a group of legal junkies because they are not treating people to get them well, but keep them doped.

Read a letter to committee from a former investigator of N.I.C. who wants to testify regarding N.I.C. and indicated he would submit a follow up letter with information.

Mr. Rolf Boether, Neurodyne and Dempsey Incorporated, stated his corporation is in favor of this bill because of the fact that the tax savings they experienced by moving from California to Nevada have been eaten up by higher premiums for workman's compensation. Stated they do not have the choice of a private insurer and the worst thing is that it is run by a government agency.

Mr. Richard Garrod testified his company has a more refined rating system.

Mr. John Reiser of the Nevada Industrial Commission brought some charts to show the committee the differences in administrative expenses between the exclusive State fund and the 3-way system. Also he presented a booklet on N.I.C. (Exhibit J) for the committee's study.

Called committee's attention to pages 9 and 10. Also submitted ExhibitsK and L for study.

Mr. Reiser indicated the National Council prepares an exhibit for each of the 3-way states. In Arizona for example, the acquisition and field supervision expense is 17.5%, general expense is 8.4%, special fund tax of 1.65%, premium tax 3.0%, miscellaneous tax .7%. Trying to get some averages for the committee, he stated.

Mr. R. Haley indicated from the floor that there is no competition in rates. He said the rates are set by the National Council nationwide. The competition is in salesmen not a competition of rates. Asked about service, Mr. Haley indicated there is a question on that.

Mr. Reiser advised the committee of rate increases in other states, as well as indicating by chart the rates increase in Nevada over the years, stating the average annual increase has been about 13%. Stated they are operating at a break even level now.

S. B. 250 REGULATES PRACTICE OF NATUROPATHY (BDR 54-600)

The first to address the committee was Mr. Leo Henrikson, Teamsters Union. Stated they were concerned about the lack of medical facilities in the rural areas and had been contacted by this group of naturopathic doctors. Hope to put this on a national basis. Asking for control on this practice and stated, further, they want to clean out less than ethical practitioners.

Dr. John Statham presented the committee with a letter from Merlin D. Anderson of the Nevada Commission on Postsecondary Education (Exhibit N), along with a court order from Judge Mendoza. Stated he is Secretary-Treasurer of the Florida State Board of Naturopathic Medical Examiners. Discussed diploma mills. Explained privileges allowed with pharmacy and drugs. Explained many are on the staffs of hospitals.

Explained naturopathic is not mode of practice but a philosophy of practice. Explained method of practice.

SENATOR CLOSE asked what other states have developed this type of legislation. Dr. Statham indicated Florida, Connecticut, Hawaii, Washington, Oregon, Utah, Arizona, Ohio, Pennsylvania, and Washington, D.C.

Practice does not include major surgery or use of radium and x-ray. Explained educational requirements. (See Exhibits N-1)

SENATOR BLAKEMORE asked number of naturopathic physicians in Oregon. Dr. Statham indicated between 200 and 225. In Washington State, he indicated the numbers of physicians is about the same. Indicated there were as many as 550 in Florida at one time.

Informed committee that their association as it now stands is requiring licensure in another state as a predication for membership in the society; his credentials are approved by the board of directors and the association is limited to 50 members. Dr. Statham stated there would not be any grandfathering of any one. Anyone who comes to Nevada must either be licensed by examination in another state or they will have to take a license examination here.

The next witness was Dr. Jeffrey Greene, Professor of Basic Sciences at Pasadena College. (Address: 715 East Garfield Avenue, Glendale, California) He has Bachelor of Science major in biology, chemistry - graduate work in physiology and pharmacology. Doctor of Naturopathic Medicine - licensed in Arizona and Oregon. Holds Nevada basic science certificate - on faculty of University of Pasadena teaching various subjects related to the clinical basic sciences.

Stated there is a need in our society for a family practitioner. SENATOR CLOSE asked how many years were required to complete their studies. After high school, Dr. Greene, advised a student would have to complete 2 years of pre-medicine (60 units), and then 4 years in a professional school. Further, in certain states, an internship is required.

The next witness was Dr. John Minasian, Professor of Anatomy at University of Southern California Dentistry School. (Address: Box 1457,Studio City, Ca.)

Dr. Minasian told the committee he practiced last summer and part of the winter months in the State of Oregon. Graduated from the Hollywood school. Indicated the school is now closed (1960). Only have 2 schools now.

Kenneth Blanker (licensed in State of Oregon #338) gave his address as 174 Emerson Way, Sparks, Nevada. Indicated quite often he spends 2 or 3 months in the L.A. area or Oregon. Indicated he had an office in Oregon and just recently closed it.

Stated the total membership in the association in Nevada at this time is 19. Told the committee the association was set up to keep any diploma men out and perhaps get grandfathered in. Further, the State would have to set up its first board and would have to have some area to draw from and since there are no men here, they would almost have to draw from the association to get qualified members.

As to educational background Mr. Blanker indicated he has a Bachelor of Science degree with a major in biology from St. Stephens College in L.A. Post graduate work at the University of California School of Medicine, U.C.L.A. School of Medicine, National Polytechnic Institute School of Medicine in Mexico City. All members he indicated take at least 200 hrs. of post graduate work every year.

SENATOR YOUNG asked if any of the 19 members in the Nevada Society engaged in any aspect of health services at this time. The answer was negative.

Dr. John W. Callister, President of the State Medical Association, spoke in opposition to S.B. 250. (See Exhibit M)

Next to speak was Dr. John Sande, Legislative Chairman for the Nevada State Medical Association. He spoke in opposition to S. B. 250. Indicated Section 2 paragraph 5 - Naturopathy means the use of drugs and other medical preparation; Psychological, mechanical and material health sciences; and any other method, except major surgery. Indicated that covered a lot in regard to the practice of medicine, not naturopathy.

Regarding naturopathic curriculum (section 2, par. 4) it goes into considerable detail. Stated if you would just eliminate that, many people would assume that you were practicing medicine as we know it today.

Regarding definitions, Dr. Sande indicated he had looked up the word naturopathy in the American Heritage Dictionary (1969) and found the following: "A system of therapy that relies exclusively on natural remedies such as sunlight, supplemented with a diet, and also the use of natural remedies to treat the sick". Stated the curriculum in the bill is entirely different.

In Section 9, page 3, line 26, he pointed out: "the licensee shall submit this proof to the board before his first application for the federal narcotics registration certificate".

They stated they will move into the State and move into the rural communities. Dr. Sande indicated that that is easy to say, but it doesn't work out that way in most instances, whether it is a chiropractor or M.D. or naturopath. He stated even foreign medical people here who move out into these rural areas stay there a short time and then move out. Stated the new 4 year medical school planned will eliminate part of this problem. Stated this a group is attempting to essentially be physicians.

The next to testify was Mr. George Bennett, Secretary of the State Board of Pharmacy. Indicated he had talked to the naturopaths to find out more about their practices.

On page 1, line 22 where it indicates drugs and other medical preparations - this means that they are requesting licensure and authority to administer, dispense and prescribe controlled substances and dangerous drugs.

Mr. Bennett found out that Drs. Statham and Blanker had gone to one of the local pharmacys and had written 2 prescriptions. They are both written for Dr. Ken Blanker (one for Combid which is a dangerous drug - and the second is for Lomotil which is a controlled substance). Mr. Bennett stated he called and talked to the pharmacist involved and asked if he filled a prescription for a naturopath. The pharmacist stated he had not. He stated Dr. Statham had identification (the best possible). Mr. Bennett indicated he had seen it also. It is a Federal Drug Enforcement Administration Control Substance Registration Certificate, and it does not have Naturopathic M.D. - it merely has M.D. Mr. Bennett indicated

that Dr. Statham had told him that in Florida they were licensed to prescribe, administer and dispense all controlled substances and dangerous drugs without restriction and apparently the computer in the D.E. Office had left off the "N", if that is the designation they use in that state. The pharmacist here told Mr. Bennett that Dr. Statham represented himself as an M.D. and he has written the prescriptions with the signature "John F. Statham, M.D.". At this point Mr. Bennett offered the prescriptions in evidence --see Exhibit O.

Dr. Statham stated the M.D. was put below the prescription - that he did not write it after his name. SENATOR WILSON asked if he had seen it written - that is, seen it on the prescription form. Dr. Statham indicated he had.

Dr. Blanker stated he was with Dr. Statham when he wrote the prescription for himself, due to his condition. He stated Dr. Statham did not introduce himself as an M.D. - he introduced himself as Dr. Statham and showed the D.E.A. ticket.

Dr. Statham stated the pharmacist suggested he put Dr. Blanker's name on the prescriptions.

Mr. Bennett, in reply to SENATOR BRYAN's question, indicated that in all states that have a state control substance act, such as Nevada, the practitioner (M.D. dentist, podiatrist, veterinarian) must first obtain a State Control Substance Registration which they do from the Board of Pharmacy in this state. In some states, but not sure about Florida, there is no state requirement. There are about 10 states that do not have the Controlled Substance Act, so they only have the Federal Controlled Substance Registrations.

SENATOR BRYAN asked if with this certificate would a pharmacist be authorized to fill a prescription. Mr. Bennett indicated it would depend upon the state, and indeed, apparently that is true in Florida, however, in Nevada that isn't true. Referred Committee to NRS 453.371 which defines physician. 453.381 is the authority to prescribe, administer and dispense controlled substances. Here they would have to be licensed by one of the recognized boards before they could write a prescription.

Mr. Bennett indicated that the State law is more restrictive than Federal law.

Mr. Milos Terzich, Health Insurance Association of America, stated the bill came to his attention and to avoid discriminating between the medical practitioners, he asked to be allowed to submit an amendment which would include naturopaths within the same scope as oriental medicine, chiropractors, osteopaths, etc.

SENATOR BRYAN asked if this was the same type amendment as to S.B. 139. Mr. Terzich indicated that was correct. (See Exhibit H-2)

ADMINISTRATIVE MEETING

BDR 10-1102 INCLUDES TIME SHARING CONDOMINUMS OR RESORTS IN REGULATION OF LAND SALES

Introduction approved by committee.

BDR 54-1038 CHANGES PROVISIONS RELATING TO REVOCATION & SUSPENSION OF BARBERS' CERTIFICATES OF REGISTRATION AND BARBERSHOP LICENSES

Introduction approved by committee.

BDR 54-1104 REVISES PROVISIONS RELATING TO REAL ESTATE BROKERS AND SALESMEN

Introduction approved by committee.

SENATOR CLOSE asked for Committee approval of a bill draft for the work he and SENATOR HERNSTADT had done on mortgage companies and escrow problems. There were no committee objections.

SENATOR CLOSE moved for approval of minutes for February 21, February 24, and March 2, 1977. SENATOR BRYAN seconded.

Minutes approved.

Meeting adjourned 7:00 P.M.

Respectfully submitted,

Lyndl Payne

Lyndl Lee Payne, Secretary

APPROVED BY

Senator Thomas Wilson, Chairman

Commerce & Labor

SENATE

~~ENVIRONMENT, PUBLIC RESOURCES and AGRICULTURE~~

ROOM 323 DATE 3-9-77

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TESTIFYING?	NAME	ORGANIZATION	ADDRESS	PHONE
Yes	George C. Evans	Mass Mutual	601 W 1st St.	323240
Yes	Martha N Coon	Govs Advis Bd Alcohol & Dr.	1550 Idlewild Reno	329-79
Yes	MICHAEL J GROVER	TITANIUM METALS	RENO, NEV	56[illegible]5734
Yes	GLEN TAYLOR	Basic Mngmnt	Henl. Nev	56[illegible]648
Yes	Dennis Compton MD	Sunrise Hospital	L.V. Nev.	8931800
NO	Dave Brandsness	Sunrise Hosp EG&G, Inc	L.V.N. LAS VEGAS, NV	7318011 0461 702/739-
Yes	CARLTON E. NAUGLE			
NO	RICHARD G. PUGH	NEV. STATE MED. ASSN.	3660 BAKER LN. RENO	825/6788
Yes	JOHN W. CALLISTER, MD	"	"	"
Yes	JOHN P. SANDE, MD	"	"	"
Yes	FRED HILLERBY	NEV. HOS. ASSOC.	Reno	329-6801
NO	BILL WOLLTZ	NASAC	RENO	7866563
NO	Tom D. Mayer	NASAC	Reno	786-6563
NO	Jody Martin	BADA	RENO	786-388[illegible]
NO	Jon M Wallace	N.A.S.A.C	Reno	786-656[illegible]
NO	John Kirk	Gaken Co	Reno	826600
NO	Georgia Massey	Insurance Dept.	Carson City	885-427[illegible]
No	Georgia Sue Carlisle	—	Carson City	882-15[illegible]
No	George T. Carlisle	—	Carson City	882-152[illegible]
No	Chris Langhem	Rehabilitation	Carson City	4440
Yes	Milos Terzich	HIAA	Virginia Town	882-6780
Yes	Leslie A. Warner	Pension. MIC.	210 Bonnie St. CC	882-[illegible]
Yes	Dave Byington	Nev State Life Underwriters	Reno.	323-1041
Yes	Clarence Hockethorn	Nev. Blue Shield	4600 Kietzke Reno	825 0350
	Dave Daley	Nev State [illegible]	Reno	329-150[illegible]

Commerce & Labor SENATE

~~ENVIRONMENT, PUBLIC RESOURCES and AGRICULTURE~~

ROOM 323 DATE 3-9-77

PLEASE PRINT PLEASE PRINT PLEASE PRINT PLEASE PRINT PLEASE PRINT PLEASE

TESTIFYING?	NAME	ORGANIZATION	ADDRESS	PHONE
	Wm Gross	[illegible] - NIC	515 E. Musser . cc	882-131[illegible]
YES ✓	FRANK PARKS	Mutual of Omaha	Omaha NE	402 342-760[illegible]
NO	G. Holbrook Hawes	NEV-STATE AFL-CIO	Carson C.ty	325-15[illegible]
yes ✓	Senator Gojack	Senate		
yes ✓	Senator Raggio	"		
" ✓	Robert [illegible]			
" ✓	Daryl Capurro			
" ✓	Richard Garrod			
" ✓	Don Heath			
" ✓	Jack Kinney			
" ✓	Bob Alkire	Kennecott		
" ✓	Senator Bill Hernstadt			
" ✓	Rolf [illegible]			
" ✓	John Reiser			
" ✓	R S Haley	NIC		
✓	Leo [illegible]	Teamsters		
✓	John F Statham	[illegible]	811 8th Ave [illegible] FLA	
✓	Jeffrey Greene			
	George Bennett			

SENATE

AGENDA FOR COMMITTEE ON COMMERCE & LABOR

Wednesday

Date Mar. 9, 1977 Time 1:30 P.M. Room 213

Bills or Resolutions to be considered	Revised Subject	Counsel requested*
S. B. 182	Requires health insurance to cover treatment for alcoholism and drug addiction (BDR 57-495)	
S. B. 257	Changes structure of Nevada industrial commission (BDR 53-687)	
S. B. 246	Provides for transition of workman's compensation insurance from Nevada industrial commission to private insurance carriers and self-insured employers (BDR 53-500)	
S. B. 250	Regulates practice of naturopathy (BDR 54-600)	

*Please do not ask for counsel unless necessary.

7421

STATE OF NEVADA
DEPARTMENT OF HUMAN RESOURCES
ROGER S. TROUNDAY, DIRECTOR
MIKE O'CALLAGHAN, GOVERNOR
DEL FROST, ADMINISTRATOR

REHABILITATION DIVISION
BUREAU OF ALCOHOL AND DRUG ABUSE
5TH FLOOR, KINKEAD BUILDING
505 EAST KING STREET
STATE CAPITOL COMPLEX
CARSON CITY, NEVADA 89710

March 1, 1977

To: Nevada Senator Spike Wilson, Chairman, Commerce and Labor Committee
From: Paul Cohen, Chief, Bureau of Alcohol and Drug Abuse

S.B. 182 HEARING NOTIFICATION

In accordance with your committee's ruling, the following individuals have been notified of S.B. 182 hearing to be conducted March 9, 1977 at 1:30 p.m.

**Senator Bill Raggio*
**Senator Mary Gojack*
**Assemblyman Bob Price*
**George Evans, Massachusetts Mutual Insurance*
**Ron Player, Nevada Blue Shield Insurance*
**Larry Sullivan, New Frontier Treatment Center*
**Robert Whiton, Raleigh Hills Hospital*
**Martha Coon, Governor's Advisory Board on Alcohol and Drug Abuse*
**Paul Cohen, Bureau of Alcohol and Drug Abuse*
**Dr. Dennis Campton, Physician, Sunrise Hospital*
**Carl Noggle, Director, Manager Employee Relations, EG-G*
**Fred Hillerby, Executive Director, Nevada Hospital Association*
**Dave Brandsness, Administrator, Sunrise Hospital*
**Dr. Richard L. Allen, Physician, Las Vegas*
John Reiser, Nevada Industrial Commission
Dick Rottman, Insurance-Commerce
James Wittenberg, State Personnel

Those marked with asterisks have notified this office that they will testify at the hearing on March 9th.

PC:br
cc: Del Frost
Roger S. Trounday

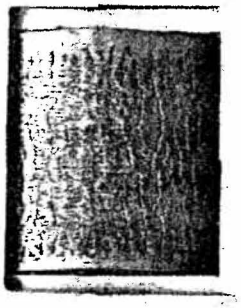
people contacted by Reuer

Reuer

MEMBERS OF THE LABOR/MANAGEMENT ADVISORY BOARD TO THE NIC.

LABOR MEMBERS 1976-1977

Mr. Harold Knudson, Secretary — 322-7447
Central Trades Council
1150 Terminal Way
Reno, Nevada 89502



Mr. Louis Paley, Secy-Treasurer — 329-1508
Nevada State AFL-CIO
P. O. Box 2999
Reno, Nevada 89505

Mr. Mike Chadburn, Secretary — 452-8899
Building Trades Council
4200 E. Bonanza Road
Las Vegas, Nevada 89102

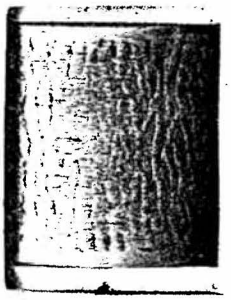
Mr. Mike Pisanello, Rep. — 385-2131
Culinary Workers, Local 226
P. O. Box 1439
Las Vegas, Nevada 89114

Mr. Tom Jones, Rep. — 235-7994
United Steelworkers of America
Local 233
P. O. Box 658
McGill, Nevada 89318

MANAGEMENT MEMBERS 1976-1977

Mr. Wallie Warren — 322-6996
1st. National Bank Bldg.
One East 1st. St., Suite 607
Reno, Nevada 89501

Mr. William Campbell — 735-2611
Resort Owners Association
932 East Sahara Ave.
Las Vegas, Nevada 89105



Mr. E.D. "Deke" Blackburn, Director — 564-2544
Safety Department
Titanium Metals Corporation
P. O. Box 2128
Henderson, Nevada 89015

Mr. Rowland Oakes — 329-6116
Associated General Contractors
P. O. Box 7315
Reno, Nevada 89502

Mr. Max Blackham, — 235-7741
Personnel Administrator
Kennecott Copper Corp., Inc.
Ruth, Nevada 89319

Exhibit A
Senator Gojack

Senator Gojack,

I'm here to support the intent of this legislative packet.

It is estimated by the Bureau of Alcohol and Drug Abuse that 5.7 million dollars are needed annually to effectively provide treatment and rehabilitation services for alcoholics and drug abusers in Nevada.

Alcoholism has been recognized as a disease by the World Health Organization in 1951 and by the American Medical Association in 1956 and by the Department of Health, Education and Welfare in 1966.

It only follows and appropriately so that mandatory health insurance coverage be provided for this disease just as others.

The alcoholic employee, for instance, files five times more compensation claims; these claims are disguised as everything from slips and fall injuries to cut fingers. The cost incurred by the insured might be better met by treating the disease rather than the results of the disease.

As an example, non-medical residential care is estimated by the BADA to cost approximately $15.00 per day versus hospital care at $150.00 to $200.00 per day plus physicians' fees.

In order to encourage service providers to offer this service area and alleviate some of the financial responsibility of state support, it is necessary to develop third-party resources of revenue.

Mandatory health insurance has been shown to be one of the most viable alternatives to deal effectively in promoting treatment and rehabilitative services for alcohol and drug addiction without undue taxation and legislative appropriation.

I have been informed by the Bureau that the overall cost of these policies will be more than compensative by significant reduction in medical costs, accident rates, both on and off the job, and life insurance payments, as well as demands upon health, society, the law, and the agency.

Direct benefits are that people with drinking problems often find they are denied services or are treated with less respect by providers than those with other kinds of problems.

This legislative mandata would, at long last, provide a healthful social climate for treating the 3rd most serious disease in America.

PB:jld
03/08/77

Exhibit B

STATE OF NEVADA
DEPARTMENT OF HUMAN RESOURCES
ROGER S. TROUNDAY, DIRECTOR
MIKE O'CALLAGHAN, GOVERNOR
[illegible] FROST, ADMINISTRATOR

REHABILITATION DIVISION
BUREAU OF ALCOHOL AND DRUG ABUSE
5TH FLOOR, KINKEAD BUILDING
505 EAST KING STREET
STATE CAPITOL COMPLEX
CARSON CITY, NEVADA 89710

TESTIMONY

Name: Paul Cohen, Chief, Bureau of Alcohol and Drug Abuse
Bill Title No.: S.B. 182, Mandatory Health Insurance
Date/Time of Hearing: March 9, 1977 - 1:30 p.m.
Committee: Commerce and Labor

The Bureau of Alcohol and Drug Abuse is responsible for the planning, implementation and evaluation of treatment and rehabilitation services to alcoholics and drug abusers.

The recent Rand Study estimates that there are 30,248 alcoholics and 25,356 drug abusers in Nevada.

It has been estimated that 5.7 to 6 million dollars are needed annually to effectively provide treatment and rehabilitation services for identified alcoholics and drug abusers in Nevada. For FY-1978, the Bureau will support, through state and federal dollars, 1.5 million dollars in services. There are approximately an additional 1.5 million dollars generated from other federal and private sources.

In order to encourage service providers to offer services and alleviate some of the financial responsibility of state support, it is necessary to develop alternative sources of revenue.

Mandatory health insurance has been shown to be one of the most viable alternatives to effectively deal in promoting treatment and rehabilitative services without undue taxation and explosive legislative appropriations. There are 12 states with mandatory health insurance and 16 additional states in the process of either requesting and/or enacting this type of insurance coverage.

For the past two years, the Bureau has accredited 24 service providers who

deal specifically with alcohol and drug abuse clientele. There are 8 residential facilities and three hospitals that the Bureau works with. Cost per week/per client at these facilities range from $84.00 to $1,000. There are 16 outpatient service agencies. Cost per month/per client for these services range from $100 to $150.

The Bureau, based upon FY-1976-77 client figures, estimates that 20% or 1,031 individuals would have been provided services under health insurance coverage.

This bill would generate approximately 1.4 to 1.8 million dollars in services to the alcoholic and drug abuser.

If needed, the additional premiums on policies will more than be compensated for by the significant reduction in medical costs, accident rates both on and off the job and life insurance payments.

ADDITIONAL INFORMATION

ACCREDITED PROGRAMS

RESIDENTIAL (8)

New Frontier Treatment Center
His Place Ministries
A.R.A. Residential
E.O.B. Reality House
Ridge House
Fitzsimmons House
Starting Point
Nike House

HOSPITALS (3)

North Las Vegas Hospital Careunit
Raleigh Hills Hospital
Sunrise Detoxification Hospital Unit

* * * *

OUT-PATIENT (16)

Carson Regional Council
Churchill County Council
Elko Area Council
Ely Substance Abuse Council
Lyon County Council
Mineral County Council
A.R.A. Counseling Services
Omega House
Addiction Treatment Clinic
Alcohol Program of Southern Nevada
Operation Bridge
Marion Bennett Youth Program
SNDAC Methadone
United Professional Services
Latino Youth and Family Counseling
Community Advocate Program

* * * *

States that have enacted legislation dealing with health insurance coverage for alcoholism treatment are:

Connecticut
Illinois
Louisiana
Massachusetts
*Michigan
*Minnesota
Mississippi
*North Dakota
South Dakota
*Tennessee
Washington
*Wisconsin

Those states marked with an asterisk have enacted legislation dealing with health insurance coverage for both alcoholism and drug abuse treatment.

****

CLIENTS IN TREATMENT FY 1976-77

	LAS VEGAS	WASHOE	RURAL	TOTAL
ALCOHOL	1025	412	516	1957
DRUGS	2782	332	090	3204
TOTALS	3807	744	606	5157

Exhibit C
Cohen

Facts

1. The disease of alcoholism is costing Nevada's business and industry at least $25 million annually. (2)

2. The alcoholic employee is absent from the job 16 times more often, with 2.5 more absences of eight days or more. (13)

3. The alcoholic employee has an accident rate of 3.5 times higher. (13)

4. The alcoholic employee files five times more compensation claims. (13)

5. The alcoholic employee is involved repeatedly in grievance procedures. (13)

6. The alcoholic employee functions at 60% of the work potential. (13)

7. 105 million Americans drink alcohol. Over 9 million are alcoholics or problem drinkers. The risk factor is thus 1 in 10. (3)

8. The annual industrial cost of alcohol is $15 billion in the United States. When you add health, criminal justice, treatment, welfare, accident and other costs, the economic impact is $25 billion. (3)

9. An alcoholic or a drug addict is a person who has lost freedom of choice.

10. The person with an alcohol problem is five times as likely to miss work from gastro-intestinal problems, four times with respiratory problems, three times with musculoskeletal problems as is the person without an alcohol problem. (11)

11. 50% of the 40,000+ automobile accident deaths in the United States annually involve a drinking driver. (4) (7)

12. 60% of pedestrians killed have significant blood/alcohol levels. (7)

13. 50% of urban adults admitted to a hospital with a fractured bone, fractured it during or after drinking. (13) (7)

14. Cigarette-induced bed fires commonly involve a drunken person. (7)

15. Violent behavior is a feature of alcohol intoxication more than any other drug, and commonly results in homicide. (7) (11)

16. 50% of murder victims have significant blood/alcohol levels, suggesting that a drinker incites others to violence against himself. (11)

17. Organ damages and diseases are caused directly by alcohol and drug abuse or inadvertently by nutrition and vitamin deficiencies or both - i.e., fatty liver, cirrhosis of the liver, gastritis, pancreatitus, ruptured esophagus, nerve and brain damage, heart muscle and skeletal muscle damage, infections of many kinds, and anemia. (7) (11)

18. If you must drink, or use drugs know the risk factors and try not to kill yourself, your family, your friends or some other innocent people.

19. For treatment, it's best to recognize alcohol problems early and get strong counseling - job-related, if possible. Cure rate - 0%, improvement and "dry" rate - 40 to 86%. (11)

20. Reasons for Drug and Alcohol Abuse are: availability, anxiety, loneliness, boredom, need for euphoria, drug-based society, peer pressure, experimentation, profit motive, permissiveness, protest and rebellion, inferiority complex, great to be high, escape from reality, and other. (11) (4)

21. There is no reason to believe that there will not always be drug abuse in this chemical age of ours, but informed use can be taught and promoted. (10)

22. In 1974, according to the National Center for Health Statistics, 33,319 Americans died from Cirrhosis of the liver. This is higher than murders (21,415) or suicides (25,683). Although some non-drinkers have cirrhosis, a dropout study found that the rate between heavy drinkers and non-drinkers is 29 to 1. (8)

23. Industrial, Economic, health, accident, criminal justice, welfare, emergency room, unemployment, treatment and other factors cost Nevadans $68 million a year for alcohol abuse. Drug abuse escalates this figure even more. (2)

24. The American Businessmen's Alcohol Report states that Nevada is 47th in the amount of money compared with revenue from alcohol that the state sets aside to take care of the problems of alcohol. (2)

25. Nevada UCR statistics show that over 22,000 persons were either arrested or put into Civil Protective Custody last year for drug and alcohol related offenses. (5)

26. In 1975, UCR statistics show that 74% of drug related arrests were for possession and or sales of Marijuana. (5)

27. Possession, use, and sale of Marijuana are felony offenses in Nevada. (15)

28. UCR statistics show that 9 out of 10 persons arrested for drug law violations in 1975 were under 30 years of age. 25% of those arrested were juveniles. (5)

29. There are more than 3,000 heroin addicts in the State of Nevada. (1)

30. Nevada is the third leading state in the number of addicts per capita. (5)

31. According to State Narcotics officers, Nevada is the third chief transmittal point for drugs from Mexico. (5)

32. In a 1976 Social Advocates for Youth Study, it was found that alcoholism begins as early as 4th grade and of the 4th-6th graders survey, 45% considered themselves to be current users of alcohol. (9)

33. In Clark County last year, 520 students were apprehended for drug and alcohol abuse. (6)

34. Students who participate in drug education programs tend to use drugs in responsible ways and have more positive self-images than students who do not. (10)

35. Heroin use is highest in the 18-29 age bracket. (3) (11)

36. Alcohol Abuse is the highest in the 36-41 age group. (4) (11)

37. With few exceptions, more males use drugs irresponsibly than females. However, females report higher usage of depressants, sleeping aids, and tranquilizers. (3)(8)(7)

38. It can be dangerous to mix drugs. Always let your doctor know all the drugs you're taking when getting a new prescription. (3)(8)(11)

39. Never mix alcohol with any antihistamines, sleeping aids, tranquilizers, over-the counter drugs, or prescriptions without consulting a knowledgeable source. You may be running into danger. (3)(8)(11)

40. If you decide to use any drug or alcohol, learn the facts for responsible use.

41. A responsible host serves food with alcohol, does not let the abuser drive his car home, and limits the amount available. The purpose of his party is social - not drinking to get drunk. (14)

42. We are living in a chemical age. By the time a modern youngster is 18 years old, he will have heard 180,000 prime time commercials telling him to swallow, drink, or inhale something to ease his stress, headache, sleeplessness, stomach ache, or whatever. This impact of chemical advertising means responsible decision making or he may have to pay a price. (10)

RESOURCES

1. State Plan for Nevada
2. American Businessmen's Alcohol Reports
3. White House White Paper on Drug Abuse, 1976
4. 1st and 2nd Report to Congress from NIAAA
5. Nevada Crime Commission
6. Clark County Metropolitan Police
7. NCA bulletins
8. National Center for Health Statistics, 1974
9. Social Advocates for Youth Study, 1976
10. Prevention in Perspectives, Schapp, Cohen and Resnick
11. USC DUI Study
12. Occupational Statistics from Various sources (National)
13. "National Safety Congress"
14. Jaycee Literature
15. NRS

exhibit N
Cohen

STATES HAVING INSURANCE COVERAGE FOR ALCOHOLISM*	STATES HAVING INSURANCE COVERAGE FOR ALCOHOLISM AND DRUG ABUSE
Connecticut	Michigan
Illinois	Minnesota
Louisiana	North Dakota
Massachusetts	Tennessee
Michigan	Wisconsin
Minnesota	
Mississippi	
North Dakota	
South Dakota	
Tennessee	
Washington	
Wisconsin	

*Sixteen additional states are in the process of requesting or enacting this type of insurance coverage.

CLIENTS TREATED DURING FY-76: BADA

	LAS VEGAS	WASHOE	RURAL	TOTAL
ALCOHOL	582	412	516	1,510
DRUGS	2,782	332	090	3,204
TOTALS	3,364	744	606	4,714

Doesnot include EDUCATION, PREVENTION, TRAINING PROGRAMS

DISTRIBUTION OF MONIES DURING FY-77

	LAS VEGAS	WASHOE	RURAL	TOTAL
ALCOHOL	$149,847	$144,187	$70,868	$364,903
DRUGS	$553,198	$106,546	$56,755	$716,504
OTHER:	This includes training, education and intervention			$173,835
TOTALS:	$703,045	$250,733	$127,623	$1,255,242

2-1-77

DRUG ABUSE RATES IN NEVADA, BY REGION*

Region	Total Arrests, 1972	Estimated "Heavy" Usage Based on on 1974 State Survey	
		Number	Rate
Las Vegas SMSA (Clark County)			
Marijuana	729	6,948	3.6%
Dangerous drugs	729	4,246	2.2%
Opiates	238	965	.5%
Total, Las Vegas area	1,696	12,159	
Reno SMSA (Washoe County)			
Marijuana	175	8,962	10.4%
Dangerous drugs	175	2,327	2.7%
Opiates	58	1,551	1.8%
Total, Reno area	408	12,840	
All other counties combined			
Marijuana	150	720	1.1%
Dangerous Drugs	150	1,244	1.9%
Opiates	49	393	.6%
Total, other counties	349	2,357	
Nevada			
Marijuana	1,054	14,630	4.2%
Dangerous drugs	1,054	7,817	2.3%
Opiates	345	2,909	.8%
Total, Nevada	2,453	25,356	

ESTIMATED RATES OF ALCOHOLISM IN NEVADA, 1970*

Region	Estimate Based on Cirrhosis Deaths		Estimate Based on Consumption	
	Number of Alcoholics	Rate	Number of Alcoholics	Rate
Las Vegas SMSA	17,623	9.1%	19,862	10.3%
Reno SMSA	4,722	5.5%	5,325	6.2%
Rural counties	4,486	6.9%	5,056	7.7%
Total, Nevada	26,831	7.8%	30,243	8.8%
Total, nation	3,587,458	2.7%	3,559,050	2.8%

*Kakalik, J. S., et.al., MENTAL HEALTH AND MENTAL RETARDATION SERVICES IN NEVADA. The Rand Corporation, Santa Monica, California, April, 1976.

COST/ANALYSIS--RESIDENTIAL FACILITIES

Private Facilities

Comprehensive Care Corporation Las Vegas	$1,050/week
Raleigh Hills Las Vegas	$1,500/week

BADA Credentialled Facilities

Alcoholics Rehabilitation Association Reno	$ 100/week
His Place Reno	$ 128/week
New Frontier Fallon	$ 350/week
Fitzsimmons House Las Vegas	$ 84/week
Nike House Las Vegas	$ 103/week

Exhibit E

DENNIS G. CAMPTON, M.D., LTD.
•DIRECTOR DEPARTMENT OF EMERGENCY SERVICES
•MEDICAL ADVISOR DRUG RECOVERY UNIT
Sunrise Hospital Medical Center
3186 Maryland Parkway
Las Vegas, Nevada 89109
Phone (702) 732-9011 Ext. 1310, 1313

DENNIS G. CAMPTON, M.D.
Diplomate
American Board of Family Practice
B-REAL MOUNTAIN SPRINGS RANCH
STAR ROUTE 89031, P.O. BOX 3130
LAS VEGAS, NEVADA 89101

This presentation will approach the problem, "Is Alcoholism a Disease?" by first offering a definition of disease; secondly a discussion of some of the determinants of lay and professional attitudes toward the USE of the term "disease", and finally the functional purpose of describing a person as "diseased" will be explained.

A review of some of the dictionary definitions of DISEASE could help us discern if indeed our concept of alcoholism as a disease fits.

Stedman's Medical dictionary will serve as an example. A disease is defined as:

An illness, sickness; an acquired morbid change or abnormal function with characteristic SYMPTOMS.

To review multiple definitions of the term disease only belabors the issue from this aspect. Suffice to say that the ultimate decision regarding the classification of alcoholism as a disease must rest upon whether the signs and symptoms associated with alcoholism are sufficiently adequate to described a specific entity.

Determination as to whether any disease possesses these characteristics necessitates evaluation of such diverse factors as its associated history, symptoms, signs, etiology, distribution, complications, prognosis and therapy. Should the majority of patients so afflicted demonstrates significant similarities in most of these categories, one would favor application of the term "disease". In

making any such measurement, some diversity must be accepted on the basis of individual variability. Hence, even tuberculosis, a disease in which the etiology is known, presents with somewhat different signs, symptoms, distribution, complications and prognosis in patients of differing social, ethnic and racial backgrounds.

The history, symptoms, and signs associated with alcoholism are largely those related to chronic or recurrent physical dependence upon any sedative drug. These signs and symptoms include character disorganization, diminished ability to achieve potential, decreased attention span, diminished ability to concentrate, tremulousness, insomnia, diminished seizure threshold, and eventually elevated tolerance, episodes of amnesia, hallucinations, and delirium. In addition, some of the recurrent somatic symptoms include headache, bowel dysfunction, muscle spasm, fatigue, palpitations and exaggerated subjective response to minor local pathology. The most critical aspect of the patient's history is that revealing recurrent use of sedative drugs despite evidence that the drug adversely affects some facet of his life. These include health, work, interpersonal relations, marriage, etc.

The progressive nature of this deterioration is an almost universal concomitant even though it may be masked by an elaborate and powerful denial system.

Regularly noted in and almost limited to the alcoholic population are recurrent episodes of increased psychomotor activity, necessitating continued use of some sedative agent in a vain attempt to control

the agitation resulting from previous sedation.

Thus, there is little question but that the history, symptoms and signs of alcoholism form a recognizable pattern.

Etiology, however, remains a particular problem for the student of alcoholism. It must be underscored that the number of diseases for which the cause is unknown are too numerous to permit listing; however, our ignorance concerning the precise etiology of alcoholism should not imply that we have no information concerning this issue.

Turning from the question of etiology to that of distribution, one again notes an easily identifiable pattern. The incidence of alcoholism follows various national, geographic, religious, racial, and socioeconomic lines of distribution - all of which have received extensive documentation.

The complications of alcoholism are so numerous and commonplace that one can but marvel at the consistency with which alcoholism results in a specific pattern.

Suicide, homicide, accidental death and injury, acute and chronic brain syndrome, peripheral neurological defects, gastrointestinal disorders, pulmonary infections, hepatic disorders, myopathy, primary myocardial disease, and metabolic defects in the handling of carbohydrates, protein, fat, urate, water and various endocrine secretions are but a few of the many wellknown complications.

Although the alcoholic may start down the path of his illness from the vantage point of various problems, including some of the aforementioned complications, he ends with a clinical picture

dominated by his difficulty with alcohol, a circumstance playing a determinate role in both the choice and efficacy of therapy.

Abstinence is the only generally accepted technique for treatment of this disease. The achievement of abstinence is only possible by the realization that the drinking of alcohol is but a symptom of the disease. The alcoholic is no more responsible for having HIS disease than the diabetic is for having HIS disease. Like the diabetic, however, the alcoholic is EQUALLY as responsible for treating his disease. Gasoline does not cause automobile accidents, nor does alcoholism cause alcoholism. The maintenance of abstinence therefore renders the patient treatable. Restoration of the alcholic's self image, ego structure, helping him to regain self honesty and REAL interpersonal relationships are all means of teaching the alcoholic to deal with stress and anxiety in a chemically free state. This remains the primary goal of treatment.

Since the clinical picture of alcoholism obviously possesses as much distinctive form as many other diseases which go unchallenged in their right to be so designated, we must now question the motives of those who would strip the alcoholic of his "disease" label. Do they question whether Parkinsonism, diabetes, or schizophrenia are diseases? These ALL involve the central nervous system, are to a greater or lesser extent still replete with medical mysteries, and entail functional, and even socioeconomic problems.

Perhaps because of their inexperience with other medical models, these purporters of alcoholism as a non-disease seem to get confused by

the concept of recovery as opposed to cure. Perhaps the analogy of peptic ulcer would better enable them to understand that a patient may totally heal certain manifestations of his disease but remains prone to its recurrence to such an extent that the medical dictum remains, "ONCE a peptic ulcer, ALWAYS a peptic ulcer." In that sense the patient is not "cured". There are numerous diseases that present such a pattern: ulcerative colitis, bronchial asthma, rheumatoid arthritis, and alcoholism should be numbered among them.

But what of our reasons for retaining the title of "disease" for alcoholism? The ultimate reason for the designation of any individual as sick or diseased is for the singular purpose of separating him from the larger normal group in order to channel special resources to him. Whether the patient has a broken bone or is addicted, the "disease" label assists him in obtaining that special care which society reserves for its ill. This is the ONE term accepted by the public as adequate reason to offer treatment to the alcoholic. To lose the legitimate use of it would ultimately result in the loss of the ability to funnel resources to the alcoholic. Society as a whole recognizes this label as that which entitles one to medical care. The common criticism that the alcoholic would use his newly-discovered "disease" label as a means of avoiding responsibility for his disease has remained theoretical at best. This fictitious concept has failed to materialize in clinical experience.

Finally, the disease concept establishes alcoholism as firmly within the province of the medical profession. This FIXES the

responsibility for clinical care of the alcoholic upon the physician and his paramedical partners. Further sluggishness in pulling this illness out from under the rug would only add to the delay in addressing the scientific community to this overwhelming problem.

FORTUNATELY, the responsible medical community has seen fit to meet this challenge with honesty and candor. The American Medical Association, American Psychiatric Association, American Public Health Association, American Hospital Association, American Psychological Association, National Association of Social Workers, World Health Organization and the American College of Physicians have now EACH and ALL officially pronounced alcoholism as a disease. The rest of us can do no less.

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T 3/7/77

DENNIS G. CAMPTON, M.D.

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EG&G

BENEFITS PROGRAM

. . . for Eligible Employees

This booklet summarizes the main provisions of the Benefits Program available to eligible employees. The governing documents in all cases will be the life insurance contract, the official texts of the plans and the trust agreements, whichever are applicable. While it is the intent of EG&G to continue benefits described in this booklet, the right to change, modify or discontinue them, without notice, is reserved to the extent permitted by law.

Exhibit 7
Mr. Carlton
Naugle
E. B. & B.

EG&G

SECTION I
BASIC LIFE INSURANCE,
WEEKLY ACCIDENT & SICKNESS
AND HEALTH PLAN

SECTION I
BASIC GROUP LIFE INSURANCE AND EG&G ACCIDENT & SICKNESS AND HEALTH PLAN

The Group Life Insurance, and Weekly Accident & Sickness and Health Plan outlined in this Section are a combination of coverages designed to provide basic protection for you and your family. Life insurance is insured by John Hancock Mutual Life Insurance Company; Accident & Sickness and Health Plan benefits are provided by EG&G and are administered by John Hancock under a service contract. Your contribution under this combined program is reasonable because the Company pays a considerable part of the program cost. Your contributory share is shown in the Contribution Schedule on page 3.

ELIGIBILITY

If you are a regular full-time employee at a location that has adopted this program, you are eligible to enroll on your first day at work. Simply complete and return the Enrollment Card provided by your Industrial Relations/Personnel Department.

You may also enroll your eligible dependents for Health Plan coverage. Eligible dependents are your spouse, and all unmarried children from birth to 19 years of age. Unmarried children who are dependent on you for support will also be covered to age 23 if they are full-time students in accredited schools, colleges or universities.

When you reach age 65, you will no longer be eligible for the Health Plan part of this program; however, you will be covered under the Federal Medicare program and you may also obtain supplementary benefits under our Medicare Major Medical plan for you and your over-age-65 spouse. (See page II-1.)

Retired Armed Services Personnel and their dependents are covered under a medical program provided by the government. Employees who are armed services retirees should consult their local Industrial Relations Department for information concerning the effect of governmental coverage on the health program provided by the Company.

EFFECTIVE DATE OF COVERAGES

If you enroll on the first day at work, your plan will become effective on that day.

If you enroll after the first day but on or before the 30th day of employment, your plan will become effective on the day you enroll, provided you are actively at work on that day.

If you apply after the 30th day of employment, you will have to furnish satisfactory evidence of health for yourself and each dependent.

If you acquire a dependent after the effective date of your plan, benefits for the dependent will be effective: (a) immediately, if you already have family coverage; or (b) immediately, provided you apply for family coverage within 30 days of the date on which you acquire the dependent.

EMPLOYEE WEEKLY CONTRIBUTION SCHEDULE
Basic Life Insurance and
Weekly A&S and Health Plan

Basic Annual Earnings		Amount of Life Insurance	Single Coverage Non-California	Single Coverage California	Family Coverage Non-California	Family Coverage California
Less than	$ 4,001	$ 6,000	$1.61	$1.42	$4.87	$4.68
$ 4,001 less than	4,667	7,000	1.66	1.45	4.92	4.71
4,667 less than	5,334	8,000	1.71	1.49	4.97	4.75
5,334 less than	6,001	9,000	1.75	1.52	5.02	4.78
6,001 less than	6,667	10,000	1.80	1.55	5.06	4.81
6,667 less than	7,334	11,000	1.85	1.59	5.11	4.85
7,334 less than	8,001	12,000	1.90	1.62	5.16	4.88
8,001 less than	8,667	13,000	1.95	1.66	5.21	4.92
8,667 less than	9,334	14,000	2.00	1.69	5.26	4.95
9,334 less than	10,001	15,000	2.05	1.72	5.31	4.98
10,001 less than	10,667	16,000	2.10	1.76	5.36	5.02
10,667 less than	11,334	17,000	2.15	1.79	5.41	5.05
11,334 less than	12,001	18,000	2.20	1.83	5.46	5.09
12,001 less than	12,667	19,000	2.24	1.86	5.51	5.12
12,667 less than	13,334	20,000	2.29	1.89	5.55	5.15
13,334 less than	14,001	21,000	2.34	1.93	5.60	5.19
14,001 less than	14,667	22,000	2.39	1.96	5.65	5.22
14,667 less than	15,334	23,000	2.44	2.00	5.70	5.26
15,334 less than	16,001	24,000	2.49	2.03	5.75	5.29
16,001 less than	16,667	25,000	2.54	2.06	5.80	5.32
16,667 less than	17,334	26,000	2.59	2.10	5.85	5.36
17,334 less than	18,001	27,000	2.64	2.13	5.90	5.39
18,001 less than	18,667	28,000	2.69	2.17	5.95	5.43
18,667 less than	19,334	29,000	2.73	2.20	6.00	5.46
19,334 less than	20,001	30,000	2.78	2.23	6.04	5.49
20,001 less than	20,667	31,000	2.83	2.27	6.09	5.53
20,667 less than	21,334	32,000	2.88	2.30	6.14	5.56
21,334 less than	22,001	33,000	2.93	2.34	6.19	5.60
22,001 less than	22,667	34,000	2.98	2.37	6.24	5.63
22,667 less than	23,334	35,000	3.03	2.40	6.29	5.66
23,334 less than	24,001	36,000	3.07	2.44	6.33	5.70
24,001 less than	24,667	37,000	3.10	2.47	6.36	5.73
24,667 less than	25,334	38,000	3.14	2.51	6.39	5.77
25,334 less than	26,001	39,000	3.17	2.54	6.43	5.80
26,001 less than	26,667	40,000	3.21	2.57	6.46	5.83
26,667 less than	27,334	41,000	3.24	2.61	6.49	5.87
27,334 less than	28,001	42,000	3.27	2.64	6.53	5.90
28,001 less than	28,667	43,000	3.31	2.68	6.56	5.94
28,667 less than	29,334	44,000	3.34	2.71	6.60	5.97
29,334 less than	30,001	45,000	3.38	2.74	6.63	6.00
30,001 less than	30,667	46,000	3.41	2.78	6.66	6.04
30,667 less than	31,334	47,000	3.44	2.81	6.70	6.07
31,334 less than	32,001	48,000	3.48	2.85	6.73	6.11
32,001 less than	32,667	49,000	3.50	2.88	6.77	6.14
32,667 and over		50,000	3.54	2.91	6.80	6.17

BASIC LIFE INSURANCE

FOR EMPLOYEES. . .

Life Insurance is provided to you as part of the Basic Group Life Insurance and EG&G Health, and Weekly Accident & Sickness Benefits Program.

AMOUNT OF INSURANCE

Your Basic Life Insurance will be an amount equal to approximately one-and-one-half times your basic annual salary or wage (in even $1,000 amounts), but in no event more than $50,000—the limit specified in the policy.

If you receive a salary or wage change which warrants a change in your life insurance, an adjustment will be made on the date of change. If you are absent from work because of disability on the day your insurance would normally be changed, the adjusted benefit will become effective on the day you return to work.

CONVERSION PRIVILEGE

If your employment ceases, you have the privilege to convert your insurance to an individual policy if written application and payment of premiums are made within 31 days after insurance ceases because of termination. You may elect any type of plan issued by John Hancock Mutual Life Insurance Company except term insurance, but such plan shall be without disability or other supplementary benefits. No medical examination is required. If you should die within 31 days after termination of employment, the Insurance Company will pay to your beneficiary the amount of insurance which you were entitled to convert.

PAYMENT OF CLAIM

Your named beneficiary will be paid the full amount of your life insurance in the event of your death from any cause. You may change your beneficiary at any time by completing a "Change of Beneficiary" form, which is available from your Industrial Relations/ Personnel Department.

WEEKLY ACCIDENT & SICKNESS BENEFIT

FOR EMPLOYEES . . .

This portion of the plan provides for continuation of income when you are absent from work because of a non-occupational disability due to accident or sickness.

BASIS FOR DETERMINING WEEKLY ACCIDENT & SICKNESS BENEFIT AMOUNTS

This benefit provides disability coverage to you of two-thirds your basic weekly earnings, up to a maximum payment of $300 per week, for disabilities resulting from a non-occupational accident or illness.

Benefits begin on the 16th calendar day of disability and continue during disability for up to 13 weeks.

EXCLUSIONS

Benefits will not be paid for a disability:

a. Caused by an injury which results from or occurs during any employment for wage or profit; or
b. Caused by an illness for which you are entitled to benefits under any Workmen's Compensation or similar law (for example, California Unemployment Insurance Code); or
c. Caused by pregnancy, childbirth, or miscarriage; or
d. While the employee is not regularly treated by a physician.

COMPREHENSIVE HEALTH PLAN BENEFITS

FOR YOU AND YOUR FAMILY. . .

CLASS A MEDICAL EXPENSE BENEFITS

Class A Medical Expense Benefits are designed to provide first-dollar coverage for unanticipated medical expense, either in or out of the hospital. Class A Medical Expense Benefits are generally NOT subject to a deductible.

HOSPITAL BENEFITS

Hospital Room and Board

Hospital Room and Board expenses during any one continuous period of hospital confinement, except for maternity, will be paid by the Plan as follows:

- up to the hospital's semi-private rate for the first 31 days of hospitalization, and
- up to 90% of semi-private charges for any subsequent days of hospitalization.

Benefits will be reduced by any amount of hospitalization benefit which an employee may be entitled to under provisions of the California Unemployment Insurance Code or other Federal or State benefit plan.

Other Hospital Charges

The Plan also pays, during one continuous period of hospital confinement, other necessary hospital charges made in connection with your confinement (but not charges for personal items) as follows:

- all charges for the first 31 days of hospitalization, and
- 80% of charges for any subsequent days of hospitalization.

Successive hospital confinements are treated as one continuous period of confinement unless: they are separated by a period of six months or more; complete recovery has taken place since the last confinement; or the reasons for confinement are different.

To qualify for hospital benefits, you or your dependent must be confined in a legally constituted hospital upon the recommendation of a licensed physician. In the case of hospital care following an accident or for surgery, confinement is not a requirement for eligibility.

SURGICAL EXPENSES

The Plan will pay the actual fee your doctor charges up to the amount listed for the procedure in a Schedule of Relative Value Procedures. Examples of Scheduled Amounts appear on page I-15 of this booklet. If the charge for a surgical procedure is more than the amount payable in the Schedule, the excess will be paid at 80%, up to Usual and Customary charges.

LABORATORY AND X-RAY EXAMINATION

If laboratory or x-ray examinations are made in connection with the diagnosis or treatment of an accidental bodily injury or an illness, benefits are payable for:

- charges incurred outside of a hospital, or
- out-patient charges (incurred in a hospital) that do not qualify for a benefit under "other hospital services",

up to $50 in connection with all injuries resulting from any one accident, and up to $50 per illness in any twelve consecutive months. However, a benefit will not be payable for any such examination due to or resulting from pregnancy, or any dental x-ray examination unless in connection with an accidental injury.

If the charge for a laboratory or x-ray expense is greater than the amount payable as set forth above, the excess will be paid as a Class B Medical Expense; as explained further beginning on page I-8.

MATERNITY AND OBSTETRICAL BENEFITS

Expenses incurred as a result of either a Normal Delivery, Caesarean Section Delivery, or Miscarriage are not subject to a deductible. Hospital and medical benefits will be paid up to a maximum of:

- $500 for a Normal Delivery;
- $750 for a Caesarean Section Delivery;
- $250 for pregnancy resulting in Miscarriage.

Expenses for a Severe Pregnancy will be treated the same as a regular health claim and will be subject to the deductible and the benefit percentage provisions. The term Severe Pregnancy shall mean only:

a) An extra-uterine pregnancy; or

b) A pregnancy associated with pernicious vomiting or toxemia with convulsions; or

c) A pregnancy with complications requiring intra-abdominal surgery when such surgery is performed within three months after termination of pregnancy; or

d) False labor resulting in hospital confinement.

Expenses incurred by the new-born child are not considered as part of the maternity reimbursement and will be treated as a separate claim.

Maternity benefits will begin nine months after you are covered. If your coverage is canceled, maternity benefits will be continued for up to nine months after the date of cancellation.

CLASS B MEDICAL EXPENSE BENEFITS

Class B Medical Expense Benefits are designed to assist when you have heavy medical expenses for serious or prolonged illness or injury which are in excess of or not payable as Class A Medical Expense Benefits. Further, Class B Expense Benefits are subject to a DEDUCTIBLE.

Briefly here's how this part of the Plan works:

In each calendar year after you pay a deductible, as described below, the Plan normally PAYS 80% of your covered medical expenses for the rest of the year (except 50% for certain items), subject to the Plan's $50,000 LIFETIME MAXIMUM for both Class A and B Expense Benefits.

MAXIMUM BENEFIT

The individual maximum lifetime benefit for you and each of your covered dependents is $50,000; however, up to $1,000 in benefits will be automatically reinstated each year without evidence of health.

CALENDAR YEAR DEDUCTIBLE

A $50 deductible applies once to all Class B expenses incurred by each eligible employee or family member during a calendar year; however, the maximum deductible for a family of any size is $150. In satisfying the family deductible, no more than $50 per individual can be credited to this amount. Once the family deductible has been satisfied, however, all eligible expenses incurred during the remainder of the calendar year will be reimbursed at the applicable rate.

All expenses incurred in the last three months of the year which are applied to a deductible either individual or family—may also be applied toward satisfaction of the appropriate deductible for the following year.

If two or more covered members of your family are injured in the same accident, only one $50 deductible will be applied that year to all expenses resulting from the accident.

The two examples shown illustrate how the deductible provisions of the plan apply.

EXAMPLE

Date	*Family Member*	*Expenses*	*Deductible Individual*	*Deductible Family*	*Reimbursement*
Jan. 12	Bill Jay	40	40	40	–0–
Mar. 4	Wife Jane	35	35	75	–0–
Mar. 16	Son Jim	30	30	105	–0–
July 12	Daughter June	45	45	150	–0–
Nov. 3	Son Jim	10	30	(satisfied)	8
Dec. 12	Son Jack	40	0	—	32

No member of the family satisfied their individual $50 deductible, but daughter June's expenses on July 12 completed the $150 family deductible. Reimbursement was made on all expenses incurred after that date (in this example, an 80% rate is assumed). No deductible carry-over credit was allowed for the expenses in November and December because reimbursement was made.

Date	Family Member	Expenses	Deductible Individual	Deductible Family	Reimbursement	Deductible Individual	Carry-Over Family
Jan. 7	Bill Jay	20	20	20	–0–	–0–	–0–
May 10	Wife Jane	20	20	40	–0–	–0–	–0–
July 12	Son Jack	40	40	80	–0–	–0–	–0–
Oct. 13	Son Jim	40	40	120	–0–	40	40
Dec. 5	Daughter June	40	30	150	8	30	70

Son Jim's expenses in October were applied towards both his individual deductible of $50 and the family deductible of $150. No reimbursement was made. Thirty dollars of daughter June's expenses in December brought the family deductible to the $150 amount, so the $10 balance was reimbursed at the 80% rate. The $30 that was applied to her individual deductible and the family deductible was carried over to the next year and applied to both.

PLAN PAYS 80% OF MOST CLASS B EXPENSES

After the deductible is met, the Plan pays 80% of most covered Class B expenses. Further, the Plan payment to an individual is reduced, per illness, for medical expenses incurred within three years from the date of first covered expenses, as follows:

Per Illness Medical Reimbursement	*Participation*
First $10,000	80% Plan/20% Employee
Next $40,000	90% Plan/10% Employee

Subsequently, the above participation must again be satisfied for each three-year period in which expenses for the same illness are incurred.

Note: This provision is not applicable with regard to Mental and Nervous Disorder illness claims.

MENTAL ILLNESS

This Plan covers psychiatric treatment for mental illness or functional nervous disorder when the treatment is undertaken for medical reasons. If you or your dependent incur Covered Expenses (as defined below) while confined in a hospital because of mental illness or functional nervous disorder, your benefits will be the same as those for any other illness. However, if Covered Expenses are incurred because of these ailments while not confined in a hospital, the Plan will pay 50% of the expenses. Prescription drug expenses will be paid at the standard 80% rate.

This Plan does not cover psychoanalysis or psychotherapy when these treatments are for training, marriage counseling, amplification or perfection of vocational skills, personality improvement, and similar conditions which cannot be specifically defined as mental illness or functional nervous disorder. The Plan also does not cover the services of a psychologist, whether or not his charges are in connection with bona fide treatment for a mental illness or functional nervous disorder. Reimbursement of medical-surgical charges is limited to those rendered by a physician licensed to practice medicine in the state in which the charge is incurred.

SUPPLEMENTAL ACCIDENT BENEFITS

Expenses incurred as the result of an accidental injury which exceed or are not covered by the benefits payable under the hospital-surgical portion of the Plan will be reimbursed to a maximum of $300 for each accident, subject to the following items a and b.

a. Covered Expenses

The following expenses will be payable if incurred within 90 days after the accident:

1. Hospital confinement;
2. Surgical fees;
3. Treatment by a physician;
4. Nursing services of a registered graduate nurse other than a member of the family;
5. Local ambulance service.

These expenses are covered whether incurred in or out of a hospital.

b. Limitations

No benefits will be paid for sickness. This provision may provide reimbursement on expenses normally subject to the deductible clause or room and board expenses above the present contractual limitation. In the event reimbursement is made on expenses normally subject to the deductible, the deductible requirement will not be satisfied and must be satisfied on any future expenses not resulting from an accident.

COVERED MEDICAL EXPENSES

Subject to previously described deductibles and limitations, the plan provides benefit payments for necessary and reasonable medical expenses for:

- Treatment by a licensed physician, surgeon or trained nurse, other than a member of your family, whether in the hospital, in the doctor's office, or at home;
- Drugs and medicines requiring prescription by a licensed physician;
- Anesthesia and its administration;
- X-ray and laboratory services;
- Blood and blood plasma;
- Use of an iron lung or other durable equipment;
- Casts, splints, braces, artificial limbs and eyes;
- Professional ambulance service to the first hospital where treatment is given;
- Removal of impacted teeth.

This listing is not all-inclusive; it merely defines the general type of expenses which are covered by the plan.

EXCLUDED EXPENSES

The principal exclusions under this plan are expenses resulting from:

- Occupational accident or sickness;
- Accident or sickness caused by war, insurrection, or participation in a riot;
- Eyeglasses and hearing aids, and examinations for prescription or fitting;
- Dental work, including those incurred for damage to natural or artificial teeth caused by an accident occurring wholly within the mouth. (An exception to this exclusion is treatment for violent, externally-induced injury to natural teeth commencing within 90 days of an accident);
- Routine or annual physical examinations;
- Cosmetic surgery, except those made necessary by a violent, external accidental injury while covered;
- Hospital and medical-surgical services and supplies for which the covered individual is not required to pay;
- Hospital services and supplies for which benefits are payable under the California Unemployment Insurance Code or any Federal, State or Local Plans.

HOSPITAL DEFINED

The term Hospital means an institution constituted and operated in accordance with the laws pertaining to hospitals, which provides, for compensation, medical and surgical treatment for injury and sickness under the care of physicians on an inpatient basis with continuous 24-hour nursing service by registered graduate nurses. The term Hospital will not include an institution which is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

COORDINATION OF BENEFITS

This group health plan includes a Coordination of Benefits provision. Simply stated, this means that when you or one of your dependents is covered by this plan and one or more other group plans, the Benefit providers involved work together in paying up to 100% of the allowable expenses (an allowable expense is any charge covered by any one of the patient's plans). This cooperative approach to group health coverage assures you of adequate benefits, but eliminates the excessive benefits or "profit" which result in increased cost of health care.

Note: Individual health insurance policies are not affected by Coordination of Benefits.

Coordination of Benefits provides an added advantage in the form of a "Benefit Credit." This means that the "profit" which may result from multiple coverage is set aside in the individual's name for use at a later date in the same calendar year, if needed. Thus, if the individual should have a second injury or illness in that year, and the allowable expenses exceed the total benefits payable, the benefit credit will be used to pay the excess expenses.

In the following examples, we will assume an employee's wife is the patient, and that she has dual coverage—as an employee of the ABC Co. and under her husband's plan.

Without Coordination of Benefits		
Total cost of appendectomy		$600
Benefits paid by Wife's plan	$450	
Benefits paid by Husband's plan	$450	
Total benefits paid		$900
"Profit"		$300
With Coordination of Benefits		
Total cost of appendectomy		$600
Benefits paid by Wife's plan	$450	
Benefits paid by Husband's plan	$150	
Total benefits paid		$600
"Profit"		—0—

In the second example, the $300 that would have been paid without Coordination of Benefits will be set aside in her name as a Benefit Credit for use at a later date that year, if needed.

CONVERSION PRIVILEGE

If you have been covered under this plan for three months or more and then leave the employ of the Company for any reason, you may obtain coverage of a basic Hospital and Surgical Expense Insurance Plan from John Hancock Mutual Life (benefits are less than the EG&G Health Plan provides) if you apply and submit the first premium within 31 days of termination.

The conversion privilege is also extended to a surviving spouse, surviving dependent children, or a dependent child whose coverage terminates because of the age of the child, of an employee covered under the family option of this plan.

WHEN BENEFITS TERMINATE

Your Health Plan will terminate when:

- Your employment is terminated.
- You discontinue contributions.
- The Plan is discontinued.
- You reach age 65.

Your dependents' Health Plan will terminate when:

- You are no longer eligible for benefits.
- Your dependent becomes eligible as an employee.
- Your dependent ceases to be eligible, as defined.
- Your spouse reaches age 65.

When you and/or your spouse reach age 65, you will be eligible to enroll for Supplemental Medicare Major Medical benefits as outlined in Section II of this Handbook.

EXAMPLES OF RELATIVE VALUE SCHEDULE

RESPIRATORY SYSTEM	
Submucous resection, nasal septum	30.0
Antrotomy, intranasal, unilateral	15.0
bilateral	25.0
Radical (Caldwell-Luc), unilateral	50.0
bilateral	65.0
Bronchoscopy, diagnostic	15.0
with removal of foreign body or tumor	25.0
Thoracotomy, exploratory, including biopsy	50.0
Lobectomy, total or subtotal	100.0
wedge resection, single or multiple	80.0
CARDIOVASCULAR SYSTEM	
Valvulotomy or commissurotomy, mitral	120.0
aortic, pulmonic, tricuspid	150.0
Varicose Veins	
Ligation and division and complete stripping	
long or short saphenous veins, unilateral	30.0
bilateral	50.0
long and short saphenous veins, unilateral	40.0
DIGESTIVE SYSTEM	
Tonsillectomy, with or without adenoidectomy, under age 18	15.0
age 18 or over	20.0
Gastrectomy, subtotal, with or without vagotomy	80.0
Colectomy, partial resection of large intestine in two stages, including first stage colostomy or cecostomy	100.0
Appendectomy	40.0
Proctectomy, complete, combined abdomino-perineal, one or two stages	100.0
Fistulotomy or fistulectomy, subcutaneous	10.0
submuscular	40.0
Hemorrhoidectomy, external	20.0
internal or internal and external	30.0
with submuscular fistulotomy or fistulectomy	40.0
Cholecystectomy: removal of gall bladder	60.0
with open exploration of common duct	70.0
Exploratory laparotomy	40.0
Herniotomy,	
Femoral, inguinal, unilateral	35.0
Inguinal, with orchidectomy or excision of hydrocele	40.0

The Conversion Factor to be applied is $6.00.

EG&G

SECTION II
SUPPLEMENTAL MEDICARE
MAJOR MEDICAL

SECTION II

SUPPLEMENTAL MEDICARE MAJOR MEDICAL

FOR YOU AND YOUR SPOUSE . . .

When you reach age 65, you are entitled to benefits of the Federal Medicare program under Social Security, and your benefits under the EG&G Group Health Plan cease. If you have a spouse who is also age 65, she or he will also be entitled to benefits under Medicare. Medicare provides a wide range of health and medical care benefits.

MEDICARE (SOCIAL SECURITY)

Medicare Part A — primarily provides protection against the costs of hospital and related care. Benefits are provided for hospital in-patient services such as room and board and normal hospital services, hospital out-patient diagnostic services, and certain nursing home expenses. Part A is a coinsurance plan; it contains deductible clauses and, for some expenses, requires a sharing of the cost.

Medicare Part B — is supplemental medical insurance which provides protection against the costs of physicians' services and certain other medical services. Enrollment in Part B is voluntary, and coverage is obtained through the Social Security Administration. Part B also contains coinsurance and deductible clauses. We recommend that you and your spouse, upon reaching age 65, when eligible, enroll for Medicare Part B.

SUPPLEMENTAL MEDICARE MAJOR MEDICAL (EG&G)

Medicare Major Medical, a group plan available through the Company, complements Medicare by covering many expenses not included in the basic program. At age 65 you and your dependent spouse can obtain this coverage through your Industrial Relations Department. In addition to Federal Medicare coverage, you may also continue your Supplemental Medicare Major Medical coverage after your retirement.

This plan will pay benefits as listed below up to a maximum of $10,000 for you and similarly a $10,000 maximum benefit for your spouse. This $10,000 maximum is not affected by any Major Medical benefits received by you or your spouse prior to the date either of you become eligible for Medicare coverage.

COVERED MEDICAL EXPENSES

A. The following covered medical expenses are reimbursed on a 100% basis:

a. Hospital Charges

i. The inpatient hospital deductible under Medicare Part A.

ii. The daily deductible under Part A for the 61st through 90th day of hospitalization.

iii. The board and room charges in either ward or semi-private accommodations and charges for hospital services and supplies furnished by the hospital for the 91st to 365th day of hospitalization.

For confinement in single-bed, private room accommodations, the daily charge most frequently made by the hospital for board and room in semi-private accommodations will be a covered medical expense.

b. Out-of-Hospital Benefits (Physician's Office and Hospital Outpatient Department)

i. The initial deductible under Medicare Part B.

ii. The 20% copayment under Medicare Part B for charges in connection with surgery, treatment of accident within 72 hours, medical emergencies, radiation therapy, diagnostic X-rays and laboratory examinations, and medical treatment within 100 days following hospital discharge for all conditions other than mental illness.

c. Extended Care Facilities

For confinement within 14 days of discharge following a hospital confinement of at least three consecutive days:

i. The Medicare Part A deductible for the 21st through 100th day of confinement.

ii. $10 per day for the 101st through 365th day of confinement.

d. Other Licensed Nursing Homes

For confinement within 14 days of discharge following a hospital confinement of at least three consecutive days:

i. $8 per day for up to 365 days per benefit period, less the number of days spent in extended care facilities.

B. The following covered expenses are reimbursed at the level of 80%:

a. Inpatient Private Duty Nursing after a $100 deductible up to a maximum benefit of $300 per benefit period.

b. Prescription Drugs

After a $25 deductible per calendar quarter, for drugs requiring prescription used outside of the hospital.

BENEFIT PERIOD

A "Benefit Period" begins on the first day a patient received covered services in a hospital or extended care facility. It ends after the patient has been out of the hospital, extended care facility, nursing home or similar institution for 60 consecutive days.

CONTINUATION OF SPOUSE'S COVERAGE

The Supplemental Major Medical Coverage can be continued for the lifetime of the spouse if she is also enrolled.

If the spouse has not become eligible for Medicare at the time of the employee's death the spouse may exercise the conversion privilege as described on page I-14 of this booklet.

CHARGES INCURRED OUTSIDE UNITED STATES

With respect to expenses incurred outside the United States for any care or services or supplies of a type for which benefits are provided under full Medicare coverage, Company benefits will be determined on the following basis:

1. If the individual is domiciled outside the United States on the date the expense is incurred, or if the individual is domiciled in the United States but has been away from the United States for more than 18 consecutive months on the date the expense is incurred, any Company benefit will be determined on the basis that the individual has full Medicare coverage, whether or not Medicare benefits are payable for the expenses so incurred.
2. If the individual is domiciled in the United States but has been away from the United States for a period of not more than 18 consecutive months on the date the expense is incurred, and if benefits that would otherwise be payable under Medicare are not payable because the expense was incurred outside the United States, then Company benefits described above will be supplemented by the benefits that would otherwise have been payable by Medicare.

EXCLUSIONS UNDER THIS SUPPLEMENTAL PLAN

The term "covered medical expense" shall not include expenses for:

a. general health examinations,

b. eye examinations made for or in connection with the diagnosis or treatment of astigmatism, myopia (nearsightedness), or hyperopia (farsightedness),

c. the fitting or cost of eye glasses or hearing aids,

d. dental work or treatment except for expenses resulting from injury to natural teeth caused by an accidental bodily injury occurring while covered,

e. cosmetic surgery or treatment unless such surgery or treatment is received as a result of an accidental bodily injury occurring while covered,

f. transportation or travel,

g. custodial care,

h. any item described under "covered medical expenses" which is

   1. received in connection with injury or disease resulting wholly or partly, directly or indirectly from war or any act of war declared or undeclared which war or act of war occurs while covered, or

   2. received in connection with an injury or disease existing on the date the individual became covered unless furnished after the completion of a 3-month period in which the individual is not under the care or treatment of a legally qualified physician for such injury or disease.

Each item of expense must be for services, supplies or equipment which are recommended and approved or performed by a legally qualified physician or surgeon.

If you are entitled to a benefit under any Workmen's Compensation Law or Act for any item of expense which is also an item of expense covered under the Plan, only the excess, if any, of the charge for such item over the benefit under the Workmen's Compensation Law or Act is considered.

No charge is covered for any item of expense of a dependent which is caused by or results from any injury arising out of and in the course of employment or from disease which is compensable under any Workmen's Compensation Law or Act.

No charge is covered for any services, supplies or equipment which are furnished by or in a United States Government hospital or elsewhere at federal government expense.

CONTRIBUTIONS

While you are covered as a regular full-time employee, the Company will pay a part of the Supplemental Medicare Major Medical cost in proportion to the normal EG&G Health Plan cost. Upon retirement, you can elect to continue this coverage for you and your spouse by paying the full cost.

EG&G

SECTION III

SUPPLEMENTAL LIFE INSURANCE

SECTION III

SUPPLEMENTAL LIFE INSURANCE

FOR EMPLOYEES . . .

LIFE INSURANCE AMOUNTS

Under the Supplemental Life Insurance Plan, you can double your insurance—provided you enroll in the Basic Life insurance program (Section 1). Your Supplemental Life Insurance will be an additional amount equal to approximately one-and-one-half times your basic annual salary or wage (in even $1,000 amounts), not to exceed $50,000 maximum. (Note: The combined Basic and Supplemental Life Insurance maximum is $100,000.) You merely request the Company to make deductions from your paycheck toward the cost of Supplemental Life Insurance. Your weekly cost can be determined from the schedule provided at the end of this section.

Note: The Supplemental Life Insurance *coverage shall cease on your 65th birthday,* or on your actual retirement date, whichever occurs first.

Your life insurance coverage will be determined by your basic annual salary or wage. If you receive a salary or wage change which warrants a change in your life insurance, an adjustment will be made on the date of change. If you are absent from work because of disability on the day your insurance would normally be changed, the adjusted benefit will become effective on the day you return to work.

ELIGIBILITY

If you are a regular full-time employee at a location that has adopted the plan of insurance described on these pages, you are eligible to enroll on your first day at work. Simply complete and return the enrollment card provided by your Industrial Relations Department.

The Supplemental Life Insurance coverage may be obtained without a medical examination if application is completed within 30 days after your date of eligibility. Otherwise, you will be required to furnish evidence of insurability satisfactory to the Insurance Company at your own expense.

CONVERSION

The same privilege to convert your supplemental life insurance is available as that available for basic life insurance.

PAYMENT OF CLAIM

Your named beneficiary will be paid the full amount of your life insurance in the event of your death from any cause. You may change your beneficiary at any time by completing a "Change of Beneficiary" form, which is available from your Industrial Relations/Personnel Department.

SUPPLEMENTAL LIFE INSURANCE

EMPLOYEE WEEKLY CONTRIBUTION SCHEDULE

Basic Annual Earnings		*Amount of Supplemental Life Insurance*	*Weekly Cost to You*
Less than	$ 4,001	$ 6,000	$ .48
$4,001 less than	4,667	7,000	.57
4,667 less than	5,334	8,000	.65
5,334 less than	6,001	9,000	.73
6,001 less than	6,667	10,000	.81
6,667 less than	7,334	11,000	.89
7,334 less than	8,001	12,000	.97
8,001 less than	8,667	13,000	1.05
8,667 less than	9,334	14,000	1.13
9,334 less than	10,001	15,000	1.21
10,001 less than	10,667	16,000	1.29
10,667 less than	11,334	17,000	1.37
11,334 less than	12,001	18,000	1.45
12,001 less than	12,667	19,000	1.54
12,667 less than	13,334	20,000	1.62
13,334 less than	14,001	21,000	1.70
14,001 less than	14,667	22,000	1.78
14,667 less than	15,334	23,000	1.85
15,334 less than	16,001	24,000	1.94
16,001 less than	16,667	25,000	2.02
16,667 less than	17,334	26,000	2.10
17,334 less than	18,001	27,000	2.18
18,001 less than	18,667	28,000	2.25
18,667 less than	19,334	29,000	2.34
19,334 less than	20,001	30,000	2.42
20,001 less than	20,667	31,000	2.50
20,667 less than	21,334	32,000	2.58
21,334 less than	22,001	33,000	2.66
22,001 less than	22,667	34,000	2.75
22,667 less than	23,334	35,000	2.83
23,334 less than	24,001	36,000	2.91
24,001 less than	24,667	37,000	2.99
24,667 less than	25,334	38,000	3.07
25,334 less than	26,001	39,000	3.15
26,001 less than	26,667	40,000	3.23
26,667 less than	27,334	41,000	3.31
27,334 less than	28,001	42,000	3.39
28,001 less than	28,667	43,000	3.47
28,667 less than	29,334	44,000	3.55
29,334 less than	30,001	45,000	3.63
30,001 less than	30,667	46,000	3.72
30,667 less than	31,334	47,000	3.80
31,334 less than	32,001	48,000	3.88
32,001 less than	32,667	49,000	3.96
32,667 and over		50,000	4.04

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SECTION IV

LONG-TERM DISABILITY INSURANCE

SECTION IV

LONG TERM DISABILITY INSURANCE

Underwritten by
Liberty Mutual Insurance Company

The group insurance plans outlined in the preceding section provide substantial life, health, and short-term disability coverage. This Long Term Disability Insurance plan provides continuing disability benefits beginning on the 107th day of your disability. The premium schedule explaining the cost of this coverage is set forth at the end of this section.

ELIGIBILITY

You may obtain this insurance if you are a full-time permanent employee under 65 years of age at a location that has adopted this plan. Simply complete and return the enrollment card supplied by your Industrial Relations Department.

EFFECTIVE DATE OF INSURANCE

If you enroll on the first day of your employment, your insurance will become effective on that day.

If you enroll after the first day but on or before the 30th day of employment, your insurance will become effective on the day you enroll, provided you are actively at work on that day.

If you apply for insurance after the 30th day of employment, you must submit to a medical examination and your application will be subject to acceptance or rejection by the Insurance Company. Your insurance will then become effective the day your application is accepted by the Insurance Company.

DURATION OF BENEFITS

Benefits for disabilities resulting from accidents and sickness are payable monthly to age 65.

AMOUNT OF BENEFIT

The monthly benefit paid will be 60% of your base monthly salary up to a maximum monthly benefit of $2,500. Base monthly salary is defined as the amount of monthly salary, exclusive of shift differential or other additive to base pay, as of the date disability begins.

The amount of benefit paid under this plan will be adjusted to an amount which, together with any payments (including dependency allowance) received from any Workmen's Compensation Law or Act, Social Security, Federal or State Cash Sickness Plan, will not exceed 70% of your basic monthly salary. However, to help protect you against inflation, any future increases in Social Security benefits enacted after Long Term Disability payments commence will not further reduce your benefit payment.

You are guaranteed a monthly payment under the plan of not less than $50.

SURVIVOR BENEFIT

In the event of your death, if you had been disabled for six months or longer and were qualified to receive benefits under this plan, your survivors will be paid an additional three months of benefits.

WAITING PERIOD

Your benefits will begin on the 107th day of disability. Coverage during this waiting period is provided by the Group Accident and Sickness Insurance Plan, if you are a participant in that plan, or a State Cash Sickness Plan, if you are eligible.

TOTAL DISABILITY

Total disability under this plan is defined as a disability that prevents you from engaging in any and every duty of your occupation for two years. After disability benefits have been paid for two years, total disability means complete inability to perform any and every duty of any gainful occupation for which you are reasonably qualified by training, education or experience. After two years of disability due to mental disorder, alcoholism, or drug addiction, an individual will not be eligible to receive benefits unless he is hospitalized or undergoing approved rehabilitative treatment.

REHABILITATION PROVISION

If you return to work for EG&G on less than a full-time basis to provide gradual rehabilitation, the plan will continue your regular monthly benefit, less 80% of the basic monthly earnings that you receive, for an additional period of up to 24 months. Gradual rehabilitation can include any occupation or employment with EG&G that you are reasonably suited for by training, education or experience. This clause enables you to return to work on a part-time basis or at a lower rated job without disability payments ceasing.

RECURRENT DISABILITY

After you have resumed all the duties of your occupation on a full-time basis for a continuous period of six months, a recurrence of your previous disability will be considered as a new disability. After satisfying the waiting period, you will again be eligible for disability benefits.

If you are disabled due to the same disability within a six-month period, you will not have to satisfy a new waiting period.

WAIVER OF PREMIUM

No premium payments are required during any period of disability for which you receive Long Term Disability benefits.

EXCLUSIONS

This plan covers all disabilities except those resulting from:

a. Intentional, self-inflicted injuries;
b. War, insurrection, or participation in a riot; and,
c. Pregnancy, childbirth, miscarriage, or abortion.

DURATION OF INSURANCE

Your insurance will remain in force until:

a. Age 65,
b. Termination of employment,
c. You fail to pay a premium, or,
d. The group contract is cancelled.

Note: If you are receiving benefits at cancellation, you will continue to do so.

SPECIAL FEATURES

1. Non-house Confinement—You are not required to be house- or hospital-confined to quality for the benefit.
2. Pre-existing Conditions—Once coverage becomes effective, disability arising from a pre-existing condition is covered.
3. Taxability—Under present law, insurance benefits are entirely free of tax.
4. Benefit Continues—Termination of insurance for any reason (other than age) will not prejudice any valid claim.
5. World-wide Coverage—Protection is provided on and off the job, 24 hours a day, anywhere in the world.

PREMIUM SCHEDULE

Your weekly premium cost is computed by multiplying your weekly base salary by 0.0056. This is equivalent to $0.056 per $10 of weekly salary. For example:

Weekly Earnings	*Weekly Cost*
$ 80	$0.45
150	0.84
250	1.40
400	2.24

EG&G

SECTION V

VOLUNTARY ACCIDENT INSURANCE

SECTION V

VOLUNTARY ACCIDENT INSURANCE

Underwritten by
Life Insurance Company of North America

This group insurance plan permits you and your eligible dependents to obtain accident insurance at a premium cost which is significantly less than the cost of a comparable individual policy.

ELIGIBILITY

You may obtain this insurance if you are a full-time employee at a location that has adopted this plan. You can enroll for either Employee Only or Employee and Family coverage.

If you elect Employee Only coverage you can be insured in units of $10,000 to a maximum of $200,000. If you elect Employee and Family coverage, your spouse will automatically be insured for $4,000 and each eligible child for $1,000 for each $10,000 of employee coverage. If you do not have any eligible children, your spouse will be insured for $5,000 for each $10,000 of employee coverage. If there is no eligible spouse to be insured, each of your eligible children will be insured for $1,500 for each $10,000 of employee coverage.

An eligible dependent is defined to include your spouse, and any unmarried children between the ages of 14 days and 23 years. Children must be dependent upon you for maintenance and support.

PILOT ELIGIBILITY

If you are a licensed pilot and meet certain requirements, you may apply for coverage for yourself while flying within the continental limits of the United States, Canada and Mexico either on business or pleasure by submitting your pilot history form to the Industrial Relations Department for approval. (Pilot History Forms may be obtained in the Industrial Relations Department). The amount of pilot coverage which you will be insured for, if you qualify, will be equal to the amount of basic coverage which you have purchased subject to a $50,000 maximum. However, you may enroll for an amount up

to the full $200,000 maximum, to apply when not subject to the reduction for pilot coverage.

EFFECTIVE DATE OF COVERAGE

Your insurance will become effective on the day your application is received by the Industrial Relations Department. If you elect family coverage, this insurance will also become effective on the day the application is received.

The Insurance Company's right to cancel your insurance or to refuse renewal of your insurance is limited to:

a. When you become 70 years of age.
b. When you retire or cease to be an active employee.
c. When you fail to pay the premium.
d. When the Insurance Company declines to renew the coverage of all employees who have enrolled under the plan.

REINSTATEMENT OR CHANGE IN BENEFITS

If you have once cancelled your insurance, but wish to be reinstated, you may do this by simply submitting an application to the Industrial Relations Department. Your coverage will become effective the day your application is accepted by the Industrial Relations Department.

PREMIUM SCHEDULE

You may elect either Employee Only or Employee and Family coverage in units of $10,000 to a maximum of $200,000.

The cost of Employee Only insurance is $0.50 per month, per $10,000 of employee coverage. The cost of Employee and Family coverage is $0.74 per month, per $10,000 of employee coverage.

COVERAGE

This plan covers you and your dependent, if insured, 24 hours a day—365 days a year— anywhere in the world—traveling or at home—for accidents suffered on or off the job. Passenger coverage is provided for employee and dependents while flying in any tried, tested, and approved aircraft. Pilot and crew member coverage is provided for employees while flying within the continental limits of the United States, Canada and Mexico in any certificated aircraft which they are qualified to fly, other than while engaged in crop dusting or seeding, racing, or endurance test, or acrobatic flying.

EXCLUSIONS

Your accident insurance does not cover:

a. Intentional self-inflicted injuries, suicide, or attempted suicide while sane or insane.

b. Injuries or death caused by declared or undeclared war.

c. Service in the armed forces.

d. Illnesses, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than that occurring as a consequence of an accidental cut or wound.

BENEFITS

If injuries result in death or dismemberment within one year of the date of the accident, the following benefits are provided:

Loss of Life	Principal Sum
Loss of both hands, feet, eyes, or any combination thereof	Principal Sum
Loss of one hand, foot, or eye	One-half Principal Sum
Loss of thumb and index finger of same hand	One-quarter Principal Sum

Only one benefit, the largest you are entitled to, will be paid for all losses resulting from one accident.

PERMANENT TOTAL DISABILITY (For employees only)

If, within 30 days after an accident, your injuries cause continuous total disability for one year (complete inability to perform every duty of your occupation), and if you are then judged to be permanently and totally disabled (unable to engage in any occupation suitable to your education, training, or experience for the rest of your life) you will be paid the Principal Sum, less any amount paid or payable for dismemberment or loss of sight.

BENEFICIARIES

Beneficiaries may be changed at any time by filing a written statement with the Industrial Relations Department.

TERMINATION

If you terminate your employment with EG&G for any reason, coverage for both you and your dependents will end on the day you leave. (Your last day at work.)

If, after enrolling, you wish to cancel your insurance you must notify the Industrial Relations Department on or before the 15th day of the month in which you wish to cancel. Your coverage will end on the last day of that month.

CONVERSION PRIVILEGE

If you have been covered under this plan and then leave the employ of the Company for any reason other than age you may convert to a basic Accidental Death and Dismemberment policy from the Life Insurance Company of North America (benefits are less than the EG&G Voluntary Accident Plan provides) if you apply and submit the premium within 31 days after termination.

The conversion privilege is also extended to your dependents if they are covered under the family option of the EG&G Voluntary Accident Insurance Plan.

Please contact your Industrial Relations Department for a conversion application and for additional information on this subject.

EG&G

SECTION VI

BUSINESS TRAVEL ACCIDENT INSURANCE

SECTION VI
BUSINESS TRAVEL ACCIDENT INSURANCE

UNDERWRITTEN BY

LIFE INSURANCE COMPANY OF NORTH AMERICA

ELIGIBILITY

All permanent full-time and permanent part-time employees at a location that has adopted this plan of insurance are eligible while traveling on Company business.

ENROLLMENTS

You are automatically enrolled in this Plan on the first day at work.

COVERAGE EFFECTIVE DATE

Your coverage is effective when you actually begin a business trip for the Company, whether from your home or place of employment. Coverage continues until you complete your trip; i. e., arrive back at your home or place of employment, whichever you reach first.

COVERAGE

Coverage is provided on a 24 hour basis for accidents sustained during travel and any activities engaged in while on business trips for the Company.

Air travel as a passenger is covered if the plane is tried, tested, and approved. Company authorized pilots are covered while piloting any tried, tested, and approved aircraft which they are qualified to fly.

Daily commuting to your regular place of employment and vacations are not covered.

AMOUNTS OF INSURANCE

You will be insured for an amount equal to four times your annual base earnings in effect at the time of the accident, subject to a minimum benefit of $50,000 and a maximum benefit of $150,000. Insurance amounts are rounded to the next highest $1,000.

Annual base earnings is defined as an employee's annualized base rate, in effect at the time of the accident; exclusive of shift differentials, overtime, bonuses, dislocation allowances or any other additives to the base rate. However, for a salesman whose earnings are comprised of both a base rate plus commissions, annual earnings is defined as the sum of his monthly base earnings plus commissions for the preceding 12 months.

BENEFITS

If injury results in any of the following losses within one year after the date of accident, this insurance will provide the following benefits:

Loss of Life	Principal Sum
Loss of both hands, feet, eyes, or any combination thereof	Principal Sum
Loss of one hand, foot, eye	One-half Principal Sum
Permanent Total Disability	Principal Sum

Only one benefit, the largest you are entitled to, will be paid for all losses resulting from one accident.

PERMANENT TOTAL DISABILITY

If, within 30 days after an accident, your injuries cause continuous total disability for one year (complete inability to perform every duty of your occupation), and if you are then judged to be permanently and totally disabled (unable to engage in any occupation suitable to your education, training, or experience for the rest of your life), you will be paid the Principal Sum; less any amount paid or payable for dismemberment, or loss of sight.

EXCLUSIONS

This insurance does not cover:

a. Intentional self-inflicted injuries, suicide, or attempted suicide while sane or insane.
b. Injuries or death caused by declared or undeclared war.
c. Service in Armed Forces.
d. Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than that occurring as a consequence of an accidental cut or wound.

BENEFICIARY

Your beneficiary designated in writing and filed with the Company, may be changed at any time by filing a new, written statement with your Industrial Relations/Personnel Department.

TERMINATION OF INSURANCE

Your insurance will terminate automatically on the earliest of the following dates:

1. Termination of employment. (Your last day at work.)
2. Upon termination of this Plan.

THE EG&G PROFIT SHARING RETIREMENT PLAN

(This plan applies to you if you are a member of an eligible group)

This booklet summarizes the main provisions of the EG&G Profit Sharing Retirement Plan. If any conflict should arise between the summary in this booklet and the Trust Agreement or if any point is not covered, the Trust Agreement is the final authority in all cases.

Effective 1/1/70

FORMATION OF THE PLAN

The Profit Sharing Retirement Plan was created December 31, 1953 under an agreement of trust known as the EG&G, Inc. Profit Sharing Trust.

The Plan qualifies under the Internal Revenue Code, thereby providing certain income tax benefits which would not otherwise be available. It is managed by the Trustees and administered by an Administrative Committee of participating employees.

PURPOSE OF THE PLAN

The Profit Sharing Retirement Plan enables you to participate in the growth of our Company by sharing in its earnings. The Plan gives you an opportunity . . .

to share in the success of the Company;
to save, with important tax advantages;
to benefit from investment growth;
to accumulate retirement income;
to build a substantial estate for the future.

Naturally, it's up to you to take advantage of the opportunities offered by the Plan by making our profits well worth sharing.

WHEN YOU BECOME ELIGIBLE

To be eligible to participate in the Profit Sharing Retirement Plan you must be employed on a full-time basis from the first working day to the last working day of the calendar year, at a location that has adopted this program.

Note: Continuous eligibility can be maintained during approved leaves of absence, or during layoff due to reduction in force, by complying with pertinent Company personnel policies.

HOW THE PLAN IS FUNDED

During the first thirteen years, the Company made the only financial contributions to the Plan. On January 1, 1966, the Trust Agreement was amended to permit additional participation by eligible employees, through voluntary contributions to their own accounts, in addition to the Company contributions.

Contributions by the Company

The Company contributes 25% of annual net profit, as defined below, but the contribution shall not exceed an amount equal to 10% of total base compensation paid to all participating employees for the year concerned.

Annual net profit is profit earned by the Company for the year concerned (as calculated by the Company's chief accounting officer in accordance with good accounting practice) before deductions for Federal and State income taxes, and before deduction for the Company's contribution to the Profit Sharing Trust.

No part of the Company's contribution can ever be repaid to the Company.

Voluntary Employee Contributions

If you are eligible to participate in the Plan, you may make voluntary contributions to the Trust Fund, in addition to any contributions made by the Company. Your contribution will in no way affect the Company's contribution to your account.

Voluntary contributions may be made only through regular payroll deductions and shall not be less than 2% nor more than 10% of your base compensation as of the first working day of each year.

Voluntary contributions shall be separately credited to your account and shall share in any increase or decrease in the net worth of the Trust.

Your Share of Annual Company Contributions

Each annual contribution made by the Company is allocated proportionately among Participants as of the end of the year concerned. Your account is credited with an amount equal to the proportion that your base compensation for such year is to the base compensation of all Participants for such year.

Example: If your base compensation were $8,000 a year and the total base compensation of all Participants is $20,000,000, your portion would be 0.04% of the Company's contribution. Thus if the Company's contribution is $1,000,000, your account would be credited with $400.

Funds are Invested for You

The Company's annual contributions, together with employee voluntary contributions, are placed in the Trust for investment by the Trustees. Your account is credited with any income or gains resulting from investments, and charged with any losses. Income and gains are credited, and any losses are charged to your account in the proportion that the balance in your account is to the balance in all accounts. You will receive a statement of your account as of the end of each year.

How You Arrange for Voluntary Contributions

Each December, during a specified period, an employee desiring to make voluntary contributions shall submit a payroll deduction authorization stating the amount to be withheld from his regular paycheck during the ensuing year. Such regular deductions shall not be less than 2% nor more than 10% of his regular base compensation. Changes in the amount of deductions can be made effective only on the first payday of each year.

You may discontinue your voluntary contributions at any time upon one week's written notice but, once discontinued, you cannot resume contributions until the first payday of the next year.

IF YOU LEAVE

1. *Employment Period Less Than Three Years*

If you terminate your employment because of death, total and permanent disability as determined by the Administrative Committee, or retirement at age 65 or older, the entire balance in your account derived from the Company's contributions, adjusted by the last previous quarterly fund evaluation, will be paid to you or your beneficiary.

If you terminate your employment for any other reason, the entire balance in your account derived from the Company's contributions is forfeited.

2. *Employment Period Three Years or More*

If you terminate your employment because of death, total and permanent disability as determined by the Administrative Committee, or retirement at age 65 or older, or layoff due to a reduction in the work force, the entire balance in your account derived from the Company's contributions, adjusted by the last previous quarterly fund evaluation, will be paid to you or your beneficiary.

If you terminate your employment for any other reason after the completion of three full continuous years of service, either voluntarily or involuntarily, 10% of the balance in your account derived from the Company's contributions is non-forfeitable; and for each additional year of continuous employment, an additional 7½% of the amount derived from the Company's contributions becomes non-forfeitable. Thus, after the completion of 15 years of service, 100% of the amount derived from the Company's contributions becomes fully vested and non-forfeitable and will be paid to you at termination for any reason. The balance in your account will be adjusted according to the most recent fund evaluation prior to termination.

Of course, the balance derived from your voluntary contributions is at all times 100% vested and non-forfeitable and an amount as determined by the last quarterly valuation will be paid in full upon termination for any reason.

WITHDRAWALS FROM THE FUND

You may withdraw a portion or all of the balance derived from your voluntary contributions, adjusted according to the most recent quarterly evaluation, at any time, subject to the following limits in any calendar year.

First Withdrawal — The minimum withdrawal allowed will be $500 or 100 per cent of your account, whichever is smaller, upon 30 days advance notice to the Administrative Committee.

Second Withdrawal — The minimum withdrawal allowed will be $500 or 100 per cent of your account, whichever is smaller, upon 60 days advance notice to the Administrative Committee.

Third Withdrawal — The minimum withdrawal allowed will be the entire balance in your account, upon 60 days advance written notice to the Administrative Committee. Voluntary contributions will be cancelled and cannot be resumed until the first payday.

Note: There are certain tax disadvantages which should be discussed with a qualified tax advisor before such a withdrawal is made.

DISTRIBUTIONS TO YOU UPON TERMINATION

If you terminate employment during the course of the year, whether through resignation, disability, retirement or any other reason, and whether voluntarily or involuntarily, any non-forfeitable balance derived from the Company's contributions to your account, adjusted according to the most recent quarterly evaluation, shall be distributed to you.

If your service is terminated due to death, normal retirement, or permanent total disability, you will also receive a current year contribution to the extent of your base wages earned during the year. Payment of the current year contribution would be made after the close of the calendar year when the Company contribution is known.

Distribution of contributions may be cash settlement, the purchase of an annuity, or some combination of both, as determined by the Administrative Committee after consultation with you.

Any portion of your account which becomes forfeitable upon termina-

tion is allocated and credited to the accounts of the remaining Participants in the same proportionate manner as are income and gains realized from investment of funds. No portion of any forfeitable amount can ever be repaid to the Company.

The account balance derived from your voluntary contribution, which is payable in full upon termination for any reason, may, if requested by you and approved by the Administrative Committee, be combined with the nonforfeitable balance derived from Company contributions in order to formulate a settlement plan.

If you die, the full amount credited to your account will be paid to your beneficiaries in such proportions and amounts as are designated in writing and filed with the Company. You may change this designation from time to time, and the designation last filed shall govern. In the absence of any such designation of beneficiaries, payment shall be made to your estate.

WHAT ELSE YOU SHOULD KNOW

The Administrative Committee

The Administrative Committee is appointed by the Board of Directors and members serve without compensation. Membership must be at least two and no more than five, and the Committee shall act by majority vote.

The Committee will keep on file a copy of the Trust Agreement and all annual reports of the Trust for examination by Participants during reasonable business hours. Annually (usually in March), the Committee furnishes each Participant a statement of his interest in the Trust as of the close of the preceding year.

The Committee is authorized to interpret the Plan, to decide all questions that arise including questions submitted by the Trustees on all matters necessary for them properly to discharge their duties, powers, and obligations; and is empowered to make policies concerning the status of participants in times of leave or layoff, and to set down rules of interpretation and administration. The Committee is responsible for acting in a uniform, nondiscriminatory manner and its decisions, made in good faith, are final.

Members of the Committee are available to answer any questions which any employee may have from time to time concerning the Plan. Names of the current Committee members are available through the Industrial Relations Department.

The Trustees

The Trustees are appointed by the Board of Directors and are responsible for proper and prudent management of the Trust in accordance with provisions of the Trust Agreement. Names of the Trustees are available through the Industrial Relations Department.

The Life of the Plan

The Company has established the Plan with the intention and expectation that it will continue indefinitely; but the Company is not and shall not be under any obligation or liability whatsoever to continue or to maintain the Plan for any given length of time and may, in its sole and absolute discretion, discontinue contributions or terminate the Plan at any time without any liability whatsoever for such discontinuance or termination.

If the Company should ever terminate the Plan, the entire balance in each Participant's account shall become 100% vested. None of the funds of the Trust can ever be repaid to the Company.

SOME QUESTIONS AND ANSWERS ABOUT THE EG&G PROFIT SHARING RETIREMENT PLAN

- When am I eligible to share in the profits of EG&G?

  You will be eligible to participate in the EG&G Profit Sharing Retirement Plan when you have been employed on a full-time basis from the first working day to the last working day of the calendar year at a location that has adopted the Plan.

- What if I transfer to an EG&G location that has not adopted the Plan?

  To encourage the mobility of our employees in event opportunities arise within our subsidiaries, we have established the following method to protect your retirement rights.

  (a) If you are transferred for a period of 12 months or less, you will remain on the EG&G payroll and continue to participate in the EG&G Profit Sharing Plan. The subsidiary will be charged your salary and other appropriate expenses.

  (b) If you are transferred for a period in excess of 12 months:

  1. You will be placed on a leave of absence from EG&G.
  2. Your account will be retained in the Profit Sharing fund, but you will not be eligible for Company contributions.
  3. Your account will be credited with a current year contribution to the extent of your base wages earned in the year prior to transfer.
  4. Your account will share in any gains or losses resulting from investments, and will also continue to share in forfeitures.
  5. Your continuous service with the subsidiary company will be counted as years of service towards vesting in the EG&G Plan.
  6. Because you would no longer be an active member of the EG&G Plan, you could not continue voluntary contributions.
  7. Any balance in your account derived from Company contributions would not be payable until you terminated from the EG&G family.

- I became an employee in November. Must I wait until I have been here a full year before I can make voluntary contributions?

  No. You may begin voluntary contributions on the first payday in January following your employment date.

- If I make voluntary contributions, will my share of the Company's contributions be larger or smaller?

  Neither. Your voluntary contributions will in no way affect the Company's contributions to your account.

- My base pay is $156 per week. What is the least and most I may contribute?

  You can authorize deductions from your salary from $3.50 to $15.50 per week. (Weekly deductions shall not be less than 2%, nor more than 10% of your weekly base compensation, and must be rounded off to even 50 cent amounts.)

- If I elect to contribute 10% of my pay and get a raise in, say, April, may I then raise my contribution to 10% of my new rate?

  No. Contributions can be changed only on the first payday of each year.

- What does "vesting" mean?

  "Vesting" means that portion of your account which is derived from Company contributions and which, under the terms of the Plan, becomes non-forfeitable due to length of employment.

- I joined EG&G on March 16, 1970. When will my account become vested?

  If you are continuously employed until March 16, 1973, 10% of your account derived from Company contributions becomes vested on that date, with an additional 7½% becoming vested for each additional year of employment so that 100% vesting will occur at the end of 15 years.

- I feel that I cannot afford to make voluntary contributions next year. Can I start them the following year?

  Yes, you can begin contributions on the first payday of any year.

- If I experience financial difficulties, can I discontinue voluntary contributions?

  Yes, you may discontinue voluntary contributions at any time by giving

one week's advance notice in writing to your Industrial Relations Department.

- Can I resume making voluntary contributions at a later date?

  Yes, but not until the first payday of the next year.

- Will the contributions I have already made share in any investment income/loss during that year?

  Yes.

- If I need the money, can I withdraw the balance in my account?

  You may withdraw part or all of the balance derived from your voluntary contributions, adjusted according to the most recent quarterly evaluation. However, you may not withdraw any portion of your account derived from Company contributions so long as you are an employee.

  There are some restrictions regarding the number of withdrawals that may be made in one calendar year:

  First Withdrawal — The minimum withdrawal allowed will be $500 or 100% of your account, whichever is smaller, upon 30 days advance notice to the Administrative Committee.

  Second Withdrawal — The minimum withdrawal allowed will be $500, or 100% of your account, whichever is smaller, with 60 days advance notice to the Administrative Committee.

  Third Withdrawal — The entire balance in your voluntary contribution account must be withdrawn, subsequent to 60 days advance written notice to the Administrative Committee. Your voluntary contributions must be canceled for the remainder of the calendar year.

- Are there disadvantages in making withdrawals?

  Yes. The amount withdrawn will not share in any investment income or appreciation subsequent to the last calendar quarter in which such withdrawal is made. Also, you may incur some tax disadvantages. Competent tax advice should be obtained prior to making such a withdrawal.

- Could I borrow from the Trust and repay my loan before the end of the year?

  No. Borrowing from the Trust is not permitted.

- May I assign the vested portion of my account as collateral for a bank or credit union loan?

  No. Assignment is prohibited by terms of the Trust Agreement.

- May I continue to participate even after reaching age 65?

  You can continue to participate so long as you are continuously employed as a permanent full-time employee of the Company.

- What if I become totally disabled?

  If your employment terminates as a result of total and permanent disability, as determined by the Administrative Committee, your account becomes fully vested.

- What if I go on leave of absence?

  The period of a leave of absence approved by the Company counts as continuous employment for purposes of eligibility required to participate in the Plan.

- Is early retirement permitted?

  There is no restriction against early voluntary retirement. However, if you voluntarily retire prior to 15 years of continuous employment, you forfeit part of your account derived from Company contributions.

- What are the advantages of this program over buying shares in a mutual fund?

  The Company pays all costs of management of the Trust, and voluntary contributions enjoy the same tax shelter as Company contributions once they are under the Trust.

- Is there any risk involved if I make voluntary contributions to the Plan?

  Your voluntary contributions share both in the annual increase or decrease in the net worth of the Trust. A decrease in net worth of the Trust in a given year will effect a decrease in the value of your voluntary contributions account.

- Do I have to pay income tax on my voluntary contributions?

  Yes, just the same as on all other portions of your wages or salary. However, there is no tax on any income or capital appreciation which is generated while the contributions remain in the Trust.

- When benefits are paid to me or to my beneficiary, are these benefits taxable?

  Only the excess above the amount of your voluntary contributions is taxable.

- Why should I name a beneficiary?

  As a participant in the Plan, you acquire an interest in property of value. If you should die, you would want your interest to be received by the person or persons of your choice. Therefore, you should designate a beneficiary on the appropriate form which is available at your Industrial Relations Department. The form may also be used to effect a change of beneficiary.

- Can the Plan be amended or terminated?

  While the Plan is intended to be a continuing program, the Company reserves the right to amend, terminate, or suspend the Plan. However, any such action may not reduce the already accrued interest of participants or their beneficiaries.

- If I have any other questions about the Plan, how do I get answers?

  Contact your Industrial Relations Department. If they do not have sufficient information to satisfactorily answer your questions, they will put you in touch with a member of the Administrative Committee.

EG&G

to Each Employee

from The Administrative Committee

subject EG&G Employees Savings Plan

The EG&G Savings Plan outlined in the attached pages has been submitted to the Internal Revenue Service for approval as a 'qualified' plan under the Internal Revenue Code.

It is important that the Plan is approved by the Internal Revenue Service so that the Company's contribution and any appreciation on your contributions (interest, dividends, market appreciation of securities, etc.) is not taxable until distributed to you at the time of a withdrawal or termination.

At the time this booklet was printed, the Internal Revenue Service has not responded to our request for approval, and therefore, the provisions of the Plan contained in these pages must be viewed as tentative since it is possible that the Internal Revenue Service will insist on some changes as a condition of approving the Plan. However, based on competent professional advice, we do not expect the Internal Revenue Service will object to the basic structure of the Plan.

EXAMPLES OF RELATIVE VALUE SCHEDULE

RESPIRATORY SYSTEM	
Submucous resection, nasal septum	30.0
Antrotomy, intranasal, unilateral	15.0
bilateral	25.0
Radical (Caldwell-Luc), unilateral	50.0
bilateral	65.0
Bronchoscopy, diagnostic	15.0
with removal of foreign body or tumor	25.0
Thoracotomy, exploratory, including biopsy	50.0
Lobectomy, total or subtotal	100.0
wedge resection, single or multiple	80.0
CARDIOVASCULAR SYSTEM	
Valvulotomy or commissurotomy, mitral	120.0
aortic, pulmonic, tricuspid	150.0
Varicose Veins	
Ligation and division and complete stripping	
long or short saphenous veins, unilateral	30.0
bilateral	50.0
long and short saphenous veins, unilateral	40.0
DIGESTIVE SYSTEM	
Tonsillectomy, with or without adenoidectomy, under age 18	15.0
age 18 or over	20.0
Gastrectomy, subtotal, with or without vagotomy	80.0
Colectomy, partial resection of large intestine in two stages, including first stage colostomy or cecostomy	100.0
Appendectomy	40.0
Proctectomy, complete, combined abdomino-perineal, one or two stages	100.0
Fistulotomy or fistulectomy, subcutaneous	10.0
submuscular	40.0
Hemorrhoidectomy, external	20.0
internal or internal and external	30.0
with submuscular fistulotomy or fistulectomy	40.0
Cholecystectomy: removal of gall bladder	60.0
with open exploration of common duct	70.0
Exploratory laparotomy	40.0
Herniotomy,	
Femoral, inguinal, unilateral	35.0
Inguinal, with orchidectomy or excision of hydrocele	40.0

The Conversion Factor to be applied is $6.00.

THE EG&G EMPLOYEES SAVINGS PLAN

CONTENTS

NOTE: This booklet summarizes the main provisions of the EG&G Employees Savings Plan available to eligible employees. The governing documents in all cases will be the official Plan document and the Trust agreement.

While it is the intent of EG&G to continue benefits described in this booklet, the right to change, modify or discontinue them, without notice, is reserved to the extent permitted by law.

A copy of the Plan and Trust document is on file in your Personnel Department for your examination.

SUMMARY OF THE SAVINGS PLAN

- You may choose your level of savings anywhere from 1% to 10% of your base compensation.
- The Company contributes 25¢ in your behalf for each dollar you contribute during the calendar year up to a maximum of 1.5% of your total base compensation during that year.
- You can have your funds invested in either a Capital Savings Fund (Fund A), or a Capital Investment Fund (Fund B).
- The Plan allows you to change, suspend or even withdraw your own contributions subject to certain conditions and requirements.
- The Company contribution and both gains and earnings on the Funds are tax free until paid out—a substantial tax savings to you.
- The Plan provides an opportunity for you to save for your retirement years, for your family in case of premature death, or in time of financial need, for example, termination of employment.

PLAN OBJECTIVES

The EG&G Employees Savings Plan has been established to:

- Encourage long-term, systematic saving
- Provide you with funds for retirement or possible earlier needs

WHO IS ELIGIBLE

All full-time permanent employees of EG&G, Inc. and its participating subsidiaries are eligible to join the Plan unless covered by a collective bargaining agreement which does not provide for participation in the Plan.

WHEN CAN YOU JOIN

You may elect to join as of the first working day of any January or July on which you are eligible by completing an enrollment form provided by your Personnel Department.

Membership in the Plan is entirely voluntary. However, you will be able to realize the maximum benefits from the Plan by enrolling at your first opportunity.

YOUR SAVINGS UNDER THE PLAN

When you join the Plan, a Member and a Company Account is established in your name. You may elect to save from 1% to 10% of your base compensation as your contribution. Base compensation is defined as your base rate exclusive of shift differentials, overtime, bonuses, or other additives to base rate.

For example, an employee whose base weekly compensation is $200.00 may contribute from $2.00 to $20.00 per week.

COMPANY CONTRIBUTION

For each dollar that you contribute during the calendar year and is still in your account at year end, the Company will contribute 25¢ up to a maximum Company Contribution of 1.5% of your total base compensation during that year. The Company contribution in your behalf will be credited to your Company Account.

That is, if you contribute during the calendar year an amount which is equal to or less than 6% of your total base compensation during that year and do not make any withdrawals in that year, the Company will contribute 25¢ for each $1.00 contributed by you. The Company

will not make any contribution with respect to your contributions which are in excess of 6% of your total base compensation during that year.

For example, if your base compensation in a given year is $10,400 and you saved $520.00 in that year, the Company will contribute $130.00 to your account at the end of the year.

If you had saved $1,040.00 during the year, the Company will contribute $156.00 to your Company Account.

While you contributed twice as much in the second example, the Company contribution is limited under the terms of the Plan to a maximum of 1.5% of your total base compensation during that year. (1.5% × $10,400 = $156.00).

If you contribute in excess of 6% of your base compensation at the start of the year and receive an increase during the year, the increase in base rate will be taken into consideration in determining the Company contribution at year end.

YOU CAN CHANGE THE AMOUNT OF YOUR CONTRIBUTIONS

You can change the amount of your contribution on the first of any January or July provided you give 30 days' advance written notice.

If your base compensation changes and you wish to adjust your contribution, you can do so on any January 1 or July 1 upon 30 days' advance written notice. Otherwise, your present rate of contribution will continue.

HOW YOUR SAVINGS ARE INVESTED

Both your contributions and the Company's contributions are placed in a Trust for investment. The Trustee(s) will maintain two investment funds designed to meet different investment objectives.

At the time you enroll, you can select the manner in which your contribution will be invested by designating either Fund A or Fund B. These two Funds are described as follows.

FUND A—CAPITAL SAVINGS FUND

Objective: Preservation of Capital

The primary purpose of Fund A is preservation of capital while providing a rate of return which is consistent with low-risk investments, yet slightly in excess of the average return on a savings account. Your contribution will be invested in savings accounts, good quality bonds, and other fixed income investments of recognized quality.

FUND B—CAPITAL INVESTMENT FUND

Objective: Long-Term Capital Growth

The primary purpose of Fund B is long-term growth of capital through appreciation of securities and income from dividends and interest. The majority of this investment portfolio will generally be in good quality common stocks and other equity securities.

While Fund A involves less risk of investment loss than Fund B, you are reminded that the market value of the securities in the Funds can go down as well as up. Therefore, there is no guarantee that the market value of the securities in the Funds attributable to your contributions will, at the time of withdrawal or distribution, be equal to or greater than your contributions.

NOTE: The Company Contribution in your behalf will be invested in Fund B.

CAN I CHANGE MY FUND DESIGNATION

Yes, you may change your fund designation with respect to future contributions on any January 1 or July 1 provided you give 30 days' advance written notice. For example, if your contributions are presently going into Fund B, you may direct future contributions into Fund A on the dates stated above.

If you are age 55 or over, you can transfer part or all of your Member Account from one fund to the other provided you give 30 days' advance written notice. This type of transfer can be made only twice and the last transfer will remain in effect until termination.

WHEN DOES THE COMPANY'S CONTRIBUTION BECOME VESTED

Since the Savings Plan is designed to encourage long-term savings, your Company Account vests in accordance with the following schedule.

Completed Years of Continuous Service	Vested Interest
Less than 5	0%
5 but less than 6	50%
6 but less than 7	60%
7 but less than 8	70%
8 but less than 9	80%
9 but less than 10	90%
10 or more	100%

Eligible employees who are on the payroll June 30, 1972 will be given credit towards vesting for service since their most recent hire date provided they elect to enroll in the Savings Plan as of July 1, 1972.

In the event an employee on the payroll June 30, 1972 does not enroll as of July 1, 1972 but elects to enroll at a subsequent entry date, his vesting period will commence on July 1, 1972, provided he has been continuously employed since July 1, 1972, and no credit will be given for service prior to July 1, 1972.

For example, if your most recent hire date is July 1, 1967 and you elect to join the Plan on July 1, 1972, you will be credited with 5 years of continuous service and will be 50% vested in your Company Account. However, if you do not enroll on July 1, 1972, but enroll on a subsequent entry date, your vesting period will commence on July 1, 1972, or your most recent date of hire, whichever is the later.

If you were hired after July 1, 1972, your most recent date of hire will be used in determining your vesting regardless of when you join the Plan. That is, if your most recent date of hire is September 1, 1972 and you did not elect to join the Plan until January 1, 1978, you would be 50% vested in the Plan, since your period of vesting would commence on September 1, 1972. Naturally, your Company Account would not contain any funds since you had not made any contributions prior to January 1978.

WHAT HAPPENS IF I LEAVE THE COMPANY

If you should terminate due to death, permanent and total disability as determined by the Administrative Committee, or retirement at age 65 or older (or under the early retirement provision of the EG&G Employees Retirement Plan), the entire amount in both your Member and Company Account will be distributable to you, or to your beneficiary in the event of your death.

If your employment should terminate for any other reason, the entire amount in your Member Account and any part of your Company Account to which you have a vested interest (see vesting schedule on page 5) will be distributable to you.

Any portion of your Company Account not distributable upon your termination will be forfeited and used to reduce the amount of the Company's contribution in a subsequent period.

If your employment is terminated for reasons of embezzlement or theft of Company money or property, you will forfeit the entire amount, vested and unvested, in your Company Account.

The method of distribution may be by lump sum settlement, the purchase of an annuity, or some combination of both.

WITHDRAWALS AND SUSPENSIONS OF CONTRIBUTIONS

As indicated above, the EG&G Savings Plan has been designed to encourage long-term savings. However, you may find it necessary to temporarily suspend contributions or to withdraw part of your savings in the event of unexpected financial needs. Therefore, the Plan does allow you to suspend contributions and/or to withdraw part or all of your savings. However, since withdrawals tend to defeat the purpose of the Plan, certain restrictions and penalties are imposed.

You may suspend your contributions at any time by providing 30 days' advance written notice. However, you will not be able to resume contributions until a subsequent entry date which is at least six months after the date of your discontinuance of contributions.

You may withdraw all or part of your Member Account by providing 45 days' advance written notice. However, if you withdraw any voluntary contributions that have not been in the fund for at least two calendar years, the Internal Revenue Service Regulations require that you forfeit the Company Contribution (adjusted for any increase or decrease in the net worth of the Trust) made with respect to those contributions. Therefore, in order to minimize the possibility of forfeiture or taxation on earnings, withdrawal of funds from a Member's Account will be taken in the following order:

1) Voluntary contributions prior to 7/1/72, if any.
2) Voluntary contributions made in the year of withdrawal, if any.
3) Voluntary contributions made after 6/30/72 which were in excess of 6% of your basic compensation.
4) Voluntary contributions after 6/30/72 with respect to which a Company contribution was made in the order in which such contributions were made.
5) Any increase in your Member Account due to an increase in the net worth of the Trust.

However, if you make a withdrawal, you must suspend contributions and you will not be able to resume contributions until a subsequent entry date which is at least six months after the date of your withdrawal.

You cannot withdraw any part of your Company Account, vested or not, while still employed by the Company.

NOTE: If you have a Voluntary Profit Sharing account balance on June 30, 1972, you may withdraw your voluntary contributions from that account without having to suspend contributions under this Plan.

YOUR RETURN UNDER THE PLAN

As you know, both your contributions and the Company's contributions are invested and, as in the case of any investment program, there can be no guarantee as to the amount you will receive from the Plan. Investments in common stocks and other securities can vary either up or down depending on the overall general economy and the specific investment decisions of the Trustee.

TAX INFORMATION

Since this Plan qualifies for exemption from Federal income taxes under sections 401 and 501 of the Internal Revenue Code, you do not have to pay Federal income taxes on the Company contributions or on any earnings credited to your account prior to the time they are distributed to you. Since state tax laws vary widely, state tax rules are not discussed in this booklet, although many states also provide tax benefits for this type of Plan.

Any amounts you withdraw from the Plan prior to termination of employment which are in excess of your contributions will be taxed as ordinary income.

In the case of a lump sum distribution upon termination of employment, the amount distributed in excess of your contributions will be taxed as follows:

(a) The Company contributions will be taxed as ordinary income subject, in most cases, to special "averaging" provisions designed to limit the amount of such tax.

(b) The earnings on both your savings and the Company contributions and realized appreciation in the value of securities will be taxed as long-term capital gains.

The general description of the Federal income tax provisions outlined above are based on present laws and regulations and are subject to change.

AMOUNT DISTRIBUTABLE

Both your Member and Company Account will be valued at the end of each calendar quarter (March, June, September, December).

In the event of a distribution the amount distributable will be in accordance with the terms of the Plan and will be based on the value of your Member and Company Accounts as of the last quarterly Fund valuation coinciding with or next preceding the date of withdrawal or termination, adjusted for any contributions or withdrawals since the last Fund valuation.

ADMINISTRATION

The Plan is administered by an Administrative Committee appointed by the Board of Directors of EG&G Inc.

The Committee is authorized to interpret the Plan, to decide all questions that arise including questions submitted by the Trustees on all matters necessary for them properly to discharge their duties, powers, and obligations; and is empowered to make policies concerning the status of participants in times of leave or layoff, and to set down rules of interpretation and administration. The Committee is responsible for acting in a uniform, nondiscriminatory manner and its decisions, made in good faith, are final.

GENERAL

If you have any questions regarding this Plan, please do not hesitate to discuss the Plan with your supervisor or the Personnel Department.

You will receive each year a statement showing the value of your Member and Company Account.

Enrollment, change, and withdrawal forms are available in your Personnel Department.

Contributions to the Plan may be made only through payroll deductions.

In the event you wish to enroll in the Plan or make any other changes, your completed form must be received in the Personnel Department in accordance with the required advance notice period.

THE LIFE OF THE PLAN

The Company has established the Plan with the intention and expectation that it will continue indefinitely; but the Company is not and shall not be under any obligation or liability whatsoever to continue or to maintain the Plan for any given length of time and reserves the right to amend the plan at any time. No amendment can be made, however, which would divest any member of any interest then vested in him. Each participating subsidiary reserves the right to discontinue its participation in the Plan without discontinuing the Plan with respect to EG&G or any other participating subsidiary.

If the Plan should ever be discontinued by EG&G Inc. or by the subsidiary with whom you are employed, your interest in your Company Account would become fully vested. At that time, the Board of Directors of EG&G will make a decision to either continue the Trust or to make a full distribution.

None of the funds of the Trust can ever be repaid to the Company.

SOME QUESTIONS AND ANSWERS ABOUT THE EG&G SAVINGS PLAN

- What if I transfer to an EG&G subsidiary or affiliate that has not adopted the Plan?

  To encourage the mobility of our employees in event opportunities arise within our subsidiaries, we have established the following method to protect your rights.

  (a) If you are transferred for a period of 12 months or less, you will remain on the EG&G payroll and continue to participate in the EG&G Savings Plan. The Subsidiary will be charged your salary and other appropriate expenses.

  (b) If you are transferred for a period in excess of 12 months:

  1. *You will be placed on a leave of absence from EG&G.*
  2. *Your account will be retained in the Plan, but you will not be eligible for Company contributions except as in 3 below.*
  3. *Your account will be credited with a current year contribution to the extent of your net contributions made up to the date of transfer.*
  4. *Your account will share in any gains or losses resulting from investments.*
  5. *Your continuous service with the subsidiary company will be counted as years of service towards vesting in the EG&G Plan.*
  6. *Because you could no longer be an active member of the EG&G Plan, you could not continue contributions.*
  7. *Any balance in your Company Account would not be distributable until you terminated from the EG&G family.*

- If I elect to contribute 10% of my pay and get a raise in, say, April, may I then raise my contribution to 10% of my new rate?

  No. Contributions can be changed only twice a year on January 1 and July 1.

- What does "vesting" mean?

  "Vesting" means that portion of your Company Account which, under the terms of the Plan, becomes non-forfeitable due to length of participation in the Plan.

- What are the advantages of this program over buying shares in a mutual fund?

  The Company pays all costs of management of the Trust, and your contributions enjoy the same tax shelter as Company contributions once they are under the Trust.

- Is there any risk involved if I make contributions to the Plan?

  Your contributions share both in the increase or decrease in the net worth of the Trust. A decrease in net worth of the Trust will effect a decrease in the value of your Member and Company Account.

- Do I have to pay income tax on my contributions?

  Yes, just the same as on all other portions of your wages or salary. However, there is no tax on any income or capital appreciation which is generated while the contributions remain in the Trust.

- When benefits are paid to me or to my beneficiary, are these benefits taxable?

  Only the excess above the amount of your contributions is taxable.

- Why should I name a beneficiary?

  As a participant in the Plan, you acquire an interest in property of value. If you should die, you would want your interest to be received by the person or persons of your choice. Therefore, you should designate a beneficiary on the appropriate form which is available at your Personnel Department. The form may also be used to effect a change of beneficiary.

- If I experience financial difficulties, may I discontinue contributions?

  Yes, you can discontinue contributions at any time by giving 30 days' advance notice in writing to your Personnel Department.

- Can I resume making contributions at a later date?

  Yes, but not until the next January 1 or July 1 which is at least six months after the date of discontinuance.

- Will the contributions I have already made share in any investment income/loss during that year?

  Yes.

- Could I borrow from the Trust and repay my loan before the end of the year?

  No. Borrowing from the Trust is not permitted.

- May I assign the vested portion of my Company Account as collateral for a bank or credit union loan?

  No. Assignment is prohibited by terms of the Trust Agreement.

- May I continue to participate even after reaching age 65?

  You can continue to participate so long as you are continuously employed as a permanent full-time employee of the Company.

- What if I become totally disabled?

  If your employment terminates as a result of total and permanent disability, as determined by the Administrative Committee, your Company Account becomes fully vested.

- If I suspend contributions during the year, will I receive a Company contribution on my contributions made prior to the time I cease contributions?

  Yes, as long as your contributions are still in your Member account at the end of the year, you will receive a Company contribution in accordance with the terms of the Plan.

- Can the Plan be amended or terminated?

  While the Plan is intended to be a continuing program, the Company reserves the right to amend, terminate, or suspend the Plan. However, any such action may not reduce the already vested interest of participants or their beneficiaries.

- If I have any other questions about the Plan, how do I get answers?

  Contact your Industrial Relations Department. If they do not have sufficient information to satisfactorily answer your questions, they will put you in touch with a member of the Administrative Committee.

- What if I go on a leave of absence?

  The period of a leave of absence approved by the Company counts as continuous employment for purposes of vesting only if you return to work. If you do not return to active service at or before the leave expires, the time spent on leave will not count as continuous service for purposes of vesting. The entire amount of your Member Account and any part of the amount of your Company Account will be distributable to you as determined by the last Fund valuation prior to the date of the termination of your leave.

THE EG&G EMPLOYEES RETIREMENT PLAN

CONTENTS

NOTE: This booklet summarizes the main provisions of the EG&G Employees Retirement Plan available to eligible employees. The governing documents in all cases will be the official Plan document and the Trust agreement.

While it is the intent of EG&G to continue benefits described in this booklet, the right to change, modify or discontinue them, without notice, is reserved to the extent permitted by law.

SUMMARY OF THE PLAN

- EG&G pays the full cost of the Plan.
- The benefits provided by the Plan are in addition to Social Security retirement income.
- Your retirement income is based on your final average earnings, as well as years of service. As your earnings increase, so does your potential retirement income.
- When you retire, you have a choice of how your retirement income may be received, such as, lifetime income, survivor's option, 5, 10 or 15 year certain.

PLAN OBJECTIVE

The EG&G, Inc. Employees Retirement Plan has been established to provide you with retirement income which will provide a measure of freedom from economic dependency in post retirement years.

WHO IS ELIGIBLE

All full-time permanent employees of EG&G, Inc. and its participating subsidiaries are eligible for Plan membership unless

a) you are covered by a collective bargaining agreement which does not provide for participation in the Plan

b) your date of employment is after you have attained age 65.

All you need to do is complete an enrollment application which may be obtained from your Personnel Department.

NORMAL RETIREMENT DATE

Your normal retirement date is the first day of the month following your 65th birthday. You may elect an early retirement date commencing on the first day of any month after you have attained age 60 and completed at least 10 years of continuous service with the Company.

BENEFITS PAYABLE AT NORMAL RETIREMENT DATE

The amount of your pension, at age 65, depends on your number of years of credited service with the Company and your "final average earnings" (the average of your earnings during the five highest consecutive years out of the last ten years preceding your date of termination).

The term earnings in the Plan means your base compensation exclusive of overtime, bonus, or any other forms of additional compensation.

Your benefit from the Plan at your normal retirement date is a monthly income payable for life which is equal to $1/12$ of the sum of (a) and (b) below:

a) For each year of credited service before July 1, 1972:

$1/3$% of your average earnings up to the Social Security Tax Base, plus

$2/3$% of any part of your average earnings in excess of the Social Security Tax Base.

b) For each year of credited service after July 1, 1972:

$1/2$% of your average earnings up to the Social Security Tax Base, plus

1% of any part of your average earnings in excess of the Social Security Tax Base.

BENEFITS PAYABLE AT EARLY RETIREMENT

You may elect early retirement if you have reached age 60 and have completed at least 10 years of continuous service with the Company. If you elect to defer benefits until age 65, the amount of your monthly retirement income will be determined in the same manner as at normal retirement multiplied by your vested interest as determined by the vesting schedule below.

If you elect to commence benefit payments at the time of your retirement, the amount of your monthly income determined above will be actuarially reduced since it is anticipated that you will receive benefits for a longer period of time.

DELAYED RETIREMENT

You may continue working after age 65 if mutually agreed to by the Company and you. In that case, monthly benefits will not begin until actual retirement. Further, additional years of service will not increase your pension benefits, and the monthly benefit will be the amount you were entitled to receive on your normal (age 65) retirement date.

TERMINATION BEFORE RETIREMENT

If you leave the Company before retirement but after you have both completed at least 10 years of continuous service and attained age 40, you will be entitled to a monthly income from the Plan beginning at age 65. The amount of your retirement income will be determined in the same manner as at normal retirement multiplied by your vested interest as determined by the vesting schedule below.

DEATH BEFORE RETIREMENT

The Company's group life insurance program provides financial protection for your family in the event you die before retirement. Therefore, no benefits will be payable to your survivors if you die before you retire. All the money paid into the Trust Fund is intended for retirement benefits only.

VESTING SCHEDULE

Once you have completed at least 10 years of continuous service and attained age 40, you are vested in the Plan according to the following schedule:

Completed Years of Continuous Service	*Percent Vested in Retirement Income*
10	50%
11	60%
12	70%
13	80%
14	90%
15	100%

However, regardless of years of service, you are 100% vested in your retirement income if you retire at your normal retirement date, or in the event of a delayed retirement, after your normal retirement date.

CREDITED SERVICE

One month's credited service is allowed for each month in which you receive compensation from the Company or are on a medical leave of absence.

Time spent on a leave of absence for other than medical reasons, while on layoff status, or while employed by a subsidiary or an affiliate that does not participate in this plan does not count as credited service.

Credited service is used as the basis in determining the amount of your retirement income.

CONTINUOUS SERVICE

Continuous service is used as the basis in determining eligibility for benefit payments in accordance with the vesting schedule, and includes the period from your most recent date of hire to date of termination.

Time spent on an authorized leave of absence or on layoff status is not considered as an interruption of employment as long as you return to active employment at or before the expiration of the leave, or, in the case of layoff, are recalled and return to active service within one year from the date of layoff.

DISABILITY BENEFITS

If you have completed 10 or more years of continuous service and incur a disability which renders you eligible for disability benefits under the Social Security Act, the period during which you are disabled will be counted as credited service whether or not you continue in the employ of the Company. Such period of disability will cease on the date the Administrative Committee determines that the employee has recovered from the disability, or the employee returns to work, whichever is earlier. In the event you remain permanently and totally disabled until your normal retirement date, you will be eligible to receive a retirement income in accordance with the terms of the Plan and your years of disability will count as credited service.

Your retirement benefit will be paid in the normal form and you will not be entitled to elect any optional form of benefit or to elect early retirement.

In determining the amount of your benefit, your final average earnings will be computed by assuming that your earnings during the period of your disability were at the same rate as your rate in effect on your last day of active service.

SOCIAL SECURITY

The Retirement Plan benefits are entirely in addition to any amount you receive from Social Security. You and the Company both pay equal taxes for Social Security which—starting in 1972—are based on the first $9,000 of your annual earnings. Full Social Security benefits start when you retire at age 65, with reduced amounts payable as early as age 62. Your dependent spouse age 62 or older is also eligible for a Social Security benefit of up to 50% of your benefit.

The EG&G Plan has been designed to complement Social Security benefits and, in general, benefits are at a lower rate on earnings for which Social Security benefits are paid.

The maximum Social Security benefit for a male employee retiring in 1972 is $216.00 per month. Under the present law, the maximum benefit increases to $295.00 for a male employee retiring in the year 2010.

Your Personnel Department has a complete Social Security benefit schedule and can assist you in estimating your Social Security benefit at retirement.

BENEFIT OPTIONS

The benefit formula set forth in the section entitled "Benefits Payable at Normal Retirement Date" establishes the retirement income you will receive for the remainder of your life. Such benefits will terminate on your death. Therefore, if you have dependents, such as a spouse, children or parents, you may wish to choose an alternate method of benefit payment to insure continued benefit payments in the event of your death.

Prior to your retirement, you will be provided a form which outlines the various options and the resultant retirement benefit.

Unless you elect one of these options, your retirement income will be paid on the basis of a lifetime income.

The various options are briefly outlined below. For more information on this subject, contact your Personnel Department.

a) 10 Year Certain—If you die before you have received benefit payments for 10 years and have elected the 10 year certain option, payments will continue to your designated beneficiary for the remainder of the ten years.

   Benefits under the 10 year certain option are actuarially reduced and are, therefore, less than under the lifetime income form.

   You may also elect either a 5 or a 15 year certain option.

b) Joint and Survivor—This option allows you to insure continued income for your spouse for the duration of her life if you should die first.

The amounts received under this option depend on both your and your spouse's age at retirement and the percent you elect your spouse to receive in the event you die first.

c) Level Income—If you elect to retire prior to being eligible for Social Security benefits, you may elect to receive a larger benefit payment up to the point where Social Security benefits begin.

The amount of income received will be actuarially reduced since you will commence benefit payments at an earlier age.

BENEFIT ILLUSTRATIONS

You can use the table below to help estimate your "combined" income from the Retirement Plan and Social Security. Remember to base the Plan benefits on your average earnings (as described on page 3), and Social Security benefits on average earnings covered by Social Security.

(A) MONTHLY RETIREMENT PLAN INCOME—Based on Employee hired July 1, 1972: (Rounded to nearest dollar)

- Payable upon retirement at age 65 or older, and
- Assuming a Social Security tax base of $9,000:

Final Average Monthly Earnings	*Years of Service at Retirement*				
	10	*20*	*30*	*35*	*40*
$ 500	$ 25	$ 50	$ 75	$ 88	$100
700	35	70	105	123	140
900	53	105	158	184	210
1100	73	145	218	254	290
1300	93	185	278	324	370
1500	113	225	338	394	450
1700	133	265	398	464	530
2000	163	325	488	569	650

(B) PLUS MONTHLY SOCIAL SECURITY INCOME
(Contact your Personnel Department for an estimated amount.)

(C) YOUR TOTAL MONTHLY RETIREMENT INCOME

from Retirement Plan		from Social Security		Total
(A) $_____	+ (B) $_____		= (C) $_____	

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INFORMATION FOR EMPLOYEES HIRED PRIOR TO 7/1/72

If you were hired prior to 7/1/72, your period of continuous employment as a full time employee since your most recent hire date is counted towards the vesting requirements of this Plan. In addition, your period of continuous employment since your most recent hire date, excluding periods of time spent on a leave of absence for other than medical reasons, while you were on lay off status, or while you were employed by an Affiliate or Subsidiary which does not participate in this Plan, will be counted as credited service in this Plan.

In addition to the benefit provided under this Plan, you will also receive any benefits accrued by you under the EG&G Profit Sharing Plan.

The balance in your Profit Sharing Account as of 7/1/72, adjusted according to the last quarterly evaluation prior to your date of termination or retirement will be distributable to you under the terms of the EG&G Profit Sharing Plan.

Exhibit D.
Fred Hilerby

ALCOHOL PILOT PROGRAM

July 1974 - May 1976 (23 Months)

FINAL REPORT

Robert W. Wilson
Martin Green
Florence Beller
Alcoholism Pilot Program
Health Benefits Division

ALCOHOL PILOT PROGRAM

JULY 1974 - MAY 1976 (23 MONTHS)

FINAL REPORT

Since the inception of the Alcohol Pilot Program, monthly reports have been prepared showing utilization and costs under the program. These have been based on monthly reports provided by each of the carriers participating in the Pilot Program.

The report prior to this one was for April 1976, based on carrier reports for that month. Pilot Program benefits terminated at midnight, May 31, 1976. This final report shows data derived from carrier reports for May through July 1976, there being a time lag between dates of actual treatment and dates that claims or reports of treatment are received by the carriers. Although additional carrier reports will be forthcoming for the month of August and beyond, the data contained in this report will include all but a fraction of total Pilot Program utilization and cost. Accordingly, this is to be considered as the final report on the program. As most of the items to be discussed are included in the standard monthly report tables, these are presented in the usual sequence. Supplemental tables have been added to cover those items not included in the standard tables. (This follows the procedure used in the preliminary evaluation made of the first year of the Pilot Program.)

It was noted above that Pilot Program benefits terminated May 31, 1976. The program thus ran for a period of 23 months, from July 1974 through May 1976. With a budget of $600,000 provided by the Office of Alcoholism, which was to cover benefits paid, carrier administrative expenses and Public Employees' Retirement System (PERS) expenses for administering the program, it was originally anticipated that the Pilot Program would run for one year. When utilization, and therefore benefits costs, were low during the first year, the Pilot Program was provisionally extended for another nine months. A budget augmentation of $31,000 was then made in the expectation of an additional three months' extension, so that two full years of experience could be provided. Usage and benefit costs then turned upward, starting with the reporting month of January 1976, and as a result the budget augmentation was increased from $31,000 to $76,000 and the Pilot Program had to be terminated one month short of a full two years.

At the writing of this report, the Pilot Program claims of one of the four major carriers, Blue Cross/Blue Shield, are being reviewed for adjustments on the basis that a portion of these should have been covered by this carrier's basic health plan. This report shall present the claims for alcoholism treatment charged against the Pilot Program as reported by Blue Cross/Blue Shield pending final adjustments.

It might be noted that another of the four major carriers, California-Western/Occidental, has reported benefits for alcoholism treatment paid under their basic health plan and under the Pilot Program and that this data is so shown.

1. Summary of Utilization and Cost

Table 1 presents a summary of program utilization and cost by carrier for the three broad benefit catagories: inpatient care, recovery home and outpatient care. As a reminder, the months indicated in this and the other standard report tables, are the reporting months and not the months of actual treatment. Therefore, although Pilot Program benefits for treatment terminated May 31, 1976, the last reporting month was July 1976.

For the 23 months of the Pilot Program, a total of 766 persons were reported as having received treatment. This compares to the total of 300 persons reported for the first twelve months. The 466 persons reported for the last eleven months represents a 55.3 percent increase over the 300 for the first year.

Although there was a significant increase in the number of individuals treated during the program's second year, the rate of utilization, based on total health plan enrollments, remained very low. This is indicated in the table following:

	*Enrollments		Persons Treated		Utilization
Carrier	Number	Percent	Number	Percent	Rate
Cal-West	38,828	27.5	167	21.8	0.4%
BC/BS	38,220	27.2	163	21.3	0.4
Kaiser-No.	34,044	24.2	185	24.2	0.5
Kaiser-So.	19,941	14.2	237	30.9	1.2
Other	9,724	6.9	14	1.8	0.1
	140,757	100.0	766	100.0	0.5

*Basic plan enrollments.

As can be seen, the overall utilization rate was only 0.5 percent and for only one carrier, Kaiser-Southern California, was the utilization rate over one percent. It has been noted in previous reports that this carrier had a benefit for outpatient alcoholism treatment prior to the Alcohol Pilot Program. A number of reasons for this low utilization rate were advanced in the 12-months' report and these shall again be reviewed in the conclusions of this report. At this point, it is sufficient to say that the low utilization parallels those found in other alcoholism treatment programs.

Looking at the broad benefit categories, 339 persons received inpatient care, 542 persons received outpatient care and 15 persons had recovery home stays. (As indicated in Table 1, a number of persons received more than one type of care and the 766 total figure is adjusted for this overlap.)

A breakdown of the types of care used by members of the four major health plans is shown in the table below. The table indicates the number of persons using inpatient or outpatient care only or a combination of inpatient and outpatient care. It further indicates the kind of inpatient care: detoxification, rehabilitation or dual (detoxification and rehabilitation).

Inpatient Only	CWO	BC-BS	K-N	K-S	Total
Detoxification	18	19	26	1	64
Rehabilitation	20	4	1	2	27
Dual	56	38	11	2	107
	94	61	38	5	198

Inpatient & Outpatient	CWO	BC-BS	K-N	K-S	Total
Detoxification	8	12	19	6	45
Rehabilitation	6	3	2	16	27
Dual	12	12	14	9	47
	26	27	35	31	119
Outpatient Only	43	63	111	201	418
TOTAL	163	151	184	237	735

The high incidence of inpatient usage has been pointed out in previous reports. The table indicates that 26.9 percent of major health plan members had inpatient care only. Of the 198 persons receiving such inpatient care, almost one-third (32.3 percent) had detoxification only, with no rehabilitative treatment.

The table makes clear the difference in utilization between the two fee-for-service plans, Cal-West and Blue Cross-Blue Shield, and the two group practice plans, Kaiser-North and Kaiser-South. Of the Cal-West members, the number receiving inpatient care only was more than twice that receiving outpatient care only. Blue Cross-Blue Shield plan members showed an almost 50/50 split in this respect. In contrast, only 38 (20.6 percent) of Kaiser-North members had inpatient only treatment while 111 (60.3 percent) had outpatient only treatment. Even more pronounced was Kaiser-South, with only 5 of 237 members (2.1 percent) having inpatient only care and 201 (84.8 percent) having outpatient care only. As mentioned earlier, the Kaiser-South plan had established a program for outpatient alcoholism treatment prior to the Pilot Program.

Recovery homes were not included as a type of care in the above table. Although it was anticipated that recovery homes would have the lowest utilization of any type of care, actual usage was surprisingly small. Only 15 persons had recovery home stays, 7 of them Cal-West and 4 Blue Cross-Blue Shield members.

Turning to expenses, Table 1 shows the total cost of services provided under the Pilot Program to be $677,577.23. The total amount of benefits paid was $596,444.31. Of this amount, $459,117.24 was paid from Pilot Program benefits; the remainder, $136,870.79, was paid from benefits of the Cal-West basic health plan. Combined Pilot Program/Cal-West benefits accounted for 88.0 percent of all treatment costs.

Previous reports have stressed that inpatient care has been the significant factor in program expenses. The table below gives a breakdown of treatment costs and benefits paid (including the Cal-West basic plan benefits) by type of care.

Type of Care	Treatment Cost		Benefits Paid		Benefits As % Of Costs
	Dollars	Percent	Dollars	Percent	
Inpatient	$587,341.03	86.7	$515,958.27	86.5	87.8
Outpatient	83,315.54	12.3	75,007.60	12.6	90.0
Recovery Home	6,920.66	1.0	5,478.44	0.9	79.2
TOTALS	$677,577.23	100.0	$596,444.31	100.0	88.0

As can be seen, inpatient care accounted for almost 87 percent of both treatment costs and benefits paid at the end of the Pilot Program. The obvious conclusion is that in developing a package of alcoholism treatment benefits the most important, at least as far as potential expense is concerned, is the benefit for inpatient treatment.

At the end of the Pilot Program, what were expenses in terms of persons treated? Overall, the cost per person treated averaged $884.57; benefits paid averaged $778.31. For inpatient care alone, costs came to $1,732.57 per person and benefits were $1,521.27 per person. For outpatient care, costs were $153.15 and benefits $137.87 per person. Recovery home costs were $432.54 and benefits $342.40 per person.

There were considerable differences in the expenses per person for the four major carriers, as shown below:

	Inpatient		Outpatient		Total*	
Carrier	Cost	Benefits	Cost	Benefits	Cost	Benefits
Cal-West	$2,082.56	$1,846.83	$231.17	$206.20	$1,613.34	$1,425.45
BC-BS	1,597.56	1,211.18	273.39	204.53	1,104.58	836.82
K-N	1,440.92	1,396.70	180.37	179.20	716.94	698.57
K-S	1,739.35	1,739.35	66.13	66.13	331.01	331.01
All Carriers	1,732.57	1,521.27	153.15	137.87	884.57	778.31

*Includes recovery home care.

The lower total costs and benefits per person for the two Kaiser plans, in particular Kaiser-South, were more a function of greater outpatient utilization than of lower average inpatient expenses than the fee-for-service plans.

Finally, how were total program expenses distributed by carrier? Excluding benefits paid by the Cal-West basic plan, Blue Cross-Blue Shield accounted for the highest amount of benefits paid, $136,401.49, followed by Kaiser-North with $129,234.97. Pilot Program benefits paid by the Cal-West plan were $101,111.82; by the Kaiser-South plan, $78,450.24. Benefits paid by the other plans combined came to only $13,918.72. Including benefits paid under their basic plan, Cal-West's benefits were $238,438.89.

The percentage distribution of benefits paid, including and excluding the Cal-West basic plan, are shown below:

Carrier	Pilot Program Benefits	Total Benefits (Incl. CWO Basic)
Cal-West	22.0	40.0
Blue Cross-Blue Shield	29.7	22.9
Kaiser-North	28.2	21.7
Kaiser-South	17.1	13.2
Others	3.0	2.2
	100.0	100.0

2. Summary of Inpatient Utilization and Cost

Table 2 presents a summary of inpatient utilization and cost by carrier and by inpatient benefit category: detoxification only; rehabilitation only; dual (cases of detoxification followed by rehabilitation) and in-hospital medical care (physician visits not included under the other categories).

As previously indicated, inpatient care was the most significant factor in program costs. Of the inpatient care categories, dual treatment accounted for the greatest proportion, almost two-thirds, of both costs and benefits paid. The distribution of costs was as follows:

	Cost	Percentage Distribution
Detoxification only	$79,770.32	13.6
Rehabilitation only	107,840.75	18.4
Dual	384,071.89	65.3
In-Hospital medical	15,658.07	2.7
	$587,341.03	100.0

The distribution of benefits, including and excluding those paid by the Cal-West basic plan, is as follows:

	Benefits (Incl. CWO Basic)		Benefits (Excl. CWO Basic)	
	Amount	Percentage Distribution	Amount	Percentage Distribution
Detox. only	$73,476.24	14.2	$64,820.72	17.0
Rehab. only	97,745.32	18.9	68,434.79	17.9
Dual	334,074.78	64.8	240.289.76	62.8
In-Hosp. med.	10,661.93	2.1	8,929.43	2.3
	$515,958.27	100.0	$382,474.70	100.0

As shown in Table 2, 135 persons received inpatient detoxification care, 70 received rehabilitation care and 155 received dual care. As a number of persons received more than one type of inpatient care, the total of 330 reflects an adjustment for this overlap. For the four major health plans, the distribution of persons by type of inpatient care (with no overlap) is as shown below:

	Number	Percentage Distribution
Detoxification only	109	34.4
Rehabilitation only	54	17.0
Dual	154	45.6
	317	100.0

As indicated, a substantial proportion of persons having inpatient care received detoxification treatment only, while only 17.0 percent had inpatient care without detoxification. It appears that although rehabilitative care is desirable, a program of alcoholism benefits must provide for detoxification.

Returning to costs, it has been noted above that inpatient costs per person averaged $1,732.57. The per person cost of rehabilitation was 2.6 times that of detoxification, $1,540.58 as compared to $590.89. The highest cost per person was for dual inpatient care, $2,477.88.

The inpatient benefit paid up to a maximum of $160 per day for detoxification and $100 per day for rehabilitation. The average cost per day for detoxification came to slightly above the benefit maximum, $164.47. The average daily cost for rehabilitation was slightly below the daily maximum, $94.12. For dual care, the daily average was $122.32. For all inpatient care, the average came to $123.21 per day.

Table 2 does not show inpatient admissions. However, a separate tabulation of number of admissions per person shows that overall, a relatively low proportion, 14.2 percent, had repeat admissions. The Blue Cross-Blue Shield plan accounted for 18 of the 45 persons having repeat admissions. Of the Blue Cross-Blue Shield members having inpatient treatment, almost 21 percent had repeat admissions. This compares to only 9 percent for the other carriers combined.

The table below shows the distribution of persons with inpatient care by number of admissions.

Number of Admissions	CWO	BC/BS	K-N	K-S	Total Number	Total Percent
One	106	70	58	24	258	81.4
Two (one set of dual)	4	-	4	6	14	4.4
Two separate	7	9	9	5	30	9.5
Three separate	2	4	1	1	8	2.5
Four or more separate	1	5	1	-	7	2.2
	120	88	73	36	317	100.0

3. Summary of Outpatient Utilization and Costs

Table 3 summarizes outpatient utilization and costs by carrier and by category of personnel providing treatment. During the 23 months of the Pilot Program, a total of 542 persons made 5,028 outpatient visits at a cost of $83,315.54. Pilot Program benefits came to $71,164.10, with another $3,843.50 from the Cal-West basic plan for a total of $75,007.60. Benefits paid 90.0 percent of total costs.

As indicated earlier, the group practice plans account for most of outpatient utilization. Kaiser-South had 238 persons and Kaiser-North 146 persons receiving outpatient care. The two major fee-for-service plans, Blue Cross/Blue Shield and Cal-West, had 92 and 69 persons, respectively.

The distribution of benefits paid by carrier does not completely match this utilization. Kaiser-North had the highest amount of outpatient benefits paid, $26,163.35. However, the amount paid by Blue Cross-Blue Shield, $18,816.80, is higher than that by Kaiser-South, $15,473.49, and that by Cal-West, $14,167.96, almost as high.

The explanation is the relatively low use of physicians and the high use of para-professional personnel in the Kaiser-South outpatient care program. The average cost per visit by type of provider is as follows:

Provider	Cost Per Visit
Physician	$20.28
Counselor	25.86
Licensed Social Worker	11.42
Psychologist	21.12
Para-Professional	4.11
All Providers	16.57

Data on costs and benefits by type of provider was not available from Kaiser-South. However, the distribution of outpatient visits shows only 18.4% to physicians and 67.3% to para-professionals. The table below shows the percentage distribution of outpatient visits for each of the four major carriers and overall.

Carrier	Physician	Counselor	LSW	Psychol.	Para-Prof.	Total
Cal-West	86.2	2.9	8.8	0.3	1.8	100.0
Blue Cross/ Blue Shield	70.6	10.9	9.3	9.0	0.2	100.0
Kaiser-North	46.3	0.5	2.6	11.9	38.7	100.0
Kaiser-South	18.4	-	8.8	5.5	67.3	100.0
All Carriers	44.1	2.4	7.2	7.1	39.2	100.0

The following table shows the distribution of costs and of benefits by type of provider for the major carriers, excluding Kaiser-South.

DISTRIBUTION OF OUTPATIENT COSTS AND BENEFITS

Carrier	Physician	Counselor	LSW	Psychol.	Para-Prof.	Total
Costs:						
Cal-West	87.2	3.0	7.5	0.5	1.8	100.0
Blue Cross/ Blue Shield	70.6	10.2	7.2	11.8	0.2	100.0
Kaiser-North	48.8	0.3	4.3	17.0	29.6	100.0
Benefits:						
Cal-West	86.4	2.5	8.5	0.6	2.0	100.0
Blue Cross/ Blue Shield	66.1	13.2	8.8	11.7	0.2	100.0
Kaiser-North	48.7	0.3	4.2	17.0	29.8	100.0

As indicated by the above tables, both outpatient utilization and expenses under the Cal-West and Blue Cross-Blue Shield plans primarily involved treatment by physicians rather than by other types of providers.

The outpatient care benefit provided for a maximum of 45 visits. Only a fraction of the persons receiving outpatient care exceeded this maximum. The table below shows the distribution by number of visits of the 537 major health plan members using outpatient care. As indicated by the table, 125 persons made only one visit and another 191 persons made only two to five visits. Slightly over three-quarters of the 537 persons had ten visits or less.

PERSONS RECEIVING OUTPATIENT CARE

Number of Visits	Cal-West	BC-BS	Kaiser-N	Kaiser-S	Total
One	14	28	42	41	125
2 - 5	20	30	43	98	191
6 - 10	16	16	25	38	95
11 - 15	6	4	9	16	35
16 - 25	5	4	11	16	36
26 - 35	4	4	8	12	28
36 - 45	4	1	5	3	13
46 & over	-	4	3	7	14
	69	91	146	231	537

A provision of the outpatient care benefit was that family visits were included. A review of all outpatient treatment found that only 46 persons had participated in one or more outpatient visits with family members. Of these 46, 19 were Kaiser-South plan members and 15 Kaiser-North plan members. Blue Cross-Blue Shield had 9 members and Cal-West 3 members utilizing such outpatient visits.

4. Summary of Recovery Home Utilization and Cost

As noted earlier, recovery home utilization under the Pilot Program was even less than expected. It appears that those State employees (and their dependents) who availed themselves of Pilot Program treatment either required the presumably more intensive type of care of a hospital or other inpatient facility or were able to function well enough so that outpatient care was sufficient. Thus, the "in-between" type of treatment offered by a recovery home was utilized to only a very limited extent.

Table 4 indicates that 15 persons had recovery home admissions for a total of 425 days. The cost of treatment was $6,920.66; benefits paid were $5,478.44. The cost per day averaged $16.28. The Pilot Program recovery home benefit paid to a maximum of $15 per day. As shown in the table, 14 of the 15 persons had stays at a primary recovery (R2s) type of recovery home while the remaining one person was in a supportive (R3) recovery home.

Although the numbers were too small to indicate any pattern of recovery home usage, 12 of the 15 persons were members of fee-for-service health plans (7 in Cal-West and 4 in Blue Cross-Blue Shield and one in ACSUP) while only 3 were group practice plan members (2 in Kaiser-North and one in Kaiser-South).

5. Medical and Non-Medical Detoxification

Table 5 shows utilization and cost of the detoxification benefit by medical and non-medical categories. As has been the case throughout the Pilot Program period, the table shows that medical detoxification has been the method of treatment most used. Thus 273 of the 326 admissions involving detoxification and 825 of the 983 days were for medical detoxification. As would be expected from this, medical detoxification also accounted for most of the benefits paid, $117,158.70 as compared to only $17,314.30 for non-medical detoxification.

The table following shows the percentage comparisons between medical and non-medical detoxification for number of admissions and days as well as for benefits paid.

Type of Detoxification	Admissions	Days	Benefits
Medical	83.7	83.9	87.1
Non-Medical	16.3	16.1	12.9
	100.0	100.1	100.0

With respect to comparative cost, there has been a change. On the basis of the first twelve months' information, there was no significant difference in the average daily cost of medical and non-medical detoxification. The final figures show that benefits paid for medical detoxification averaged $142.01 per day as compared to $109.58 per day for non-medical detoxification, a difference of almost 30 percent.

6. Inpatient Utilization and Cost by Type of Facility

Table 6 presents inpatient utilization and cost by type of facility for the 23 months of the Pilot Program. As was the case at the end of the first twelve months, the highest utilization on the basis of admissions was to general hospitals. However, hospital alcohol units accounted for the next highest number of admissions, followed by alcohol hospitals, rather than the reverse. The same reversal of positions also took place with regard to number of days, with alcohol units accounting for more than half (52.2 percent) of inpatient days at the end of the Pilot Program, while alcohol hospitals accounted for 25.2 percent and general hospitals for only 11.8 percent. One further note, residential treatment centers accounted for 7.8 percent of total inpatient days.

Costs of treatment and benefits paid were in general proportionate to the relative number of days by type of facility. The table below shows percentage distributions of admissions, days, costs and benefits by type of facility.

Facility	Admissions	Days	Cost	Benefits
General Hospital	37.8	11.8	16.6	18.0
Alcohol Unit	34.8	52.2	50.6	53.9
Alcohol Hospital	20.6	25.2	27.7	23.2
Community Center	2.6	2.5	0.6	0.6
Res. Treatment	2.8	7.8	3.9	3.7
Other	1.4	0.5	0.6	0.6
	100.0	100.0	100.0	100.0

General hospitals had the highest cost of any facility, averaging $175.56 per day. Alcohol hospitals had a cost of $132.14 per day, while alcohol units were $115.85 per day. Average costs by type of facility for the four major plans and overall were as follows:

Carrier	General Hospital	Alcohol Unit	Alcohol Hospital	Co. Alc. Center	Total - All Facilities
Cal-West	$175.56	$122.31	$165.51	$28.72	$127.89
BC-BS	132.95	110.57	179.29	25.50	129.64
Kaiser-North	194.22	119.85	173.57	-	136.08
Kaiser-South	174.96	93.98	65.12	-	85.31
All Plans	169.72	115.85	132.14	28.07	123.21

Charges of course varied by individual facility. The Care Unit in Mercy San Juan Hospital, Sacramento, went from $121.50 and $83.50 daily for detoxification and rehabilitation, respectively, as of November 1974 to $225.00 and $125.00 as of May 1976. By comparison, the Care Unit in the South Coast Hospital, South Laguna, charged $140.00 per day for detoxification and $99.00 per day for rehabilitation as of May 1976.

Charges at the Raleigh Hills Alcohol Hospital in Sacramento were $160.00 per day for detoxification and $95.00 per day for rehabilitation as of April 1976. These were up from $151.00 and $71.00 in November 1974. Additionally, the charge for the conditioned reflex program increased from $575.00 to $825.00. Raleigh Hills in Newport Beach charged $165.00 for detoxification and $95.00 for rehabilitation in April 1976. The conditioned reflex program charge was $800.00. Patients at Raleigh Hills are also charged for a daily physician visit at an average cost of $25.00.

The average cost per admission for an inpatient facility, as derived from Table 6, was $1,354.70. Hospital alcohol units had an average cost of $1,964.67 per admission; alcohol hospitals, $1,822.60; and general hospitals, $597.75. This last figure of course reflects the lower length of stay and the higher incidence of detoxification care in general hospitals.

The distributions of costs per inpatient admission for the four major carriers are shown in Table 6A. One-half (50.0 percent) of all admissions for the four carriers combined cost $1,000 or less. About one-third of all admissions were over $2,000 and almost one-tenth were over $3,000. The cost of an inpatient admission can therefore be a relatively high one. This is especially true in a facility such as a Care Unit or a Raleigh Hills alcohol hospital, where a rehabilitation program runs for two to three weeks.

7. Inpatient Utilization: Length of Stay

Inpatient admissions by length of stay are shown in Table 7. The Pilot Program inpatient benefit provided up to six days for detoxification and up to 21 days for rehabilitation. Of the 137 admissions for detoxification only treatment (which excludes 27 emergency room cases), only five were longer than six days. The median length of stay was 3.6 days.

Of the 75 admissions for rehabilitation only treatment, 17 exceeded 21 days. The median length of stay was 11.5 days. There were 167 dual treatment admissions, of which only 15 were longer than 27 days. The median length of stay was 22.1 days.

In general, length of stay data at the end of the program gives no reason to change the statement in the 12-months' report that the number of days provided in the inpatient benefit is adequate relative to treatment.

8. Utilization by Sex and Age

Table 8 summarizes Pilot Program utilization by the sex and age of persons treated. The male to female ratio for all persons treated was 68.9/31.1 and the average age 46.9. Persons utilizing inpatient care had a higher proportion of males, 70.7 percent, and a higher average age, 49.8. For persons utilizing outpatient care, the male/female ratio was 67.9/32.1 and the average age 45.7.

A comparison of the male/female ratios and average ages of persons treated with those of the total enrollments of the four major health plans is given below:

MALE/FEMALE RATIOS: TOTAL UTILIZATION

Carrier	Persons Treated	Basic Plan Enroll.
Cal-West	73.1/26.9	63.4/36.6
Blue Cross-Blue Shield	62.6/37.4	58.6/41.4
Kaiser-North	71.7/28.3	55.8/44.2
Kaiser-South	67.5/22.5	62.5/37.5
All Plans	68.9/31.1	60.0/40.0

AVERAGE AGE: TOTAL UTILIZATION

Carrier	Persons Treated	Basic Plan Enroll.
Cal-West	47.3	45.3
Blue Cross-Blue Shield	49.3	46.4
Kaiser-North	45.4	40.6
Kaiser-South	46.4	41.9
All Plans	46.9	N.A.

As can be seen, for all plans the persons treated had a higher male to female ratio and a higher average age than the enrollments as a whole. This gives some indication that age and sex are factors in alcoholism among State employees.

9. Utilization by Type of Enrollee

Utilization by type of enrollee is shown in Table 9. Although public agency (other than State) employees and their family members enrolled in Meyers-Geddes health plans were eligible for the Alcohol Pilot Program, these accounted for only 18 of the 766 persons treated. Of the 18, 11 were active public agency employees, one was an annuitant and 6 were dependents. Thirteen were Kaiser plan members (9 in Kaiser-North and 4 in Kaiser-South). Of the 748 State enrollees treated, 453 were active employees, 48 were annuitants, and 244 were dependents (with the status of the remaining 3 being unknown).

The table below gives the distribution of persons treated by type of enrollee.

Type of Enrollee	Inpatient Care	Outpatient Care	Total
Employee	55.5	64.4	60.6
Annuitant	8.0	5.9	6.4
Dependent	36.3	29.5	32.6
Unknown	0.2	0.2	0.4
	100.0	100.0	100.0

Dependents accounted for a significant proportion of the persons receiving both inpatient and outpatient care, in particular the former. It may be supposed that the time available for dependents to spend in an inpatient facility was a factor in this situation. The proportion of annuitants, although only 6.4 percent, is also surprisingly high in that they had much less exposure to information and publicity about the Pilot Program than active employees and also presumably did not have their jobs at risk in seeking alcoholism treatment.

The table below summarizes utilization by type of carrier. The proportion of dependents ranged from 28.1 to 37.4 percent for the four major carriers.

Carrier	Employees	Annuitants	Dependents	Unknown	Total
Cal-West	92	20	55	-	167
BC-BS	93	7	61	2	163
Kaiser-North	123	10	52	-	185
Kaiser-South	150	11	75	1	237
Others	6	1	7	-	14
	464	49	250	3	766

10. Utilization by County

Utilization by county of residence is shown in Table 10. Highest utilization was in Sacramento County, 152 persons, followed by Los Angeles County, 143 persons. No other county had more than 50 persons treated. Of the 152 in Sacramento County, 95 were members of Kaiser-North; of the 143 persons in Los Angeles County, 110 were Kaiser-South members. Perhaps most surprising was that only 14 persons treated were from San Francisco County.

The tables below show the distribution of persons treated by geographical area, by number and by percent, for the four major plans and for all plans combined.

Geographical Area	Cal-West	BC-BS	Kaiser-No.	Kaiser-So.	All Plans
L. A. Metropolitan	21	40	-	123	186
San Diego Metropolitan	3	5	-	36	46
Southeast Area	7	12	-	69	90
San Francisco Bay	10	30	59	2	102
Sacramento Valley	46	13	106	-	169
San Joaquin Valley	47	13	-	1	61
Other	33	50	20	6	112
Total	167	163	185	237	766
L. A. Metropolitan	12.6	24.5	-	51.9	24.3
San Diego Metropolitan	1.8	3.1	-	15.2	6.0
Southeast Area	4.2	7.4	-	29.1	11.8
San Francisco Bay	6.0	18.4	31.9	0.8	13.3
Sacramento Valley	27.5	8.0	57.3	-	22.1
San Joaquin Valley	28.1	8.0	-	0.4	8.0
Other	19.8	30.6	10.8	2.6	14.4
Total	100.0	100.0	100.0	100.0	100.0

The San Francisco Bay Area, which includes Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara and Solano counties, accounted for 13.3 percent of persons treated. Almost 60 percent of all persons treated were in the San Francisco Bay, Los Angeles Metropolitan or Sacramento Valley areas.

11. Carrier Administrative Costs and Total Program Cost

Carrier administrative costs for the Pilot Program are shown in Table 11. Total carrier administrative costs came to $93,631.33. Benefits paid under the program were $459,117.24. The sum of these two items, which constitutes the total costs charged to the Pilot Program was $552,748.57. The administrative costs were 16.9 percent of this total.

Of the carrier administrative costs, $27,072.60 were for the printing and distribution of booklets describing program benefits effective July 1, 1975. With the expense of these booklets excluded, carrier administrative costs were 12.7 percent of total program cost. The table below shows costs for the four major carriers.

Carrier	Total Costs	Administrative Costs	Admin. as % of Total Costs
Cal-West	$115,007.82	$13,896.00	12.1
Blue Cross-Blue Shield	167,107.16	30,705.67	18.4
Kaiser-North	151,466.42	22,231.45	14.7
Kaiser-South	91,619.16	13,168.92	14.4

12. P.E.R.S. Administrative Expenses

P.E.R.S. expenses for administering the Alcohol Pilot Program came to $104,007.18 through June 30, 1976. Of this amount, $88,935.70, or 85.5 percent, were for personal services (salaries and benefits), and $15,071.48, 14.5 percent, for operating expenses. It is estimated that expenses for the last two months of program administration, July - August 1976, will be another $5 - $6,000.

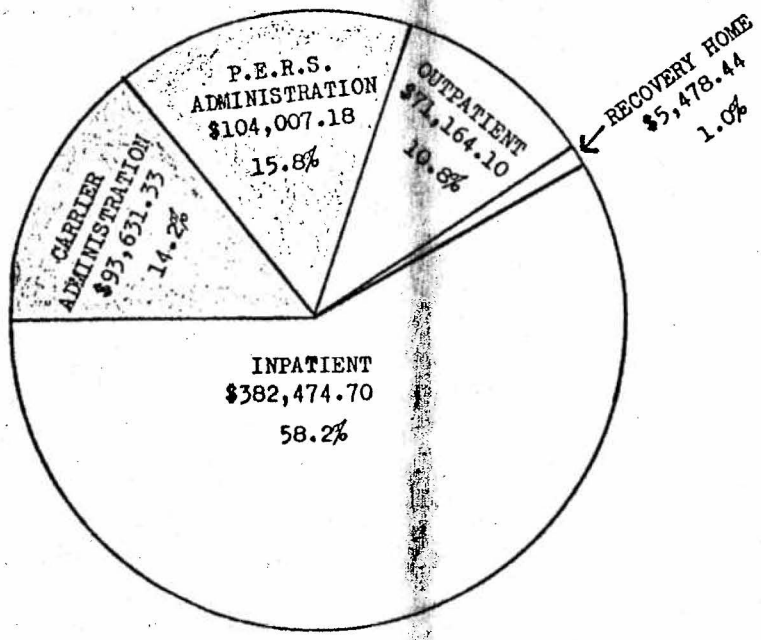
An itemized table of P.E.R.S. administrative expenses is given below.

P.E.R.S. ADMINISTRATIVE EXPENSES

Item	1974-75	1975-76	Total
General expense	$1,202.11	$ 992.56	$2,194.67
Printing	807.17	619.80	1,426.97
Postage	2,763.32	144.49	2,907.81
Tel. & Tel.	664.09	556.63	1,220.72
Travel - In-State	1,460.26	376.54	1,836.80
Rent	1,936.69	1,918.61	3,855.30
Equipment	1,629.23	-	1,629.23
	$10,462.87	$4,608.61	$15,071.48
Personal Services	$43,891.10	$45,044.60	$88,935.70
Total	$54,353.97	$49,653.21	$104,007.18

13. Summary of Pilot Program Costs

When all expenses are taken into account, total Pilot Program cost (through the end of June 1976) came to $656,755.75. This includes P.E.R.S. administrative expenses, carrier administrative expenses and benefits paid for treatment under the program. A breakdown of total program cost is shown in the following pie-chart.



14. Utilization and Cost Trends

A. Utilization and Cost by Reporting Month

As in the report on the first twelve months of the Pilot Program, Table I shows the number of cases of treatment, the amount of benefits paid and carrier administrative costs by reporting month. It was stated in the 12-months' report that this table showed no significant upward trend in either the number of cases or benefits paid. Starting with the second year of the program (July 1975), the number of cases increased to 92, as compared to the previous high of 85 in June, and then over 100 cases for each succeeding month, with 131 reported in December 1975, 140 in January 1976, a single monthly high of 165 in March 1976 and 181 for May - July 1976.

Benefit costs also increased starting in July 1975, going over $20,000 per month for the first time and remaining over except for one month, February 1976. September 1975 was the first month when benefits reported were over $30,000. Subsequently, January 1976 benefits reported were slightly over $39,000 and March 1976 reached a high of slightly over $42,000. Both inpatient and outpatient benefit costs participated in this upward trend, with inpatient benefits jumping because of the high cost per case while outpatient benefits had a more moderate rise.

A comparison of average monthly cases and costs for the first twelve months of the program with the entire 23 months indicates the significant increase which began with the second year.

Monthly Average	First 12 Months	23 Months
Cases	55	90
Benefits	$11,410.00	$19,962.00
Total Program Costs	14,26[illegible]00	24,047.00

Table I also indicates the difficulty of projecting program costs as the expenses reported varied from month to month. This was especially true for the last few months of the program.

B. Utilization and Cost by Month of Treatment

Table II shows the number of cases of alcoholism treatment and the benefits paid for the four major carriers combined by month of treatment. Because recovery home utilization and cost were so minimal, these have been omitted to simplify the table.

Table II, because it is based on actual date of treatment, gives a better picture than Table I of the trend of utilization and cost during the 23 months of the Pilot Program. As an example, Table II shows that utilization and benefits paid over the first six months of the program were considerably greater than would be indicated by the data reported for those months. This is of course as a result of the lag in reporting of claims or services provided to the carriers.

The Pilot Program then was not as slow in getting underway as indicated in the first monthly reports. However, Table II is in accord with Table I in showing that the upturn in utilization started with the program's second year. Based on month of treatment, the number of inpatient cases went up to 24 in July 1975 (from a prior high of 17) and, except for February and May 1976 remained above 20 for each subsequent month. The number of outpatient cases increased steadily starting with July 1975 and going through March 1976.

The upturn in benefit costs became apparent in August 1975, with October and December 1975 and then March and April 1976 each showing benefits paid of over $30,000.

C. Utilization and Cost by Month of Treatment: Four Major Carriers

Tables III and IV show utilization and benefits paid respectively by quarter (in which treatment occurred) for the four major carriers.

Table III clearly indicates the upward trend in the number of cases of treatment. Inpatient admissions numbered 34 for the first quarter of the program, July - September 1974, and then increased for each quarter through October - December 1975. There followed a slight drop in January - March 1976 and of course the last period of time was the two months, April - May, rather than a full quarter. The number of outpatient cases increased steadily each quarter through January - March 1976, then dropped for the final two months' period, April - May 1976. For inpatient admissions, the third and fourth quarters of 1975 were peak periods, with 67 and 71 respectively. The fourth quarter of 1975 and first quarter of 1976 were the peak periods for outpatient cases, with 335 and 368 respectively.

Regarding benefit costs, Table IV shows a jump from almost $30,000 in the first quarter of the program (July - September 1974) to slightly over $51,000 in the second quarter of the program (October - December 1974). There followed a steady increase in each of the four quarters of 1975, reaching $109,058 in October - December. The first quarter of 1976 saw a slight decrease to about $104,000; benefits paid in the last two months of the program (April - May 1976) were about $75,000.

Of the four major carriers, Kaiser-South was an exception to the overall upward trend in that the number of inpatient admissions under this plan dropped off after the second quarter of 1975, resulting in a decrease in the amount of total benefits paid from that time on.

The number of inpatient admissions and number of persons receiving outpatient care by month of service are shown graphically on the following page.

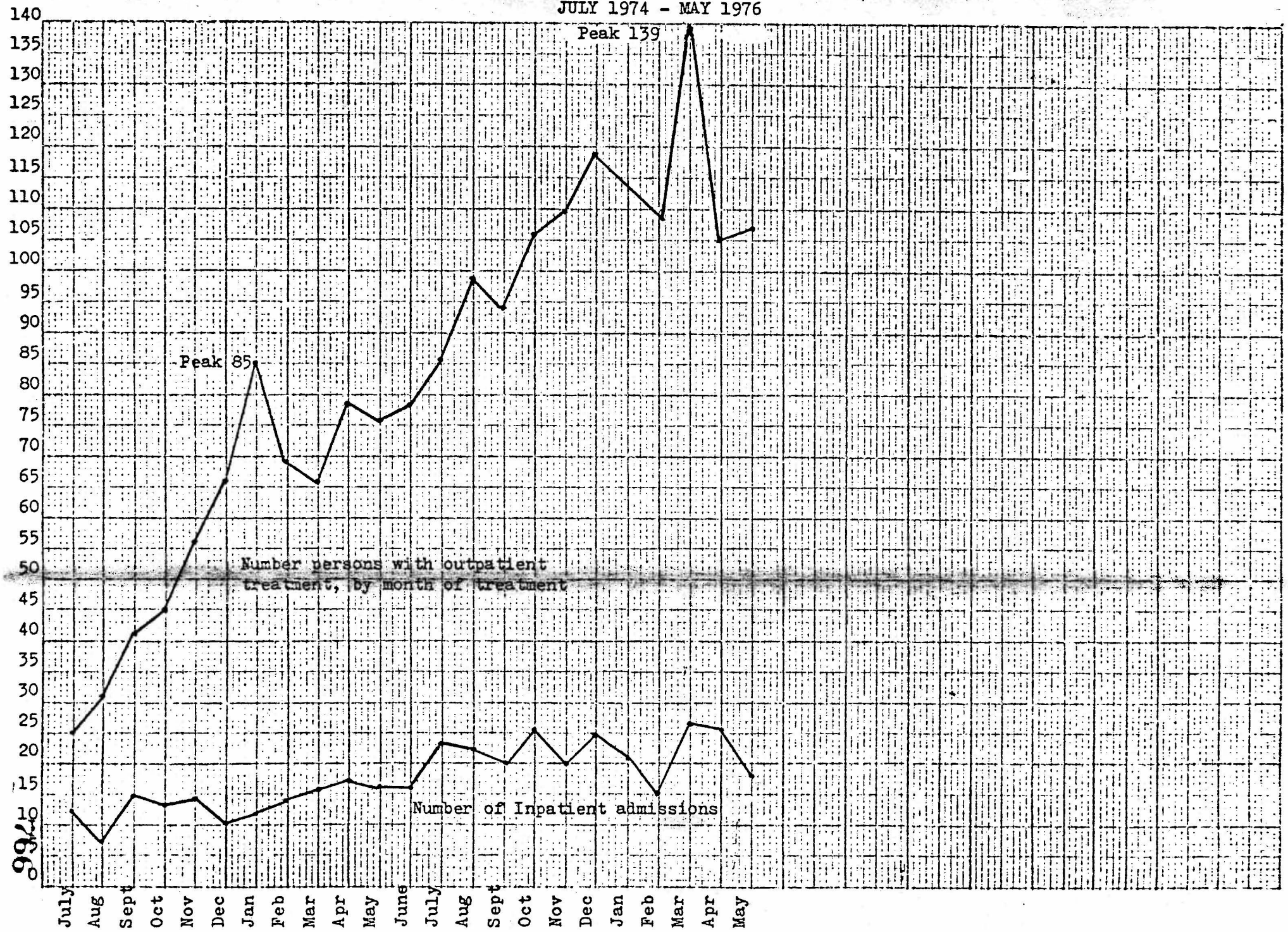
Utilization and cost of alcoholism treatment by month of service is shown for each of the four major carriers in Tables V through VIII.

15. Differential Utilization by Carrier

A number of differences in the utilization patterns of the four major carriers have been touched upon previously in this report, most notably the greater incidence of outpatient care for the two Kaiser plans as compared with the two fee-for-service plans, Cal-West and Blue Cross-Blue Shield. The table below shows the percentage distributions of persons receiving the different types of alcoholism treatment.

	Cal-West	BC-BS	Kaiser-No.	Kaiser-So.	Total - 4 Plans
Inpatient only	57.7	40.4	20.7	2.1	26.9
Inpatient/Outpatient	16.0	17.9	19.0	13.1	16.2
Outpatient only	26.3	41.7	60.3	84.8	56.9
	100.0	100.0	100.0	100.0	100.0

UTILIZATION BY MONTH OF TREATMENT
INPATIENT ADMISSIONS AND PERSONS WITH OUTPATIENT CARE
JULY 1974 - MAY 1976



Differences in the type of inpatient care received, again based on number of persons treated, were as follows:

Inpatient Care	Cal-West	BC-BS	Kaiser-No.	Kaiser-So.	Total - 4 Plans
Detox. only	21.7	35.2	61.6	19.4	34.4
Rehab. only	21.7	8.0	4.1	50.0	17.0
Dual	56.6	56.8	34.3	30.6	48.6
	100.0	100.0	100.0	100.0	100.0

As can be seen, there is a distinct difference in the percentage of persons having detoxification only care between the two Kaiser plans. Kaiser-South was unique in that one-half of its members having inpatient care were provided with rehabilitation only. It can be said that a sizeable proportion of inpatient users in each of the four plans received dual treatment, although the proportion in the fee-for-service plans was some 23 to 26 percent higher than in the Kaiser plans.

Another measure of utilization differences is based on number of inpatient and recovery home admissions and outpatient visits, as shown below:

Carrier	Inpatient Admissions	Recovery Home Admissions	Outpatient Visits
Cal-West	139	7	659
Blue Cross-Blue Shield	124	2	874
Kaiser-North	91	2	1,338
Kaiser-South	49	1	2,139
Others	19	1	18
	422	13	5,028

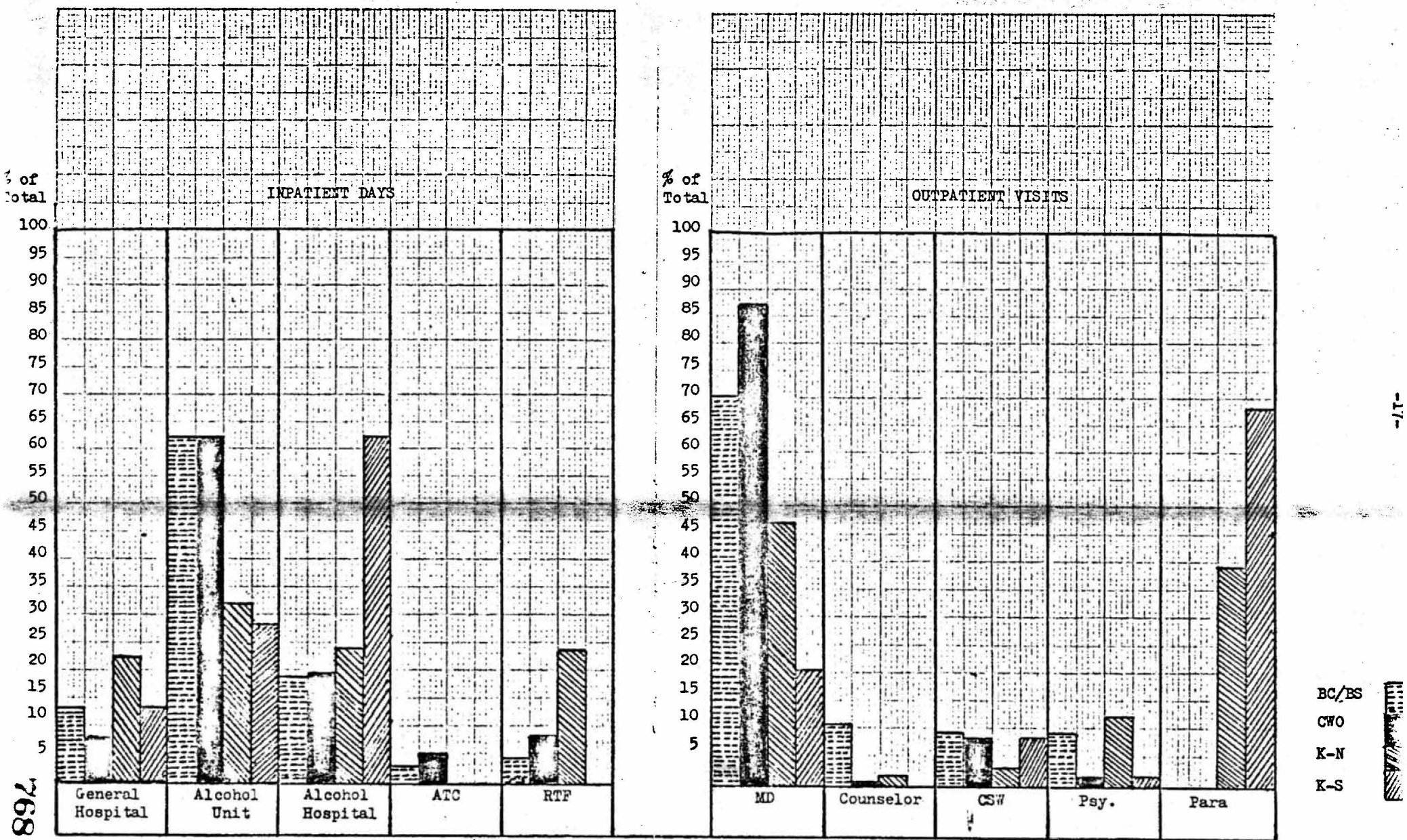
Turning to comparative costs, the distribution of benefits paid (including those paid by the Cal-West basic plan) by type of care was as follows:

Carrier	Inpatient	Outpatient	Recovery Home	Total
Cal-West	93.0	5.9	1.1	100.0
Blue Cross-Blue Shield	85.2	13.8	1.0	100.0
Kaiser-North	78.9	20.2	0.9	100.0
Kaiser-South	79.8	19.7	0.5	100.0
All Plans	86.5	12.6	0.9	100.0

Although the benefits paid by each plan were primarily for inpatient care, this was especially true of Cal-West and, to a somewhat lesser extent, of the Blue Cross-Blue Shield plan.

A comparison of inpatient care utilization by type of facility and outpatient care utilization by type of provider for the four major carriers is shown on the following graph.

INPATIENT AND OUTPATIENT PROVIDER USAGE BY FOUR MAJOR CARRIERS



The four major carriers (Blue Cross/Shield, Cal-West, Kaiser-North, and Kaiser-South) reported totals of 4,644 days Inpatient care and 5,010 Outpatient visits.

16. Utilization

In the 12-months' report, the low utilization reported under the Alcohol Pilot Program up to that time was noted and the variety of reasons advanced for this low utilization were given. These reasons included: lack of employee awareness; lack of provider awareness; lack of time for impact of the State occupational program; reluctance of employees to use plan benefits despite assurances of confidentiality; and the basic fact that because alcoholism is a disease of denial, a crisis episode is required before treatment is sought. It was stated in the 12-months' report that the second year of the Pilot Program would be watched for any significant uptrend in utilization and any change in treatment patterns.

The increase in second year utilization, which took place for all major plans and for both inpatient and outpatient care, has already been pointed out. What caused this increase? During the latter part of 1975, individual booklets describing the Pilot Program benefits available were distributed on a one-to-one basis to all health plan members. This distribution may well have had some impact in increasing employee awareness of the program. However, the starting point of the upward trend in utilization was July 1975, before the booklets were sent out. Regarding provider awareness, it seems safe to say that most inpatient facilities, which accounted for the major share of program benefit costs, knew of the Pilot Program shortly after its inception. It must also be pointed out that the upturn in utilization during the second year was only a relative one and that, as indicated at the beginning of this report, the overall utilization rate was only one-half of one percent.

Despite awareness of the availability of benefits, a crisis episode was in many cases required before treatment was sought. This conclusion is borne out by the relatively high utilization of the inpatient benefit and in particular of the detoxification benefit. The second year increase in utilization would appear to be more a function of the length of time program benefits were made available than of any change in employee perception of the program. The slow start in program usage, followed by a significant increase as the program was extended to a second year albeit still on a low level relative to potential users, is in accord with the experience of other programs of this kind. It was expected that a further uptrend in utilization would occur had the Pilot Program been extended for a third year. Such an extension was not possible because of funding problems.

There were no significant changes in the overall patterns of utilization during the second year of the program. The table below shows that the percentage distribution of cases, costs and benefits did not vary greatly from the end of the first twelve months to the end of the 23 months.

12 Months	Cases	Cost	Benefits
Inpatient Care	19.4	84.6	85.2
Outpatient Care	79.9	14.3	13.9
Recovery Home	0.7	1.1	0.9
	100.0	100.0	100.0

23 Months	Cases	Cost	Benefits
Inpatient Care	20.3	86.7	86.5
Outpatient Care	78.8	12.3	12.6
Recovery Home	0.9	1.0	0.9
	100.0	100.0	100.0

MONTHLY ALCOHOLISM UTILIZATION AND COST REPORT

TABLE 1

SUMMARY OF UTILIZATION AND COST

May - July 1976 and July 1974 - July 1976

CARRIER	INPATIENT		RECOVERY HOME		OUTPATIENT		TOTALS[a]	
	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76
ACSUP-Equity Educators								
Persons	ø	1	ø	1			ø	1
Costs	ø	$ 547.00	ø	$ 331.50			ø	$ 878.50
Benefits	ø	$ 320.00	ø	$ 292.50			ø	$ 612.50
Blue Cross/Blue Shield								
Persons	13	96	1	4	30	92	42	163
Costs	$16,010.43	$153,365.54	$ 84.00	$1,529.16	$4,970.60	$25,151.67	$21,065.03	$180,046.37
Benefits	$13,463.40	$116,273.75	$ 84.00	$1,310.94	$3,939.10	$18,816.80	$17,486.50	$136,401.49
Blue Cross, C.H.P.								
Persons	ø	2			ø	1	ø	2
Costs	ø	$ 1,137.40			ø	$ 121.00	ø	$ 1,258.40
Benefits	ø	$ 1,137.40			ø	$ 101.00	ø	$ 1,238.40
Cal-Western								
Persons	21	120	1	7	15	69	39	167
Costs	$54,239.02	$249,906.72	$175.00	$3,587.50	$3,821.71	$15,951.03	$58,235.73	$269,445.25
Benefits								
Alcohol	$19,145.13	$ 88,384.86	$105.00	$2,402.50	$2,343.74	$10,324.46	$21,593.87	$101,111.82
CWO	$30,748.64	$133,483.57	ø	ø	$1,171.00	$ 3,843.50	$31,919.64	$137,327.07
Total	$49,893.77	$221,868.43	$105.00	$2,402.50	$3,514.74	$14,167.96	$53,513.51	$238,438.89
Consolidated Medical								
Persons	ø	1					ø	1
Costs	ø	$ 2,338.05					ø	$ 2,338.05
Benefits	ø	$ 2,338.05					ø	$ 2,338.05

Table 1 Continued

CARRIER	INPATIENT May - July 1976	INPATIENT July'74- July'76	RECOVERY HOME May - July 1976	RECOVERY HOME July'74- July'76	OUTPATIENT May - July 1976	OUTPATIENT July'74- July'76	TOTALS[a] May - July 1976	TOTALS[a] July'74- July'76
Family Health								
Persons	1	2					1	2
Costs	$ 25.00	$ 1,550.85					$ 25.00	$ 1,550.85
Benefits	$ 25.00	$ 1,550.85					$ 25.00	$ 1,550.85
Kaiser North								
Persons	8	73	ø	2	38	146	44	185
Costs	$14,926.26	$105,187.41	ø	$1,112.50	$1,314.00	$26,333.35	$ 16,240.26	$132,633.26
Benefits	$14,913.15	$101,959.12	ø	$1,112.50	$1,314.00	$26,163.35	$ 16,227.15	$129,234.97
Kaiser South								
Persons	ø	36	ø	1	53	232	53	237
Costs	ø	$ 62,616.75	ø	$ 360.00	$ 707.04	$15,473.49	$ 707.04	$ 78,450.24
Benefits	ø	$ 62,616.75	ø	$ 360.00	$ 707.04	$15,473.49	$ 707.04	$ 78,450.24
United Foundation								
Persons	2	8			1	2	2	8
Costs	$ 815.80	$ 10,691.31			$ 90.00	$ 285.00	$ 905.80	$ 10,976.31
Benefits	$ 583.30	$ 7,893.92			$ 90.00	$ 285.00	$ 673.30	$ 8,178.92
Totals								
Persons	45	339	2	15	137	542	181	766
Costs	$86,016.51	$587,341.03	$ 259.00	$6,920.66	$10,903.35	$83,315.54	$ 97,178.86	$677,577.23
Benefits								
Alcohol	$48,129.98	$382,474.70	$ 189.00	$5,478.44	$ 8,393.88	$71,164.10	$ 56,712.86	$459,117.24
CWO	$30,748.64	$133,483.57	ø	ø	$ 1,171.00	$ 3,843.50	$ 31,919.64	$137,327.07
Total	$78,878.62	$515,958.27	$ 189.00	$5,478.44	$ 9,564.88	$75,007.60	$ 88,632.50	$596,444.31

[a]Corrected for multiple utilization.

TABLE 2

SUMMARY OF INPATIENT UTILIZATION AND COST

May - July 1976 and July 1974 - July 1976

CARRIER	DETOXIFICATION ONLY		REHABILITATION ONLY		DUAL		IN-HOSPITAL MEDICAL[b]		TOTALS[a]	
	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76
ACSUP-Equity Educators										
Persons	ø	1							ø	1
Days or Visits	ø	2							ø	2
Costs	ø	$ 547.00							ø	$ 547.00
Benefits	ø	320.00							ø	320.00
Blue Cross/Blue Shield										
Persons	6	40	ø	14	6	45	9	50	12	88
Days or Visits	26	141	ø	134	90	908	41	349	116	1183
Costs	$3,948.90	$21,569.72	ø	$15,223.52	$10,838.53	$107,109.98	$1,223.00	$9,462.32	$16,010.43	$153,365.54
Benefits	$3,347.90	$17,838.36	ø	$10,173.30	$ 9,280.50	$ 83,067.91	$ 835.00	$5,194.18	$13,463.40	$116,273.75
Blue Cross, C.H.P.										
Persons	ø	1	ø	1					ø	2
Days or Visits	ø	1	ø	11					ø	12
Costs	ø	$ 111.00	ø	$ 1,026.40					ø	$ 1,137.40
Benefits	ø	$ 111.00	ø	$ 1,026.40					ø	$ 1,137.40
Cal-Western										
Persons	4	27	2	28	17	64	1	34	21	120
Days or Visits	12	114	36	419	382	1421	4	199	430	1954
Costs	$2,013.35	$15,635.63	$5,706.52	$46,957.58	$46,414.15	$182,482.76	$ 105.00	$4,830.75	$54,239.02	$249,906.72
Benefits										
Alcohol	$ 779.00	$ 5,848.47	$1,128.00	$14,380.60	$17,182.13	$ 65,785.54	$ 56.00	$2,370.25	$19,145.13	$ 88,384.86
CWO	$1,234.35	$ 8,655.52	$4,001.27	$29,310.53	$25,200.02	$ 93,785.02	$ 313.00	$1,732.50	$30,748.64	$133,483.57
Total	$2,013.35	$14,503.99	$5,129.27	$43,691.13	$42,382.15	$159,570.56	$ 369.00	$4,102.75	$49,893.77	$221,868.43
Consolidated Medical										
Persons	ø	1	ø	1			ø	1	ø	1
Days or Visits	ø	2	ø	15			ø	15	ø	17
Costs	ø	$ 260.00	ø	$ 1,328.05			ø	$ 750.00	ø	$ 2,338.05
Benefits	ø	$ 260.00	ø	$ 1,328.05			ø	$ 750.00	ø	$ 2,338.05

Table 2 continued

CARRIER	DETOXIFICATION ONLY		REHABILITATION ONLY		DUAL		IN-HOSPITAL MEDICAL[b]		TOTALS[a]	
	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76
Family Health										
Persons	1	1			ø	1	ø	1	1	2
Days or Visits	1	1			ø	11	ø	9	1	12
Costs	$ 25.00	$ 25.00			ø	$ 1,075.85	ø	$ 450.00	$ 25.00	$ 1,550.85
Benefits	$ 25.00	$ 25.00			ø	$ 1,075.85	ø	$ 450.00	$ 25.00	$ 1,550.85
Kaiser North										
Persons	4	49	ø	4	4	34	ø	ø	8	73
Days or ER	17	164	ø	79	78	530	ø	ø	95	773
Costs	$3,447.46	$30,313.43	ø	$ 6,227.45	$11,478.80	$68,481.53	ø	$ 165.00	$14,926.26	$105,187.41
Benefits	$3,434.35	$30,298.67	ø	$ 4,888.42	$11,478.80	$66,607.03	ø	$ 165.00	$14,913.15	$101,959.12
Kaiser South										
Persons	ø	10	ø	21	ø	8			ø	36
Days	ø	45	ø	479	ø	210			ø	734
Costs	ø	$ 8,241.57	ø	$ 36,562.60	ø	$17,812.58			ø	$ 62,616.75
Benefits	ø	$ 8,241.57	ø	$ 36,562.60	ø	$17,812.58			ø	$ 62,616.75
United Foundation										
Persons	2	6	ø	1	ø	3			2	8
Days	4	15	ø	5	ø	60			4	80
Costs	$ 815.80	$ 3,969.31	ø	$ 515.15	ø	$ 7,109.19			$ 815.80	$ 10,691.31
Benefits	$ 583.30	$ 1,877.65	ø	$ 75.42	ø	$ 5,940.85			$ 583.30	$ 7,893.92
Totals										
Persons	17	135	2	70	27	155	10	86	44	331
Days or Visits	60	485	36	1142	550	3140	45	572	646	4767
Costs	$10,250.51	$79,770.32	$5,706.52	$107,840.75	$68,731.48	$384,071.89	$1,328.00	$15,658.07	$86,016.51	$587,341.03
Benefits										
Alcohol	$ 8,169.55	$64,820.72	$1,128.00	$ 68,434.79	$37,941.43	$240,289.76	$ 891.00	$ 8,929.43	$48,129.98	$382,474.70
CWO	$ 1,234.35	$ 8,655.52	$4,001.27	$ 29,310.53	$25,200.02	$ 93,785.02	$ 313.00	$ 1,732.50	$30,748.64	$133,483.57
Total	$ 9,403.90	$73,476.24	$5,129.27	$ 97,745.32	$63,141.45	$334,074.78	$1,204.00	$10,661.93	$78,878.62	$515,958.27

[a] Corrected for multiple utilization.

[b] Figures under In-Hospital Medical refer to visits.

TABLE 3

SUMMARY OF OUTPATIENT UTILIZATION AND COSTS

May - July 1976 and July 1974 - July 1976

CARRIER	PHYSICIAN		COUNSELOR		LICENSED SOCIAL WORKER		PSYCHOLOGIST		PARAPROFESSIONAL		TOTALS[a]	
	May - July 1976	July'74- July'76	May - July 1976	July'74- July'76	May - July 1976	July'74- July'76	May - July 1976	July'74- July'76	May - July 1976	July'74- July'76	May - July 1976	July'74- July'76
Blue Cross/Blue Shield												
Persons	23	88	5	6	1	5	2	5	Ø	1	30	92
Visits	92	617	66	95	6	81	5	79	Ø	2	169	874
Costs	$2,995.10	$17,760.17	$1,777.00	$2,562.00	$ 26.00	$1,815.00	$172.50	$2,974.50	Ø	$ 40.00	$ 4,970.60	$25,151.67
Benefits	$2,086.10	$12,427.80	$1,702.00	$2,487.00	$ 26.00	$1,655.00	$125.00	$2,207.00	Ø	$ 40.00	$ 3,939.10	$18,816.80
Blue Cross, C.H.P.												
Persons	Ø	1									Ø	1
Visits	Ø	5									Ø	5
Costs	Ø	$ 121.00									Ø	$ 121.00
Benefits	Ø	$ 101.00									Ø	$ 101.00
Cal-Western												
Persons	11	62	Ø	3	3	6	Ø	1	1	2	15	69
Visits	104	568	Ø	19	29	58	Ø	2	4	12	137	659
Costs	$3,212.71	$13,905.53	Ø	$ 486.50	$529.00	$1,199.00	Ø	$ 80.00	$80.00	$ 280.00	$ 3,821.71	$15,951.03
Benefits												
Alcohol	$1,734.74	$ 8,443.96	Ø	$ 351.50	$529.00	$1,199.00	Ø	$ 50.00	$80.00	$ 280.00	$ 2,343.74	$10,324.46
CWO	$1,171.00	$ 3,813.50	Ø	Ø	Ø	Ø	Ø	$ 30.00	Ø	Ø	$ 1,171.00	$ 3,843.50
Total	$2,905.74	$12,257.46	Ø	$ 351.50	$529.00	$1,199.00	Ø	$ 80.00	$80.00	$ 280.00	$ 3,514.74	$14,167.96
Kaiser North												
Persons	20	133	Ø	2	Ø	10	3	16	18	37	38	146
Visits	32	619	Ø	7	Ø	35	4	159	60	518	96	1338
Costs	$ 305.25	$12,862.75	Ø	$ 80.00	Ø	$1,121.50	$ 74.25	$4,484.10	$934.50	$7,785.00	$ 1,314.00	$26,333.35
Benefits	$ 305.25	$12,752.75	Ø	$ 80.00	Ø	$1,111.50	$ 74.25	$4,434.10	$934.50	$7,785.00	$ 1,314.00	$26,163.35
Kaiser South												
Persons	19	141			Ø	30	6	14	41	198	53	232
Visits	22	394			Ø	188	13	117	89	1440	124	2139
Costs	*	*			*	*	*	*	*	*	$ 707.04	$15,473.49
Benefits	*	*			*	*	*	*	*	*	$ 707.04	$15,473.49

*Included in total.

Table 3 continued

CARRIER	PHYSICIAN		COUNSELOR		LICENSED SOCIAL WORKER		PSYCHOLOGIST		PARAPROFESSIONAL		TOTALS[a]	
	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76	May - July 1976	July'74-July'76
United Foundations												
Persons	1	2									1	2
Visits	5	13									5	13
Costs	$ 90.00	$ 285.00									$ 90.00	$ 285.00
Benefits	$ 90.00	$ 285.00									$ 90.00	$ 285.00
Totals												
Persons	74	427	5	11	4	51	11	36	60	238	137	542
Visits	255	2216	66	121	35	362	22	357	153	1972	531	5028
Costs	$6,603.06	$44,934.45	$1,777.00	$3,128.50	$555.00	$4,135.50	$246.75	$7,538.60	$1,014.50	$8,105.00	$10,903.35	$83,315.54
Benefits												
Alcohol	$4,216.09	$34,010.51	$1,702.00	$2,918.50	$555.00	$3,965.50	$199.25	$6,691.10	$1,014.50	$8,105.00	$ 8,393.88	$71,164.10
CWO	$1,171.00	$ 3,813.50	ø	ø	ø	ø	ø	30.00	ø	ø	$ 1,171.00	$ 3,843.50
Total	$5,387.09	$37,824.01	$1,702.00	$2,918.50	$555.00	$3,965.50	$199.25	$6,721.10	$1,014.50	$8,105.00	$ 9,564.88	$75,007.60

[a] Corrected for usage in more than one month or multiple provider usage.

TABLE 4

SUMMARY OF RECOVERY HOME UTILIZATION AND COST

May - July 1976 and July 1974 - July 1976

CARRIER	R2s		R3s		TOTAL	
	May - July 1976	July '74- July '76	May - July 1976	July '74- July '76	May - July 1976	July '74- July '76
ACSUP-Equity Educators						
Persons	ø	1			ø	1
Days	ø	34			ø	34
Costs	ø	$ 331.50			ø	$ 331.50
Benefits	ø	$ 292.50			ø	$ 292.50
Blue Cross/Blue Shield						
Persons	1	4			1	4
Days	7	75			7	75
Costs	$84.00	$1,529.16			$84.00	$1,529.16
Benefits	$84.00	$1,310.94			$84.00	$1,310.94
Cal-Western						
Persons	1	6	ø	1	1	7
Days	7	161	ø	89	7	250
Costs	$175.00	$2,497.50	ø	$890.00	$175.00	$3,387.50
Benefits	$105.00	$2,102.50	ø	$300.00	$105.00	$2,402.50
Kaiser North						
Persons	ø	2			ø	2
Days	ø	45			ø	45
Costs	ø	$1,112.50			ø	$1,112.50
Benefits	ø	$1,112.50			ø	$1,112.50
Kaiser South						
Persons	ø	1			ø	1
Days	ø	21			ø	21
Costs	ø	$ 360.00			ø	$ 360.00
Benefits	ø	$ 360.00			ø	$ 360.00
Total						
Persons	2	14	ø	1	2	15
Days	14	336	ø	89	14	425
Costs	$259.00	$6,030.66	ø	$890.00	$259.00	$6,920.66
Benefits	$189.00	$5,178.44	ø	$300.00	$189.00	$5,478.44

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TABLE 5

INPATIENT UTILIZATION AND COST:

Medical and Non-Medical Detoxification

July 1974 - July 1976

CARRIER	MEDICAL DETOX.	NON-MEDICAL DETOX.	TOTAL[a] DETOX.
ACSUP			
Admissions	1		1
Days	2		2
Benefits	$ 320.00		$ 320.00
Blue Cross/Blue Shield			
Admissions	82	26	102[b]
Days	257	81	338
Benefits	$ 35,791.91	$9,325.58	$ 45,117.49
Blue Cross, C.H.P.			
Admissions		1	1
Days		1	1
Benefits		$ 111.00	$ 111.00
Cal-Western			
Admissions	94	14	108
Days	244	37	281
Benefits	$ 21,877.67	$1,734.00	$ 23,611.67
Consolidated Medical Systems			
Admissions	2		2
Days	2		2
Benefits	$ 260.00		$ 260.00
Family Health			
Admissions	1	1	2
Days	2	1	3
Benefits	$ 368.70	$ 25.00	$ 393.70
Kaiser North			
Admissions	68	15	83
Days	225	36	261
Benefits	$ 41,819.40	$5,702.27	$ 47,521.67
Kaiser South			
Admissions	18		18
Days	80		80
Benefits	$ 13,997.14		$ 13,997.14
United Foundations			
Admissions	7	2	9
Days	13	2	15
Benefits	$ 2,723.88	$ 416.45	$ 3,140.33
Total			
Admissions	273	59	326
Days	825	158	983
Benefits	$117,158.70	$17,314.30	$134,473.00

[a]Includes separate Emergency Room treatment.

[b]Both types detox during one entry.

TABLE 6

INPATIENT ADMISSION UTILIZATION AND COST: TYPE OF FACILITY

July 1974 - July 1976

CARRIER	GENERAL HOSPITAL	ALCOHOL UNIT	ALCOHOL HOSPITAL	COUNTY ALCOHOL TREATMENT CENTER	RESIDENTIAL TREATMENT FACILITY	OTHER	TOTAL[a]
ACSUP							
Admissions			1				1
Days			2				2
Cost			$ 547.00				$ 547.00
Benefits			$ 320.00				$ 320.00
Blue Cross/Blue Shield							
Admissions	34	56	25	2	1	6	124
Days	143	734	209	24	49	24	1183
Costs	$19,011.34	$ 81,155.29	$37,471.40	$ 612.00	$2,302.27	$3,350.92	$143,903.22
Benefits	$16,585.34	$ 68,318.81	$21,296.90	$ 612.00	$1,296.00	$2,970.52	$111,079.57
Blue Cross, C.H.P.							
Admissions	1	2					3
Days	1	11					12
Costs	$ 111.00	$ 1,026.40					$ 1,137.40
Benefits	$ 111.00	$ 1,026.40					$ 1,137.40
Cal-Western							
Admissions	38	59	28	9	5		139
Days	147	1203	362	95	147		1954
Costs	$25,806.78	$147,139.25	$59,914.00	$2,727.95	$9,487.99		$245,075.97
Benefits							
Alcohol	$ 5,997.82	$ 38,147.39	$31,017.41	$2,456.95	$8,395.04		$ 86,014.61
CWO	$19,438.84	$107,833.89	$ 4,471.34	$ 7.00	ø		$131,751.07
Total	$25,436.66	$145,981.28	$35,488.75	$2,463.95	$8,395.04		$217,765.68
Consolidated Medical Systems							
Admissions	2	1					3
Days	2	15					17
Costs	$ 260.00	$ 1,328.05					$ 1,588.05
Benefits	$ 260.00	$ 1,328.05					$ 1,588.05

Table 6 continued

CARRIER	GENERAL HOSPITAL	ALCOHOL UNIT	ALCOHOL HOSPITAL	COUNTY ALCOHOL TREATMENT CENTER	RESIDENTIAL TREATMENT FACILITY	OTHER	TOTAL[a]
Family Health							
Admissions	1	1					2
Days	1	11					12
Costs	$ 25.00	$ 1,075.85					$ 1,100.85
Benefits	$ 25.00	$ 1,075.85					$ 1,100.85
Kaiser North							
Admissions	61	12	12		6		91
Days	173	244	181		175		773
Costs	$33,599.27	$ 29,244.35	$ 31,416.20		$10,762.59		$105,022.41
Benefits	$33,597.67	$ 28,200.27	$ 31,101.20		$ 8,894.98		$101,794.12
Kaiser South							
Admissions	18	11	20				49
Days	80	209	445				734
Costs	$13,997.14	$ 19,641.91	$ 28,977.70				$ 62,616.75
Benefits	$13,997.14	$ 19,641.91	$ 28,977.70				$ 62,616.75
United Foundations							
Admissions	4	5	1				10
Days	13	66	1				80
Costs	$ 2,256.00	$ 8,195.51	$ 239.80				$ 10,691.31
Benefits	$ 917.72	$ 6,816.20	$ 160.00				$ 7,893.92
Total							
Admissions	159	147	87	11	12	6	422
Days	560	2493	1200	119	371	24	4767
Costs	$95,041.53	$288,806.61	$158,566.10	$3,339.95	$22,552.85	$3,350.92	$571,682.96
Benefits							
Alcohol	$71,466.69	$164,554.88	$112,873.21	$3,068.95	$18,586.02	$2,970.52	$373,545.27
CWO	$19,438.84	$107,833.89	$ 4,471.34	$ 7.00	ø	ø	$131,751.07
Total	$90,905.53	$272,388.77	$117,344.55	$3,075.95	$18,586.02	$2,970.52	$505,296.34

[a]Totals reflect number of admissions rather than persons.

TABLE 6A

DISTRIBUTION OF INPATIENT ADMISSION COSTS - FOUR MAJOR CARRIERS

Cost Per Admission	CAL-WESTERN			BLUE CROSS/BLUE SHIELD			KAISER-NORTH			KAISER-SOUTH			TOTAL - FOUR PLANS		
	No.	Percent	Cumulative Percent	No.	Percent	Cumulative Percent	No.	Percent	Cumulative Percent	No.	Percent	Cumulative Percent	No.	Percent	Cumulative Percent
$ 0 - $ 250	8	5.9	5.9	14	11.6	11.6	1	1.4	1.4	1	2.1	2.1	24	6.4	6.4
251- 500	19	14.2	20.1	29	24.1	35.7	4	5.6	7.0	2	4.2	6.3	54	14.4	20.8
501- 750	15	11.1	31.2	21	17.5	53.2	22	30.5	37.5	14	29.2	35.5	72	19.1	39.9
751- 1,000	12	8.9	40.1	9	7.4	60.6	13	18.0	55.5	4	8.3	43.8	38	10.1	50.0
1,001- 1,250	1	0.7	40.8	5	4.1	64.7	5	6.8	62.3	7	14.6	58.4	18	4.8	54.8
1,251- 1,500	2	1.5	42.3	4	3.3	68.0	1	1.4	63.7	3	6.2	64.6	10	2.7	57.5
1,501- 1,750	8	5.9	48.2	5	4.1	72.1	-	-	-	2	4.2	68.8	15	4.0	61.5
1,751- 2,000	6	4.4	52.6	7	5.8	77.9	5	6.9	70.6	2	4.2	73.0	20	5.3	66.8
2,001- 2,250	9	6.7	59.3	2	1.6	79.5	4	5.6	76.2	7	14.6	87.6	22	5.8	72.6
2,251- 2,500	6	4.4	63.7	11	9.1	88.6	3	4.2	80.4	3	6.2	93.8	23	6.1	78.7
2,501- 2,750	21	15.7	79.4	2	1.6	90.2	2	2.8	83.1	3	6.2	100.0	28	7.4	86.1
2,751- 3,000	11	8.9	88.3	4	3.3	93.5	4	5.6	88.8	-	-	-	11	5.0	91.1
3,001- 3,250	5	3.7	92.0	5	4.1	97.6	3	4.2	93.0	-	-	-	13	3.5	94.6
3,251- 3,500	2	1.5	93.5	1	0.2	98.4	3	4.2	97.2	-	-	-	6	1.6	96.2
3,501- 3,750	2	1.5	95.0	-	-	-	1	1.4	98.6	-	-	-	3	0.8	97.0
3,751- 4,000	2	1.5	96.5	1	0.8	99.2	-	-	-	-	-	-	4	1.1	98.1
4,001- 4,500	1	0.7	97.2	-	-	-	1	1.4	100.0	-	-	-	2	0.5	98.6
4,501- 5,000	1	0.7	97.9	-	-	-	-	-	-	-	-	-	1	0.3	98.9
5,001- 5,500	1	0.7	98.6	-	-	-	-	-	-	-	-	-	1	0.3	99.2
5,501- 6,000	1	0.7	99.3	1	0.8	100.0	-	-	-	-	-	-	2	0.5	99.7
6,001- 6,500	1	0.7	100.0	-	-	-	-	-	-	-	-	-	1	0.3	100.0
TOTALS	135	100.0		121	100.0		72	100.0		48	100.0		376	100.0	

TABLE 7

INPATIENT UTILIZATION: LENGTH OF STAY

July 1974 - July 1976

Number of Days	Detox Only	Rehabilitation Only	Dual	TOTAL[a]
ER	27			27
1	19	1		20
2	26	4	1	31
3	38	5	5	48
4	24	6		30
5	14	7	1	22
6	11	2	3	16
7	4	4	1	9
8		7	2	9
9	1		2	3
10		1		1
11		1	10	11
12		1	14	15
13			10	10
14		1	9	10
15		1	4	5
16		1		1
17		2	1	3
18			1	1
19		1	2	3
20		1	3	4
21		12	12	24
22		3	24	27
23			16	16
24			9	9
25		2	4	6
26			7	7
27		3	8	11
28		3	3	6
29		1	1	2
30			4	4
31		4	3	7
32			2	2
35			2	2
36		1	2	3
49			1	1
TOTALS	164	75	167	406

[a]Includes multiple admissions.

TABLE 8

UTILIZATION BY SEX AND AGE

July 1974 - July 1976

	ACSUP	BLUE CROSS/ BLUE SHIELD	BLUE CROSS C.H.P.	CAL-WEST/ OCCIDENTAL	CONSOLIDATED MEDICAL	FAMILY HEALTH	KAISER NORTH	KAISER SOUTH	UNITED FNDS.	TOTALS
Total Utilization										
Male	1	102	2	122	1	2	132	160	5	527
Female		61		45			52	77	3	238
Total	1	163	2	167	1	2	185[a]	237	8	766
Range Male	50	15-68	45-58	15-66	47	15-47	15-66	13-66	30-50	13-68
Range Female		16-65		14-69			22-64	11-67	43-61	11-69
Average Age[b]		49.3	51.5	47.3		31	45.4	46.4	48.5	46.9[b]
Inpatient										
Male	1	50	2	90	1	2	59	30	5	239
Female		46		30			14	6	3	99
Total	1	96	2	120	1	2	73	36	8	339
Average Age	50	51	51.5	49.7	47	31	48.2	51.6	48.5	49.8
Outpatient										
Male		62	1	45			103	155	2	368
Female		30		24			43	77		174
Total		92	1	69			146	232	2	542
Average Age		47.8		45.4			43.7	46.2	40	45.7

[a] Sex not available for all patients.

[b] Age not available on all patients.

TABLE 9

UTILIZATION BY TYPE OF ENROLLEE:

Total Utilization, July 1974 - July 1976

	ACSUP	BLUE CROSS/ BLUE SHIELD	BLUE CROSS C.H.P.	CAL-WEST/ OCCIDENTAL	CONSOLIDATED MEDICAL	FAMILY HEALTH	KAISER NORTH	KAISER SOUTH	UNITED FNDS.	TOTALS
State										
Active Employees		93	1	90	1	1	117	148	2	453
Annuitants		7	1	19			10	11		48
Dependents	1	60		55		1	49	73	5	244
Unknown		2		0			0	1		3
Subtotal	1	162	2	164	1	2	176	233	7	748
Public Agency										
Active Employees		0		2			6	2	1	11
Annuitants		0		1			0	0		1
Dependents		1		0			3	2		6
Subtotal		1		3			9	4	1	18
Total, State & Public Agency	1	163	2	167	1	2	185	237	8	766

Inpatient Utilization, July 1974 - July 1976

State										
Active Employees		55	1	62	1	1	41	20	2	183
Annuitants		0	1	17			5	4		27
Dependents	1	39		40		1	23	11	5	120
Unknown		1		0			0	0		1
Subtotal	1	95	2	119	1	2	69	35	7	331

Table 9 continued

Inpatient continued

	ACSUP	BLUE CROSS/ BLUE SHIELD	BLUE CROSS C.H.P.	CAL-WEST/ OCCIDENTAL	CONSOLIDATED MEDICAL	FAMILY HEALTH	KAISER NORTH	KAISER SOUTH	UNITED FNDS.	TOTALS
Public Agency										
Active Employee		0		1			2	1	1	5
Annuitants		0		0			0	0	0	0
Dependents		1		0			2	0	0	3
Subtotal		1		1			4	1	1	8
TOTAL, State & Public Agency	1	96	2	120	1	2	73	36	8	339

Outpatient Utilization, July 1974 - July 1976

State										
Active Employees		57	1	39			96	145	2	340
Annuitants		8		8			7	9		32
Dependents		27		20			36	73		156
Unknown		0		0			0	1		1
[illegible]		[illegible]		[illegible]			[illegible]	[illegible]	[illegible]	[illegible]
Public Agency										
Active Employees				2			5	2		9
Annuitants				0			0	0		0
Dependents				0			2	2		4
Subtotal				2			7	4		13
TOTAL, State & Public Agency		92	1	69			146	232	2	542

TABLE 10

UTILIZATION BY COUNTY

July 1974 - July 1976

COUNTY	ACSUP	BLUE CROSS/ BLUE SHIELD	BLUE CROSS C.H.P.	CAL-WEST/ OCCIDENTAL	CONSOLIDATED MEDICAL	FAMILY HEALTH	KAISER NORTH	KAISER SOUTH	UNITED FNDS.	TOTALS
Alameda		7		1			16	1		25
Amador		1								1
Calaveras				2						2
Contra Costa		2		3			5			10
Del Norte				1						1
El Dorado				3					1	4
Fresno		4		3						7
Humboldt				2						2
Imperial				1						1
Kern		1		3				1		5
Los Angeles		22		9		2		110		143
Marin		3					1			4
Mariposa		1								1
Mendocino				2						2
Merced		2		1						3
Monterey		3								3
Napa		5		1			11			17
Orange		18		12				13		43
Placer		5		1			1			7
Plumas		1								1
Riverside		5		3				30	1	39
Sacramento		11		42			95		4	152
San Bernardino		7	1	3				39		50
San Diego		5	1	3	1			36		46

Table 10 continued

COUNTY	ACSUP	BLUE CROSS/ BLUE SHIELD	BLUE CROSS C.H.P.	CAL-WEST/ OCCIDENTAL	CONSOLIDATED MEDICAL	FAMILY HEALTH	KAISER NORTH	KAISER SOUTH	UNITED FNDS.	TOTALS
San Francisco		2					12			14
San Joaquin		4		12						16
San Mateo		4		3			8	1		16
San Luis Obispo		14		7						21
Santa Barbara		2		1						3
Santa Clara		3		1			15		1	20
Santa Cruz		1		1						2
Siskiyou				1						1
Solano	1	2		1			3			7
Sonoma		9		2			2			13
Stanislaus		1		2						3
Sutter				1						1
Tehama				1						1
Tulare		1		26						27
Tuolumne				2						2
Ventura		9		6				2	1	18
Yolo		2		2			11			15
Unknown		3					5			8
Fontana Clinic								1		1
Harbor Clinic								3		3
Florida				1						1
Pennsylvania		1								1
Nevada				1						1
Oregon		1								1
New York		1								1
TOTALS	1	163	2	167	1	2	185	237	8	766

TABLE 11

ADMINISTRATIVE COSTS BY CARRIER

AND

TOTAL COST OF PROGRAM TO DATE

CARRIER	MAY - JULY 1976	JULY 1, 1974 - JULY 1976
ACSUP-American National	ø	$ 189.74
ACSUP-Equity Educators	ø	$ 94.00
Blue Cross-Blue Shield, Statewide	ø	$ 30,705.67
Cal-Western	$ 1,296.00	$ 13,896.00
Kaiser-North	$ 641.90	$ 22,231.45
Kaiser-South	$ 425.00	$ 13,168.92
Blue Cross - C.H.P.	ø	$ 2,533.83
Blue Cross - C.T.A.	ø	$ 800.00
Blue Cross - F&G	ø	$ 559.31
United Foundations	$ 551.57	$ 4,279.85
Family Health Program	$ 79.27	$ 1,089.41
Ross-Loos	ø	$ 3,448.15
Consolidated Medical Systems, Ltd.	ø	$ 1,060.00
TOTAL ADMINISTRATIVE COST	$ 2,568.74	$ 93,631.33
TOTAL ALCOHOL PROGRAM BENEFIT COST	$56,712.86	$459,117.24
TOTAL COSTS TO PILOT PROGRAM (Services and Administrative Costs)	$59,281.60	$552,748.57

TABLE I
ALCOHOLISM UTILIZATION AND COST BY MONTH REPORTED

	NUMBER OF CASES				ALCOHOLISM PROGRAM BENEFIT COSTS						
MONTH REPORTED	In-patient	Out-patient	Recovery Home	Total	In-patient	Out-patient	Recovery Home	Total	ADMINISTRATIVE COSTS[a]	TOTAL COSTS	CUMULATIVE COSTS
July 1974									$ 639.00	$ 639.00	$ 639.00
August 1974	1			1	$ 39.00			$ 39.00	544.00	583.00	1,222.00
September 1974	7	41		48	7,198.12	$ 2,071.50		9,269.62	5,135.10	14,404.72	15,626.72
October 1974	9	33		42	6,660.97	1,554.10		8,215.07	6,143.59	14,358.66	29,985.38
November 1974	11	44		55	17,230.79	1,741.75		18,972.54	4,230.08	23,202.62	53,188.00
December 1974	8	56	1	65	7,300.96	1,859.29	$ 255.00	9,415.25	4,659.23	14,074.48	67,262.48
January 1975	17	64		81	14,150.88	2,589.08		16,739.96	2,202.46	18,942.42	86,204.90
February 1975	11	52		63	7,639.48	2,070.55		9,710.03	1,915.17	11,625.20	97,830.10
March 1975	14	48	2	64	14,797.36	1,911.54	585.00	17,293.90	2,172.82	19,466.72	117,296.82
April 1975	17	59		76	13,171.30	2,708.15		15,879.45	1,963.01	17,842.46	135,139.28
May 1975	19	61	1	81	13,734.70	3,181.49	350.00	17,266.19	2,388.90	19,655.09	154,794.37
June 1975	14	70	1	85	9,924.14	3,905.89	285.00	14,115.03	2,238.96	16,353.99	171,148.36
July 1975	22	69	1	92	16,987.20	3,091.36	285.00	20,363.56	9,897.31[b]	30,260.87	201,409.23
August 1975	25	88	2	115	16,547.84	2,586.00	1,055.00	20,188.84	21,040.47[c]	41,237.31	242,646.54
September 1975	34	81	1	116	29,084.87	3,450.00	30.00	32,564.87	4,373.29	36,938.16	279,584.70
October 1975	18	91		109	16,089.59	3,916.00		20,005.59	3,028.08	23,033.67	302,618.37
November 1975	16	95	2	113	16,193.12	4,686.27	660.00	21,539.39	3,947.62	25,487.01	328,105.38
December 1975	25	105	1	131	21,712.43	4,850.80	250.00	26,813.23	2,722.01	29,535.24	357,640.62
January 1976	35	109	1	145	33,172.93	5,703.00	225.00	39,100.93	2,594.00	41,694.93	399,355.55
February 1976	12	94		106	10,257.36	4,222.31		14,479.67	2,079.46	16,559.13	415,894.68
March 1976	31	133	3	167	35,230.69	5,556.47	1,309.44	42,096.60	2,775.31	44,871.91	460,766.59
April 1976	28	100		128	26,774.93	3,773.48		30,548.41	2,488.08	33,036.49	493,803.08
May - July 1976	45	137	2	184	48,129.98	8,393.88	189.00	56,712.86	2,568.74	59,281.60	553.084.68
TOTALS	419	1,630	18	2,067	382,028.64	73,822.91	5,478.44	461,329.99	91,754.69	553,084.68	

a-Includes $27,072.60 cost of printing and distributing Alcohol Program Benefit booklets to health plan members
b-Includes $12,000.00 refund in administrative costs from Kaiser Southern California
c-Includes July 1974 - June 1975 (12 mo.) administrative costs reported by Blue Cross-Blue Shield
Note: Total figures in this table differ from those in standard tables as monthly figures are as reported without later adjustments.

TABLE II

UTILIZATION AND COST BY MONTH OF SERVICE—FOUR MAJOR CARRIERS TOTAL

PILOT PROGRAM

MONTH OF SERVICE	NUMBER OF CASES			BENEFITS COST		
	In-patient	Out-patient	Total	In-patient	Out-patient	Total
July 1974	12	25	37	4,526.49	86.50	4,612.99
August 1974	7	31	38	4,437.08	297.35	4,734.43
September 1974	15	41	56	14,979.60	2,506.00	17,485.60
October 1974	13	45	58	11,012.80	1,950.07	12,962.87
November 1974	14	56	70	15,309.24	1,770.53	17,079.77
December 1974	10	66	76	9,729.22	3,387.44	13,116.66
January 1975	12	85	97	10,478.77	3,569.48	14,048.25
February 1975	14	69	83	12,823.70	2,666.02	15,489.72
March 1975	16	66	82	14,648.50	2,667.99	17,316.49
April 1975	17	79	96	13,131.68	3,584.05	16,715.73
May 1975	16	76	92	12,102.62	3,589.72	15,692.34
June 1975	16	79	95	12,733.63	2,777.89	15,511.52
July 1975	24	86	110	15,418.77	2,388.30	17,807.07
August 1975	23	98	121	22,520.70	2,895.55	25,416.25
September 1975	20	94	114	18,503.04	3,075.74	21,578.78
October 1975	26	106	132	28,017.57	4,032.53	32,050.10
November 1975	20	110	130	13,607.51	4,245.30	17,852.81
December 1975	25	119	144	29,518.47	4,766.89	34,285.36
January 1976	21	116	137	14,476.66	4,852.27	19,328.93
February 1976	15	113	128	16,588.81	4,311.37	20,906.18
March 1976	27	139	166	30,801.79	5,298.14	36,099.93
April 1976	26	106	132	27,662.86	3,246.18	30,909.04
May 1976	14	107	121	16,204.25	2,813.04	19,017.29
TOTALS	403	1,912	2,315	369,233.76	70,778.35	440,012.11

TABLE III

UTILIZATION BY CARRIER BY QUARTER

PERIOD OF SERVICE	INPATIENT ADMISSIONS					OUTPATIENT CASES				
	CWO	BC/BS	K-N	K-S	TOTAL	CWO	BC/BS	K-N	K-S	TOTAL
July - Sept. 1974	9	6	12	7	34	17	6	7	67	97
October - December	10	13	7	7	37	26	28	28	85	167
Jan. - March 1975	12	10	9	11	42	30	34	52	104	220
April - June	18	16	6	9	49	32	50	59	93	234
July - Sept.	21	26	15	5	67	31	41	86	120	278
October - December	25	27	15	4	71	47	47	110	131	335
Jan. - March 1976	25	22	13	3	63	31	50	134	153	368
April - May	19	4	14	3	40	20	18	75	100	213
Totals	139	124	91	49	403	234	274	551	853	1,912

TABLE IV

TOTAL BENEFITS PAID (INCLUDING CWO BASIC PLAN) BY CARRIER BY QUARTER

PERIOD OF SERVICE	CWO	BC/BS	K-N	K-S	TOTAL
July - Sept. 1974	$ 4,185.76	$ 7,023.09	$ 10,209.75	$ 8,255.33	$ 29,673.93
October - December	12,971.40	16,683.86	11,362.29	10,208.73	51,226.28
Jan. - March 1975	$14,729.54	$ 9,010.27	$ 13,796.90	$15,637.05	$ 53,173.76
April - June	27,312.88	15,064.99	8,179.85	13,554.65	64,112.37
July - September	38,679.11	28,324.81	15,854.90	7,612.75	90,471.57
October - December	44,388.97	30,475.28	26,394.72	7,799.33	109,058.30
Jan. - March 1976	$51,844.59	$ 24,468.90	$ 19,232.26	$ 8,679.15	$104,224.90
April - May	41,923.42	4,039.35	23,092.05	6,343.25	75,398.07
Totals	$236,035.67	$135,090.55	$128,122.72	$78,090.24	$577,339.18

TABLE V

UTILIZATION AND COST BY MONTH OF SERVICE - CAL-WESTERN

	INPATIENT				OUTPATIENT				TOTAL			
	CASES	COSTS	BENEFITS		CASES	COSTS	BENEFITS		CASES	COSTS	BENEFITS	
			ALCOHOL	CWO			ALCOHOL	CWO			ALCOHOL	CWO
1974												
July	7	$ 2,296.16	$ 506.00	$ 1,790.16	3	$ 81.50	$ 39.50	$ 42.00	10	$ 2,377.66	$ 545.50	$ 1,832.16
August	1	263.90	43.00	220.70	7	317.35	217.35	93.00	8	581.25	260.35	313.70
September	1	806.05	222.00	584.05	7	496.00	317.00	111.00	8	1,302.05	539.00	695.05
October	5	5,264.74	1,506.85	3,709.89	10	633.57	429.57	108.00	15	5,898.31	1,936.42	3,817.89
November	4	6,321.25	1,971.36	3,592.89	9	340.79	236.79	72.00	13	6,662.04	2,208.15	3,664.89
December	1	785.80	328.60	439.20	7	614.75	431.25	145.00	8	1,400.55	759.85	584.20
1975												
January	4	3,345.70	1,094.00	2,138.20	11	787.47	539.19	159.00	15	4,133.17	1,633.19	2,297.20
February	2	5,376.18	3,133.00	342.78	9	532.00	368.00	122.00	11	5,908.18	3,501.00	464.78
March	6	6,440.92	2,857.60	3,467.32	10	557.45	418.45	90.00	16	6,998.37	3,276.05	3,557.32
April	7	10,016.87	3,926.50	3,737.47	11	883.45	569.85	256.00	18	10,900.32	4,496.35	3,993.47
May	6	3,277.11	1,177.90	2,099.21	12	865.00	558.15	264.00	18	4,142.11	1,736.05	2,363.21
June	5	14,738.50	4,673.20	9,716.10	9	339.50	214.50	120.00	14	15,078.00	4,887.70	9,836.10
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	311.80	160.30	144.00	17	13,804.79	5,548.30	8,349.49
August	6	14,769.85	4,524.00	7,919.65	10	719.50	419.50	266.00	16	15,489.35	4,943.50	8,185.65
September	7	14,166.63	3,821.60	8,926.33	12	1,019.11	696.24	208.00	19	15,185.74	4,517.84	9,134.33
October	10	18,941.92	9,000.46	6,280.86	17	1,015.61	654.11	255.00	27	19,957.53	9,654.57	6,535.86
November	7	6,007.22	1,595.05	3,931.57	15	863.97	557.47	228.00	22	6,871.19	2,152.52	4,159.57
December	8	21,216.54	7,009.94	13,942.60	15	1,166.41	701.91	232.00	23	22,382.95	7,711.85	14,174.60
1976												
January	7	15,276.25	3,251.20	11,611.45	12	956.97	685.47	209.50	19	16,233.22	3,936.67	11,820.95
February	5	11,103.16	5,171.20	2,080.00	9	790.39	520.39	168.00	14	11,893.55	5,691.59	2,248.00
March	13	30,639.31	13,795.00	13,634.91	10	912.47	525.47	192.00	23	31,551.78	14,320.47	13,826.91
April	12	26,757.15	10,869.68	12,112.47	11	870.97	559.00	183.00	23	27,628.12	11,428.68	12,295.47
May	7	18,602.52	4,518.00	13,000.27	9	775.00	505.00	140.00	16	19,377.52	5,023.00	13,140.27
June	-	-	-	-	1	100.00	Ø	36.00	1	100.00	Ø	36.00
TOTAL	139	$249,906.72	$88,384.14	$133,483.57	235	$15,951.03	$10,324.46	$3,843.50	374	$265,857.75	$98,708.60	$137,327.07

TABLE VI .

UTILIZATION AND COST BY MONTH OF SERVICE - BLUE CROSS/BLUE SHIELD

MONTH	INPATIENT			OUTPATIENT			TOTAL		
	CASES	COST	BENEFITS	CASES	COST	BENEFITS	CASES	COST	BENEFITS
1974									
July	2	$ 4,007.49	$ 3,701.79	-	-	-	2	$ 4,007.49	$ 3,701.79
August	1	639.05	639.05	1	$ 95.00	$ 25.00	2	734.05	664.05
September	3	3,688.60	2,493.25	5	189.00	164.00	8	3,877.60	2,657.25
October	5	5,848.83	4,549.00	10	778.00	700.00	15	6,626.83	5,249.00
November	4	6,681.18	6,659.23	7	644.49	543.49	11	7,325.67	7,202.72
December	4	3,460.05	2,703.45	11	1,727.08	1,528.69	15	5,187.13	4,232.14
1975									
January	2	2,205.29	1,818.04	12	1,408.35	1,258.21	14	3,613.64	3,076.25
February	6	3,355.16	2,988.50	10	1,206.47	772.47	16	4,561.63	3,760.97
March	2	1,487.55	1,291.05	12	1,567.00	882.00	14	3,054.55	2,173.05
April	3	1,519.64	1,449.64	15	1,818.00	1,298.00	18	3,337.64	2,747.64
May	6	8,627.08	7,491.96	16	2,212.19	1,442.58	22	10,839.27	8,934.54
June	7	2,622.55	2,365.65	19	1,496.08	1,017.16	26	4,118.63	3,382.81
July	11	10,107.00	8,038.85	12	1,106.72	712.00	23	11,213.72	8,750.85
August	8	13,415.15	9,948.40	14	957.55	669.55	22	14,372.70	10,617.95
September	7	9,317.52	8,382.51	15	797.00	573.50	22	10,114.52	8,956.01
October	9	18,984.73	12,454.58	14	918.30	649.30	23	19,903.03	13,103.88
November	10	12,018.48	8,924.75	16	1,280.39	1,011.80	26	13,298.87	9,936.55
December	7	10,346.55	6,326.35	17	1,308.50	1,108.50	24	11,655.05	7,434.85
1976									
January	7	15,702.40	7,445.00	14	1,108.80	813.80	21	16,811.20	8,258.80
February	8	7,326.04	6,645.30	19	1,376.00	1,049.00	27	8,702.04	7,694.30
March	7	7,783.30	7,250.80	17	1,512.50	1,265.00	24	9,295.80	8,515.80
April	4	3,996.90	2,481.60	12	965.75	757.75	16	4,962.65	3,239.35
May	-	225.00	225.00	6	678.00	575.00	6	903.00	800.00
TOTALS	123	$153,365.54	$116,273.75	274	$25,151.17	$18,816.80	397	$178,516.71	$135,090.55

TABLE VII

UTILIZATION AND COST BY MONTH OF SERVICE - KAISER-NORTH

MONTH	INPATIENT			OUTPATIENT			TOTAL		
	CASES	COST	BENEFITS	CASES	COST	BENEFITS	CASES	COST	BENEFITS
1974									
July	3	$ 318.70	$ 318.70	2	$ 47.00	$ 47.00	5	$ 365.70	$ 365.70
August	3	1,200.85	1,200.85	2	55.00	55.00	5	1,255.85	1,255.85
September	6	8,781.95	8,435.20	3	153.00	153.00	9	8,934.95	8,588.20
October	0	ø	ø	4	170.50	170.50	4	170.50	170.50
November	4	5,492.07	5,281.66	9	454.25	454.25	13	5,946.32	5,735.91
December	3	5,519.17	4,750.38	15	705.50	705.50	18	6,224.67	5,455.88
1975									
January	1	964.10	964.10	19	1,054.50	1,054.50	20	2,018.60	2,018.60
February	2	2,869.25	2,869.25	18	805.00	805.00	20	3,674.25	3,674.25
March	6	7,478.37	7,469.85	15	634.20	634.20	21	8,112.57	8,104.05
April	3	2,246.10	2,246.10	22	978.90	978.90	25	3,225.00	3,225.00
May	1	667.30	667.30	20	861.50	861.50	21	1,528.80	1,528.80
June	2	2,616.30	2,616.30	15	809.75	809.75	17	3,426.05	3,426.05
July	3	1,943.32	1,943.32	24	924.00	924.00	27	2,867.32	2,867.32
August	6	4,132.15	4,132.15	31	1,286.50	1,281.50	37	5,418.65	5,413.65
September	6	6,770.28	6,298.93	31	1,315.00	1,275.00	37	8,085.28	7,573.93
October	5	6,667.27	5,831.34	33	2,076.19	1,991.19	38	8,743.46	7,822.53
November	2	2,772.91	2,212.58	39	2,047.06	2,007.06	41	4,819.97	4,219.64
December	7	12,099.55	12,099.55	38	2,253.00	2,253.00	45	14,352.55	14,352.55
1976									
January	6	1,588.85	1,588.85	41	2,637.00	2,637.00	47	4,225.85	4,225.85
February	2	4,785.41	4,772.31	42	2,031.50	2,031.50	44	6,816.91	6,803.81
March	5	5,491.60	5,491.60	51	2,711.00	2,711.00	56	8,202.60	8,202.60
April	7	9,307.55	9,307.55	36	1,297.25	1,297.25	43	10,604.80	10,604.80
May	7	11,474.36	11,461.25	39	1,026.00	1,026.00	46	12,500.36	12,487.25
TOTALS	90	$105,187.41	$101,959.12	549	$26,333.60	$26,163.60	639	$131,521.01	$128,122.22

TABLE VIII

UTILIZATION AND COST BY MONTH OF SERVICE - KAISER-SOUTH

MONTH	INPATIENT		OUTPATIENT		TOTAL	
	CASES	COSTS AND BENEFITS	CASES	COSTS AND BENEFITS	CASES	COSTS AND BENEFITS
1974						
July	-	-	20	*	20	-
August	2	$ 2,554.18	21	*	23	$ 2,554.18
September	5	3,829.15	26	$ 1,872.00	31	5,701.15
October	3	4,956.95	21	650.00	24	5,606.95
November	2	1,396.99	31	536.00	33	1,932.99
December	2	1,946.79	33	722.00	35	2,668.79
1975						
January	5	6,602.63	43	717.58	48	7,320.21
February	4	3,832.95	32	720.55	36	4,553.50
March	2	3,030.00	29	733.34	31	3,763.34
April	4	5,509.44	31	737.30	35	6,246.74
May	3	2,765.46	27	727.49	30	3,492.95
June	2	3,078.48	35	736.48	37	3,814.96
July	2	2,048.60	41	592.00	43	2,640.60
August	3	3,916.15	43	525.00	46	4,441.15
September	-	-	36	531.00	36	531.00
October	1	731.19	42	737.93	43	1,469.12
November	1	875.13	40	668.97	41	1,544.10
December	2	4,082.63	49	703.48	51	4,786.11
1976						
January	1	2,191.61	49	716.00	50	2,907.61
February	-	-	43	710.48	43	710.48
March	2	4,264.39	61	796.67	63	5,061.06
April	3	5,004.03	47	632.18	50	5,636.21
May	-	-	53	707.04	53	707.04
TOTALS	49	$62,616.75	853	$15,473.49	902	$78,090.24

*Included in September 1974 figure.

ALCOHOL "PILOT" PROGRAM
MONTHLY FINANCIAL STATEMENT

Reporting Period May - July 1976
(calendar month)

Date:

CARRIER	PREMIUMS PAID	NO. MONTHS PAID	LATEST MONTH PAID	INCURRED CLAIMS/ SERVICE EXPENSES	ADMINISTRATIVE COST	TOTAL EXPENSES	DIFFERENCE(±)
ACSUP-American National	$ 189.74	1	Feb. 1976	ø	$ 189.74	$ 189.74	ø
ACSUP-Equity Educators	706.50	3	Sept. 1974	$ 612.50	94.00	706.50	ø
Blue Cross/Blue Shield	170,084.46	14	May 1976	136,401.49	30,705.67	167,107.16	$2,977.30
Blue Cross-C.H.P.	4,564.35	3	Sept. 1974	1,238.40	2,533.83	3,772.23	792.12
Blue Cross-C.T.A.	800.00	3	Sept. 1974	ø	800.00	800.00	ø
Blue Cross-P&G	688.50	3	Sept. 1974	ø	559.31	559.31	129.19
Cal-Western States Life	114,189.20	13	May 1976	101,111.82	13,896.00	115,007.82	-818.62
Consolidated Medical Systems, Ltd.	7,575.74	3	Sept. 1974	2,338.05	1,060.00	3,398.05	4,177.69
[illegible]	[illegible][a]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Kaiser Foundation Northern Region	151,466.67	22	April 1976	129,234.97	22,231.45	151,466.42	.25
Kaiser Foundation Southern Region	91,619.16	19	Jan. 1976	78,450.24	13,168.92	91,619.16	ø
Ross-Loos Medical Group	3,312.00	3	Sept. 1974	ø	3,448.15	3,448.15	-136.15
United Foundations for Medical Care	12,458.77[b]	14	Feb. 1976	8,178.92	4,279.85	12,458.77	ø
TOTAL	560,295.35			459,117.24	94,056.33	553,173.57	7,121.78

796

[a] Received refund of $635.32 8/27/76.

[b] Received refund of $911.99 8/23/76.

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/s/_____

Exhibit H
Robert Whiton

CONSIDERATIONS ON NEVADA STATE LEGISLATION MANDATING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM TREATMENT

Prepared By: Robert R. Whiton
Vice President
Raleigh Hills Hospitals

March 8, 1977

CONSIDERATIONS ON NEVADA STATE LEGISLATION MANDATING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM TREATMENT

Abstract

This paper presents empirical and logical considerations regarding coverage for alcoholism treatment by financiers of health care. The history, status and trends of third party payors' coverage for the treatment of alcoholism, insurers' experiences in adding alcoholism benefits, definition and costs of alcoholism, the status of similar legislation in other states and experiences in rehabilitating alcoholics are discussed. The paper concludes that legislation mandating health insurance coverage for the treatment of alcoholism should be enacted in the State of Nevada. Sources used in the preparation of this paper include extensive literature research, personal interviews, and independent studies.

Preface

In the last twenty-five years, we have witnessed the growing acceptance of the disease concept of alcoholism and the increasing level of coverage for alcoholism treatment by third-party payors.

However, some health care insurers and administrators of health and welfare plans still limit or exclude alcoholism treatment benefits for their members. These insurers have historically based their limitations or exclusions on the belief that most alcoholics cannot be successfully rehabilitated and/or that the benefit would significantly increase their expenses and therefore premiums.

Until recently these concerns and reservations were well founded, but in the last few years many professional studies have been conducted to assess the implications of this added benefit to health care financiers. Also, many insurers have added alcoholism coverage on an experimental basis and have reported their findings and experiences.

This paper is the result of an extensive literature search, assisted by the National Institute of Alcohol Abuse and Alcoholism, independent studies, and personal interviews. It will inform those concerned with legislation for mandatory coverage of alcoholism treatment by insurers of health care of the latest understanding of the disease of alcoholism, the costs of alcoholism, the treatment of alcoholism, and the cost of providing insurance coverage for treatment of this disease.

I. Alcoholism

A. Definition

The use of alcohol today is socially accepted and often even expected. An estimated seventy percent of the adult population in the United States drinks. Of these, approximately ten percent have developed the disease of alcoholism. When a person's use of alcohol consistently interferes with his health, his home, his business, or his social standing, that person is by definition an alcoholic. There are nearly ten million Americans with alcoholism. An alcoholic can be any age, male or female, any race or nationality. Most alcoholics are employed and come from every socio-economic level. Alcoholism is one of the most democratic of diseases and now ranks with heart disease and cancer as a major killer-- many call alcoholism the nation's

number one health problem.

Alcoholism was recognized as a disease state by: the World Health Organization in 1951, the American Medical Association in 1956, and the U.S. Department of Health, Education, and Welfare in 1966. Many professional groups and the National Council on Alcoholism have taken similar official positions. The American Bar Association, legislative and judicial organizations have been instrumental in changing the legal status of alcoholism from a criminal offense to that of a disease.[1]

Alcoholism is a progressive disease, but one which can be arrested at any point. It is initially characterized by a psychological dependence on alcohol. However, at some point the person loses control over his drinking and is then considered biologically dependent or addicted. If his drinking continues, it makes increasing inroads upon the alcoholic's life and health until he either receives treatment or dies.[2]

B. Alcoholism Costs

A recent study of the economic effects of alcoholism in the United States estimated for the year of 1976, a loss to society of over $30 billion dollars.[3] Of this, excessive use of alcoholism costs American industry about $14 billion in days lost from work. Furthermore, excessive use of alcohol will cause nearly $12.5 billion in unnecessary health care claim costs. Neither of these figures considers the cost of property damage, loss of life, etc., associated with the activities of the alcoholism victims.

Treatment for alcohol-related conditions accounted for more than twelve percent of the total health bill for adult Americans. These expenses were adjusted so that they reflect only the share specifically attributable to alcohol-induced problems. Account was taken of the costs of medical care which these patients would have been expected to incur even if they had not been impaired with alcohol and these were excluded in arriving at the final estimate.[5]

In a 1970 report to Congress, the Comptroller General of the United States stated that approximately twenty-five to thirty percent of the wages paid to alcoholic employees are lost as a result of inferior work performance and excessive absenteeism.

The disease of alcoholism has a significant financial impact on any state government, its revenue, and its people.

C. Alcoholism Treatment

Research and organized treatment have demonstrated that although alcoholism is a chronic disease, it is responsive to treatment. Government social services and concerned citizens have recognized that the phenomenal social and monetary costs of alcoholism mean aggressive corrective action must be taken and that our obligation to provide care for the alcoholic is the same as it is to provide care for the diabetic, coronary patient, or any other sick person.[6]

Pell and D'Alonzo have clearly outlined the source of lost productivity among alcoholic employees:

> The cost of alcoholism to industry is made up of several components including loss of efficiency, absenteeism, lost time on the job, faulty decision-making, accidents, and impaired morale of co-workers. A large significant portion of the economic impact of alcoholism also includes premature disability and death, resulting in the loss of many employees in their prime who have skills which are difficult to replace.[4]

The real impetus for a decisive action upon this disease occurred with the passage of federal legislation in 1970 known as the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act. This Act established and funded the National Institute of Alcohol Abuse and Alcoholism as a branch of the Department of Health, Education and Welfare.

Meaningful medical research is now being carried out and is recognized as "respectable." Treatment facilities outside general hospitals have been established. Industry has moved into the forefront in the fight against this disease, through management's initiative and through union pressures where management failed to act.

Robert E. Schmitz, M. D., Corporate Medical Director and Vice President of Raleigh Hills Hospitals, states that "a major problem in treating alcoholism today has nothing to do with the physical condition of the patient. It involves a mental preset in our society; a dichotomy that states that while social drinking is acceptable, a person who becomes an alcoholic is somehow morally deficient and uses alcohol as an excuse to escape from the responsibilities of life that "good" people endure. So engrained is this notion that many people with an alcohol problem believe it of themselves. Where the truth lies, as we are discovering and reinforcing through research is that alcoholism is a disease - an actual organic disease.

It is no longer a question of saving the souls of the wicked; we are salvaging lives and re-establishing health through a program of education and treatment. The positive results of this knowledge will contribute to our understanding of alcoholism and provide us with supplemental means of treatment in the future."[7]

The alcoholic can be rehabilitated and returned to a productive life. Raleigh Hills Hospitals' experience in treating over 14,000 patients since 1942 shows that their program can help the alcoholic. A recent study by the University of Oregon Medical School of all patients treated at Raleigh Hills Hospital during 1970 found that nearly seventy percent remained abstinent for one year or longer.[8]

II. Insurance and Alcoholism

A. History of Alcoholism Coverage

In 1968 the National Center for Prevention and Control of Alcoholism (predecessor to the current NIAAA) began the first study on the extent of alcoholism coverage by private insurers. One of the major findings was that there were still outright sanctions against alcohol treatment by many companies.

In 1969 many financiers of health care were re-examining their role in treating the alcoholic. Blue Cross Association was one of the first to remove the exclusions for alcoholism treatment from its national contracts in that year. Most Blue Cross contracts include hospitalization for acute alcoholism. However, it became

increasingly apparent that follow-up care is the most important part of a total treatment program. Alcoholism, as we discussed earlier, has a multiple causality. Once the patient is through his acute physical phase those causes must be dealt with. Follow-up care has been developed in most programs to meet that need. The American Hospital Association noted this in a recent publication: "If the revolving door syndrome is to be avoided, the alcoholic patient cannot be deserted after (hospital) treatment for his acute illness. He must have assistance in adjusting to his environment or help in modifying it, if such aid is essential to his recovery."[9]

In 1972 another study was released by NIAAA which indicated that although coverage for alcoholism had improved, it still lagged far behind benefits provided for other physical conditions. Also in 1972, the Social Security Amendments (PL 92-603) appeared. These Amendments expanded the coverage for treatment of alcoholism for Medicare members. During this same year, other insurance carriers began broadening their alcoholism coverage, both in response to legislative activity mandating inclusion of alcoholism benefits, and because the carriers became convinced that the traditional limitations were actually counterproductive. Some of the expanded coverages were offered without an increase in premiums. In October 1972 the Prudential Insurance Company of American began to delete from new policies their standard exclusion for treatment of alcoholism in "a facility for the care of alcoholics." This meant providing benefits for treatment in facilities other than acute care general hospitals.

In June 1973 the Kemper Insurance Companies announced that coverage for alcoholism treatment in their group accident and health policies would be broadened without premium increases to include outpatient care at hospitals and all care at state-licensed alcoholism treatment facilities.

In September 1973 Employers Insurance of Wausau broadened their available coverages to include benefits for both inpatient and outpatient care of alcoholism at approved treatment centers. Also in 1973 a study conducted by the Health Insurance Institute found at least sixty-six insurance companies which covered alcoholism treatment under their group plans. Another report, published in 1973 by Jerome B. Hallan, Ph.D., under a joint NIAAA and NCA project, examined the extent of coverage among major United States corporations. Of the twenty-one responding corporations, covering an employee population of almost one million, only one corporation did not provide coverage for the treatment of alcoholism in its benefits package.[10]

By 1974 the number of insurance carriers providing coverage for the treatment of alcoholism began to expand dramatically. Blue Cross of Maryland expanded its group health coverage to include the rehabilitation of alcoholic persons at state-licensed, non-hospital, residential facilities. The Hartford Insurance Group announced in June 1974 that it would offer coverage for alcoholism "on the same basis as any other disease." Hartford also exapnded its interpretation of "hospital" to include qualified

alcoholism treatment facilities. In August of 1974 Capital Blue Cross of Harrisburg, Pennsylvania, introduced an alcoholism rehabilitation benefit that paid for the treatment of alcoholism under "allowable hospital days" instead of the more limited category "nervous and mental disorders," and without any premium increase. At about the same time, the State of California began a project to provide alcoholism treatment benefits for all California state employees. By the end of 1974, nine states had passed some form of legislation or statute concerning mandatory inclusion of health insurance benefits for alcoholism.

In 1975 Blue Cross of Maryland began offering outpatient coverage for the treatment of alcoholism to their subscribers.

As insurance companies began to expand their coverage for the treatment of alcoholism, insurance industry officials demanded assurance from the National Institute of Alcohol Abuse and Alcoholism that alcoholism treatment program costs and procedures were responsibly managed, and that benefits for such treatment were, therefore, actuarially sound. As a principle step in this effort, the NIAAA chartered the Joint Commission on Accreditation of Hospitals (JCAH) to develop standards for the accreditation of alcoholism treatment programs. JCAH is a nationally recognized accrediting agency for health programs and facilities. This accreditation procedure for alcoholism treatment was of significant importance to the insurance industry since the insurance industry recognizes and accepts the availability of

quality treatment and management in facilities accredited by the JCAH. Its standards for alcoholism programs, developed by more than three hundred experts in the field of alcoholism treatment and rehabilitation, have now been published in the form of a manual by which nearly all reputable alcoholism treatment programs abide.

B. Cost Considerations and Experiences

Although some insurance policies continue to exclude or limit the benefits for the treatment of alcoholism, there are many reasons to doubt that exclusion of alcoholism achieves any savings for either the policyholders or carriers. Physicians and hospitals often treat alcoholism under other diagnoses either from ignorance of the primary diagnosis or intentionally to protect reputations and to obtain insurance benefits despite exclusions (see Table 1). A 1973 meeting of the Health Insurance Association of America was told by James S. Ray, then a health service consultant for Employers Insurance of Wausau: "From a practical standpoint, this system has said in effect 'call alcoholism by some other name and we will cover it under our group contract.'"

Such evasive diagnoses are not entirely false, but they furnish only partial truth. The ailment entered on a chart is actually present, but the underlying problem of alcoholism is frequently not mentioned and is probably not treated effectively, if at all.[11] Furthermore, even though hospital treatment of some kind is being supplied to alcoholic persons under other diagnoses, many

TABLE 1

ALCOHOL-RELATED DISORDERS[12]

Gastrointestinal	Esophagitis
	Esophageal carcinoma
	Gastritis
	Malabsorption
	Chronic diarrhea
	Pancreatitis
	Fatty liver
	Hepatitis
	Cirrhosis
Cardiac	Cardiomyopathy
	Beriberi
Skin	Rosacea
	Telangiectasia
	Rhinophyma
	Cutaneous ulcers
Neurologic and Psychiatric	Peripheral neuropathy
	Convulsive disorders
	Hallucinations
	Delirium tremens
	Wernicke's syndrome
	Korsakoff's psychosis
	Marchiafava's syndrome
Muscle	Myopathy
Hemtologic	Megaloblastic anemia
Vitamin Deficiency Diseases	Beriberi
	Pellagra
	Scurvy
Metabolic	Hypoglycemia
	Diabetes

alcoholics are kept out of actual alcoholism treatment precisely because of exclusions or limitations in their health insurance.

Underwriters of health and disability insurance are incurring substantial costs due to alcoholism amongst their policyholders. Various sources indicate that up to forty-five percent of hospital beds are occupied by patients with alcohol problems. A recent American Hospital Association publication noted that some hospitals have found that as many as fifty percent of their inpatients in specific service categories were admitted because of an involvement with alcohol. It is also noted that repeated admissions of the same patients occur with discouraging frequencies.[12] One reason for the variance and lack of statistics on alcohol-related health care utilization is the earlier referenced common practice of admitting alcoholics under a pseudo or secondary diagnosis. It is known that alcohol abuse is either the main or a contributing factor in many pathological diseases. It has been linked with nutritional deficiencies responsible for diseases of the neurological and digestive systems, and it is known to have a high incidence in heart disorders as well as muscle, blood, mental, respiratory, and other tissue diseases.[13] In a recent study of patients admitted to a private alcoholism treatment hospital, it was found that they had spent an average of 12.5 days in hospitals in the previous five years for alcohol-related treatment.[14]

Numerous credible studies indicate that alcoholics utilize a disproportionately high percentage of health benefits. A five-year mortality study of alcoholic persons by Pell and D'Alonzo indicates the mortality rate for alcoholics is 3.22 times that of non-alcoholics.[15] Since alcoholism significantly affects mortality rates, employee health must also be affected. "On the job" differences in accidents are approximately twice that for problem drinkers as for other employees. The problem drinker's overall accident rate has been shown to be 3.6 times that of other employees.

The Pell and D'Alonzo study indicates also that alcoholics experience two to three times the illnesses of other employees in terms of specific health disorders or infections, and that, in total, alcoholics cost employers three times the sickness benefits of other employees. Also, the alcoholic group's total days absent is two and one half times that of the control group, indicating a tremendous loss in productivity to the employer.[17]

The NIAAA estimates that five percent of an employee population are alcoholics. Also, Maxwell's findings indicate that problem-drinking employees utilize three dollars in health benefits for every one dollar for the average employee.[18] Therefore, an employer can estimate that problem-drinking employees are responsible for fifteen percent of claims paid annually.

FREQUENCY RATES OF ALCOHOLICS AND CONTROLS

BY DIAGNOSTIC CATEGORY*

Diagnostic Category	+	No. of Absences	Frequency Rate (%)	Ratio of Frequency Rates: A/C	
Respiratory infections	A	294	38.5	1.7	Alcohol 63% of Total
	C	194	22.5		
Digestive disorders	A	215	28.1	2.4	
	C	103	11.9		
Musculoskeletal disorders	A	111	14.5	2.7	
	C	46	5.3		
Virus infections, unspecified	A	53	6.9	1.3	
	C	45	5.2		
Cardiovascular disease	A	40	5.2	1.9	
	C	23	2.7		
Accidents	A	35	4.6	3.5	
	C	11	1.3		
Alcoholism	A	26	3.4	-	
	C	0	0.0		
Neurological disorders	A	23	3.0	1.5	
	C	17	2.0		
Genitourinary disorders	A	19	2.5	0.6	
	C	34	3.9		
Mental illness	A	15	2.0	3.3	
	C	6	0.6		
Other illnesses	A	75	9.8	2.0	
	C	42	4.9		
Unknown	A	78	10.2	1.8	
	C	48	5.6		
Total	A	984	128.8	2.0	
	C	569	65.9		

+A = Alcoholics: C = Controls.

* Pell, S. and D'Alonzo, C. A.: Sickness Absenteeism of Alcoholics. Journal of Occupational Medicine. 12:198-210, (June) 1970.

Enos L. Cook. C.L.U., contends that "all other factors being equal, adequate health insurance coverage for alcoholism should result in a decrease in the total health insurance premiums when combined with an effective employee alcoholism control program. It is known that 1) large numbers of alcoholics are treated under some other diagnosis, 2) alcoholism contributes to higher incidences of other diseases and illnesses, and 3) the incidence of other diseases, illnesses, and accidents is reduced following successful treatment and recovery from alcoholism."[19]

There is no doubt that alcoholic employees have a significant impact on employers' operating costs and the level of utilization of health benefits. Many businesses have proven that employers can expect high rehabilitation success rates and significant reductions in health costs by instituting adequate health benefits for alcoholism treatment.

1. Employers' Experiences[20]

The following are examples of the experiences of employers in implementing alcoholism programs:

Scovill Manufacturing Company, Waterbury, Connecticut, with 6,500 employees, realized an annual saving of $186,555; seventy-eight percent of alcoholic employees identified and referred for treatment were successfully rehabilitated.

Economic Laboratory, Inc., St. Paul, Minnesota, with 3,500 employees experienced a rehabilitation success rate of eighty percent.

DePaul Industrial Alcoholism Project of Milwaukee, Wisconsin, reported a success rate of seventy-one percent of their employees identified and treated were significantly improved after nine months.

Illinois Bell Telephone Company studied 402 employees for five years prior to referral for alcoholism treatment and for five years after. The job rehabilitation rate was seventy-two percent In addition, those 402 employees had 602 cases of sickness disability before rehabilitation and 356 cases after rehabilitation. This is a reduction of forty-six percent of sickness disability indicating a tremendous decrease in utilization of the employer's insurance benefits.

Kennecott Copper Company, Salt Lake City, Utah, found sickness and accident costs for alcoholic employees, as compared with the average employee, to be five to one; hospital, medical, and surgical costs were more than three to one. After a twelve and a half month involvement in an alcoholism program, Kennecott Copper was able to reduce their cost for hospital, medical, and surgical costs by 55.35 percent.

2. Insurers' Experiences

As mentioned earlier, the costs of alcoholism to an insurance company are high even when the medical label is something other than alcoholism. However, ". . . there is evidence that insurance claims go down significantly in the years following recovery as compared to the years prior to identification and treatment of an employee for alcoholism. At least the Kemper Insurance Company and number of other insurers have been sufficiently influenced by their research to extend health coverage to alcoholism treatment with no additional premium."[21]

The decision by Capital Blue Cross to extend their coverage to include the treatment of alcoholism was based primarily upon the following factors:[22]

1) Recognition of alcoholism as a chronic disease makes it incumbent upon the third-party payor to provide adequate benefits.

2) The alcoholic rehabilitation providers are stringent about re-admitting a patient who did not "make it" in their program initially.

3) Capital Blue Cross recognized that it had been "paying" for alcoholism indirectly through claims paid in the general hospital for alcoholism or alcohol-associated admissions under other diagnoses.

The plan recognized that "applying sanctions through limitation or exclusion of benefits contributed to the frequent practice of disguising the true cause of admission. This, in turn, supported continued

denial by the alcoholic of his or her problem, thereby reinforcing what is commonly termed "the revolving door." Here the alcoholic is treated and released without referral to appropriate rehabilitation - only to typically return to drinking and ultimately to the hospital."[23]

The Capital Blue Cross decision to provide the new benefit at no rate increase was based on the foregoing rationale plus control of utilization while obtaining direct experience data. Their first year experience indicated a low volume in utilization in terms of the potential - the alcoholics known to exist based upon national figures. Utilization of the benefit is expected to increase due to a variety of factors. However, based on the belief that alcoholics will not "come out of the woodwork" at the availability of the new benefit, this increase should be gradual - the natural maturation of a new program. Capital Blue Cross also feels that there may be some cost savings to the plan from those subscribers, who by "virtue of receiving rehabilitation, maintain sobriety, and thus better general health, thereby utilizing fewer or less costly medical services."[21]

A 1975 pilot program to cover alcoholism treatment for all California state employees found that during the first seventeen months of operation, their costs for this added benefit averaged approximately 3.6 cents per premium month. This cost does not include any off-setting benefits realized by reduced utilization of other hospital and medical expenses.

State Legislation - Fifteen states have now passed legislation mandating that insurance carriers provide, or at least offer, coverage for the treatment of alcoholism. State legislation has been and will continue to be a factor in expanding third party coverage for alcoholism treatment in the health insurance industry.

Federal Legislation - The Health Maintenance Organization (HMO) Act of 1973 requires that all HMO's receiving federal assistance include alcoholism services in their benefit package. Other national health insurance proposals have included the requirement for appropriate alcoholism treatment coverage. The Secretary of Health, Education and Welfare indicated in the Second Special Report to Congress on Alcohol and Health that "third-party coverage for alcoholism treatment costs is essential and feasible to provide adequate service for all who require such treatment." And further, "quality and comprehensive care be extended to alcoholic people through coverage under health and disability benefits."

Insurance Industry - Public opinion strongly favors the inclusion of alcoholism in health insurance plans in line with the growing awareness of alcoholism as an illness and the fact that insurance companies can cover alcoholism without raising premiums. With new developments in the areas of cost data, licensing of facilities, certification of personnel, and treatment effectiveness, it is anticipated that health insurance companies will further expand their benefits to meet the needs of alcoholic persons.[27] Although

Jack W. Guest, Manager of Employee Counseling, Corporate Industrial Relations of Hughes Aircraft Company in Los Angeles, indicates "since establishing the benefit for alcoholism, there has been no increase in their major medical premium rates." He further stated that "hospitals specifically organized to treat alcoholics are much better - they are better staffed, have meaningful programs, and get better results at less cost."

A recent study of a North Carolina rehabilitation program analyzed the impact of alcoholism rehabilitation on subsequent medical and hospital use. Their follow-up of patients after treatment indicated that demands for acute medical care dropped from forty-eight to twenty-eight percent.[25]

Thus, it has been shown that "health insurance plans and employee alcoholism programs, when well-structured and coordinated, will contribute to rehabilitation of alcoholic employees and reduce insurance costs."[26]

C. Trends

As noted earlier, discriminatory clauses in many health insurance policies have historically denied access to treatment for alcoholism except under subterfuge diagnoses. However, the growing recognition of alcoholism as an illness, for which treatment is more economical than neglect, is beginning to transform this picture. New attitudes, legislation, regulations, personnel policies, payment sources, and a variety of government-fostered actions are expected to stimulate new health insurance practices which will enable most alcoholic people to obtain treatment and rehabilitation services openly and earlier.

alcoholism is not a fully accepted benefit in all health insurance policies today, the prospects are improving greatly. Both public and private insurers are becoming more responsive to the needs, rights, and demands of alcoholic individuals and are accepting new responsibility for underwriting this kind of care.[28] At a meeting of the National Alcoholism Forum of the National Council on Alcoholism, Dr. James G. Westbay, Associate Medical Director of the Metropolitan Life Insurance Company, stated "treatment of alcoholism belongs in every health insurance contract written."

Unions - In the organized labor segment, over one and a quarter million auto industry workers and their dependents now have coverage for the treatment of alcoholism in approved rehabilitation programs. Officials of all major unions openly demonstrate support for alcoholism programs and treatment benefits.

Employers - Employers are becoming increasingly aware of the benefits of adding alcoholism coverage to the employee insurance plans.[29]

There are ever-increasing signs of a growing sensitivity to the needs of alcoholic persons for health care services and appropriate insurance coverage. Recently, the House of Delegates of the American Medical Association formally resolved that "insurance companies and pre-paid plans be urged to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism, recognizing that alcoholism is an illness."[30]

III. Summary

This paper has shown both logically and empirically that:

Alcoholics cost their employers and health insurance underwriters a disproportionately high share of expenses.

Alcoholism is a prevalent, democratic, progressive, chronic, costly, and treatable disease.

There is a significant reduction in the utilization of health insurance benefits, and a return to full productivity by the alcoholic following successful treatment.

Many insurers have added alcoholism benefits in the last ten years, often with no increase in premiums.

The trend at all levels - federal, state, employers, professional associations, unions, and insurers - is strongly toward providing alcoholism treatment benefits at levels "the same as for any other disease."

In all respects, state lawmakers would best serve their constituents by enacting legislation that mandates appropriate coverage for alcoholism treatment in all health insurance policies offered or sold in their state.

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Exhibit H-1

Melos Jarnick submitted 3-10-75

State Statutory Requirements
For Insurance Coverage for Alcoholism

The NIAAA has a strong interest in the development of health insurance coverage for alcoholism. An increasing number of States have recently enacted legislation requiring coverage for the treatment of alcoholism under group hospital or medical expense insurance policies. The purpose of this document is to summarize each State's requirements in this respect. Those States that have enacted legislation dealing with health insurance coverage for alcoholism treatment are as follows: Connecticut, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, North Dakota, South Dakota, Tennessee, Washington, and Wisconsin. In addition, there are a number of States in which legislation is pending.

Connecticut

Effective - May 10, 1974.

Statutory Requirements - Every group hospital or medical expense insurance policy issued, or amended to substantially alter benefits on or after the effective date, must provide coverage for treatment of alcoholism or medical complications thereof pursuant to diagnosis or recommendation by a licensed physician.

"Medical complications" is defined to mean such diseases as cirrhosis of the liver, gastrointestinal bleeding, pneumonia and delirium tremens.

Confinement in a hospital for such treatment must be recognized to the extent specified for any other disease. Confinement for effective treatment in a facility licensed primarily for treatment of alcoholism must be recognized for a period of at least 45 days in any period of 12 consecutive months or in any calendar year.

Illinois

Effective - January 30, 1974.

Statutory Requirements - The exclusion of hospital treatment for alcoholism is not permitted in any policy delivered on or after January 30, 1974 which provides in-patient hospital coverage for sickness.

Louisiana

Effective - July 1, 1975.

Statutory Requirements - Any group policy issued after July 1, 1975 is to include, at the option of the policyholder, benefits for treatment of alcoholism rendered or prescribed by a physician which is received in a hospital or other facility authorized by the appropriate State authority to provide alcoholism treatment. These benefits must be offered before July 1, 1976 to all group policies issued on or before July 1, 1975.

Page 2

Massachusetts

Effective - January 1, 1974 on an optional basis; mandatory in all policies and certificates issued on or after January 1, 1976.

Statutory Requirements - Benefits for treatment of alcoholism must be at least equal to the following minimums:

(a) 30 days per calendar year for in-patient confinement in a hospital or a public or private facility licensed by the State public health department for the detoxification or rehabilitation of alcoholics.

(b) $500 in any 12-month period for out-patient services in an institution described in (a). Consultant or treatment services must be by a licensed physician or psychotherapist devoting a substantial portion of time to treating alcoholics.

Michigan

Effective - July 1, 1974.

Statutory Requirements - An insurer must offer on every policy issued after the effective date to provide coverage for treatment of alcoholism and drug abuse provided in a facility approved by the State department of public health for the treatment of alcoholism or drug abuse. The amounts of coverage are subject to agreement between the insurer and the policyholder.

Minnesota

Effective - September 30, 1973.

Statutory Requirements - All policies issued on or after the effective date must provide coverage for treatment of alcoholism, chemical dependence or drug addiction in a licensed hospital or under a licensed residential primary treatment program. Coverage must be for at least 20% of number of days in the benefit period under the Hospital benefit, but in no event less than 28 days in a calendar year.

Mississippi

Effective - January 1, 1975

Statutory Requirements - Every group health policy issued on or after such date must provide benefits for care and treatment of alcoholism on the same basis as other benefits. Alcoholism is defined as the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages. Coverage need not exceed $1,000 per calendar year and includes only treatment and services rendered by a physician or a licensed hospital.

North Dakota

Effective - July 1, 1975.

Statutory Requirements - Every group policy which covers 50 or more persons or covers more than 70% of the eligible persons and which is issued on or after the effective date must provide benefits of the same type offered for other illnesses, for the diagnosis, evaluation, and treatment of mental illness, alcoholism, drug addiction, or other related illnesses, in a licensed hospital. Coverage must be at least -

1. 70 days per calendar year for in-patient treatments; and

2. 140 days per calendar year for partial hospitalization.

For combinations of in-patient and partial hospitalization, 2 days of partial hospitalization equal one day of in-patient treatment.

South Dakota

Effective - July 1, 1975.

Statutory Requirements - An insurer must offer in every group policy issued on or after the effective date to provide coverage for in-patient treatment of alcoholism in a licensed hospital or residential primary treatment facility. Benefits must be on the same basis as benefits for other sicknesses but coverag need not exceed 30 days in any 6 months nor 90 days during the lifetime of the contract. It need not be included in major medical only policies.

Tennessee

Effective - July 1, 1974.

Statutory Requirements - Every group policy providing hospital and surgical expense insurance "entered into" or issued on or after such date must provide benefits for Tennessee residents for expenses arising from psychiatric disorders, mental or nervous conditions, alcoholism, drug dependence, or the medical complication of mental illness or mental retardation, unless the policy specifically excludes or reduces such benefits.

Washington

Effective - July 1, 1974.

Statutory Requirements - All group hospital or medical care policies issued on or after the effective date must provide for the treatment of alcoholism rendered in approved alcoholism treatment facilities.

Wisconsin

Effective September 8, 1972, every group policy issued thereafter which

included hospital coverage was required to provide coverage for treatment in an institution providing in-patient treatment of alcoholism and licensed by Wisconsin. Special plans were developed. Description of the plan and applicable rates were announced in G.1.555, April 16, 1973. This has now been superseded by the following legislation.

Effective - September 1, 1974.

Statutory Requirements: Group - Every group policy issued or renewed on or after the effective date which provides hospital treatment coverage must provide coverage for:

group only

(a) In-patient hospital treatment of mental and nervous disorders, alcoholism and drug abuse, providing not less than 30 days confinement in any calendar year.

(b) If the policy provides coverage for out-patient treatment it must cover out-patient services for mental and nervous disorders, alcoholism and drug abuse in a hospital or out-patient treatment facility, or by a physician at any location, in an amount "not less than the first $500.00 in any 12-month period."

(c) Hospital treatment for kidney disease, including dialysis treatment, in an amount not less than $30,000 annually.

Statutory Requirements: Individual - Individual accident and sickness policies, which include our SE program and conversion policies, must provide coverage for in-patient and out-patient kidney disease treatment, including dialysis, transplantation and donor-related services, in an amount not less than $30,000 annually. Coverage for alcoholism, drug abuse and mental and nervous disorders is not required.

NORM SOUTHERBY
NIAAA/NCALI WESTERN REGIONAL CONSULTANT

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Exhibit 4
Daryl Capurro R/3

NEVADA FRANCHISED
AUTO DEALERS ASSOC.

700 RYLAND STREET
PHONE: 323-5159

P.O. BOX 7320
RENO, NEVADA 89510

January 30, 1976

Mr. Harry Brandise, President
Clover Underwriters General Agency
Post Office Box 14983
Las Vegas, Nv.

Dear Harry:

This letter will serve to clarify the position of the Nevada Franchised Auto Dealers Association Insurance Trust in regard to the benefit provisions of our group health and life insurance program.

During the negotiations on our revised program, which became effective on January 1, 1976, Universe Life Insurance Company President Benedict J. Dasher outlined the provisions of Nevada law relating to policy coverage for the treatment of alcohol and drug abuse. As the group policyholder, the Nevada Franchised Auto Dealers Association Insurance Trust was given the option of providing this coverage within the Master Policy provisions, in accordance with NRS Chapter 689A.030(9). With full understanding of the ramifications of this optional coverage, the Nevada Franchised Auto Dealers Association Insurance Trust Board of Trustees were polled by telephone and unanimously declined to have this optional coverage included in the Master Policy provisions. Thus, this coverage was not included in the revised NFADA group health and life insurance plan which became effective on January 1, 1976.

If you have any further questions regarding the NFADA program, please advise our office at your convenience.

Very truly yours,

NEVADA FRANCHISED AUTO DEALERS ASSOCIATION
INSURANCE TRUST

Robert F. Guinn
Trustee

DEC:RFG/dm

NEVADA INDUSTRIAL COMMISSION STUDY

Bulletin No. 104

LEGISLATIVE COMMISSION
LEGISLATIVE COUNSEL BUREAU

STATE OF NEVADA

December 1972

Carson City, Nevada

FINAL REPORT OF THE SUBCOMMITTEE FOR STUDY OF THE NEVADA INDUSTRIAL COMMISSION

Bulletin No. 104

LEGISLATIVE COMMISSION
LEGISLATIVE COUNSEL BUREAU

STATE OF NEVADA

December 1972

Carson City, Nevada

FINAL REPORT OF THE SUBCOMMITTEE FOR STUDY OF THE NEVADA INDUSTRIAL COMMISSION

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LEGISLATIVE COMMISSION

B. Mahlon Brown
Carl F. Dodge
John Fransway
James I. Gibson
Emerson F. Titlow
C. Clifton Young
Keith Ashworth
Joseph E. Dini, Jr.
Virgil M. Getto
Zelvin D. Lowman
Donald R. Mello
Roy L. Torvinen

Senate Bill No. 654—Committee on Federal, State and Local Governments

CHAPTER 614

AN ACT directing the legislative commission to make a comprehensive study of the Nevada industrial commission; directing that the costs of such study be paid from funds of the Nevada industrial commission; and providing other matters properly relating thereto.

WHEREAS, There have been questions raised recently concerning the Nevada industrial commission's administration of its various funds; and

WHEREAS, Criticism has been directed at the relationship of the commission to the practicing physicians of Nevada; and

WHEREAS, There have been other questions and criticisms concerning the operations of the commission; and

WHEREAS, It is in the best interest of the people of the State of Nevada to have these questions and criticisms answered; now, therefore,

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. The legislative commission is hereby directed to:

1. Make a thorough study of the Nevada industrial commission, including, but not limited to, the organization of the commission, the qualifications of commissioners and the commission's methods of operation, an examination of the relationship of the commission to practicing physicians, the method of determining the amount of fees to be paid to physicians, inquiring as to the advantages and disadvantages of a fixed fee schedule, or in the alternative, usual and customary fees and a consideration of the safeguards necessary to implement the rates or fees, evidence of any abuses by physicians, the amount of benefits paid to employees by the commission, the schedules of benefits paid to employees, the amount of premium payments and the effect of private disability and death benefit insurance on the programs under the Nevada Industrial Insurance Act and the Nevada Occupational Diseases Act.

2. Report the results of such study and make recommendations for any necessary legislation to the 57th session of the legislature.

SEC. 2. Notwithstanding the provisions of any other law, the costs of the study herein directed to be made shall be paid from any funds available to the Nevada industrial commission upon a claim or claims therefor made by the legislative commission on the Nevada industrial commission.

SEC. 3. This act shall become effective upon passage and approval.

REPORT OF THE LEGISLATIVE COMMISSION

TO THE MEMBERS OF THE 57th SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Senate Bill No. 654 of the 56th session (chapter 614, Statutes of Nevada 1971) which directed the legislative commission to make a comprehensive study of the Nevada industrial commission; directing that the costs of any such study be paid from funds of the Nevada industrial commission. The legislative commission appointed a subcommittee to make the study and recommend appropriate legislation to the next session of the legislature. Senator Carl F. Dodge was designated chairman of the subcommittee and the following legislators were named as members: Senators Melvin D. Close, Jr., Boyd D. Manning, Assemblymen Norman D. Glaser, Keith Ashworth and Randall V. Capurro. Nonlegislative members were: William B. Harris, M. D., William M. Tappan, M. D., Howard W. Gray, Esq., and Louis Paley.

The subcommittee worked diligently during a period of 17 months and its report with suggested draft legislation, attached for your examination, was approved by the legislative commission on November 27, 1972

Respectfully submitted,

Legislative Commission
State of Nevada

November 27, 1972

FINAL REPORT OF THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE FOR STUDY OF THE NEVADA INDUSTRIAL COMMISSION

INTRODUCTION

Senate Bill 654 of the 1971 legislative session (chapter 614 of Statutes of Nevada 1971) directed the Legislative Commission to make an interim study of the Nevada Industrial Commission. Pursuant to this directive, the Legislative Commission appointed the following subcommittee to prosecute the study:

Name	Representing
Senator Carl F. Dodge (Chairman)	Legislature
Senator Melvin D. Close, Jr.	Legislature
Senator Boyd D. Manning	Legislature
Assemblyman Norman D. Glaser	Legislature
Assemblyman Keith Ashworth	Legislature
Assemblyman Randall V. Capurro	Legislature
W. Howard Gray, Esq.	Employers
Mr. Louis Paley	Employees
William B. Harris, M.D.	Medical-Las Vegas
William M. Tappan, M.D.	Medical-Reno

This subcommittee held its organizational meeting June 14, 1971, and agreed upon the following scope of the study:

1. Administrative structure
2. Internal procedure
3. Investment performance
4. Physicians' fees
5. Specific areas of inquiry

Subsequently, following a selection procedure, the subcommittee commissioned Peat, Marwick, Mitchell & Co. (hereafter PMM), Certified Public Accountants, Los Angeles, California, to assist in making the major portion of the study having to do with internal procedure and, to some extent, administrative structure and physicians' fees. The extensive PMM report was received by the subcommittee on March 24, 1972, and subsequently distributed to legislators following approval by the Legislative Commission.

The subcommittee retained Segal Advisors, Inc., investment consultants and actuaries, New York, New York, to evaluate the investment performance over the 4-year period ended June 30, 1971. Its report, dated March 15, 1972, has been distributed to legislators.

Many of the 38 PMM recommendations have been or are in the process of being implemented. Others require statutory implementation and are contained in an omnibus draft bill (BDR 53-17, see Appendix 1 of this report). A few of the recommendations were modified or not accepted by the subcommittee.

The Nevada Industrial Commission was prominently before the public during the 1970 political campaigns in Nevada. There were many charges of mismanagement, inefficiencies, financial problems and abuses. Some doctors in southern Nevada were refusing to perform services for the industrial commission in the care of injured employees. Numerous pieces of legislation affecting the commission were before the 1971 legislature. This study was an obvious outgrowth.

The subcommittee assumed many imperfections in the Nevada Industrial Commission operations. By the same token, it was felt the system had served Nevada, with its small work force, reasonably well over the years. It was not the intention to perform a witch hunt. The subcommittee's mission was to make the industrial commission a better and more efficient system to meet the needs of the future. Therefore, while there was no intent to whitewash or treat lightly the problems of the past, the subcommittee was looking primarily to learn from them in bringing about future improvements.

The balance of this report is made up of comment upon specific areas of concern by the legislature, the public and those who finance, use and provide the services of the Nevada Industrial Commission.

PUBLIC RELATIONS

One of the most glaring deficiencies of the Nevada Industrial Commission has been poor public relations. The public has had little or no understanding of the commission's activities or programs. At the time this study was commenced, there appeared to be a virtually complete breakdown of communications with

the medical profession--and there needed to be communication. The commission seemed unable to overcome the distortions and misunderstandings about so many phases of its affairs. The commissioners seemed to be completely on the defensive rather than to be embarking upon a positive program of better understanding and rapport with all groups.

In recognition of these problems, PMM has recommended the establishment of a full-time position of Training and Information Director. One of the functions of this official would be to aid the commissioners in providing public relations and information dissemination services.

PMM has recommended the appointment of consulting physicians--in Las Vegas, in the Reno-Carson area and in the rural counties, to perform certain functions. It is the subcommittee's thinking that this suggestion should be expanded upon by the creation of medical advisory committees. These committees, made up of respected and capable members of the medical profession, would have several functions. Some of these will be discussed later in this report. Suffice it to say here the creation of these committees would be an enormous step forward in generating and maintaining good communication and better understanding between the Nevada Industrial Commission and the essential medical profession and related vendor groups.

The new Chairman of the Nevada Industrial Commission, Mr. John R. Reiser, appears to be fully aware of the need for better public relations. It is the hope of the subcommittee that he will take recommended steps and fashion additional means to accomplish this.

INVESTMENT PERFORMANCE

During the 1970 campaign, there were numerous charges of mismanagement of the investment portfolio. The charges ranged from virtual bankruptcy to a $1/2 million loss on common stocks. Though a subsequent problem of inadequate reserves developed (which will be discussed later), the fear of bankruptcy was completely unfounded.

Upon analysis it was found that it is very difficult to compare the industrial commission's investment performance with other accepted yardsticks, i.e., the Dow-Jones Average, Standard &

Poor's Composite Stock Index and pooled equity trusts maintained by major banks. The reason is that none of these yardsticks is under similar investment restrictions as the legislature has statutorily placed on the Nevada Industrial Commission. So, in a sense, it is like comparing apples and oranges. This problem of comparison is mentioned in several places in the Segal report.

The loss on the common stock portion of the portfolio was an unrealized paper loss due to the drastic general downturn of the stock market. This stood at $504,723 as of June 30, 1970. As of June 30, 1972, that unrealized loss has been fully recovered and has been turned into an unrealized paper profit of $87,261. There has been a small realized loss on that portion of the portfolio resulting from a sale of common stocks at a market value below the cost of those particular stocks. That amount is $30,224.25. Actually, the common stock portion of the portfolio only constitutes 4 percent of the total, even though there is statutory authority to invest up to 10 percent.

One thing can be said about the common stocks. The timing of the purchase program was not good. Purchases started at a time when the market was moving toward a relative high point. When the market turned downward and stocks were at then favorable prices, the purchases stopped. As Segal comments, "If common stock transactions are to be governed by such short term considerations, and subject to political pressures, it might be best to avoid the acquisition of such holdings altogether." (Segal report, p. 2.)

A more fundamental reason than the common stocks for below average performance during the period under review (4 years ending June 30, 1971) had to do with that portion of the portfolio in United States and corporate bonds. At the beginning of the period, 75 percent of the portfolio was in this category with an average length of time to maturity of 20 years. The interest income return rate over the 4-year period was 4.8 percent. Interest rates started up in the fall of 1968 and peaked in June of 1970, when high grade bonds were returning 8 percent. The industrial commission was caught with a large amount of low yielding long term bonds. Not only were returns low compared to current offerings, but the market value of the bonds fell off substantially because of unattractive yields. Had the industrial commission been forced to liquidate a considerable amount of these bonds due to adverse experience and the need for cash, it would have

taken large losses on the difference between the book value and market value of the bonds liquidated. As of June 30, 1971, the book value of the corporate bonds in the portfolio was $14 million while the market value was $10.5 million, a shrinkage of $3.5 million or 25 percent. It should be pointed out that, if these bonds are held to maturity, they will be redeemed at par and no loss sustained.

Segal and others point out a way of softening the impact in such a trend in the bond market as experienced by the Nevada Industrial Commission. This is what is known as exchange. This involves approval of some changes in accounting procedures which are currently being implemented by the commission after consultation with accounting and actuarial consultants.

In fairness to the investment advisor for the industrial commission, the Segal report (p. 22) indicates that its timing was excellent in the investing of about $1.4 million of new money in 1970 in bonds when prices actually bottomed out for the period under review and interest returns were about 8 percent.

While investment performance left much to be desired for the period under review, it is difficult to determine whether the investment advisor should be replaced. Again, the primary reason is the unique industrial commission restrictions under which the investment advisor must operate. It is difficult, if not impossible, to make direct comparisons. For this reason, and others, the subcommittee is suggesting relaxations in those restrictions. These are concurred in by the Nevada Industrial Commission, the investment advisor and the actuarial consultants to the commission. They are contained in a draft bill (BDR 53-38, see Appendix 2 of this report).

It is recommended that the Nevada Industrial Commission explore the propriety of retaining two investment advisors, each to manage half of the investment portfolio. This would afford an opportunity to directly measure the investment performance of each advisor.

As to the selection of investment advisors, it appears that the qualification requirements set out in NRS 616.4971 are such as to rule out many fine investment counseling firms. The subcommittee is, therefore, recommending some changes in the qualifications which are more realistic in today's business world and still offer adequate safeguards against unqualified firms. These are

contained in an attached draft bill (BDR 53-192, see Appendix 3 of this report).

DEPLETION OF RESERVES AND HIGHER RATES

The PMM report, page IV-15, contains an analysis of Required Liability Reserve which reflects a trend over the last few years of costs substantially greater than those estimated and set up. Page IV-16 details the reasons for the insufficiencies, a majority of which arose from unpredictable legislative, judicial and medical cost changes. So while there may have been some in-house error in reserve estimates, there were substantial exterior influences.

Attached is a draft bill (BDR 17-15, see Appendix 4 of this report), which requires a fiscal note on any legislative proposal which would increase costs. Another draft bill (BDR 53-39, see Appendix 5 of this report), provides that the findings of the medical review board are final and binding upon the employee as well as the industrial commission as to medical determinations and facts. This draft bill, along with a provision of the draft bill (BDR 53-193, see Appendix 6 of this report), making commission hearings subject to the Administrative Procedures Act whereby the Nevada Industrial Commission findings of fact are final and binding on the court, will go far to minimize a growing trend of court reversal--both as to eligibility for payment and the level of payment.

The aforementioned trend of encroachment on the Nevada Industrial Commission's provisions for anticipated contingencies reduced those reserves in the aggregate $5,414,726 during 1970-71. This required an immediate infusion of substantial additional revenues. Accordingly, an 18 percent rate increase went into effect July 1, 1971, and an additional 30 percent increase on January 1, 1972. Compounded, the 1972 rate structure represents a 53.4 percent increase over that of January 1, 1971. Under any reasonable conditions, this action should reverse the unacceptable trend of the last 3 or 4 years.

Because of this large increase in rates, which has a major effect upon employer costs, it is felt it would not be prudent to recommend substantial benefit increases until the Provision for Fluctuation in Experience, which was depleted from $6,239,125 in 1970 to $1,606,067 in 1971, is rebuilt to approximately $8 million as recommended by PMM.

ADMINISTRATIVE STRUCTURE

The subcommittee's analysis indicates that the top echelon administrative structure in the Nevada Industrial Commission is still valid for the forseeable future. The Nevada Industrial Commission is not large enough yet to warrant splitting the administrative and adjudicative functions performed by the commissioners. PMM recommended an executive director, which position would assure professional continuity in the operation of an insurance business, even though commissioners came and went by executive appointment. This recommendation was not adopted. However, the subcommittee is suggesting one change, contained in the omnibus draft bill (BDR 53-17, see Appendix 1). This would designate the commission chairman as the executive director. He would have final responsibility for general administrative functions and personnel administration. This is in accord with similar action taken by the 1971 legislature in the case of the Gaming Control Board, also a three-person group. It is also in accord with firm recommendations of the National Commission on State Workmen's Compensation Laws contained in its report which came to the subcommittee in August 1972. Other recommendations in that report will be discussed later herein.

In this connection, it is hoped that future governors of Nevada will act responsibly in appointing chairmen with professional rather than political qualifications. Governor O'Callaghan is commended for such an appointment.

USUAL AND CUSTOMARY FEES

Considerable time has been spent with members of the Nevada medical profession discussing the merits and pitfalls of paying for medical services on a usual and customary fee basis rather than on the relative value schedule now used by the Nevada Industrial Commission.

It has been determined that the term "usual and customary" means different things to different people. So before the industrial commission could seriously consider this approach, there would need to be a common agreed upon definition of what the term means. From there, the matter should be pursued by the commission on its merits.

The position of the subcommittee is that the Nevada Industrial Commission should take all reasonable action to maintain a good

working relationship with the medical profession. In the main, it is thought, that relationship exists now. Dissatisfaction exists among a minority of doctors, mainly in Las Vegas.

There is nothing inherently wrong or unworkable about a usual and customary fee basis. There should be no concept of welfare service contributions or subsidization by doctors to the industrial commission. The doctor is entitled to receive approximately the same fee from the commission as he would charge the man off the street or the person with partial private medical coverage in like economic circumstances. Medical costs are substantially higher in southern Nevada than in the north. But that is a fact of life for everyone, and, presumably, abundant competition will one day be the leveling influence in these costs. In the meantime competition is not all that abundant in any part of Nevada, particularly among anesthesiologists and orthopedic surgeons--the principal medical practitioners involved in industrial commission work. And this is a fact of life with which the Nevada Industrial Commission must deal.

If the Nevada Industrial Commission were to institute a usual and customary fee schedule, it would need to institute adequate and effective controls to prevent escalating medical costs not projected in rates. It would not be defensible to Nevada employers, or, for that matter, to employees, for the commission to operate a gravy train for any Nevada doctor who wished to avail himself of the ride.

PMM discusses this problem in considerable detail, commencing at page IV-4 of its report. The subcommittee concurs with its observations and recommendations.

SECOND INJURY FUND

One of the improvements to the Nevada Industrial Commission advocated by labor and other groups is the establishment of a second injury fund.

If a worker sustains an original injury in the course of employment, the costs attendant thereto are charged to his employer's account. If he sustains a later injury which actually is traceable to the first injury (e.g., a chronic weak back) the costs of the second injury are charged against whomever his employer happened to be at the time of the second injury. Obviously,

the subsequent employer will not wish to hire a man with a known history of recurring injury.

The second injury fund, proposed in an attached draft bill (BDR 53-13, see Appendix 7 of this report), would be charged for the cost of the subsequent injury rather than the subsequent employer, as at present. The additional cost of maintaining such a fund is not considered excessive by the commission. Legislative committees considering this proposal can make their own evaluation of cost impact.

The subcommittee felt that the social and humanitarian considerations of encouraging employers to gainfully employ people in this category were so strong as to warrant this proposal.

EXCLUSIVE STATE FUND

The subcommittee retained, as a special consultant, F. Britton McConnell, Esq., Attorney at Law, Los Angeles, California. Mr. McConnell has had a lifetime of experience in all phases of workmen's compensation. He served under two governors as Insurance Commissioner of the State of California. He has been very helpful as a counselor to the subcommittee. His report is attached hereto as Exhibit "A". Because of his broad experience, he was asked to make an assessment of whether the industrial commission should remain a monopoly or be exposed to the competition of private carriers. As indicated in his report, his judgment is that the Nevada Industrial Commission should be continued as an exclusive state fund at this point in time.

Although PMM was not asked to comment on this matter, its thorough analysis of the Nevada Industrial Commission led it to the same conclusion, as conveyed in personal conversations with its representatives.

The national AFL-CIO feels that the industrial commission should remain an exclusive fund for the reason that, not having to pull out a profit percentage from the premium dollar, more of the premium is available to pay benefits to workers.

The subcommittee concurs that, for the present, the industrial commission should not be exposed to competition. The work force and the number of employers in Nevada is small. If Nevada were to lose many of the large employers upon whom it depends for

actuarial validity, the health of the fund would be endangered. The 28 largest private employers reported 31 percent of the payroll and 22 percent of the Nevada Industrial Commission's premium in fiscal 1970. The 181 largest private employers (1.4 percent of 12,800 employers) reported 41.7 percent of the payroll and premium.

One of the problems with the industrial commission's being an exclusive state fund is that it has not been viewed strictly as an insurance business operated under state auspices. Nevada governors have viewed it as another executive agency subject to their orders and a place where people, who may or may not be qualified, can be given jobs as a matter of political patronage. The legislature has viewed it from time to time as a welfare activity where increased benefits, sometimes retroactive, should be financed out of existing reserves, with no thought of making such benefits prospective from a time when increased premium rates would be instituted to finance them. Part of the present depleted reserve situation is traceable to this type of legislative thinking.

To so consider the Nevada Industrial Commission as a political entity is counterproductive if Nevada's professed purpose is to operate it as an insurance business. The state would be forced to consider it as a proprietary operation if it permitted coverage by private carriers. In the absence of private competition, the legislature might well wish to consider operating the industrial commission as a quasi-public corporation in the same way that the United States Postal Service is now operated. The governor would appoint a multimember board of directors representing labor, management, vendors and the public. This board would select and replace commissioners (observing present labor and management representation), determine policy, set rates, review benefits, adopt budgets and generally oversee the business. The industrial commission would not be part of the state personnel system, but would compete in the marketplace for the type of personnel necessary to run an efficient insurance business.

The one basic problem which concerns the subcommittee, and employers and employees generally, is how to insure proper efficiency in the commission without the pressures of competition to hone the operation. It is of paramount importance to see to it that the Nevada Industrial Commission Chairman is a qualified,

capable man and performs accordingly. Also, periodic reviews, such as this study, will place the commission under the same analysis and suggestions for improvement as are periodically made in the private insurance business.

SAFETY

The industrial commission embarked upon a safety program in 1955 with the legislative creation of the Department of Industrial Safety. Today, 18 of the 129 employees in the Nevada Industrial Commission are involved in this department.

As far as the subcommittee is able to determine, the safety program is adequate and helpful in reducing accidents.

One of the reasons the subcommittee did not explore this area further is because of the federal Occupational Safety and Health Act of 1970, commonly referred to as OSHA. This is a stringent piece of legislation under which the United States Department of Labor has issued occupational safety and health standards which are federally enforced with severe sanctions and penalties.

By virtue of executive action by Governor O'Callaghan, a committee within the executive branch has been working out the details of a state act which, hopefully, would comply with the federal requirement and permit enforcement here at home.

Federal attitudes, guidelines and enforcement procedures are just now coming prominently to the attention of the states and employers therein. For this reason, this whole matter was considered by the subcommittee to be in a state of flux.

For purposes of early and complete consideration of this matter by the legislature, the subcommittee discussed a draft proposal known as the Nevada Occupational Safety and Health Act. The Governor's committee authored the proposed bill, which was presented about the time the subcommittee was completing its study. The subject is extensive and it was felt that the subcommittee could not give it proper consideration within the purview of its study. A bill will be introduced on this subject early in the 1973 legislative session.

PMM cautions that if the Nevada Industrial Commission is the state's agency to implement the federal mandates (and this is

the plan), the commission will become involved in performing certain services of a general state nature. In anticipation, the commission should set up an accounting system which can properly segregate costs so that Nevada employers will not be paying for services properly chargeable to the state general fund or federal programs.

PREVENTION OF ABUSES

It is common knowledge that various kinds of abusive practices are perpetrated against the Nevada Industrial Commission. Some constitute fraud, some are petty larceny and some, unilateral license.

PMM has made some excellent suggestions for reducing these practices by the establishment of a fidelity control program (see PMM report, p. III-20, et seq.).

In the subcommittee's opinion, enormous strides could be made in reducing some of these practices through the creation of regional medical advisory committees, as previously mentioned. Many matters involving technical and professional medical judgment could be considered by them and resolved in a fair and objective way. Some of the matters, reviewable on a case-by-case basis, which come to mind are:

1. Is the patient a malingerer?
2. Is the doctor prolonging treatment for his own financial gain, or as a result of supervisory inattention?
3. Has the medical attention been proper and adequate?
4. When should medical treatment be considered complete? This is particularly important in the case of the psychotic patient who is never convinced that he has had adequate treatment.
5. Is the doctor performing unnecessary procedures or loading costs with in-house services, i.e., extensive therapy treatment, X-rays, clinical tests?

MANDATORY COVERAGE

The subcommittee is not recommending mandatory coverage in the two optional areas existing under Nevada law, namely, agricultural employers and those employers having less than two employees.

Attention is called, however, to the fact that the National Commission on State Workmen's Compensation Laws recommends that coverage in these areas be mandated by 1975 or before. These recommendations will have significant impact throughout America, and it is the opinion of the subcommittee that states which do not comply will be forced to do so by federal legislation. Agricultural interests and employers of domestic help need to be fully aware that time is probably running out on the present exemptions in Nevada's law.

REHABILITATION

Presently in Nevada, as in over half the states, the rehabilitation of injured workmen is handled by the Rehabilitation Division of the Department of Health, Welfare and Rehabilitation. This activity is largely funded by federal money and little or none of the industrial commission premiums are used in this type of case. There is a large question as to whether Nevada would be better off if the Nevada Industrial Commission assumed this responsibility, including the cost.

The subcommittee intended to pursue this question when Mr. Thomas L. Hutchings was the Chairman of the Nevada Industrial Commission. Mr. Hutchings suggested, as a first step, that he arrange a trip to Vancouver, British Columbia, to observe a notably successful rehabilitation facility operated by the workmen's compensation system. Soon after that, Mr. Hutchings was replaced, and his successor, Mr. Reiser, had many other immediate things to do in orienting himself, so the matter became sidetracked. At the end of September 1972, Mr. Reiser and Mr. Evans from the commission, accompanied by several labor and management representatives, did make such an observation trip to Vancouver, British Columbia. The consensus of this group was that British Columbia is doing a noticeably better job than Nevada in rehabilitating injured workmen, and is absorbing the cost within substantially lower rate structure.

In British Columbia, 76 percent of those undergoing rehabilitation have been able to return to jobs where they maintained or improved their previous salary levels. Further, it appears that they are returned to those jobs in a much shorter time than in Nevada.

The subcommittee does not profess to know all the reasons for this difference in performance. But the fact that the difference

exists indicates that the industrial commission should study this matter intensively, with a view toward developing a body of information upon which collective decisions can be made about how it can best discharge this very important responsibility to workers.

A draft bill (BDR 53-194, see Appendix 8 of this report) will provide the framework for action by the industrial commission to accomplish a rehabilitation program. Its adoption is recommended by the subcommittee.

MISCELLANEOUS BILLS

Included herewith are the following recommended draft bills.

1. Appendix 9 (BDR 53-16) is a housekeeping draft bill to remove an unrealistic requirement upon physicians to inform the injured workman of his rights under the Nevada Industrial Insurance Act.
2. Appendix 10 (BDR 53-195) is a bill to place the Nevada Industrial Commission on a calendar year basis rather than fiscal July 1-June 30. This is a recommendation of PMM contained on page IV-24, with reasons therefor.
3. Appendix 11 (BDR 53-14) is a draft bill covering the subject of legal fees in industrial commission cases. PMM points out on pages III-28 and III-29 that Nevada is the only state which is silent on the subject. The object, of course, is to protect workmen against excessive legal costs.

CONCLUSION

The subcommittee has not attempted to comment on all of the many and varied matters which it reviewed. Attention is again called to the fact that the PMM and Segal Advisors reports, previously circulated, are components of this report. The PMM report covered the major areas of review in considerable detail with recommendations.

The Nevada Industrial Commission, which financed this study, has been most cooperative in furnishing information to the subcommittee and its consultants. The subcommittee is convinced that the industrial commission wants to improve its operations and its public image. It can only be hoped that this study will prove fruitful to that end.

Respectfully submitted,

Senator Carl F. Dodge, Chairman
Senator Melvin D. Close, Jr.
Senator Boyd D. Manning
Assemblyman Norman D. Glaser
Assemblyman Keith Ashworth
Assemblyman Randall V. Capurro
W. Howard Gray, Esq.
Mr. Louis Paley
William B. Harris, M.D.
William M. Tappan, M.D.

SUMMARY--Makes technical changes in Nevada industrial commission organization and procedures. Fiscal Note: No. (BDR 53-17)

AN ACT relating to Nevada industrial commission; providing for reports of earnings by persons receiving permanent total disability benefits; making commission chairman responsible for administration of Nevada industrial commission; deleting all references to accident benefit fund, compensation payment fund and rent and expense fund; establishing state insurance fund deposit account; permitting adoption of voluntary rating plans; increasing amount of charge in premium contributions; permitting extension of accident benefits without commission approval; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto a new section which shall read as follows:

Any employee receiving permanent total disability benefits shall report annually on the anniversary date of the award to the commission all of his earnings for the prior 12-month period. In the event the employee fails to make such a report to the commission within 30 days following the anniversary date, the commission shall notify the employer and the employee that such reports have not been received and the commission may then suspend any further payments until such report of earnings is filed with the commission.

Sec. 2. NRS 616.140 is hereby amended to read as follows:

616.140 1. The third commissioner selected by the governor shall be the chairman. The appointee shall have not less than 5 years' actuarial experience and shall have a degree of master of business administration or experience deemed equivalent to that degree.

2. The annual salary of the chairman shall be in an amount determined pursuant to the provisions of NRS 284.182.

3. The chairman, in addition to the other duties prescribed by this chapter, shall serve as executive director. In the capacity of executive director he shall be responsible for all general administrative and clerical functions of the commission, including maintenance of files and records and personnel administration.

Sec. 3. NRS 616.165 is hereby amended to read as follows:

616.165 [A] Except as otherwise provided by this chapter, a decision on any question arising under this chapter concurred in by two of the commissioners shall be the decision of the commission.

Sec. 4. NRS 616.220 is hereby amended to read as follows:

616.220 The commission shall:

1. Adopt reasonable and proper rules to govern its procedure.

2. Prescribe the time within which adjudications and awards shall be made.

3. Prepare, provide and regulate forms of notices, claims and other blank forms deemed proper and advisable.

4. Furnish blank forms upon request.

5. Regulate the nature and extent of the proofs and evidence, and the method of taking and furnishing the same, to establish the rights to compensation from the state insurance fund .
[and the accident benefit fund.]

6. Provide the method of making investigations, physical examinations, and inspections.

7. Prescribe the methods by which the staff of the commission may approve or reject claims, and may determine the amount and nature of benefits payable in connection therewith. Every such approval, rejection and determination shall be subject to review by the commission.

8. Provide for adequate notice to each claimant of his right:

(a) To review by the commission of any determination or rejection by the staff.

(b) To judicial review of any final decision by the commission.

Sec. 5. NRS 616.285 is hereby amended to read as follows:

616.285 Where an employer has in his service two or more employees under a contract of hire, except as otherwise expressly provided in this chapter, the terms, conditions and provisions of

this chapter for the payment of premiums to the state insurance fund [and, except as further otherwise provided, to the accident benefit fund,] for the payment of compensation and the amount thereof for such injury sustained by an employee of such employer, shall be conclusive, compulsory and obligatory upon both employer and employee.

Sec. 6. NRS 616.365 is hereby amended to read as follows:

616.365 If the happening of the accident or the infliction of the injury to the employee shall not have been reported by the employee or his physician forthwith, as described in this chapter, and immediately after the happening of the accident and injury, or if the injured employee or those in charge of him (the injured employee being a party to the refusal) shall refuse to permit the physician so designated to make an examination and to render medical attention as may be required immediately, no compensation shall be paid for the injury claimed to result from the accident; but it shall be within the discretion of the commission to relieve the injured person or his dependents from loss or forfeiture of compensation if the commission shall be of the opinion, after investigation, that:

1. The circumstances attending the failure on the part of the employee, or of his physician, to report the accident and injury

are such as to have excused the employee and his physician for the failure to so report; and

2. Relieving the employee or his dependents from the consequences of the failure to report will not result in an unwarrantable charge against the state insurance fund . [or the accident benefit fund.]

Sec. 7. NRS 616.380 is hereby amended to read as follows:

616.380 1. In addition to the authority given the commission to determine and fix premium rates of employers as provided in NRS 616.395 to 616.405, inclusive, the commission:

(a) Shall apply that form of rating system which, in its judgment, is best calculated to merit or rate individually the risk more equitably, predicated upon the basis of the employer's individual experience;

(b) Shall adopt equitable rules and regulations controlling the same, which rules and regulations, however, shall conserve to each risk the basic principles of workmen's compensation insurance; and

(c) May subscribe to a rating service of any rating organization for casualty, fidelity and surety insurance rating.

2. The rating system or any rating by a rating organization pursuant to this section is subject to the limitation that the

amount of any increase or reduction of premium rate or additional charge or rebate of premium contributions shall be in the discretion of the commission . [, but shall not exceed 20 percent where the accident experience of an employer comprises less than 24 consecutive months or 30 percent where the accident experience comprises more than 24 consecutive months.]

3. The rating system provided by this section is subject to the further limitation that no increase or reduction of premium rate or additional charge or rebate of premium contributions shall become effective for 60 days after adoption by the commission. Upon the adoption of any increase or reduction of premium rate or additional charge or rebate of premium contributions provided by this section the commission shall give written notice thereof to the employer affected by such rate change, charge or rebate and grant the employer, if requested by him, a hearing before the commission prior to the effective date of such rate change, charge or rebate. At such hearing consideration shall be given to the objections as made by the parties appearing, and all matters in dispute shall be resolved after such hearing by the commission in a manner which will not unjustly affect the objecting party. The objective to be accomplished by the commission shall be to prescribe and collect only such premiums

as may be necessary to pay the obligations created by this chapter, administrative expenses, and to carry such reasonable reserves as may be prescribed by law or may be deemed necessary to meet such contingencies as may be reasonably expected.

4. Subsections 2 and 3 of this section shall not apply to rating plans made by voluntary agreement between the commission and employer which increases or reduces premium contributions for employers. Such voluntary rating plans may be retrospective in nature. A voluntary rating plan must be in writing and signed by both the commission and the employer.

Sec. 8. NRS 616.395 is hereby amended to read as follows:

616.395 1. Every employer within, and those electing to be governed by, the provisions of this chapter, with the exception of the state, counties, municipal corporations, cities, and school districts, shall, on or before July 1, 1947, and thereafter, as required by the commission, pay to the commission, for a state insurance fund [and, except as otherwise provided herein, for an accident benefit fund, premiums in such a percentage of his estimated total payroll for the ensuing 2 months] , premiums in the form of an advance deposit as shall be fixed by order of

the commission. All premium rates now in effect shall be continued in full force and effect until changed, altered or amended by order of the commission.

2. Every employer within, and those electing to be governed by, the provisions of this chapter, who shall enter into business or resume operations subsequent to July 1, 1947, shall, before commencing or resuming operations, as the case may be, notify the commission of such fact, accompanying such notification with an estimate of his monthly payroll, and shall make payment of the premium on such payroll for the first 2 months of operations.

3. The commission shall be empowered to accept as a substitute for payment of premiums [, for the ensuing or first 2 months of operation as provided by this section,] either a bond or pledge of assets. The amount and sufficiency of security required, other than cash, shall be determined by the commission but shall not be of a value less than the amount of cash required by this section.

4. The commission shall accept as a substitute for cash payment of premiums as required in this section a savings certificate issued by a bank or savings and loan association in Nevada, which certificate shall indicate an amount at least equal to, but shall not be required to be more than, the next integral multiple of $100 above the cash which would otherwise be required by this

section and shall state that such amount is unavailable for withdrawal except by direct and sole order of the commission. Interest earned on the deposit shall accrue to the account of the employer and not the commission.

Sec. 9. NRS 616.410 is hereby amended to read as follows:

616.410 1. [For the purpose of providing a fund to take care of accident benefits as provided in this chapter, the] The commission is authorized and directed to collect a premium upon the total payroll of every employer within the provisions of this chapter, except as otherwise provided, in such a percentage as the commission shall fix by order [.] for accident benefits.

2. Every such employer paying such premium shall be relieved from furnishing accident benefits, and the same shall be provided by the commission. [Every employer paying such premium for accident benefits may collect one-half thereof, not to exceed $1 per month, from each employee, and may deduct the same from the wages of the employee.]

3. All fees and charges for accident benefits shall be subject to regulation by the commission and shall not be in excess of such fees and charges as prevail in the same community for similar treatment of injured persons of like standard of living.

4. The commission may adopt reasonable rules and regulations necessary to carry out the provisions of this section.

5. The state insurance fund provided for in this chapter shall [not] be liable for any accident benefits provided in this section, but the [fund] account provided for accident benefits shall be a separate and distinct [fund,] account, and shall, on the commission records, be so kept.

Sec. 10. NRS 616.415 is hereby amended to read as follows:

616.415 1. Every employer operating under this chapter, alone or together with other employers, may make arrangements for the purpose of providing accident benefits as defined in this chapter for injured employees. [Such employer may collect one-half of the cost of such accident benefits from his collective employees, not to exceed $1 per month from any one employee, and may deduct the same from the wages of each employee.]

2. Employers electing to make such arrangements for providing accident benefits shall notify the commission of such election and render a detailed statement of the arrangements made, which arrangements shall not become effective until approved by the commission.

3. Every employer who maintains a hospital of any kind for his employees, or who contracts with a physician for the hospital care of injured employees, shall, on or before January 30 of each

year, make a written report to the commission for the preceding year, which report shall contain a statement showing:

(a) Total amount of hospital fees collected, showing separately the amount contributed by the employees and the amount contributed by the employers; and

(b) An itemized account of the expenditures, investments or other disposition of such fees; and

(c) What balance, if any, remains.

Such reports shall be verified by the employer, if an individual; by a member, if a partnership; by the secretary, president, general manager or other executive officer, if a corporation; by the physician, if contracted to a physician.

4. Every employer who fails to notify the commission of such election and arrangements, or who fails to render the financial report required, shall be liable for accident benefits as provided by NRS 616.410.

Sec. 11. NRS 616.420 is hereby amended to read as follows:

616.420 If it be shown or the commission finds that the employer is furnishing the requirements of accident benefits in such a manner that there are reasonable grounds for believing that the health, life or recovery of the employee is being

endangered or impaired thereby, the commission may, upon application of the employee, or upon its own motion, order a change of physicians or of any other accident benefit requirements, and if the employer fails to comply promptly with such order, the injured employee may elect to have accident benefits provided by or through the commission, in which event the cause of action of the injured employee against the employer or hospital association shall be assigned to the commission for the benefit of the [accident benefit] state insurance fund, and the commission shall furnish to the injured employee the accident benefits provided for in this chapter.

Sec. 12. NRS 616.425 is hereby amended to read as follows:

616.425 1. All premiums, contributions, penalties, bonds, securities and all other properties received, collected or acquired by the commission pursuant to the terms of this chapter shall:

(a) Be credited on the records of the commission to the [proper] state insurance fund.

(b) Constitute, for the purpose of custody thereof, the state insurance fund, which shall be held by the commission as custodian thereof for the benefit of employees and their dependents within the provisions of this chapter. Each commissioner shall be liable on his official bond for the faithful performance of his custodial duty as a member of the commission.

2. The commission shall deliver from such state insurance fund to the custody of the state treasurer such moneys as are deemed by the commission necessary to maintain an adequate balance in the [compensation payment fund,] state insurance fund deposit account, which is hereby created for the transaction of the ordinary business and functions of the commission, including compensation.

Sec. 13. NRS 616.435 is hereby amended to read as follows:

616.435 1. All disbursements from the [compensation payment] state insurance fund shall be paid by the state treasurer upon warrants or vouchers of the commission authorized and executed by the commission pursuant to chapter 351 of NRS (Uniform Facsimile Signatures of Public Officials Act). The state treasurer shall be liable on his official bond for the faithful performance of his duty as custodian of the [compensation payment fund.] state insurance fund deposit account. The State of Nevada shall not be liable for the payment of any compensation or any salaries or expenses in the administration of this chapter, except from the [compensation payment fund,] state insurance fund deposit account, but shall be responsible for the safety and preservation of the state insurance fund.

2. A sum of $200,000 in the aggregate may be regularly maintained on deposit by the commission in all the collection depositary banks. Such [fund] account kept currently on deposit shall be used for the transaction of the ordinary business and functions of the commission, including compensation. Such [fund] account shall be a trust [fund,] account, and shall not be removed or drawn upon except on checks or drafts of the commission authorized and executed by the commission pursuant to chapter 351 of NRS (Uniform Facsimile Signatures of Public Officials Act), and shall be made payable to the state treasurer for the [compensation payment fund.] state insurance fund deposit account.

3. Anything to the contrary in this chapter notwithstanding, the commission shall authorize disbursements from the [accident benefit fund and the compensation payment] state insurance fund to provide all benefits provided for in this chapter.

Sec. 14. NRS 616.450 is hereby amended to read as follows:

616.450 Any income derived from rentals, as provided in NRS 616.180, shall be placed in [a fund] an account to be known as the rent and expense [fund.] account. All disbursements on account of expenses incurred in the operation and maintenance of the buildings shall be [paid from] charged against the rent and expense [fund.] account. The fund shall constitute a part of the assets of the [compensation payment] state insurance fund.

Sec. 15. NRS 616.480 is hereby amended to read as follows:

616.480 The commission may reinsure any risk, or any part thereof, and arrange for such other reinsurance as, in its opinion, will properly protect the state insurance fund . [and the accident benefit fund.]

Sec. 16. NRS 616.485 is hereby amended to read as follows:

616.485 If the provisions of NRS 616.395, 616.400 and 616.405 for the creation of a state insurance fund , [and an accident benefit fund,] or the provisions of this chapter making the compensation to the workman provided in it exclusive of any other remedy on the part of the workman, shall be held invalid, the entire chapter shall be thereby invalidated, except the provisions of NRS 616.495, and an accounting according to the justice of the case shall be had on moneys received. In other respects an adjudication of invalidity of any part of this chapter shall not affect the validity of the chapter as a whole or any part thereof.

Sec. 17. NRS 616.490 is hereby amended to read as follows:

616.490 1. If the provisions of this chapter relative to compensation for injuries to or death of workmen become invalid because of any adjudication, or be repealed, the period intervening between the occurrence of an injury or death, not previously

compensated for under this chapter by lump sum payment or completed monthly payments, and such repeal or the rendition of the final adjudication of the validity shall not be computed as a part of the time limited by law for the commencement of any action relating to such injury or death; provided, that such action be commenced within 1 year after such repeal or adjudication.

2. In any such action any sum paid out of the state insurance fund [or the accident benefit fund] by reason of injury to a workman by whom, or by whose dependents, the action is prosecuted, shall be taken into account or disposed of as follows: If the defendant employer shall have paid without delinquency into the state insurance fund [and the accident benefit fund] the premiums provided for by NRS 616.395, 616.400 and 616.405, or furnished accident benefits pursuant to NRS 616.415, any such sums shall be credited upon the recovery as payment thereon, otherwise the sum shall not be so credited.

Sec. 18. NRS 616.495 is hereby amended to read as follows:

616.495 If this chapter shall hereafter be repealed, all moneys which are in the state insurance fund [or the accident benefit fund] at the time of the repeal shall be subject to such disposition as may be provided by the legislature, and in

default of such legislative provisions distribution thereof shall be in accordance with the justice of the matter, due regard being had to obligations of compensation incurred and existing.

Sec. 19. NRS 616.500 is hereby amended to read as follows:

616.500 1. Notice of the injury for which compensation is payable under this chapter shall be given to the commission as soon as practicable, but within 30 days after the happening of the accident.

2. In case of death of the employee resulting from such injury, notice shall be given to the commission as soon as practicable, but within 60 days after death.

3. The notice shall:

(a) Be in writing; and

(b) Contain the name and address of the injured employee; and

(c) State in ordinary language the time, place, nature and cause of the injury; and

(d) Be signed by the injured employee or by a person in his behalf, or in case of death, by one or more of his dependents or by a person on their behalf.

4. No proceeding under this chapter for compensation for an injury shall be maintained unless the injured employee, or someone on his behalf, files with the commission a claim for compensation

with respect to the injury within 90 days after the happening of the accident, or, in the case of death, within 1 year after death.

5. The notice required by this section shall be served upon the commission either by delivery to and leaving with it a copy of the notice, or by mailing to it by registered or certified mail a copy thereof in a sealed postpaid envelope addressed to the commission at its office in Carson City, Nevada. Such mailing shall constitute complete service.

6. Failure to give notice or to file a claim for compensation within the time limit specified in this section shall be a bar to any claim for compensation under this chapter, but such failure may be excused by the commission on one or more of the following grounds:

(a) That notice for some sufficient reason could not have been made.

(b) That failure to give notice will not result in an unwarrantable charge against the state insurance fund . [or the accident benefit fund.]

(c) That failure to give notice was due to the employee's or beneficiary's mistake or ignorance of fact or of law, or of his physical or mental inability, or to fraud, misrepresentation or deceit.

Sec. 20. NRS 616.515 is hereby amended to read as follows:

616.515 Every injured employee within the provisions of this chapter shall be entitled to receive, and shall receive promptly, such accident benefits as may reasonably be required at the time of the injury and within 6 months thereafter, which may be further extended [by unanimous vote of the commission] for additional periods as may be [in the opinion of the commission,] required.

Sec. 21. NRS 617.320 is hereby amended to read as follows:

617.320 1. The occupational diseases fund and the medical benefits fund are hereby created.

2. The occupational diseases fund shall be a separate and distinct fund and shall be so kept on the records of the commission, but shall, in the hands of the commission and, for the purposes of custody thereof, be and constitute a part of the state insurance fund, subject to the same provisions in regard thereto as are contained in chapter 616 of NRS.

3. The commission shall have all of the powers, authority and duties with respect to the prosecution and defense of suits, the collection, administration, investment and disbursement of the occupational diseases fund as are provided for in chapter

616 of NRS relative to the prosecution and defense of suits, the collection, administration, investment and disbursement of the state insurance fund [and the accident benefit fund] for the compensation of injured employees which are not inconsistent with the terms of this chapter.

SUMMARY--Authorizes modification of Nevada industrial commission investment procedures to increase returns. Fiscal Note: No. (BDR 53-38)

AN ACT relating to modification of investment procedures of the Nevada industrial commission; authorizing certain additional investments; eliminating certain restrictions on investments in common stock; increasing permissible percentage of investments in common and preferred stock; reducing restrictions on bond investments; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. The commission may invest and reinvest the moneys in its funds in:

1. Commercial paper as it is set forth in the Uniform Commercial Code - Commercial Paper NRS 104.3101 et seq. Eligible commercial paper may not exceed 180 days maturity and must be of prime quality as defined by a nationally recognized organization which rates such securities. It is further limited to issuing corporations with net worth in excess of 50 million dollars ($50,000,000) which are incorporated under the laws of the United States or any state thereof or the District of Columbia.

2. Collective or part interest in commercial paper held by national banks and issued by companies whose commercial paper meets the requirements prescribed in paragraph 1 hereof.

3. Bankers' acceptances of the kind and maturities made eligible by law for rediscount with Federal Reserve Banks, and generally accepted by banks or trust companies which are members of the Federal Reserve System.

4. Time certificates of deposit issued by commercial banks.

5. Savings accounts in state banks, located in and organized under the laws of this state, or national banks.

Sec. 3. 1. Subject only to the limitations of NRS 616.4984 and not in any way subject to the limitations of NRS 616.4981, the commission may invest and reinvest the moneys in its funds in securities and stock recommended by investment counsel whether or not the securities or stock are expressly authorized or qualify under chapter 616 of NRS if, in the opinion of the investment counsel, the investment conforms to the overall investment objectives of the commission subject to the standard as set forth in the following paragraph, and provided that the aggregate of the investments under this section at cost shall not exceed 10 percent of the assets.

2. In investing in securities and stock under this section for the commission, investment counsel shall exercise the judgment and

care under the circumstances then prevailing which men of prudence, discretion and intelligence exercise in the management of their own affairs, not in regard to speculation but in regard to the permanent disposition of their funds considering the probable income as well as the probable safety of their capital. Within the limitation of the foregoing standard there may be acquired and retained as investments of the commission under this section every kind of investment which men of prudence, discretion and intelligence acquire or retain for their own account.

Sec. 4. NRS 616.4972 is hereby amended to read as follows:

616.4972 1. The commission may invest and reinvest the moneys in its funds in bonds or other evidences of indebtedness of the United States of America or any of its agencies or instrumentalities when such obligations are guaranteed as to principal and interest by the United States of America or by any agency or instrumentality thereof.

2. The commission may invest and reinvest the moneys in its fund in obligations of the United States Postal Service or the Federal National Mortgage Association, whether or not guaranteed as to principal and interest by the United States of America.

3. The commission may invest and reinvest the moneys in its funds in obligations issued or guaranteed by the International Bank for Reconstruction and Development and the Inter-American Development Bank.

Sec. 5. NRS 616.4978 is hereby amended to read as follows:

616.4978 1. The commission may invest and reinvest the moneys in its funds in bonds, debentures, notes and other evidences of indebtedness issued, assumed or guaranteed by any solvent corporation or corporations (other than those organized and chartered for the sole purpose of holding stocks of other corporations) created or existing under the laws of the United States or of any of the states of the United States or the District of Columbia, or the Dominion of Canada or any of its provinces, which are not in default either as to principal [and] or interest; provided:

(a) In the case of any public utility company, the net earnings available for its fixed charges for a period of 5 fiscal years next preceding the date of investment therein have averaged per year not less than [two] one and one-half times its average annual fixed charges after depreciation and income taxes applicable to such period and if, during either of the last 2 years of such period, such net earnings have been not less than [two] one and one-half times its fixed charges for such year.

(b) In the case of any finance company, the net earnings available for its fixed charges for a period of 5 fiscal years next preceding the date of investment therein have averaged per year not less than one [and one-half] times its average annual fixed charges after depreciation and income taxes applicable to such period and if, during either of the last 2 years of such period, such net earnings have not been less than one [and one-half] times its fixed charges for such year.

(c) In the case of any solvent institution other than those described in paragraphs (a) and (b) above, the net earnings available for its fixed charges for a period of 5 fiscal years next preceding the date of investment therein have averaged per year not less than [three] one and one-half times its average annual fixed charges after depreciation and income taxes applicable to such period and if, during either of the last 2 years of such period, such net earnings have been not less than [three] one and one-half times its fixed charges for such year.

2. The commission shall not invest in any one issue of such bonds described in paragraphs (a), (b) and (c) of subsection 1 in an amount in excess of 10 percent of any one such issue.

Sec. 6. NRS 616.498 is hereby amended to read as follows:

616.498 1. The commission may invest and reinvest the moneys in its funds in preferred or guaranteed stock or shares of any

solvent institution created or existing under the laws of the United States or of any state, district or territory thereof, if all the prior obligations and prior preferred stocks, if any, of such institutions at the date of acquisition are eligible as investments under this section and if the net earnings of such institution available for its fixed charges during either of the last 2 years have been, and during each of the last 5 years have averaged not less than [two] one and one-half times, in the case of a public utility company, [and three times,] one times in the case of a finance company and one and one-half times in the case of any solvent institution other than a public utility company [,] or a finance company, the sum of its average annual fixed charges, if any, its average annual maximum contingent interest, if any, and its average annual preferred dividend requirements. For the purpose of this section, such computation shall refer to the fiscal years immediately preceding the date of acquisition, and the term "preferred dividend requirement" shall be deemed to mean cumulative or non-cumulative dividends, whether paid or not.

2. The commission shall not invest more than 1 percent of its assets in the preferred stock of any one issuing company, nor shall the aggregate of its investments under this section exceed 10 percent of its assets.

Sec. 7. NRS 616.4981 is hereby amended to read as follows:

616.4981 1. The commission may invest and reinvest the moneys in its funds in nonassessable (except for taxes or wages) common stock or shares of any solvent institution created or existing under the laws of the United States or any state, district or territory thereof, if [:

(a) All the obligations and preferred stock, if any, of such institution are eligible as investments under NRS 616.4971 to 616.4984, inclusive; and

(b) Such] <u>such</u> institution has paid cash dividends for a period of 5 fiscal years next preceding the date of acquisition.

2. The commission shall not invest more than 1 percent of its assets in the common stock or capital stock of any one issuing company, nor shall the aggregate of its investments under this section at cost exceed [10] <u>20</u> percent of its assets.

SUMMARY--Revises qualifications and terms of employment of investment counsel for Nevada industrial commission. Fiscal Note: No. (BDR 53-192)

AN ACT relating to industrial insurance; revising qualifications and terms of employment of investment counsel for Nevada industrial commission; permitting employment of more than one investment counsel; revising procedure for investment program review by state board of finance; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 616.4971 is hereby amended to read as follows:

616.4971 1. No person, firm or corporation engaged in business as a broker or dealer in securities or who has a direct pecuniary interest in any such business who receives commissions for transactions performed as agent for the commission shall be eligible for employment as investment counsel for the commission.

2. The commission shall not engage investment counsel unless:

(a) The principal business of the person, firm or corporation selected by the commission consists of rendering investment supervisory services, that is, the giving of continuous advice as to the investment of funds on the basis of the individual needs of each client;

(b) [The principal ownership and control of such person, firm or corporation rests with individuals who are actively engaged in such business;

(c)] Such person, firm or corporation and its predecessors have been continuously engaged in such business for a period of [10 or more years;] 3 or more years, and the senior management personnel of such person, firm or corporation have an average of 10 years professional experience as investment managers;

(c) Such person, firm or corporation shall, as of the time originally hired, have at least $250,000,000 of assets under management contract, exclusive of any assets related to governmental agencies in the State of Nevada;

(d) Such person, firm or corporation is registered as an investment adviser under the laws of the United States of America as from time to time in effect [;] , or is a national bank or an investment management subsidiary of a national bank; and

(e) The contract between the commission and the investment counsel is of no specific duration and is voidable at any time by either party;

(f) [Such person, firm or corporation is a member of the Investment Counsel Association of America; and

(g)] Such person, firm or corporation has been approved by the state board of finance for employment as investment counsel.

3. More than one investment counsel may be employed in the discretion of the commission.

4. The expense of such employment shall be paid from the state insurance fund.

[4. All investments made by the commission and any investment program undertaken by the commission shall be subject to review by the state board of finance each quarter. If after such review, the state board of finance finds that the investment policies pursued by the commission are not in the best interests of the state insurance fund or the State of Nevada, the state board of finance may require the commission to discharge any investment counsel employed by it.]

5. Any investment program adopted by the commission and all investments made thereunder shall be reported quarterly in writing by the commission to the state board of finance, and such report shall be subject to review by the state board of finance. The state board of finance may require the commission to provide further reports and may recommend modifications in the investment program, including replacement of the investment counsel. If, after a reasonable time, the commission has not taken suitable corrective

action in response to recommendations by the state board of finance, the state board of finance may direct the commission to implement its recommendations in a manner acceptable to the state board of finance. Any directives from the state board of finance shall be in writing.

6. With the approval of the state board of finance, the commission may designate the bank or banks which shall have the custody of the various investments authorized in NRS 616.4972 to 616.4984, inclusive.

[6.] 7. The commission may accept due bills from brokers upon delivery of warrants if the certificates representing such investments are not readily available.

SUMMARY--Provides for fiscal notes showing financial impact of any legislative bill or amendment thereto for all bills affecting Nevada industrial insurance premiums or state insurance fund. Fiscal Note: No. (BDR 17-15)

AN ACT relating to legislative bills or amendments thereto; requiring fiscal notes showing financial impact on Nevada industrial insurance premiums or state insurance fund created by chapter 616 of NRS for all legislative bills or amendments thereto; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 218 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. Before any bill which affects the premiums charged to employers as provided in chapters 616 or 617 of NRS or the state insurance fund established by chapter 616 of NRS is considered at a public hearing of any committee of the assembly or the senate or before a vote is taken thereon by such committee, the legislative counsel shall obtain a fiscal note in the manner and form, to the extent applicable, provided for in NRS 218.271 to 218.2758, inclusive, showing the financial impact on the premiums charged employers by the Nevada industrial commission and on the state insurance fund.

2. Such information shall be provided by the Nevada industrial commission upon request of the legislative counsel.

3. The department of administration is not required to review such fiscal notes but upon request of any legislator, the fiscal analyst shall review such fiscal note and submit his findings to the requester.

Sec. 2. NRS 218.271 is hereby amended to read as follows:

218.271 [The] Except as otherwise provided by this chapter, the requirement of NRS 218.272 to 218.2758, inclusive, that a fiscal note be obtained before a bill is considered in committee applies only to bills whose preparation is requested of the legislative counsel by an agency or officer of the executive branch of the state government, but any legislator may reqest the preparation of a fiscal note for a bill whose fiscal effect is $2,000 or more which he has introduced or is about to introduce, and the provisions of NRS 218.272 to 218.2758, inclusive, concerning the form, preparation and printing of fiscal notes apply also to such requests.

SUMMARY--Provides that Nevada industrial commission medical board's findings shall be binding on employee and empowers commission to set compensation of medical board. Fiscal Note: No. (BDR 53-39)

AN ACT to amend NRS 616.190 to provide that Nevada industrial commission medical board's findings shall be binding on employee; empowering commission to set compensation of medical board; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 616.190 is hereby amended to read as follows:

616.190 1. The chairman of the commission annually shall request the Nevada State Medical Association to select and establish two lists, each composed of three designated and three alternate licensed physicians, who are in good professional standing and who have displayed an active interest in the advancement of their profession, any three of which physicians from each list, when appointed by the governor shall be and constitute two separate medical boards with concurrent jurisdiction throughout the state for the purposes mentioned in this chapter.

2. The state is hereby divided into two medical board districts, as follows:

(a) Carson City and the counties of Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Mineral, Pershing, Storey and Washoe shall constitute the first medical board district.

(b) The counties of Clark, Esmeralda, Lincoln, Nye and White Pine shall constitute the second medical board district.

3. One of the lists referred to in subsection 1 shall be composed of licensed physicians practicing in the first medical board district and the other list shall be composed of physicians practicing in the second medical board district.

4. The jurisdiction of the medical boards shall be concurrent and shall be limited solely to the consideration and determination of medical questions and the extent of disability of injured employees referred by the commission. It shall not consider or determine legal questions such as whether or not the injury arose out of and in the course of employment. The findings of the medical boards or a majority of the members of each board shall be final and binding on the commission [.] and on the employee.

5. Each member of the medical boards shall receive as full compensation for his services a sum [not to exceed $50] to be fixed by the commission for each referred case, which sum shall

represent compensation for the initial review of medical records, the meeting and the preparation of the report.

6. Each member of the medical boards shall be entitled to reasonable and necessary traveling expenses incurred while actually engaged in the performance of his duties.

SUMMARY--Clarifies application of Nevada Administrative Procedure Act to Nevada industrial commission. Fiscal Note: No. (BDR 53-193)

AN ACT relating to the Nevada industrial commission; clarifying the application of the Nevada Administrative Procedure Act to proceedings of the commission; providing for judicial proceedings from final decisions of the commission; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. The Nevada Administrative Procedure Act, chapter 233B of NRS, shall apply to all proceedings by the commission under this chapter.

Sec. 3. 1. No judicial proceedings shall be instituted for compensation for an injury or death under this chapter unless:

(a) A claim for compensation is filed as provided in NRS 616.500; and

(b) A final decision of the commission has been rendered on such claim.

2. Judicial proceedings instituted for compensation for an injury or death under this chapter shall be limited to

judicial review as prescribed by NRS 233B.130 to 233B.150, inclusive.

Sec. 4. Chapter 617 of NRS is hereby amended by adding thereto the provisions set forth as sections 5 and 6 of this act.

Sec. 5. The Nevada Administrative Procedure Act, chapter 233B of NRS, shall apply to all proceedings by the commission under this chapter.

Sec. 6. 1. No judicial proceedings shall be instituted for benefits for an occupational disease under this chapter, unless:

(a) A claim is filed within the time limits prescribed in NRS 617.330; and

(b) A final decision of the commission has been rendered on such claim.

2. Judicial proceedings instituted for benefits for an occupational disease under this chapter shall be limited to judicial review as prescribed by NRS 233B.130 to 233B.150, inclusive.

Sec. 7. NRS 616.220 is hereby amended to read as follows:

616.220 [The] In accordance with the Nevada Administrative Procedure Act, the commission shall:

1. Adopt reasonable and proper rules to govern its procedure.

2. Prescribe the time within which adjudications and awards shall be made.

3. Prepare, provide and regulate forms of notices, claims and other blank forms deemed proper and advisable.

4. Furnish blank forms upon request.

5. Regulate the nature and extent of the proofs and evidence, and the method of taking and furnishing the same, to establish the rights to compensation from the state insurance fund and the accident benefit fund.

6. Provide the method of making investigations, physical examinations, and inspections.

7. Prescribe the methods by which the staff of the commission may approve or reject claims, and may determine the amount and nature of benefits payable in connection therewith. Every such approval, rejection and determination shall be subject to review by the commission.

8. Provide for adequate notice to each claimant of his right:

(a) To review by the commission of any determination or rejection by the staff.

(b) To judicial review of any final decision by the commission.

Sec. 8. NRS 616.245 is hereby amended to read as follows:

616.245 1. A transcribed copy of the evidence and proceedings, or any specific part thereof, of any final hearing or investigation, made by a stenographer appointed by the commission, being certified by that stenographer to be a true and correct transcript of the testimony in the final hearing or investigation, or of a particular witness, or of a specific part thereof, and carefully compared by him with his original notes, and to be a correct statement of the evidence and proceedings had on the final hearing or investigation so purporting to be taken and transcribed, may be received in evidence with the same effect as if the stenographer were present and testified to the facts so certified.

2. A copy of the transcript shall be furnished on demand to any party upon the payment of the fee therefor as provided for transcripts in courts of record.

Sec. 9. NRS 617.160 is hereby amended to read as follows:

617.160 1. This chapter shall be administered by the Nevada industrial commission.

2. [The] In accordance with the Nevada Administrative Procedure Act, the commission shall:

(a) Adopt reasonable and proper rules to govern its procedure.

(b) Prescribe the time within which adjudications and awards shall be made.

(c) Prepare, provide and regulate forms of claims and such other forms deemed proper and advisable.

(d) Regulate the nature and extent of the proofs and evidence, and the method of taking and furnishing the same, to establish the rights to compensation from the [occupational diseases fund and the medical benefits] <u>state insurance</u> fund.

(e) Provide the method of making investigations, physical examinations, and inspections.

(f) Adopt such other reasonable rules and regulations as may be necessary to carry out the provisions of this chapter.

SUMMARY--Establishes subsequent accident account of the state insurance fund of the Nevada industrial commission and provides for charges thereto. Fiscal Note: No. (BDR 53-13)

AN ACT relating to Nevada industrial insurance; establishing a subsequent accident account of the state insurance fund of the Nevada industrial commission; providing for charges thereto; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 4, inclusive, of this act.

Sec. 2. There shall be a special account within the state insurance fund to be known and designated as the subsequent injury account, which shall be used only for the purpose of defraying charges against it as provided in section 3 of this act.

Sec. 3. Whenever a workman has sustained previous bodily infirmity or disability from any previous injury whether or not arising out of and in the course of employment and shall suffer a further injury in employment covered by this chapter

and becomes disabled from the combined effects thereof, then the accident experience of the employer at the time of the subsequent injury or disease shall be charged only with the injury cost which would have resulted solely from the subsequent injury had there been no preexisting disability. Such injury cost shall be based upon an evaluation of the disability by one of the medical boards created by this chapter. The difference between the charge attributed solely to the subsequent injury and charged to the employer's experience, and the total cost of the total disability compensation reserve shall be charged against the subsequent injury account.

Sec. 4. The total incurred costs charged to the subsequent injury account shall be distributed as loss expense to each manual class of the state insurance fund as of June 30 of each year, and the total industrial premium contributions of each manual class for the preceding fiscal year shall be used in determining the proportionate charge to each manual class to defray the total accumulated charges to the subsequent injury account during the current fiscal year.

SUMMARY--Empowers Nevada industrial commission to provide rehabilitation services. Fiscal Note: No. (BDR 53-194)

AN ACT relating to industrial insurance; empowering the Nevada industrial commission to provide rehabilitation services to injured workmen; providing that commission may refuse to pay compensation benefits to workmen refusing rehabilitation services; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. To aid in getting injured workmen back to work or to assist in lessening or removing any resulting handicap, the commission may take such measures and make such expenditures from the state insurance fund as it may deem necessary or expedient to accomplish such purpose, regardless of the date on which such workman first became entitled to compensation.

2. Any workman eligible for rehabilitation benefits will not be paid those benefits if he refuses counseling, training or other rehabilitation services offered to him by the commission.

SUMMARY--Deletes provision requiring physicians to advise workman of rights under Nevada Industrial Insurance Act. Fiscal Note: No. (BDR 53-16)

AN ACT relating to Nevada Industrial Insurance Act; deletes requirement of chapter 616 of NRS that physicians have duty of advising workman of his rights under act; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 616.350 is hereby amended to read as follows:

616.350 It shall be the duty of the physician [to inform the injured workman of his rights under this chapter and] to lend [all necessary] assistance in making application for compensation and such proof of other matters as required by the rules of the commission, without charge to the workman.

SUMMARY--Requires Nevada industrial commission to use calendar year in determining premium rates. Fiscal Note: No. (BDR 53-195)

AN ACT relating to industrial insurance; providing that the Nevada industrial commission shall use a calendar year in determining and fixing premium rates; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto a new section which shall read as follows:

The commission shall use a calendar year basis in calculating, determining and fixing premium rates of employers.

SUMMARY--Provides for allowance of reasonable attorney fees for services performed representing any workman or beneficiary under Nevada Industrial Insurance Act. Fiscal Note: No. (BDR 53-14)

AN ACT to provide for attorney fees for services before the Nevada industrial commission or before a court on appeal from a decision of the Nevada industrial commission; prescribing how such fees shall be fixed; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. It shall be unlawful for an attorney engaged in the representation of any workman or beneficiary under the provisions of this chapter or chapter 617 of NRS to charge for services before the commission any fee in excess of a reasonable fee of not more than 33 1/3 percent of the increase in the award secured by the attorney's services. Such reasonable fee shall be fixed by the commission and payable from the funds of the commission. Any attorney's fee set by the commission may be reviewed by a court upon application by such attorney. The commission shall implement these provisions by appropriate rules and regulations.

2. If on appeal to the court from the decision on compensation of the commission, such decision is reversed or modified and additional relief is granted to a workman or beneficiary, a reasonable fee for the services of the workman's or beneficiary's attorney shall be fixed by the court not to exceed 33 1/3 percent of the increase in the award secured by the attorney's services. In addition, upon proper application, the court may review and adjust, if necessary, the fee set by the commission, but any adjustment by the court shall not exceed 33 1/3 percent of the increase in the award.

3. Where the commission or court, pursuant to this section, fixes the attorney's fee, it shall be unlawful for an attorney to charge or receive any fee for services before the commission or court in excess of the fee so fixed.

4. Any person who violates any provision of this section shall be guilty of a misdemeanor.

Sec. 2. NRS 616.550 is hereby amended to read as follows:

616.550 [Compensation] Except as otherwise provided in this chapter, compensation payable under this chapter, whether determined or due, or not, shall not, prior to the issuance and delivery of the warrant thereof, be assignable, shall be exempt from

attachment, garnishment and execution, and shall not pass to any other person by operation of law; but in any case of the death of an injured employee covered by this chapter from causes independent from the injury for which compensation is payable, any compensation due such employee which was awarded or accrued but for which the warrant or warrants were not issued or delivered at the date of death of such employee shall be payable to his dependents as defined in NRS 616.615.

F. BRITTON McCONNELL
ATTORNEY AT LAW

Carson City, Nevada
August 14, 1972.

BEFORE THE

LEGISLATIVE COMMISSION'S SUBCOMMITTEE
FOR STUDY OF THE NEVADA INDUSTRIAL COMMISSION

Statement of F. Britton McConnell*

My name is F. Britton McConnell and I am and have been an attorney-at-law since admitted to practice in California and Federal Courts in 1925. At present, I am in private practice in Los Angeles.

At the request of insurance clients, I attended a meeting of the Nevada Commerce Committee in Las Vegas on February 26, 1971, and conferred informally with the members of that Committee and with some of the witnesses regarding the Nevada workmen's compensation system and functioning of the Nevada Industrial Commission; I also discussed these matters with representatives of private insurance companies and insurance agents in Reno who transact substantial business in other lines than workmen's compensation.

In the proceedings of the Commerce Committee, the NIC was only one of a number of important subjects assigned to that Committee. The Commerce Committee concluded that a more thorough study of NIC should be undertaken by another Committee assigned to survey the past and current affairs and financial condition of NIC. Your present Subcommittee was therefore established and after

informal consultations and commencing on August 4, 1971, I was employed as a special consultant with respect to the administrative structure of NIC and related matters. Since attending the meeting on August 4, 1971, I have attended meetings of your Committee in Carson City, in Reno and in Las Vegas, have read the exhibits that have been filed and have conferred extensively with Peat, Marwick, Mitchell & Company during the course of their study of NIC and preparation of their report filed with your Committee in February 1972.

* A concise biography of experience in workmen's compensation insurance is attached--Exhibit 1.

I am appearing before you to-day to make a report to you and to make myself available for discussion of matters that have been brought before your Committee in the course of your extensive proceedings. I feel that your Committee has functioned with exceptionally good efficiency because of strong executive planning and also because of having established and maintained good relations with and resulting full co-operation from the organizations, agencies and individuals who have furnished the testimony and prepared the exhibits.

Senator Carl F. Dodge, your Chairman, and the other members of your Committee have kept in the forefront explicitly and throughout your proceedings, that the Nevada Industrial Insurance Act, the Nevada Occupational Diseases Act and the Industrial Safety Act were enacted and exist for the benefit and safety of employees.

The Nevada System of Workmen's Compensation Laws.

Nevada was one of the first states to enact workmen's compensation laws. Since original enactment in 1913, your Legislature has studied the system and adopted amendments where

shown by legislative hearings and debates to be appropriate. This is a proper and orderly system of procedure and it is worth remembering and preserving in order to avoid political devices whereby some State Legislatures have been bypassed through "Governors' Commissions" and similarly Congress has been bypassed in like manner through "Presidents' Commissions."

Following is the legislative history of the Nevada workmen's compensation system.

The Nevada Industrial Insurance Act was passed in 1913 (NCL 616). The Act has been amended by the Legislature in 1915, 1917, 1919, 1921, 1923, 1925, 1927, 1931, 1935, 1937, 1939, 1941, 1943, 1945, 1947, 1949, 1951, 1953, 1955, 1957, 1959, 1961, 1963, 1965, 1966, 1967, 1969 and 1971.

The Nevada Occupational Diseases Act was passed in 1947 (NCL 617). Amendments were passed in 1949, 1951, 1953, 1955, 1957, 1959, 1961, 1963, 1965, 1966, 1967, 1969 and 1971.

The Industrial Safety Act was passed by the 1955 Legislature (NCL 618). It has been amended in 1967 and 1971.

The above legislative history covers a span of 58 years. At 29 of its Sessions, your Legislature adopted amendments and those actions, of necessity, took into account, among other relevant matters, the population and the economic conditions of their times. The following facts as to the population and distribution of the population must be causally related to this legislative history.

The population of Nevada as shown by census data:

1910 - 81,875
1920 - 77,407
1930 - 91,058
1940 - 110,247
1950 - 160,083
1960 - 285,278
1970 - 488,738.

The population of Washoe and Clark County:

	Washoe	Clark
1910	17,434	3,321
1920	18,627	4,859
1930	27,158	8,532
1940	32,476	16,414
1950	50,205	48,289
1960	84,743	127,016
1970	121,068	273,288

It is estimated that at this time, 1971-1972, Nevada has a total of approximately 240,000 employees in all occupations of which number 200,000 are covered under the workmen's compensation law. Employees of the State of Nevada and political subdivisions are covered.

In recent years, NIC has not been in compliance with basic principles of insurance. These principles and the substance of the Nevada Statutes are summarized as follows in the report of Peat, Marwick, Mitchell & Co. filed with your Committee in February, 1972:

> "The Nevada Industrial Commission, like all insurers, operates not on a pay-as-you-go system, but on the basis of charging to a year for which premiums are paid the ultimate and total costs of all accidents occurring in that year. Thus, for most claimants, the benefits provided by law can be effectively guaranteed only if the Commission sets aside from premiums each year the amounts needed to pay the costs which will accrue in the future for accidents of that year. The amounts so set aside are very real liabilities of the Commission. To the extent the amounts set up are insufficient, current accident victims could suffer the loss of future benefits to

which they are entitled by law. The significance of this liability is recognized in other jurisdictions where State regulators of commercial insurers manifest constant concern over the adequacy of the amounts set up."

A recent test of claim reserves set up as of June 30, 1968, and reappraised as of June 30, 1971, showed a deficiency of $4,696,000.

At this point, a concise statement of customary and, in fact, necessary administrative procedures of workmen's compensation will be of interest. When a claim is first recorded, a reserve must be set up as a liability, generally called "incurred but not paid." The amount of the reserve is the total amount estimated to be required to fully pay the claim regardless of whether the times and amounts of payment terminate within a short period or extend over a period of many years. In insurance accounting, the amount of the reserve includes the amounts paid on the claim. Inevitably, the first reserve established is not the precise amount required. Claim files must be reviewed systematically and frequently so that the reserve can be adjusted as the facts as to disability, medical expense, and death are taken into account. The individual reserves are thus required to be increased or decreased but each should be redundant, that is, a little more than is considered safely adequate and so that as claims are closed, there will not be a drain upon surplus but rather a planned, reasonable increase of surplus. Such an increase is required on good actuarial principles to maintain a proper relation between annual premium volume and surplus. The closing of a claim with what is presumably a final adjustment of the reserve to the actual final cost is an important administrative decision that requires skill and experience. At June 30, 1972, NIC had 12,318 open claims.

The following tabulation shows for the years 1960 - 1972 the numbers of insured employers, total premiums and changes of surplus in the operation of NIC:

	Number of Employer Accounts	Premium	Surplus
1960	8,015	5,653,631	6,074,926
1961		6,301,659	6,811,543
1962	9,016	6,960,125	6,871,191
1963	9,936	8,614,832	7,608,463
1964	10,819	9,212,803	8,514,852
1965	11,316	9,422,673	9,952,128
1966	11,615	9,039,804	10,837,136
1967	11,547	8,910,113	8,886,201
1968	11,869	10,081,858	9,241,736
1969	12,430	11,829,519	7,084,817
1970	12,923	14,049,509	6,239,125
1971	13,223	16,889,310	1,606,067

It will be noted that there were slight decreases of surplus in 1963 and in 1967 with small but not very significant decreases in 1969 and 1970. A dramatic loss of surplus occurred in 1971 and this drain of surplus may have continued into 1972.

Claim Volume - Medical Facilities:

As shown above, the population of Nevada tripled in the past two decades and is now more than 540,000. The number of workmen's compensation claims also tripled. In 1952, NIC recorded 10,699 claim files; in 1962, the number had increased to 19,057; and the estimate for 1972 is 29,382.

Almost half of workmen's compensation claims involve only medical expense. This is true in Nevada and in other jurisdictions. The report of PMM&Co shows that NIC has or is in the course of installing good systems and plans for levels of administration and of responsibility and authority in the personnel of NIC according to the nature and potentials of change in the course of the history of individual claim cases.

An essential of an efficient workmen's compensation system is prompt and first-class medical treatment for injured employees. Your Committee has received testimony and exhibits covering that subject and it has been shown that there is good communication and a spirit of co-operation between NIC and the medical associations. A report furnished by Mr. Nelson B. Neff, Executive Secretary of the Nevada State Medical Association, dated July 27, 1972, supplies the following summary as to present numbers and places of practice of physicians:

"On July 5, 1955 Nevada had a total of 227 physicians licensed and practicing in Nevada. As of July 1, 1972 there were 582 doctors licensed in Nevada and in practice in the state. This supplies some indication of the growth of medical practitioners in the state, which has been accelerated as the population has grown. There were 81 doctors licensed between September 7, 1971 and June 10, 1972.

"With reference to the physician population, Clark and Washoe Counties, Clark County has 5 physicians in service in Boulder City, 12 in Henderson, 240 in Las Vegas and 10 in North Las Vegas, for a total as of August 1, 1971, according to the listing of the Nevada State Board of Medical Examiners, of 267.

"Washoe County as of the same date had 3 physicians in practice in Incline Village, 210 in Reno and 12 in Sparks for a total of 225. Both counts, for Washoe County and for Clark County, include specialists of every branch of medicine. ".

"Taking the 1970 census figure of 489,000 persons living in Nevada, and adding conservatively 51,000 growth factor since the 1970 census, you get an estimated state population of 540,000, and dividing this figure by the 582 doctors who practice in Nevada as of this date we get a rough average of 940 persons per physician."

Your Nevada State Division of Health has furnished a list of licensed hospitals as of March 1972 showing their locations, ownership, size and facilities. The total in the State is 24.

The distribution of physicians and of hospitals is a natural process that is governed by need and this can be discerned from the above population statistics and from consideration of the locations of the operations of the large employers. NIC states that the twelve largest employers employ approximately 18.5% of all employees covered by workmen's compensation in Nevada.

General Discussion:

Under this heading, I will only briefly discuss a number of subjects which are under consideration and which will require decisions either of action in the 1973 Session of your Legislature or decisions to postpone and perhaps schedule for further study. I anticipate that it may be appropriate for me to file a supplement to the report I am submitting to you to-day and this will be governed by our discussions. I previously mentioned the facts which showed that NIC had departed from basic principles of insurance in recent years and I discussed one of the causes which apparently was inadequate review and revisions to assure maintenance of adequate claim reserves. There was another important departure from basic principles of insurance and this arose from one or more acts of the Legislature which increased disability benefits retroactively. This put your workmen's compensation system into the political arena and if the precedent is continued, the pretense that NIC is an insurance operation will have to be abandoned because there will be no standards but only political pressures. The history of social security is sufficient to illustrate this point. If additional payments are to be made to workmen's compensation claimants to supplement the benefits payable because of the rate of compensation payable under the Statute at the time of injury, this should be done as a welfare action by the State and its taxpayers and explicitly so identified because the funds come from the general funds supplied by all taxpayers and not from premiums paid

by employers. Facing the difficult and almost unique situation, the report of PMM&Co recommended that for a period of future years, the rates be increased enough to repair the dangerous invasion of NIC's surplus. This is contrary to all principles of insurance and actuarial science. Rates must be adequate to pay the claims that arise during the period of their use and must be adjusted upward or downward by actuarial treatment of statistics. Whether adjustments are politically wise should never be a consideration.

Nevada premium and loss statistics are not of sufficient volume, considered alone, to meet actuarial standards of credibility for rate-making. For this reason, Nevada must continue its reliance upon statistics accumulated in other jurisdictions and applied by analogy to Nevada conditions. The essential and unchangeable standard for insurance rates is and must continue to be that they shall not be excessive nor inadequate nor unfairly discriminatory and subject to experience rating plans with debits and credits to encourage safety activities and capital expenditures for safety installations by employers.

Your Committee heard many witnesses on the subject of whether or not NIC should continue as a state monopoly. Understandably, the staff of NIC produced testimony and exhibits in defense of their past activities and present status. The witnesses in favor of relaxing the monopoly and allowing private insurance and self-insurance by large employers who would post security bonds, presented valuable testimony but on the whole, not as comprehensive and persuasive as would, in my opinion, be required to justify a recommendation that the present monopoly be terminated. I think a period of several years will have to elapse before there can exist the essential conditions that would justify such a basic change in the historically necessary and now existing state monopoly. If private insurance and self-insurance were to be authorized by legislation, there would have to be a whole new complex of Statutes. Rates would have to be regulated; policyholder dividends would also have to be regulated; the Anti-Rebate Statutes would have to be revised and amended; a system of test audits would

have to be instituted through the office of the Insurance Commissioner and the Insurance Commissioner would have to develop a staff of experienced examiners in workmen's compensation and a whole new set of periodical verified reports and Manual governing examinations to assure protection of the public interest.

It may be significant that although witnesses favored private insurance and a right to self-insurance, no insurer or association of insurers or agents came forward with specific proposals. As a statutory monopoly, NIC is in constant danger of drifting into the inefficiencies inherent in monopoly and which are guarded against and corrected by competition. Unquestionably, competition is the greatest regulator as to prices and services and the best protection of the public interest. Lacking it, I think that the Nevada Legislature should continue its excellent practice of consideration of its workmen's compensation system by one or more of its Committees at every Session.

I have enjoyed the personal associations which have developed in the course of this employment by your Committee. To make sure that my critical comments will not be misinterpreted, I will repeat my assurances of esteem for all of the people in NIC, the Members of your Subcommittee and the witnesses I have met and heard.

Respectfully submitted.

F. Britton McConnell.

August 14, 1972

EXHIBIT 1

BIOGRAPHY
OF F. BRITTON McCONNELL's
EXPERIENCE IN WORKMEN'S COMPENSATION INSURANCE

1914 - 1925	Employed by California State Compensation Insurance Fund (interrupted by service in U. S. Army 1917-1919). This employment included office, field and branch office experience in every phase of workmen's compensation insurance administration and at conclusion, Assistant Secretary, resigned to enter practice of law.
1925 - 1940	In private practice, principally trial work of thousands of state and federal workmen's compensation cases and hundreds of trials of other kinds of cases, and close association with executives of numerous workmen's compensation insurers.
1940 - 1955	General Counsel, Pacific Employers Insurance Group.
1947 - 1952	Member of Insurance Committee as City Councilman and a period as Mayor of the City of Beverly Hills.
1955 - 1963	Insurance Commissioner of California including personal participation and supervision of the administration of workmen's compensation laws and administrative procedures, including participation in functions of California Inspection Rating Bureau.
1963 - Present	In private practice in Los Angeles and San Francisco dealing principally with casualty insurance carrier executive matters.

Exhibit K
Revised

NATIONAL COUNCIL ON COMPENSATION INSURANCE

ARIZONA

EXHIBIT III

Allowances for Expenses, Taxes, Profit and Contingencies

Underlying the present and proposed rates are allowances of 25.9% of standard premium for company expenses, 2.5% of standard premium for profit and contingencies, 5.35 % of standard premium for taxes, coupled with 12.5% of expected losses for loss adjustment expenses, plus an expense constant on premiums under $500.

The items comprising the expense allowance are as follows:

	Item	
(1)	Acquisition and Field Supervision	17.50%
(2)	General Expenses	8.40
(3)	Total for Company Expenses (1)+(2)	25.90
(4)	Taxes, Licenses and Fees other than Federal Income Tax	
	(a) Special Fund Tax	1.65
	(b) Premium Tax	3.00
	(c) Miscellaneous Tax	.70
(5)	Profit and Contingencies	2.50
(6)	Total for Company Expenses, Taxes and Profit and Contingencies (3)+(4)+(5)	33.75%
(7)	Permissible Loss and Loss Adjustment Ratio	66.25
	Loss Adjustment Expense:	
(8)	Related to Premium	7.36
(9)	Related to Losses	12.50
(10)	Total Expense Allowance Related to Premium (6)+(8)	41.11%
(11)	Expense Constant	
	Risks Under $200 Premium	$15.00
	Risks Between $200 and $500 Premium	$10.00

It should be borne in mind that the allowances shown above apply only to the first $1,000 of premium. For risks with premium over $1,000 which in this state represent about 47% of the total number of risks and about 97% of the total premium, manual rules provide for a reduction of rates through application of premium discounts (or their equivalents included in the Retrospective Rating Plan Values). Premium discounts result from the reduction of expense requirements for Acquisition and General Administration with increasing premium size. The premium discounts are as follows:

53% under $1000

8-2-1975

ARIZONA - EXHIBIT III (CONTD.)

Division of Standard Premium	Stock Co. Discount	Non-Stock Co. Discount	Assigned Risks*
First $ 1,000	-	-	-
Next 4,000	9.4%	3.0%	9.4%
Next 95,000	14.7	6.0	14.7
Over 100,000	16.3	8.5	16.3

*To be used by all carriers for policies issued under an assigned risk plan.

A tabulation of the state experience by risk size for the latest available policy period shows that for stock carriers the proposed discounts would produce a net discount of 12.21%. This figure undoubtedly is on the conservative side because in actual practice the discounts, which increase by risk size, are based on the total risk premium, including premium developed by operations in all states.

The tables below indicate for the stock carriers, the proposed expense, taxes and profit and contingencies allowances on two bases. Column (1) lists the net allowances after reduction for the proposed premium discounts, such allowances being expressed as a precentage of standard premium. Column (2) expresses these allowances as a percentage of the net premium resulting from premium discounts.

Item	(1) Net Allowance (% of Standard Premium)	(2) Net Allowance (% of Net Prem.) (Col.(1) ÷.8779)
Acquisition and Field Supervision	9.56	10.89
General Expenses	5.09	5.80
Total for Company Expenses	14.65%	16.69%
Taxes, Licenses and Fees other than Federal Income Taxes	4.70	5.35
Profit and Contingencies	2.19	2.50
Loss Adjustment Expense - Related Premium	7.36	8.38
Losses	58.89	67.08
Total	87.79%	100.0%
Premium Discounts	12.21	xxx
Total	100.0 %	100.0%

NATIONAL COUNCIL ON COMPENSATION INSURANCE

ARIZONA

EXHIBIT III

Allowances for Expenses, Taxes, Profit and Contingencies

Underlying the present and proposed rates are allowances of 25.9% of standard premium for company expenses, 2.5% of standard premium for profit and contingencies, 5.35 % of standard premium for taxes, coupled with 12.5% of expected losses for loss adjustment expenses, plus an expense constant on premiums under $500.

The items comprising the expense allowance are as follows:

	Item	
(1)	Acquisition and Field Supervision	17.50%
(2)	General Expenses	8.40
(3)	Total for Company Expenses (1)+(2)	25.90
(4)	Taxes, Licenses and Fees other than Federal Income Tax	
	(a) Special Fund Tax	1.65
	(b) Premium Tax	3.00
	(c) Miscellaneous Tax	.70
(5)	Profit and Contingencies	2.50
(6)	Total for Company Expenses, Taxes and Profit and Contingencies (3)+(4)+(5)	33.75%
(7)	Permissible Loss and Loss Adjustment Ratio	66.25
	Loss Adjustment Expense:	
(8)	Related to Premium	7.36
(9)	Related to Losses	12.50
(10)	Total Expense Allowance Related to Premium (6)+(8)	41.11%
(11)	Expense Constant	
	Risks Under $200 Premium	$15.00
	Risks Between $200 and $500 Premium	$10.00

It should be borne in mind that the allowances shown above apply only to the first $1,000 of premium. For risks with premium over $1,000 which in this state represent about 47% of the total number of risks and about 97% of the total premium, manual rules provide for a reduction of rates through application of premium discounts (or their equivalents included in the Retrospective Rating Plan Values). Premium discounts result from the reduction of expense requirements for Acquisition and General Administration with increasing premium size. The premium discounts are as follows:

8-2-1975

ARIZONA - EXHIBIT III (CONTD.)

Division of Standard Premium	Stock Co. Discount	Non-Stock Co. Discount	Assigned Risks*
First $ 1,000	-	-	-
Next 4,000	9.4%	3.0%	9.4%
Next 95,000	14.7	6.0	14.7
Over 100,000	16.3	8.5	16.3

*To be used by all carriers for policies issued under an assigned risk plan.

A tabulation of the state experience by risk size for the latest available policy period shows that for stock carriers the proposed discounts would produce a net discount of 12.21%. This figure undoubtedly is on the conservative side because in actual practice the discounts, which increase by risk size, are based on the total risk premium, including premium developed by operations in all states.

The tables below indicate for the stock carriers, the proposed expense, taxes and profit and contingencies allowances on two bases. Column (1) lists the net allowances after reduction for the proposed premium discounts, such allowances being expressed as a precentage of standard premium. Column (2) expresses these allowances as a percentage of the net premium resulting from premium discounts.

Item	(1) Net Allowance (% of Standard Premium)	(2) Net Allowance (% of Net Prem.) (Col.(1) ÷.8779)
Acquisition and Field Supervision	9.56	10.89
General Expenses	5.09	5.80
Total for Company Expenses	14.65%	16.69%
Taxes, Licenses and Fees other than Federal Income Taxes	4.70	5.35
Profit and Contingencies	2.19	2.50
Loss Adjustment Expense - Related Premium	7.36	8.38
Losses	58.89	67.08
Total	87.79%	100.0%
Premium Discounts	12.21	xxx
Total	100.0 %	100.0%

From Exhibit L
7/1/76 Rate
Filing

NATIONAL COUNCIL ON COMPENSATION INSURANCE

OREGON

EXHIBIT III

Allowances for Expenses, Taxes, Profit and Contingencies

Underlying the present and proposed rates are allowances of 25.9% of standard premium for company expenses, 2.5% of standard premium for profit and contingencies, 5.7% of standard premium for taxes, coupled with 12.5% of expected losses for loss adjustment expenses, plus an expense constant on premiums under $500.

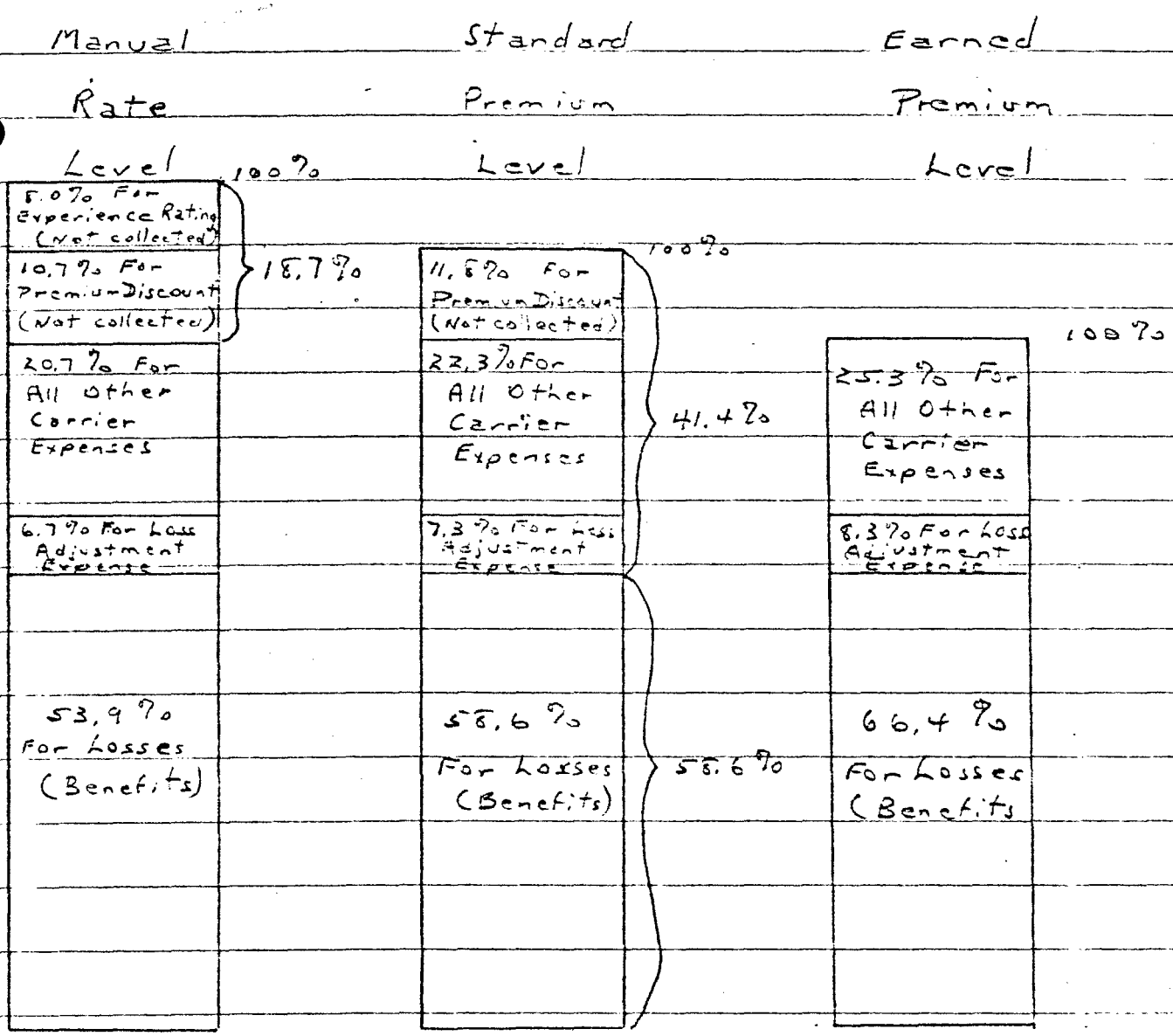
The items comprising the expense allowance are as follows:

	Item	Standard Premium (After Experience Rating but Before Premium Discount)
(1)	Acquisition and Field Supervision	17.5%
(2)	General Expenses	8.4
(3)	Total for Company Expenses (1)+(2)	25.9%
(4)	Taxes, Licenses and Fees other than Federal Income Tax	
	(a) Premium Tax	5.0%
	(b) Miscellaneous Tax	0.7%
(5)	Profit and Contingencies	2.5
(6)	Total for Company Expenses, Taxes and Profit and Contingencies (3)+(4)+(5)	34.1%
(7)	Permissible Loss and Loss Adjustment Ratio	65.9
	Loss Adjustment Expense:	
(8)	Related to Premium	7.3
(9)	Related to Losses	12.5
(10)	Total Expense Allowance Related to Premium (6)+(8)	41.4%
(11)	Expense Constant	
	Risks Under $200 Premium	$15.00
	Risks Between $200 and $500 Premium	$10.00

It should be borne in mind that the allowances shown above apply only to the first $1,000 of premium. For risks with premium over $1,000 which in this state represent about 24% of the total number of risks and about 95% of the total premium, manual rules provide for a reduction of rates through application of premium discounts (or their equivalents included in the Retrospective Rating Plan Values). Premium discounts result from the reduction of expense requirements for Acquisition and General Administration with increasing premium size. The premium discounts are as follows:

76% under $1000

Carrier Expense Allowance Built Into Oregon's Manual Rate Level, Standard Premium Level & Earned Premium Lev



Source: Data from 7/1/76 NCCI Rate Filing

Division of Standard Premium	Stock Co. Discount	Non-Stock Co. Discount
First $ 1,000	-	-
Next 4,000	9.4%	3.0%
Next 95,000	14.7	6.0
Over 100,000	16.3	8.5

*To be used by all carriers for policies issued under an assigned risk plan.

A tabulation of the state experience by risk size for the latest available policy period shows that for stock carriers the proposed discounts would produce a net discount of 12.2%. This figure undoubtedly is on the conservative side because in actual practice the discounts, which increase by risk size, are based on the total risk premium, including premium developed by operations in all states.

The tables below indicate for the stock carriers, the proposed expense, taxes and profit and contingencies allowances on two bases. Column (1) lists the net allowances after reduction for the proposed premium discounts, such allowances being expressed as a percentage of standard premium. Column (2) expresses these allowances as a percentage of the net premium resulting from premium discounts.

Item	(1) Net Allowance (% of Standard Premium)	(2) Net Allowance (% of Net Prem.) (Col.(1) ÷ .878)
Acquisition and Field Supervision	9.5	10.8
General Expenses	5.2	6.0
Total for Company Expenses	14.7 %	16.8 %
Taxes, Licenses and Fees other than Federal Income Taxes	5.0	5.7
Profit and Contingencies	2.2	2.5
Loss Adjustment Expense - Related Premium	7.3	8.3
Losses	58.6	66.7
Total	87.8 %	100.0 %
Premium Discounts	12.2	XXX
Total	100.0 %	100.0 %

NATIONAL COUNCIL ON COMPENSATION INSURANCE

OREGON

EXHIBIT I-G

Derivation of Industry Group Differentials

Policies Becoming Effective During Period	Ratio of Manual To Earned Premium (See Exhibit IV)	(1) Premiums At 7-1-75 Manual Rates	To Indicated Manual Rate Level for Experience Period 7-1-73 to 7-1-75	(2) Losses and Loss Adjustment Expense on 7-1-75 Law Level
Manufacturing Group - Schedules 5 - 25 Inclusive†				
8-1-72 to 7-31-73		65,670,539		38,043,074
8-1-73 to 4-30-74*		35,795,194		22,003,384
TOTAL	1.1013	101,465,733	93,132,691	60,046,458
Contracting Group - Schedules 26 and 27†				
8-1-72 to 7-31-73		31,030,689		19,617,831
8-1-73 to 4-30-74*		17,141,344		10,358,386
TOTAL	1.0661	48,172,033	45,185,285	29,976,217
All Other Group - Other Schedules Except Schedule 29†				
8-1-72 to 7-31-73		117,924,234		68,773,945
8-1-73 to 4-30-74*		64,142,728		35,220,803
TOTAL	1.0546	182,066,962	167,865,537	103,994,748
All Industry Groups				
8-1-72 to 7-31-73		214,625,462		126,434,850
8-1-73 to 4-30-74*		117,079,266		67,582,573
TOTAL	1.0869	331,704,728	305,183,513	194,017,423

*Last policy expired April 30, 1975
†Schedules are those set forth in Classifications Code Book issued by National Council

305,183,513 / 331,704,728 = .92000 manual premium remains at standard earned premium level. .08 is uncollected.

NATIONAL COUNCIL ON COMPENSATION INSURANCE

OREGON

EXHIBIT IV

COMPUTATION OF FINAL MANUAL RATE

A. Reviewed Classifications

The following items are combined with the proposed pure premium to obtain the final manual rate for a reviewed classification:

(1) Rate Level Adjustment Factor and Trend Factor

See Exhibit I for explanation of these factors. As previously stated, the classification experience shown in Exhibit II-A has been compiled excluding the rate level adjustment factor and the trend factor. It is necessary to bring in these factors (1.012 x 1.072 = 1.085) before translating the proposed pure premiums to rates.

(2) Effect of Benefit Change

The partial pure premiums are multiplied by the three part effect of the July 1, 1976 legislation change in benefit level namely:

Serious	1.032
Non-Serious	1.011
Medical	1.000

(3) Ratios of Manual Premiums to Earned Premiums

The ratios of manual premiums to earned premiums by industry group have also been excluded from the classification experience, and it is necessary to apply these factors to the proposed pure premiums. These factors are as follows: Manufacturing 1.1013; Contracting 1.0661; All Other 1.0846.

(4) Rates - Test Correction Factor

The payrolls are now extended by the rates presently in effect and by the indicated proposed rates to determine if the required change in manual premium level has been achieved. Since at first this calculation may not yield the required results, an iterative process is initiated which continuously tests the proposed rates including tentative Test Correction Factors until the required change in manual premium level is obtained. The test correction factors are applied to the proposed pure premiums.

The factors referred to in (1) and (4) above are as follows:

Industry Group	(1) Test Correction Factor	(2) RLAF x Trend	(3) Product (1)x(2)
Manufacturing	1.165	1.085	1.264
Contracting	1.162	1.085	1.261
All Other	1.078	1.085	1.170

NATIONAL COUNCIL ON COMPENSATION INSURANCE

OREGON

EXHIBIT I-A

Conversion of State Fund Net Earned Premium to State Fund Standard Earned Premium

A. Conversion of 1973 Policy Year Net Earned Premium to Standard Earned Premium

(1) Calendar Period	(2) Standard Earned Premium	(3) Net Earned Premium	(4) Conversion Factor (2)÷(3)
1-1-73 to 12-31-73	98,656,584	86,460,742	1.141
1-1-74 to 12-31-74	126,975,265	111,382,052	1.140
			1.141

	(5) Net Earned Premium	(6) Conversion Factor	(7) Standard Earned Premium (5)x(6)
Policy Year 1973 as of 12-31-75	97,779,313	1.141	111,566,196

B. Conversion of 1974 Policy Year Net Earned Premium to Standard Earned Premium

(1) Calendar Period	(2) Standard Earned Premium	(3) Net Earned Premium	(4) Conversion Factor (2)÷(3)
1-1-74 to 12-31-74	126,975,265	111,382,052	1.140
1-1-75 to 12-31-75	139,258,471	121,222,406	1.149
			1.145

	(5) Net Earned Premium	(6) Conversion Factor	(7) Standard Earned Premium (5)x(6)
Policy Year 1974 as of 12-31-75	113,133,101	1.145	129,537,401

PC

Standard Earned Premium

Net Earned Premium

1-1-75 to 12-31-75 94,995,047 85,188,527

State Fund

1-1-74 to 12-31-74 139,258,471

234,256,518

Uncollected = 21,250,[illegible] = 11.[illegible] Standard

NATIONAL COUNCIL ON COMPENSATION INSURANCE

OREGON

EXHIBIT I-A

Conversion of Private Carrier Net Earned Premium to Private Carrier Standard Earned Premium

A. Conversion of 1973 Policy Year Net Earned Premium to Standard Earned Premium

(1) Calendar Period	(2) Standard Earned Premium	(3) Net Earned Premium	(4) Conversion Factor (2)÷(3)
1-1-73 to 12-31-73	61,029,153	55,526,809	1.099
1-1-74 to 12-31-74	80,361,782	71,190,561	1.129
			1.114

	(5) Net Earned Premium	(6) Conversion Factor	(7) Standard Earned Premium (5)x(6)
Policy Year 1973 as of 12-31-75	59,593,184	1.114	66,386,807

B. Conversion of 1974 Policy Year Net Earned Premium to Standard Earned Premium

(1) Calendar Period	(2) Standard Earned Premium	(3) Net Earned Premium	(4) Conversion Factor (2)÷(3)
1-1-74 to 12-31-74	80,361,782	71,190,561	1.129
1-1-75 to 12-31-75	94,993,047	85,803,527	1.107
			1.118

	(5) Net Earned Premium	(6) Conversion Factor	(7) Standard Earned Premium (5)x(6)
Policy Year 1974 as of 12-31-75	72,316,127	1.118	80,849,430

NATIONAL COUNCIL ON COMPENSATION INSURANCE

OREGON

EXHIBIT IV-A

CALCULATION OF PROPOSED RATE - CODE 2960- MANUFACTURING GROUP

A. REVIEWED CLASSIFICATIONS

		Serious	Non-Serious	Medical	Total
1.	Proposed pure premiums (Exhibit II-A)	4.326	2.618	1.495	8.44
2.	Product of RLAF, Trend and Test Correction Fac.	1.264	1.264	1.264	xx
3.	Adjusted pure premiums, unrounded (1)x(2)	5.468064	3.309152	1.889680	xx
4.	Effect of benefit change in parts	1.032	1.011	1.000	xx
5.	Proposed pure premiums (3)x(4)	5.643	3.346	1.890	10.879
6.	Adjusted pure premiums to rounded total	5.644	3.346	1.890	10.88
7.	Ratio of manual premium to earned premium				1.1013
8.	Permissible loss and loss adjustment ratio				.659
9.	Proposed manual rate [(6)x(7)÷(8)]				18.18

CALCULATION OF PROPOSED RATE - CODE 7207- ALL OTHER GROUP

B. NON-REVIEWED CLASSIFICATIONS

1.	Present rate	xx	xx	xx	15.62
2.	Pure premiums underlying present rate	4.873	3.350	1.467	9.69
3.	Industry Group change in premium level excluding legislation	xx	xx	xx	1.358
4.	Permissible Loss & Loss Adj. Ratio	xx	xx	xx	.659
5.	Ratio of Manual premium to earned premium	xx	xx	xx	1.0846
6.	Partial Pure Premium Conversion Factor [(1)x(3)x(4)÷(5)÷ total of (2)]	xx	xx	xx	1.330
7.	Adj. Partial Pure Premiums excluding legislation (2)x(6) unrounded	6.481090	4.455500	1.951110	xx
8.	Effect of Legislation, in parts	1.032	1.011	1.000	xx
9.	Pure Premiums incl. legislation (7)x(8)	6.688	4.505	1.951	13.144
10.	Adj. pure premiums to rounded total	6.684	4.505	1.951	13.14
11.	Proposed manual rate (10)x(5)÷(4)				21.63

Exhibit M

NEVADA STATE MEDICAL ASSOCIATION

RICHARD G. PUGH, Executive Director
3660 Baker Lane
Reno, Nevada 89509 • (702) 825-6788

DOUGLAS HACKETT, Associate Director
850 E. Desert Inn Road, #802
Las Vegas, Nevada 89109

March 9, 1977

TO: SENATE COMMERCE COMMITTEE
Senator Spike Wilson, Chairman

FROM: John W. Callister, M.D.

SUBJ: S.B. 250 - Licensure of Naturopaths

The Nevada State Medical Association is opposed to the licensing of practitioners of Naturopathy in Nevada for the following reasons:

1. Naturopathic theory and practice are not based upon the body of basic knowledge related to health sciences and health care which have been widely accepted by the scientific community.

2. Irrespective of naturopathic theory, the scope and quality of naturopathic education do not prepare the practitioner to make an adequate diagnosis or make appropriate treatment recommendations.

3. It is the duty of the medical profession to protect the public from unproven practitioners of health care.

4. The U.S. Office of Education does not designate any accrediting body for naturopathic schools.

5. In a U.S. Government study by the Department of Health, Education and Welfare in 1968, the statement was made that naturopathy "...conflicts with other concepts of health and disease."

6. Two major publications, HEALTH RESOURCES STATISTICS(an HEW publication prepared by the National Center for Health Statistics) and THE BUREAU OF LABOR OUTLOOK HANDBOOK (1975 edition which is the most current and which is considered as the most comprehensive directory of health professions) have omitted naturopathy as a recognized health profession.

7. Approximately thirty separate lawsuits are now in Federal District Courts, charging discrimination by HEW, state licensure boards, other state boards of medicine, pharmacy and social services. In other words, naturopaths are attempting to accomplish through the courts (and now this legislature) what they cannot do through their schools.

We urge your defeat of S.B. 250.

Exhibit N

NEVADA COMMISSION ON
POSTSECONDARY INSTITUTIONAL AUTHORIZATION

February 16, 1977

Dr. John F. Stapham, Secretary Treasurer
Florida State Board of Naturopathic Examiners
811 8th Avenue
Palmetto, Florida 33561

Dear Dr. Stapham:

Your telegram to Governor Mike O'Callahan dated February 10, 1977, has been referred to the Commission on Postsecondary Institutional Authorization for response.

Dr. Stapham, you may recall that on January 26, 1976, you talked to me on the telephone referent to the application of Bernadean University which was before the CPIA for a license to operate. Your telephone message given to me that day was read into the record of the hearing on the application. The result of that hearing was that the license to operate Berndean University was denied. Mr. Joseph Kadans, President of Bernadean University, subsequently appealed to the courts. After extensive court proceedings finally ending on December 23, 1976, the Commission was upheld in their decision denying the license to operate Bernadean University. A copy of that court order is enclosed.

We would be most appreciative should you be aware of any more degrees emanating from Mr. Kadans or Bernadean University if you would notify us of the particulars and send a copy of the document granting the degree. We will then be able to take additional legal action. The action taken by the Commission in no way reflects either "pro" or "con" relative to the practice of naturopathy in the State. We do appreciate the information you provided to us in our investigation of the application.

Sincerely,

Merlin D. Anderson, Administrator

MDA:ve
Enclosure
cc: Dr. Edwards, Chief, Community Health Services
Cynthia Cunningham, Chairperson CPIA
Rosemary Clarke, Member, State Board of Education
Robert List, Attorney General
Roger Trounday, Director, Human Resources
Gov. Mike O'Callahan

STATE CAPITOL COMPLEX • 308 N. CURRY STREET • CARSON CITY, NEVADA 89710 • PHONE (702) 885-5690

ORDERS

IT IS HEREBY ORDERED, ADJUDGED AND DECREED:

1. That the request for issuance of a Writ of Mandamus by Plaintiff Trustees Of the Church Of Universology, Inc., Bernadean University, is denied.

2. That the decision of the Commission On Postsecondary Institutional Authorization taken at its January 26, 1976, meeting with action denied the Trustees Of The Church Of Universology, Inc., Bernadean University is upheld.

3. That the Trustees Of The Church Of Universology, Inc., Bernadean University and all agents, servants, representatives, directors and officers are temporarily and permanently enjoined from operating a postsecondary educational institution in Nevada until which time that the appropriate license is obtained from the Commission On Postsecondary Institutional Authorization.

4. That the Trustees Of The Church Of Universology, Inc., Bernadean University and all agents, servants, representatives, directors and officers are temporarily and permanently enjoined from offering, awarding, bestowing, conferring, giving, granting, conveying or selling to any other person a degree or honorary degree upon which is inscribed, in any language, the word "associate," "bachelor," "baccalaureate," "master," "doctor," or "fellow," or any abbreviation thereof until which time that the Church Of Universology, Inc., Bernadean University is qualified as a degree granting institution pursuant to NRS 394.620 et seq.

5. That the State of Nevada's request for civil penalties is denied.

Dated this 27 day of January, 1977.

JOHN F. MENDOZA
District Judge

LICENSE

No. 342

State of Oregon
Naturopathic Board of Examiners

848

This Is to Certify, *That* John Minasian

having been duly examined and found qualified by the Board, as provided in ORS 685.010 to 685.990 inclusive, is hereby granted this license to practice Naturopathic Medicine in the State of Oregon in accordance with and subject to the provisions of said law.

In Witness Whereof, *The Naturopathic Board of Examiners has caused the Seal of the Board and their signatures to be affixed this* 15th *day of* June, 1974.

Lyford D. Clanghanour, N.D.
President

Joseph A. Bombaugh, N.D.
Member

John W. Deeble, N.D.
Secretary

This license must be renewed December 31 of each year.

847

Certificate of Proficiency in the Basic Sciences

issued by the

Board of Examiners in the Basic Sciences of the State of Nevada

Certificate by Reciprocity

No. 1489 Date May 29, 1968

THIS IS TO CERTIFY THAT John L. Minasian,

residing at Studio City, California, aged 38 years,

has presented satisfactory evidence of passing an examination in Anatomy, Bacteriology, Chemistry, Pathology, and Physiology, given by the Board of Examiners in the Basic Sciences of the State of New Mexico.

R. D. Brown
Chairman

Lowell L. Jones
Secretary-Treasurer

Address of Board: P. O. Box 8355, Reno, Nevada 89507

June 19, 1975

To Whom It May Concern

Dear Sir:

Dr. John Leon Minasian presently is a Clinical Instructor in the Department of Anatomy, and has been for the past 2 years. In this capacity he instructs first year pre-doctoral dental students in the Human Gross Anatomy Laboratory. He is also occasionally responsible for special dissections, presenting demonstrations and preparing laboratory examinations. He is competent in these duties and has excellent rapport with our students.

Sincerely,

McCormick Templeton

McCormick Templeton, Ph.D.
Associate Professor
Chairman (Acting)
Department of Anatomy

MT/md

cc John Leon Minasian

UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

UNIVERSITY EXTENSION
DEPARTMENT OF CONTINUING EDUCATION
IN HEALTH SCIENCES

P. O. BOX 24902
LOS ANGELES, CALIFORNIA 90024
TELEPHONE (213) 825-7241

TO WHOM IT MAY CONCERN:

John Minasian, M.D.

4029 Goodland Avenue

Studio City, CA 91604

attended The Third Annual Joint UCLA-Santa Monica Hospital Medical Center Family Practice Refresher Course

on August 18-22, 1976

at Neuropsychiatric Institute Auditorium, UCLA

Hours of credit provided were 42½

Martin D. Shickman, MD

Martin D. Shickman, M.D.
Director

MDS/mn

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
2025 Zonal Avenue
Los Angeles, California 90033

Office of the Associate Dean
For Postgraduate Affairs

This is to certify that JOHN MINASIAN, M.D.

has attended the USC School of Medicine postgraduate course

SURGICAL ANATOMY AND SURGERY

(Tuesday Evenings - Six Sessions)

held on October 26 thru November 30, 1976

This course consists of 12 *hours of CMA and AAGP credit,* of which the above attended 6 hours - Oct. 26, Nov. 9 & 16, 1976.

Phil R. Manning, M.D.
Associate Dean
Postgraduate Medical Education

1/21/77 jf

No. SDT 31536

Reg. No. 567-38-1095

850

State of California

in accordance with provisions of the Education Code issues this

Standard Designated Teaching Credential

to

JOHN LEON MINASIAN

Title . . . . . Adult Education

Authorizations . . . . 203d ****

Renewal . . . . . .

Valid . . . . . 9-13-76 for Life

Subjects or Field: Health Education
Gerontology
Behavioral Sciences
Comparative Religions
****

Marcelle T. Johnson
CHAIRMAN, COMMISSION FOR TEACHER PREPARATION AND LICENSING

Peter L. LoPresti
EXECUTIVE SECRETARY, COMMISSION FOR TEACHER PREPARATION AND LICENSING

SEE REVERSE FOR EXPLANATION OF CODED ITEMS

Newton R. Steward
PRESIDENT, STATE BOARD OF EDUCATION

Wilson Riles
SUPERINTENDENT OF PUBLIC INSTRUCTION
SECRETARY, STATE BOARD OF EDUCATION

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF DENTISTRY
Certification of Enrollment and Attendance

JOHN MINASIAN, M.D.

		Clock hours
Course	ACUPUNCTURE	
Instructor(s)	HARRY QUINT, JR., D.D.S.	14
Date	FEBRUARY 21, 22, 1976	

Richard C. Oliver
Dean

Howard M. Willis
Division of Continuing Education *Director*

Signature _____ License No. 295

Arizona

Naturopathic Physicians State Board Examiners

THIS IS TO CERTIFY THAT John F. Statham has paid the $20.00 License Renewal Fee required by Sec. 10, Ch. 105, Session Laws of 1935, regulating the practice of Naturopathy and all branches thereof, and is legally entitled to practice same until December 31, 19 77

Issued at Phoenix, Arizona, this 27 day of January, 19 77

(SEAL) By _____ Sec'y-Treas.

STATE OF FLORIDA

Department of Professional And Occupational Regulation

BOARD OF NATUROPATHIC EXAMINERS

STATHAM, JOHN F

NATUROPATH

HAS PAID THE FEE REQUIRED BY CHAPTER 462

FOR THE YEAR EXPIRING MAY 1, 1977

SIGNATURE

GOVERNOR _____ PLEASE READ IMPORTANT INFORMATION ON REVERSE _____ SECRETARY OF PROFESSIONAL AND OCCUPATIONAL REGULATION

WALLET CARD — FOLD HERE

BOARD OF NATUROPATHIC EXAMINERS
315 SOUTH CALHOUN STREET SUITE 300
TALLAHASSEE, FL 32301

AUDIT CONTROL NO	FILE NO	BATCH NO.	FEE AMOUNT
055984	NA0000555	003	$20.00

BOARD OF EXAMINERS IN THE BASIC SCIENCES

State of Florida

No. 6271

Certificate

OF PROFICIENCY IN THE BASIC SCIENCES

ISSUED TO

JOHN F. STATHAM

UNDER THE PROVISIONS OF CHAPTER 19281 OF THE LAWS OF FLORIDA 1939

BOARD OF EXAMINERS
IN THE BASIC SCIENCES

Chairman

Secretary

THIS CERTIFICATE IS NOT A LICENSE AND DOES NOT ENTITLE THE HOLDER TO PRACTICE THE HEALING ART

EXECUTIVE DEPARTMENT

STATE OF FLORIDA

IN THE NAME AND BY THE AUTHORITY OF THE

STATE OF FLORIDA

Whereas, JOHN F. STATHAM

hath been duly appointed by the Governor according to the Constitution and Laws of said State to be MEMBER OF THE STATE BOARD OF NATUROPATHIC EXAMINERS FOR A TERM BEGINNING ON THE EIGHTH DAY OF JULY, A. D., 1976 UNTIL THE FIFTEENTH DAY OF JULY, A. D. 1979.

Now, Therefore, Reposing especial trust and confidence in the loyalty, patriotism, fidelity and prudence of the said

JOHN F. STATHAM

I, Reubin O'D. Askew, Governor of the State of Florida, do and by virtue of the authority vested in me by the Constitution and Laws of the said State, Do Hereby Commission the JOHN F. STATHAM *to be such* MEMBER *according to the Constitution and Laws of said State for the term aforesaid. In the Name of the People of the State of Florida, and to hold and exercise the said office, and all the powers appertaining thereto, and to fulfill the duties thereof and to receive the profits thereof, in accordance with the requirements*

RULES
OF
THE FLORIDA STATE BOARD
OF
NATUROPATHIC EXAMINERS

CHAPTER 21N-1
EDUCATION

21N-1.01 Annual Educational Requirements.

(1) Each license holder under Chapter 462, Florida Statutes, except as otherwise provided, shall be required to attend an educational program in the twelve months as a prerequisite to annual renewal of licenses to practice Naturopathy in this State. Such educational programs may be conducted by the board, the Florida Naturopathic Physicians Association, Inc., or any equivalent program duly approved by the Board as a substitute therefor as provided in Section 462.18, Florida Statutes, shall be submitted to the Board annually at least twenty days prior to he scheduled date of said program. The said submission shall show the subject matter of the educational program, the duration of each lecture or demonstration.

(2) The educational program shall consist of no less than a two-day educational program which program shall include a series of lectures or visual demonstrations, of no less than four hours duration for each of the two days, or a total of at least eight hours for the entire two-day educational program.

(3) The series of lectures or visual demonstrations required by the provisions of section 1 of this rule shall be based upon selections from at least three of the fields of Naturopathic Medicine:

(a) Internal Medicine.
(b) Diagnosis.
(c) Therapeutics.
(1) Narcotics (federal laws).
(2) Legend Drugs.
(3) New Medications.
(4) Physical Therapy.
(d) Public Health.

General Authority 462.04 FS. Law Implemented 462.18 FS. History—Amended 5-25-66.

21N-1.02 Exceptions.

(1) The board shall have the authority to excuse licensees, as a group or as individuals, from the annual educational requirements in any of the following instances:

(a) When no educational program meeting the requirements approved by the board is conducted within this state.

(b) The submission of sufficient statements to the board that the licensee, for good cause, was prevented from attending an educational program at the proper time and evidence that the licensee had paid the fee for such education program as provided in Section 462.18(3), Florida Statutes.

(c) In the event of an unusual emergency.

(d) For other good and sufficient reason.

General Authority 462.04 FS. Law Implemented 462.18 FS. History—New 5-25-66.

Hollywood College

SCHOOL OF NATUROPATHIC PHYSICIANS AND SURGEONS

INCORPORATED JANUARY 22, 1922

2009 W. 9th Street - Los Angeles, California

TRANSCRIPT OF RECORD

TRANSCRIPT RECORD OF KENNETH P. BLANKER Social Security #: 380-28-0042

Birth Date: December 16, 1933 Grand Rapids, Michigan

ATTENDANCE Four (4) academic years - A min. total of 5,000 hours in Naturopathic MEDICINE

DEGREE GRANTED DOCTOR OF NATUROPATHY ON June 17, 1960

SUBJECT	Units of Credit	Hours	Grade	SUBJECT	Units of Credit	Hours	Grade
Histology	(7)	162	B	Dermatology	(1)	18	B
Human Anat.&Dissect.	(11)	360	C	Syphilology	(1)	18	C
Anat-Topographical	(3)	72	B	Pediatrics	(2)	36	C
Anat. Special Senses	(2)	36	B	E.E.N.T.	(3)	72	C
General Chemistry	(6)	162	B	Obstetrics & Gyn.	(6)	144	B
Biochemistry	(7)	180	C	Orthopedics	(3)	72	C
Physiology I	(3)	72	C	Rehabilitation	(2)	36	C
Physiology II	(6)	144	B	Physical Medicine I	(2)	36	A
Physiology III	(3)	72	C	Physical Medicine II	(3)	72	B
[illegible]ysiology IV	(2)	36	C	Manipulative Tech. I	(2)	36	B
[illegible]thology I	(6)	144	C	Manipulative Tech. II	(3)	72	C
Pathology II	(3)	72	C	Geriatrics	(3)	72	C
Pathology III Clin.	(3)	72	A	Clinical Laboratory	(2)	*(36)	C
Neurology I	(8)	180	B	Hypnosis	(2)	*(36)	C
Neurology-Clin. II	(2)	36	C	Psychiatry I	(2)	36	B
Microbiology	(5)	144	C	Psychiatry II	(3)	72	C
Prevent.Med.& P.H. I	(3)	72	B	Roentgenology I	(2)	36	C
Prevent.Med.& P.H. II	(3)	72	C	Roentgenology II	(4)	190	C
Nat. Medicine I	(1)	18	C	Pharmacology I-Toxicology	(2)	36	B
Nat. Medicine II	(2)	36	B	Pharmacology II **	(3)	72	B
Clin. Nutrition I	(3)	72	C	Pharmacology III **	(3)	72	B
Clin. Nutrition II	(3)	72	C	SURGERY-Minor & Emerg.I	(3)	72	B
Parasitology	(2)	36	C	SURGERY-Minor&Emegr.II	(3)	72	B
Med.Diag. Physical	(3)	72	C	SURGERY-Anesthesiology	(2)	36	C
Med.Diag. Clinical	(7)	162	B	Office Proced. & Juris-	(3)	*(72)	
Med.Diag.Differential	(3)	72	C	prudence			A
Med.Diag. Laboratory	(3)	72	C	Clin.&/or Hosp.Practice		800	B
Semester Units				TOTAL	(175)	5058	

*=Inc.in clinic hours

**=Inc.Natura Med.& Phytotherapy

Units of Credit — The number in parentheses following the course description. Each unit represents one hour per week of lecture or recitation, or a longer time in laboratory or other exercises not requiring outside preparation.

SIGNED THIS 17th day of June 1960

REGISTRAR [signature]

Seal of

[illegible]rading System

Grade	Grade Points Per Unit	Grade	Grade Points Per Unit
A—Excellent	4	Inc—Incomplete	0
B—Good	3	W—Withdrawn	0
C—Average	2	WF—Failing at time of withdrawal or dropped for non-	
D—Poor	1		

854

855

California Doctor's Hospital

on the recommendation of the Faculty
and by virtue of the authority vested in them, the Board of Directors
of the California Doctors Hospital Corp. does hereby confer on

Dr. Kenneth Paul Blanker

THIS CERTIFICATE OF INTERNSHIP

With all the rights & privileges pertaining thereto
in recognition of the satisfactory Completion of the required Course of Internship.

In testimony whereof the Seal of the Hospital & the
Signature of its duly Authorized officer are hereto affixed.

Given at Los Angeles, California on this 1st day of AUGUST 1960

Hugh McCutchen M.D
President, Board of Directors

LICENSE

No. 338

State of Oregon
Naturopathic Board of Examiners

This Is to Certify, *That* Kenneth Klanker

having been duly examined and found qualified by the Board, as provided in ORS 685.010 to 685.990 inclusive, is hereby granted this license to practice Naturopathic Medicine in the State of Oregon in accordance with and subject to the provisions of said law.

In Witness Whereof, *The Naturopathic Board of Examiners has caused the Seal of the Board and their signatures to be affixed this* 15 th *day of* June, 1974.

B. A. Smith, N.D.
President

Lafford K. Vaughan, M.D.
Member

J. H. Noble, M.D.
Secretary

This license must be renewed December 31 of each year.

856

[redacted] 31

RECEIPT FOR CERTIFIED MAIL—30¢ (plus postage)

SENT TO
Nevada State Board of Medical
STREET AND NO. Examiners
P.O., STATE AND ZIP CODE
Carson City, Nevada 89701

POSTMARK OR DATE

OPTIONAL SERVICES FOR ADDITIONAL FEES

RETURN RECEIPT SERVICES
1. Shows to whom and date delivered ..... 15¢
With delivery to addressee only ..... 65¢
2. Shows to whom, date and where delivered .. 35¢
With delivery to addressee only ..... 85¢
DELIVER TO ADDRESSEE ONLY ..... 50¢
SPECIAL DELIVERY (extra fee required) .....

PS Form 3800 Apr. 1971 NO INSURANCE COVERAGE PROVIDED— NOT FOR INTERNATIONAL MAIL (See other side)

☆ GPO : 1972 O- 460-743

No. 719382

Ker
I
Long

Nevada State Board of Medical
Examiners
Carson City, Nevada 89701

Gentlemen:

I am a Naturopathic Physician in practice in the State of Oregon at the present time. I would like to obtain a Naturopathic Physician's license in the State of Nevada.

Please forward to me any required applications which are necessary to apply for licensure in the State of Nevada.

Your prompt attention to this matter will be appreciated. Kindest regards.

Very truly yours,

Kenneth P. Blanker, N.D.

KPB:mas

saif

STATE ACCIDENT INSURANCE FUND

SAIF BUILDING • SALEM • ORE. 97310 • 378-3400

DISTRICT OFFICES

ASTORIA
325-7252

BAKER
523-6342

BEAVERTON
644-3118

BEND
382-0322

CORVALLIS
754-1224

EUGENE
686-7652

KLAMATH FALLS
882-4454

MEDFORD
779-1441

MILWAUKIE
777-2242

NORTH BEND
756-3118

PENDLETON
276-4130

PORTLAND Metropolitan
229-5881

PORTLAND Northeast
252-4308

ROSEBURG
672-6541

SALEM
378-3411

THE DALLES
296-9173

September 24, 1975

K. Paul Blanker, ND
250 Bush Street
Central Point, OR 97501

Dear Dr. Blanker:

Medical Account Number 17034 has been assigned to identify your statements for injured workmen of SAIF insured employers.

Please use this number when submitting statements, to properly identify your billing.

As a suggestion to eliminate transposing of numbers, a rubber stamp for your account number may be worth considering.

Should you have any questions or require billing forms, please contact us.

Sincerely,

T. R. Mueller, Supervisor
Initial Claims Processing

TRM:WW

858

1216

Nevada State Board of Medical Examiners

AIRPORT CENTER BUILDING
1281 Terminal Way, Suite 211 • Reno, Nevada 89502 • (702) 329-2559

August 27, 1975

Kenneth P. Blanker, N.D.
P. O. Box 588
Long Beach, California 90801

Dear Dr. Blanker:

There is no provision in Nevada Law for licensure or certification of Naturopathic Physicians.

Sincerely,

Mrs. Evelyn Hilsabeck

INSTITUTO POLITECNICO NACIONAL

ESCUELA NACIONAL DE MEDICINA HOMEOPATICA

ESCUELA INTERNACIONAL DE HOMEOPATIA

Otorga el Presente

Diploma

A DR. KENNETH P. BLANKER

Por su asistencia al Primer Curso Introductorio de Homeopatia.

Ciudad de México, Abril de 1976.

El Director de la E. N. M. H.
y E. I. H.

Dr. José Luis Romero E.

Profesor Titular del Curs

Dr. Roberto Mendiola G

860

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
2025 Zonal Avenue
Los Angeles, California 90033

Office of the Associate Dean
For Postgraduate Affairs

This is to certify that K. P. BLANKER, M.D.

has attended the USC School of Medicine postgraduate course
BEDSIDE CLINICS IN INTERNAL MEDICINE

(Thursdays Evenings)

held on September 26 to December 19, 1974

This course consists of 24 *hours of CMA and AAGP credit.*

Phil R. Manning, M.D.
Associate Dean
Postgraduate Medical Education

1/27/75 jf

Hollywood College

SCHOOL OF NATUROPATHIC PHYSICIANS AND SURGEONS

INCORPORATED JANUARY 22, 1922

2009 W. 9th Street - Los Angeles, California

TRANSCRIPT OF RECORD

TRANSCRIPT RECORD OF KENNETH P. BLANKER Social Security #: 380-28-0042

Birth Date: December 16, 1933 Grand Rapids, Michigan

ATTENDANCE Four (4) academic years - A min. total of 5,000 hours in Naturopathic MEDICINE

DEGREE GRANTED DOCTOR OF NATUROPATHY ON June 17, 1960

SUBJECT	Units of Credit	Hours	Grade	SUBJECT	Units of Credit	Hours	Grade
Histology	(7)	162	B	Dermatology	(1)	18	B
Human Anat.&Dissect.	(11)	360	C	Syphilology	(1)	18	C
Anat-Topographical	(3)	72	B	Pediatrics	(2)	36	C
Anat. Special Senses	(2)	36	B	E.E.N.T.	(3)	72	C
General Chemistry	(6)	162	B	Obstetrics & Gyn.	(6)	144	B
Biochemistry	(7)	180	C	Orthopedics	(3)	72	C
Physiology I	(3)	72	C	Rehabilitation	(2)	36	C
Physiology II	(6)	144	B	Physical Medicine I	(2)	36	A
Physiology III	(3)	72	C	Physical Medicine II	(3)	72	B
ysiology IV	(2)	36	C	Manipulative Tech. I	(2)	36	B
thology I	(6)	144	C	Manipulative Tech. II	(3)	72	C
Pathology II	(3)	72	C	Geriatrics	(3)	72	C
Pathology III Clin.	(3)	72	A	Clinical Laboratory	(2)	*(36)	C
Neurology I	(8)	180	B	Hypnosis	(2)	*(36)	C
Neurology-Clin. II	(2)	36	C	Psychiatry I	(2)	36	B
Microbiology	(5)	144	C	Psychiatry II	(3)	72	C
Prevent.Med.& P.H. I	(3)	72	B	Roentgenology I	(2)	36	C
Prevent.Med.& P.H. II	(3)	72	C	Roentgenology II	(4)	190	C
Nat. Medicine I	(1)	18	C	Pharmacology I-Toxicology	(2)	36	B
Nat. Medicine II	(2)	36	B	Pharmacology II **	(3)	72	B
Clin. Nutrition I	(3)	72	C	Pharmacology III **	(3)	72	B
Clin. Nutrition II	(3)	72	C	SURGERY-Minor & Emerg. I	(3)	72	B
Parasitology	(2)	36	C	SURGERY-Minor&Emegr.II	(3)	72	B
Med.Diag. Physical	(3)	72	C	SURGERY-Anesthesiology	(2)	36	C
Med.Diag. Clinical	(7)	162	B	Office Proced. & Juris-	(3)	*(72)	
Med.Diag.Differential	(3)	72	C	prudence			A
Med.Diag. Laboratory	(3)	72	C	Clin.&/or Hosp.Practice		800	B
Semester Units	*=Inc. in clinic hours **=Inc.Natura Med.& Phytotherapy			TOTAL	(175)	5058	

Units of Credit — The number in parentheses following the course description. Each unit represents one hour per week of lecture or recitation, or a longer time in laboratory or other exercises not requiring outside preparation.

SIGNED THIS 17th day of June 1960

REGISTRAR

Seal

862

Grading System

Grade	Grade Points Per Unit	Grade	Grade Points Per Unit
A—Excellent	4	Inc—Incomplete	0
B—Good	3	W—Withdrawn	0
C—Average	2	WF—Failing at time of withdraw-	
D—Poor	1	al or dropped for non-	

California Doctor's Hospital

on the recommendation of the Faculty
and by virtue of the authority vested in them, the Board of Directors
of the California Doctors Hospital Corp. does hereby confer on

Dr. Kenneth Paul Blanker

THIS CERTIFICATE OF INTERNSHIP

With all the rights & privileges pertaining thereto
in recognition of the satisfactory Completion of the required Course of Internship.

In testimony whereof the Seal of the Hospital & the
Signature of its duly Authorized officer are hereto affixed.

Given at Los Angeles, California on this 1st day of AUGUST 1960

Hugh McCutchan M.D
President, Board of Directors

LICENSE

No. 338

State of Oregon
Naturopathic Board of Examiners

This Is to Certify, *That* Kenneth Blanker

having been duly examined and found qualified by the Board, as provided in ORS 685.010 to 685.990 inclusive, is hereby granted this license to practice Naturopathic Medicine in the State of Oregon in accordance with and subject to the provisions of said law.

In Witness Whereof, *The Naturopathic Board of Examiners has caused the Seal of the Board and their signatures to be affixed this* 15th *day of* June, 1974.

B. A. Smith, N.D.
President

Lafford K. Vaughan, M.D.
Member

J. H. Noble, M.D.
Secretary

This license must be renewed December 31 of each year.

864

80931

Ker
I
Long

No. 719382

RECEIPT FOR CERTIFIED MAIL—30¢ (plus postage)

SENT TO Nevada State Board of Medical	POSTMARK OR DATE
STREET AND NO. Examiners	
P.O., STATE AND ZIP CODE Carson City, Nevada 89701	
OPTIONAL SERVICES FOR ADDITIONAL FEES	
RETURN RECEIPT SERVICES 1. Shows to whom and date delivered ..... 15¢ With delivery to addressee only ..... 65¢ 2. Shows to whom, date and where delivered .. 35¢ With delivery to addressee only ..... 85¢	
DELIVER TO ADDRESSEE ONLY ..... 50¢	
SPECIAL DELIVERY (extra fee required)	

PS Form 3800 Apr. 1971 NO INSURANCE COVERAGE PROVIDED— NOT FOR INTERNATIONAL MAIL (See other side)

☆ GPO : 1972 O - 460-743

Nevada State Board of Medical
Examiners
Carson City, Nevada 89701

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KPB:mas

STATE ACCIDENT INSURANCE FUND

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DISTRICT OFFICES

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523-6342

BEAVERTON
644-3118

BEND
382-0322

CORVALLIS
754-1224

EUGENE
686-7652

KLAMATH FALLS
882-4454

MEDFORD
779-1441

MILWAUKIE
777-0242

NORTH BEND
756-3118

PENDLETON
276-4130

PORTLAND Metropolitan
229-5881

PORTLAND Northeast
287-4308

ROSEBURG
672-6541 ext. 240

SALEM
378-3411

THE DALLES
296-9173

September 24, 1975

K. Paul Blanker, ND
250 Bush Street
Central Point, OR 97501

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Sincerely,

T. R. Mueller, Supervisor
Initial Claims Processing

TRM:WW

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Nevada State Board of Medical Examiners

AIRPORT CENTER BUILDING
1281 Terminal Way, Suite 211 • Reno, Nevada 89502 • (702) 329-2559

August 27, 1975

Kenneth P. Blanker, N.D.
P. O. Box 588
Long Beach, California 90801

Dear Dr. Blanker:

There is no provision in Nevada Law for licensure or certification of Naturopathic Physicians.

Sincerely,

Mrs. Evelyn Hilsabeck

868

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
2025 Zonal Avenue
Los Angeles, California 90033

Office of the Associate Dean
For Postgraduate Affairs

This is to certify that K. P. BLANKER, M.D.

has attended the USC School of Medicine postgraduate course
BEDSIDE CLINICS IN INTERNAL MEDICINE

(Thursdays Evenings)

held on September 26 to December 19, 1974

This course consists of 24 *hours of CMA and AAGP credit.*

Phil R. Manning, M.D.
Associate Dean
Postgraduate Medical Education

1/27/75 jf

INSTITUTO POLITECNICO NACIONAL

ESCUELA NACIONAL DE MEDICINA HOMEOPATICA

ESCUELA INTERNACIONAL DE HOMEOPATIA

869

Otorga el Presente

Diploma

A DR. KENNETH P. BLANKER

Por su asistencia al Primer Curso Introductorio de Homeopatia.

Ciudad de México, Abril de 1976.

El Director de la E. N. M. H.
y E. I. H.

[redacted] José Luis Romero E.

Profesor Titular del Cur

Dr. Robe[redacted]endiola

870

Certificate of Proficiency in the Basic Sciences

issued by the

Board of Examiners in the Basic Sciences of the State of Nevada

Certificate by Reciprocity

No. 1489 Date May 29, 1968

THIS IS TO CERTIFY THAT John L. Minasian,

residing at Studio City, California, aged 38 years,

has presented satisfactory evidence of passing an examination in Anatomy, Bacteriology, Chemistry, Pathology, and Physiology, given by the Board of Examiners in the Basic Sciences of the State of New Mexico.

R. O. Brown
Chairman

Lowell L. Jones
Secretary-Treasurer

Address of Board: P. O. Box 8355, Reno, Nevada 89507

128

LICENSE

No. 342

State of Oregon
Naturopathic Board of Examiners

This Is to Certify, *That* John Minasian

having been duly examined and found qualified by the Board, as provided in ORS 685.010 to 685.990 inclusive, is hereby granted this license to practice Naturopathic Medicine in the State of Oregon in accordance with and subject to the provisions of said law.

In Witness Whereof, *The Naturopathic Board of Examiners has caused the Seal of the Board and their signatures to be affixed this* 15th *day of* June, 1974.

Lyford D. Clough, M.D.
President

Joseph A. Bombaugh, N.D.
Member

John W. Noble, M.D.
Secretary

This license must be renewed December 31 of each year.

UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

UNIVERSITY EXTENSION
DEPARTMENT OF CONTINUING EDUCATION
IN HEALTH SCIENCES

P. O. BOX 24902
LOS ANGELES, CALIFORNIA 90024
TELEPHONE (213) 825-7241

TO WHOM IT MAY CONCERN:

John Minasian, M.D.

4029 Goodland Avenue

Studio City, CA 91604

attended The Third Annual Joint UCLA-Santa Monica Hospital Medical Center Family Practice Refresher Course

on August 18-22, 1976

at Neuropsychiatric Institute Auditorium, UCLA

Hours of credit provided were 42½

Martin D. Shickman, MD

Martin D. Shickman, M.D.
Director

MDS/mn

June 19, 1975

To Whom It May Concern

Dear Sir:

Dr. John Leon Minasian presently is a Clinical Instructor in the Department of Anatomy, and has been for the past 2 years. In this capacity he instructs first year pre-doctoral dental students in the Human Gross Anatomy Laboratory. He is also occasionally responsible for special dissections, presenting demonstrations and preparing laboratory examinations. He is competent in these duties and has excellent rapport with our students.

Sincerely,

McCormick Templeton

McCormick Templeton, Ph.D.
Associate Professor
Chairman (Acting)
Department of Anatomy

MT/md

cc John Leon Minasian

UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF DENTISTRY 925 WEST THIRTY-FOURTH STREET, LOS ANGELES, CALIFORNIA 90007

EILEEN AND KENNETH T. NORRIS DENTAL SCIENCE CENTER

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF DENTISTRY
Certification of Enrollment and Attendance

JOHN MINASIAN, M.D.

		Clock hours
Course	ACUPUNCTURE	
Instructor(s)	HARRY QUINT, JR., D.D.S.	14
Date	FEBRUARY 21, 22, 1976	

Richard C. Oliver
Dean

Howard M. Willis
Division of Continuing Education *Director*

874

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
2025 Zonal Avenue
Los Angeles, California 90033

Office of the Associate Dean
For Postgraduate Affairs

This is to certify that JOHN MINASIAN, M.D.

has attended the USC School of Medicine postgraduate course

SURGICAL ANATOMY AND SURGERY

(Tuesday Evenings - Six Sessions)

held on October 26 thru November 30, 1976

This course consists of 12 *hours of CMA and AAGP credit,* of which the above attended 6 hours - Oct. 26, Nov. 9 & 16, 1976.

Phil R. Manning, M.D.
Associate Dean
Postgraduate Medical Education

875

1/21/77 jf

Signature

License No. 29

Arizona

Naturopathic Physicians State Board Exa

THIS IS TO CERTIFY THAT John F. Statham has paid the $20.00 License Renewal Fee required by Sec 105, Session Laws of 1935, regulating the practice of Na and all branches thereof, and is legally entitled to pract until December 31, 19 77

Issued at Phoenix, Arizona, this 27 January 19 77

(SEAL)

By _____ Sec'y-Tr

STATE OF FLORIDA

Department of Professional And Occupational Reg

BOARD OF NATUROPATHIC EXAMIN

STATHAM, JOHN F

NATUROPATH

HAS PAID THE FEE REQUIRED BY CHAPTER

FOR THE YEAR EXPIRING MAY 1, 1977

SIGNATURE

GOVERNOR

PLEASE READ IMPORTANT INFORMATION ON REVERSE

SECRETARY OF AND OCCUPATION

WALLET CARD — FOLD HERE

BOARD OF NATUROPATHIC EXAMINERS

315 SOUTH CALHOUN STREET SUI

TALLAHASSEE, FL 32301

AUDIT CONTROL NO.	FILE NO.	BATCH NO.	FE
055984	NA0000555	003	

BOARD OF EXAMINERS IN THE BASIC SCIENCES

State of Florida

No. 6271

Certificate

OF PROFICIENCY IN THE BASIC SCIENCES

ISSUED TO

JOHN F. STATHAM

UNDER THE PROVISIONS OF CHAPTER 19281 OF THE LAWS OF FLORIDA 1939

BOARD OF EXAMINERS
IN THE BASIC SCIENCES

P. A. Vidal
Chairman

Secretary

THIS CERTIFICATE IS NOT A LICENSE AND DOES NOT ENTITLE THE HOLDER TO PRACTICE THE HEALING ART

EXECUTIVE DEPARTMENT

STATE OF FLORIDA

IN THE NAME AND BY THE AUTHORITY OF THE

STATE OF FLORIDA

Whereas, JOHN F. STATHAM

hath been duly appointed by the Governor according to the Constitution and Laws of said State to be MEMBER OF THE STATE BOARD OF NATUROPATHIC EXAMINERS FOR A TERM BEGINNING ON THE EIGHTH DAY OF JULY, A. D., 1976 UNTIL THE FIFTEENTH DAY OF JULY, A. D. 1979.

Now, Therefore, Reposing especial trust and confidence in the loyalty, patriotism, fidelity and prudence of the said

JOHN F. STATHAM

I, Reubin O'D. Askew, Governor of the State of Florida, do and by virtue of the authority vested in me by the Constitution and Laws of the said State, Do Hereby Commission the said JOHN F. STATHAM *to be such* MEMBER *according to the Constitution and Laws of said State for the term aforesaid. In the Name of the People of the State of Florida, and to have, hold and exercise the said office, and all the powers appertaining thereto, and to fulfill the duties thereof and to receive the profits thereof in accordance with the requirements*

RULES
OF
THE FLORIDA STATE BOARD
OF
NATUROPATHIC EXAMINERS

CHAPTER 21N-1
EDUCATION

21N-1.01 Annual Educational Requirements.

(1) Each license holder under Chapter 462, Florida Statutes, except as otherwise provided, shall be required to attend an educational program in the twelve months as a prerequisite to annual renewal of licenses to practice Naturopathy in this State. Such educational programs may be conducted by the board, the Florida Naturopathic Physicians Association, Inc., or any equivalent program duly approved by the Board as a substitute therefor as provided in Section 462.18, Florida Statutes, shall be submitted to the Board annually at least twenty days prior to he scheduled date of said program. The said submission shall show the subject matter of the educational program, the duration of each lecture or demonstration.

(2) The educational program shall consist of no less than a two-day educational program which program shall include a series of lectures or visual demonstrations, of no less than four hours duration for each of the two days, or a total of at least eight hours for the entire two-day educational program.

(3) The series of lectures or visual demonstrations required by the provisions of section 1 of this rule shall be based upon selections from at least three of the fields of Naturopathic Medicine:

(a) Internal Medicine.
(b) Diagnosis.
(c) Therapeutics.
(1) Narcotics (federal laws).
(2) Legend Drugs.
(3) New Medications.
(4) Physical Therapy.
(d) Public Health.

General Authority 462.04 FS. Law Implemented 462.18 FS. History—Amended 5-25-66.

21N-1.02 Exceptions.

(1) The board shall have the authority to excuse licensees, as a group or as individuals, from the annual educational requirements in any of the following instances:

(a) When no educational program meeting the requirements approved by the board is conducted within this state.

(b) The submission of sufficient statements to the board that the licensee, for good cause, was prevented from attending an educational program at the proper time and evidence that the licensee had paid the fee for such education program as provided in Section 462.18(3), Florida Statutes.

(c) In the event of an unsual emergency.

(d) For other good and sufficient reason.

General Authority 462.04 FS. Law Implemented 462.18 FS. History—New 5-25-66.

Miles Zurzick
Exhibit H-2

Amend S.B. 250 as follows: Add Section 16 to read as follows:

Sec. 16 N.R.S. 689A.380 is hereby amended to read as follows:

689A.380 Definitions of terms used in policies. As used in any policy of health insurance delivered, issued for delivery or used in this state, unless otherwise provided in the policy or in an endorsement thereon or in a rider attached thereto:

1. "Accidental death" means death by accident exclusively and independently of all other causes.

2. "Confinement to house" or "house confinement" includes the activities of a convalescent not able to be gainfully employed.

3. "Medical or surgical services" includes also services within the scope of his license rendered by any individual while duly licensed by the State of Nevada under any of the following chapters of NRS: 631 (dentistry); 633 (osteopathy); 634 (chiropractic); 634A (Oriental medicine); 635 (podiatry); or 636 (optometry). No policy of health insurance shall exclude coverage for services of any licensee provided for in this subsection.

4. "Total disability" means inability to perform the duties of any gainful occupation for which the insured is reasonably fitted by training, experience and accomplishment.

(Added to NRS by 1971, 1766; A 1971, 1953; 1975, 240)

; naturopathy. No policy of health insurance shall deny any insured the free choice of any licensee provided for in this subsection to perform any medical or surgical service covered by the policy which such licensee is entitled by his license to perform.

SB182
3-9-77

Nevada Nurses' Association

Submitted
15 Mar. 77

750 East 2nd Street • Reno, Nevada 89502 (702) 329-3555
3660 Baker Lane Reno, Nevada 89509 (702) 825-3555

TESTIMONY

SB182 - Mandatory Insurance Coverage for Alcoholism and Drug Abuse.

I am Ann Hibbs, representing the Nevada Nurses' Association.

Since all major health care organizations recognize alcoholism as an illness and the third most serious disease in the United States today, the Nevada Nurses' Association wishes to go on record as supporting this Bill SB182.

AMH:jlz
3/14/77

Exhibit O

HENRY STEWART, M. D.

923 MOUNTAIN STREET — CARSON CITY, NEVADA 89701

PHONE 882-3441

FOR Ken Blanker DATE 3-9-77

ADDRESS 174 Emerson Way Sparks

℞

Combid # 20

T 9 6 #

177951

380

LABEL
REFILL ____ TIMES
NON REPETATUR ☐
BNDD NO. ASO 255112

John J Statham MD M.D. 3/9

Dea - Alaska ab

HENRY STEWART, M. D.

923 MOUNTAIN STREET — CARSON CITY, NEVADA 89701

PHONE 882-3441

FOR DR. Ken Blanker DATE 3-9-77

ADDRESS 174 Emerson Way Sparks

℞

Tomofil # 30

Sig: 1 at bed

177952

360

LABEL
REFILL ____ TIMES
NON REPETATUR ☐
BNDD NO. ASO 255112

John J Statham MD M.D. 3/9

A7007488/