

# Return to State of the Union Report

## Alcohol Use

Information Retrieved from AI - To Be Verified

Section 1: Top 35 Countries with Lowest Alcohol Use .....	2
Section 2: What Other Countries Have Done to Lower Alcohol Use .....	5
Section 3: What the U.S. Can Do to Reduce Alcohol Use .....	11
Section 3: What the U.S. Can Do to Decrease Its Alcohol Use.....	12
Section 4: References.....	14
Section 5: Draft of a House Bill.....	16

## Section 1: Top 35 Countries with Lowest Alcohol Use

Rank	Country	Lowest Alcohol Use (%)
1	Indonesia	3%
2	پاکستان (Pakistan)	3%
3	বাংলাদেশ (Bangladesh)	3%
4	مصر Misr (Egypt)	4%
5	ایران (Iran)	4%
6	Türkiye (Turkey)	5%
7	المغرب Al-Maghrib (Morocco)	5%
8	الجزائر Al-Jaza'ir (Algeria)	5%
9	السعودية Al-Su'ūdiyya (Saudi Arabia)	1%
10	العراق Al-'Iraq (Iraq)	3%
11	O'zbekiston O'zbekiston (Uzbekistan)	6%
12	Malaysia	6%
13	السودان As-Sudan (Sudan)	2%
14	اليمن Al-Yaman (Yemen)	1%
15	الأردن Al-Urdunn (Jordan)	5%
16	سوريا Suriyya (Syria)	4%
17	تونس Tūnis (Tunisia)	6%
18	ليبيا Libiyā (Libya)	2%
19	नेपाल (Nepal)	7%
20	ශ්‍රී ලංකා (Sri Lanka)	7%
21	Pilipinas (Philippines)	8%
22	भारत Bharat (India)	8%
23	ประเทศไทย Prathet Thai (Thailand)	9%
24	Việt Nam (Vietnam)	9%
25	中国 Zhongguo (China)	10%
26	Nigeria	8%

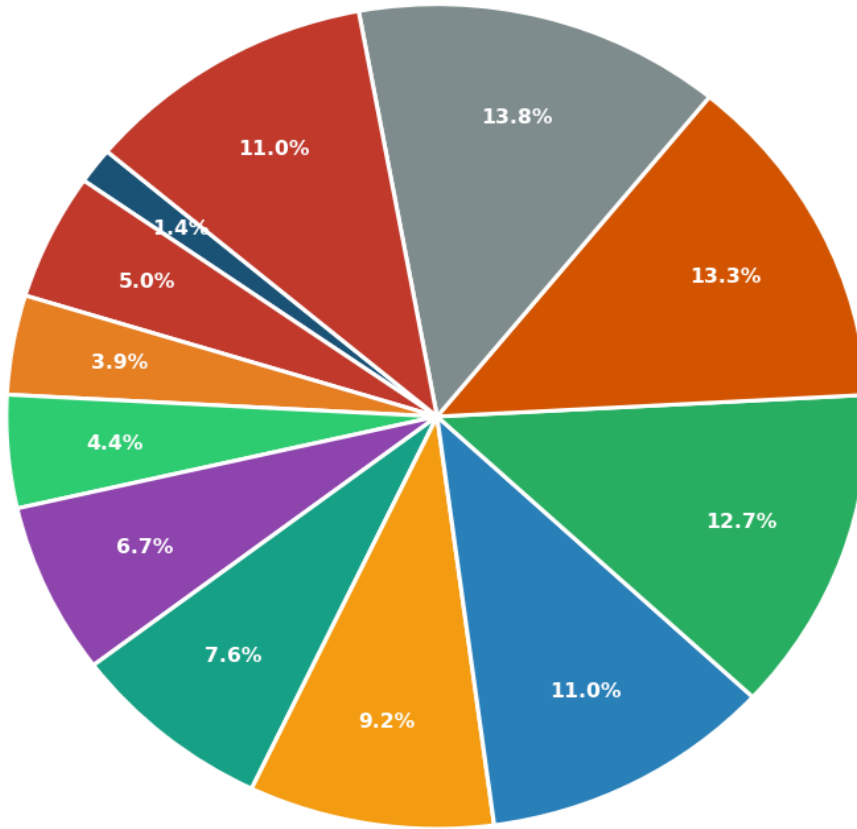
27	ኢትዮጵያ Ityop'iya (Ethiopia)	7%
28	Kenya	9%
29	Tanzania	8%
30	Ghana	8%
31	မြန်မာ Myanmar (Myanmar)	7%
32	افغانستان (Afghanistan)	1%
33	កម្ពុជា Kampuchea (Cambodia)	9%
34	Perú	10%
35	Colombia	10%
—	<b>United States</b>	~62% (Not in Top 35)

Source data year: 2023 international survey estimates compiled from Gallup World Poll and international public health alcohol consumption datasets.

The United States does not appear among the countries with the lowest alcohol use because alcohol consumption is relatively common in the population. Recent national surveys indicate roughly 60-65 percent of American adults report consuming alcohol in the past year. Cultural acceptance of drinking, large alcohol retail availability, and extensive alcohol marketing contribute to higher consumption compared to countries with religious, legal, or strict regulatory restrictions.

Sources: Gallup World Poll <https://www.gallup.com> | World Health Organization Global Health Observatory <https://www.who.int/data/gho> | Institute for Health Metrics and Evaluation <https://www.healthdata.org>

## Alcohol Use by World Region (Estimated % of Population that Drinks)



Regions		
Middle East (8%)	Central America (38%)	Australia & Other (72%)
China (28%)	South America (43%)	Western Europe (Excl. Russia) (75%)
Asia (Excl. China) (22%)	Mexico (52%)	Canada (78%)
Africa (25%)	Russia (62%)	United States (62%)

## **Section 2: What Other Countries Have Done to Lower Alcohol Use**

### **Indonesia**

Indonesia maintains one of the strictest alcohol retail regulatory systems in Southeast Asia.

The Ministry of Trade regulates importation, distribution, and licensing of alcoholic beverages. Retail alcohol sales are restricted in many convenience stores and supermarkets under regulations implemented in 2015 and expanded by local governments.

The Ministry of Health coordinates national prevention campaigns through public hospitals and community clinics.

Local governments such as those in Jakarta and West Java impose zoning laws restricting alcohol sales near schools, religious institutions, and residential communities.

Enforcement activities are conducted jointly by municipal police units and the Indonesian National Police.

Religious organizations and community groups often cooperate with public health officials to conduct education programs discouraging alcohol consumption.

Government agencies involved include the Ministry of Health <https://www.kemkes.go.id> and the Ministry of Trade <https://www.kemendag.go.id>.

### **پاکستان (Pakistan)**

Pakistan enforces one of the world's strictest alcohol prohibition regimes under the Prohibition (Enforcement of Hadd) Order 1979, which makes alcohol consumption illegal for Muslims (who comprise approximately 97% of the population). Non-Muslims may obtain permits through the Excise and Taxation Departments of provincial governments.

Alcohol regulation is administered by provincial governments with enforcement support from the Ministry of Interior and provincial police authorities. Limited licenses are issued for non-Muslim communities and certain hotels, but distribution is tightly controlled.

Public health campaigns coordinated by the Ministry of National Health Services focus on addiction prevention and rehabilitation services. Religious institutions and community

organizations actively support education campaigns emphasizing the social and health consequences of alcohol misuse.

Government organizations include the Ministry of Interior <https://www.interior.gov.pk> and the Ministry of National Health Services <https://www.nhsrc.gov.pk>.

The Federal Excise Department (<https://www.fbr.gov.pk>) maintains oversight of any licensed production facilities, which are extremely limited. Penalties for illegal production, sale, or consumption include fines, imprisonment, and public flogging for Muslims under Sharia law.

The Pakistan Narcotics Control Board ([www.pncb.gov.pk](http://www.pncb.gov.pk)) coordinates anti-narcotics campaigns that include alcohol. Cultural stigma associated with alcohol use is reinforced through education, religious messaging in mosques, and community policing.

### **বাংলাদেশ (Bangladesh)**

Bangladesh has adopted a combination of licensing restrictions, public education programs, and treatment services to limit alcohol consumption. The Department of Narcotics Control oversees licensing of alcohol production and sales and enforces strict restrictions on distribution.

Alcohol production, sale, and public consumption are strictly regulated by the Prohibition Act 1950, which prohibits alcohol for Muslims and requires non-Muslims to obtain government permits to purchase or consume alcohol

The Ministry of Health and Family Welfare coordinates addiction treatment programs and public education initiatives designed to discourage alcohol misuse. Hospitals and community clinics provide counseling services for individuals experiencing alcohol dependency.

Organizations include the Department of Narcotics Control <https://dnc.gov.bd> and the Ministry of Health and Family Welfare <https://www.mohfw.gov.bd>.

The Bangladesh government, through the Ministry of Home Affairs and the Excise and Taxation Department, enforces licensing of all alcohol outlets and bans advertising of alcoholic beverages.

The National Narcotic Control Board (NNCB) ([www.narcotics.gov.bd](http://www.narcotics.gov.bd)) coordinates enforcement actions against illegal production and distribution of country liquor.

Religious institutions and community-based organizations reinforce social norms against consumption.

The combined effect of legal restrictions, religious prohibition, and social enforcement has maintained consumption near zero.

### **Misr (Egypt)**

Misr does not impose a total prohibition on alcohol, but it maintains a set of regulatory and tax measures that keep consumption among the lowest in the world.

The government, through the Misr Tax Authority ([www.eta.gov.eg](http://www.eta.gov.eg)), imposes high excise taxes on alcoholic beverages. Sales are restricted to licensed outlets, hotels, and tourist facilities, and the Ministry of Interior ([www.moiegypt.gov.eg](http://www.moiegypt.gov.eg)) enforces licensing requirements.

Advertising of alcohol is banned on public media under the Misr Radio and Television Union regulations.

Misr regulates alcohol production and retail through licensing systems administered by the Ministry of Tourism and Antiquities and the Ministry of Health.

Alcohol advertising is restricted in many media platforms and taxation policies increase the price of alcoholic beverages.

Public awareness campaigns emphasize the risks associated with alcohol use, including traffic accidents and chronic disease.

Medical treatment programs are offered through public hospitals and rehabilitation centers supported by the government.

Relevant organizations include the Ministry of Health and Population <https://www.mohp.gov.eg>.

The Ministry of Education incorporates anti-drug and anti-alcohol messages into the school curriculum.

Religious institutions, predominantly Islamic, play a significant role in discouraging consumption.

The Misr Food Drug Authority ([www.eda.gov.eg](http://www.eda.gov.eg)) monitors the quality and legal distribution of alcoholic products.

## **ایران (Iran)**

Iran enforces a nationwide prohibition on alcohol under national law. Enforcement is conducted by national law enforcement authorities and border control agencies to prevent alcohol importation and illegal production.

The Ministry of Health and Medical Education operates prevention programs and substance abuse treatment centers that provide medical care and rehabilitation services for individuals affected by alcohol misuse.

Agency website <https://behdasht.gov.ir>.

## **Al-Su'ūdiyya (Saudi Arabia)**

Al-Su'ūdiyya prohibits alcohol nationwide under national law. Enforcement is conducted by the Ministry of Interior and border control agencies. Strict penalties discourage illegal importation or distribution. The Presidency of State Security and the Commission for the Promotion of Virtue and the Prevention of Vice (formerly known as the religious police, now reformed as the General Presidency for the Promotion of Virtue and the Prevention of Vice) ([www.cpc.gov.sa](http://www.cpc.gov.sa)) conduct enforcement.

Public health programs emphasize substance abuse prevention and family support services. Educational campaigns in schools highlight the health and legal consequences of alcohol use.

Government agencies include the Ministry of Interior <https://www.moi.gov.sa> and the Ministry of Health <https://www.moh.gov.sa>.

The Ministry of Health ([www.moh.gov.sa](http://www.moh.gov.sa)) coordinates public health campaigns highlighting the dangers of alcohol abuse.

Alcohol smuggling is addressed by Saudi Customs ([www.zatca.gov.sa](http://www.zatca.gov.sa)).

Under Al-Su'ūdiyya's Vision 2030 initiative, some cultural venues have been developed, but alcohol remains strictly prohibited. Penalties include imprisonment, deportation for expatriates, and lashes. Religious institutions reinforce prohibitions through education and community outreach.

## **Malaysia**

Malaysia uses taxation policies and licensing restrictions to regulate alcohol consumption. The Ministry of Finance imposes excise taxes that increase alcohol prices while the Ministry of Health conducts public health campaigns.

Local governments regulate alcohol retail hours and advertising restrictions. Community outreach programs educate the public about alcohol-related disease and encourage responsible behavior.

Relevant agencies include the Ministry of Health <https://www.moh.gov.my>.

### **Bharat (India)**

Bharat regulates alcohol primarily at the state level. Some states including Gujarat and Bihar maintain prohibition policies while others implement high excise taxes and strict licensing rules.

State excise departments monitor alcohol production and sales while the Ministry of Health and Family Welfare supports treatment and prevention programs. Public awareness campaigns address alcohol-related disease and road safety risks.

Agency website <https://www.mohfw.gov.in>.

### **Other Countries that Lowered Alcohol Consumption**

#### **Al-Kuwayt (Kuwait)**

Al-Kuwayt maintains a complete prohibition on the sale, import, and public consumption of alcohol for all residents and citizens under Law No. 21 of 1964. This prohibition is enforced by the Ministry of Interior ([www.moi.gov.kw](http://www.moi.gov.kw)) and the Al-Kuwayt Public Prosecution, with offenders subject to fines and imprisonment.

There are no licensed premises for alcohol sales, and the Customs Authority actively prevents smuggling at borders and ports.

The Al-Kuwayt Alcohol Prohibition Law applies to all nationalities residing in Al-Kuwayt, including expatriates.

Anti-alcohol messaging is integrated into the national education curriculum and supported by religious authorities through the Ministry of Awqaf and Islamic Affairs ([www.awqaf.gov.kw](http://www.awqaf.gov.kw)). Private possession and consumption carry criminal penalties.

#### **Lībiyā (Libya)**

Lībiyā enacted a total prohibition on alcohol in 1969 following the revolution led by Colonel Muammar Gaddafi.

The Libyan Prohibition Law bans the production, sale, and consumption of alcohol by all residents. The Ministry of Interior and local police forces enforce the prohibition. Violators face

imprisonment and fines. Despite ongoing political instability, alcohol prohibition has remained one of the few consistently enforced laws in Lībiyā.

Social and religious norms among the predominantly Muslim population (approximately 97%) provide a strong cultural foundation for the legal prohibition. International organizations such as the United Nations Support Mission in Lībiyā (UNSMIL) ([www.unsmil.unmissions.org](http://www.unsmil.unmissions.org)) do not engage in alcohol regulation, though general governance

## **Indonesia**

Indonesia regulates alcohol through Government Regulation No. 74 of 2013 and Ministerial Regulation No. 06/M-Dag/Per/1/2015, which restricts alcohol sales to licensed supermarkets, hotels, and restaurants; bans retail alcohol sales in minimarkets and convenience stores; and classifies alcohol into three categories based on alcohol content, with category C (above 20%) subject to the strictest controls.

The National Agency of Drug and Food Control (BPOM) ([www.pom.go.id](http://www.pom.go.id)) oversees licensing and product quality.

Several provinces have enacted regional alcohol prohibition ordinances (Perda) under regional autonomy.

The Ministry of Health ([www.kemkes.go.id](http://www.kemkes.go.id)) conducts public awareness campaigns. Aceh Province enforces Sharia law and maintains total prohibition.

Religious organizations, including Nahdlatul Ulama ([www.nu.or.id](http://www.nu.or.id)) and Muhammadiyah ([www.muhammadiyah.or.id](http://www.muhammadiyah.or.id)), the two largest Islamic organizations in the world, advocate for abstinence and have lobbied for stricter national regulations.

## **Al-Maghrib (Morocco)**

Al-Maghrib permits alcohol consumption but restricts it through taxation, licensing, and social regulation.

The Ministry of Interior ([www.interieur.gov.ma](http://www.interieur.gov.ma)) regulates licensing of establishments that sell alcohol, limiting sales to licensed hotels, restaurants, nightclubs, and specialized stores.

Advertising alcohol on public billboards and television is prohibited by the High Authority of Audiovisual Communication (HACA) ([www.haca.ma](http://www.haca.ma)).

The Office National des Aéroports and Al-Maghrib Customs monitor importation.

Islamic values hold significant social influence, with religious messaging from the Ministry of Endowments and Islamic Affairs ([www.habous.gov.ma](http://www.habous.gov.ma)) reinforcing abstinence norms.

High taxes on alcohol are administered through the Directorate General of Taxes ([www.tax.gov.ma](http://www.tax.gov.ma)).

The National Center for Addiction Prevention and Treatment ([www.cnsmd.ma](http://www.cnsmd.ma)) coordinates prevention and treatment programs, particularly for youth.

### **Section 3: What the U.S. Can Do to Reduce Alcohol Use**

1. Increasing federal alcohol excise taxes to reduce affordability of alcoholic beverages.
2. Establishing minimum unit pricing policies for alcohol products.
3. Restricting alcohol advertising on television, streaming services, and social media platforms.
4. Expanding national alcohol education campaigns led by the CDC.
5. Requiring health warning labels on alcoholic beverage containers.
6. Limiting alcohol retail outlet density through zoning regulations.
7. Expanding screening and early intervention programs in hospitals.
8. Increasing funding for addiction treatment services.
9. Developing school-based alcohol prevention education programs.
10. Encouraging workplace alcohol prevention initiatives.
11. Strengthening drunk driving enforcement programs.
12. Expanding sobriety checkpoint programs nationwide.
13. Funding research through the National Institute on Alcohol Abuse and Alcoholism.
14. Regulating alcohol marketing is directed toward young adults.
15. Providing grants to states implementing alcohol reduction policies.
16. Encouraging community coalitions focused on substance abuse prevention.
17. Expanding alcohol-free recreational programs for youth.
18. Supporting mental health services that reduce substance abuse risk.
19. Developing alcohol misuse surveillance systems for public health monitoring.

20. Encouraging insurance coverage for addiction treatment.
21. Regulating online alcohol sales and delivery services.
22. Strengthening enforcement of minimum drinking age laws.
23. Reducing alcohol availability in high-risk communities.
24. Supporting rehabilitation programs for individuals with alcohol dependency.
25. Funding community education campaigns about alcohol-related disease.
26. Encouraging partnerships between public health agencies and nonprofit organizations.
27. Developing public transportation options that reduce impaired driving risks.
28. Creating tax incentives for companies promoting alcohol-free workplace programs.
29. Improving data collection on alcohol consumption patterns.
30. Supporting university alcohol prevention initiatives.

### **Section 3: What the U.S. Can Do to Decrease Its Alcohol Use**

The United States faces a significant public health challenge related to alcohol use. Approximately 95,000 people die from alcohol-related causes annually, making alcohol the third leading preventable cause of death in the country. Addressing this challenge requires a coordinated, multi-sector approach involving government agencies at all levels, elected officials, corporations, healthcare providers, educational institutions, and private citizens.

#### **Federal Government Agencies**

##### **The Substance Abuse and Mental Health Services Administration (SAMHSA)**

([www.samhsa.gov](http://www.samhsa.gov)) should increase funding for state and community alcohol prevention grants, expand access to evidence-based treatment programs, and develop national awareness campaigns targeting high-risk populations including young adults, veterans, and pregnant women. SAMHSA should mandate that states receiving federal behavioral health funding implement evidence-based prevention programs in schools, workplaces, and communities.

**The National Institute on Alcohol Abuse and Alcoholism (NIAAA)** ([www.niaaa.nih.gov](http://www.niaaa.nih.gov)) should expand research funding for alcohol use disorder treatments, including medication-assisted treatment with naltrexone, acamprosate, and disulfiram. NIAAA should partner with universities and hospitals to disseminate findings directly into clinical practice guidelines and train healthcare providers in identifying and treating alcohol use disorder.

**The Centers for Disease Control and Prevention (CDC)** ([www.cdc.gov](http://www.cdc.gov)) should expand its community preventive services task force recommendations for effective alcohol policies, including minimum legal drinking age enforcement, sobriety checkpoints, and alcohol outlet density restrictions. The CDC should publish annual state-by-state alcohol use reports to drive policy accountability. The CDC should also expand partnerships with state health departments to implement evidence-based community interventions.

**The Food and Drug Administration (FDA)** ([www.fda.gov](http://www.fda.gov)) should require larger and more prominent health warning labels on all alcoholic beverages, including information about cancer risk, fetal alcohol syndrome, and risk of dependence. The FDA should update warning labels to reflect current scientific evidence, which shows links between alcohol and seven types of cancer.

**The Federal Trade Commission (FTC)** ([www.ftc.gov](http://www.ftc.gov)) should strengthen restrictions on alcohol advertising to prevent marketing targeted at minors, including digital and social media platforms. The FTC should require that all alcohol advertisements include prominent health warnings and prohibit advertising in media where a significant portion of the audience is below legal drinking age.

**The Department of Education** ([www.ed.gov](http://www.ed.gov)) should require all federally funded schools and universities to implement evidence-based alcohol prevention curricula. Institutions of higher education should be required to report alcohol-related incidents and implement SAMHSA-approved prevention programs as a condition of receiving federal financial aid funds.

**The Department of Defense** ([www.defense.gov](http://www.defense.gov)) and the Department of Veterans Affairs (VA) ([www.va.gov](http://www.va.gov)) should expand screening for alcohol use disorder among active-duty military and veterans, increase access to treatment programs, and address the culture of drinking prevalent in military communities through structured prevention programs.

### **Government Officials**

Members of Congress should pass legislation increasing the federal excise tax on alcoholic beverages and indexing it to inflation. Federal excise taxes on alcohol have not been meaningfully adjusted since 1991, and evidence demonstrates that price increases are among the most effective interventions to reduce consumption. Legislators should also support mandatory health warning updates on alcohol product labeling.

**State governors and legislators** should enact laws restricting the density of alcohol retail outlets, particularly in communities with high rates of alcohol-related harm. Governors should direct state departments of health to integrate alcohol use disorder treatment into Medicaid programs and expand coverage for brief intervention services in primary care settings.

**Local elected officials** including mayors and city councils should implement zoning regulations that limit the proximity of alcohol outlets to schools, churches, and residential neighborhoods. Local officials should fund community coalitions that bring together law enforcement, educators, healthcare providers, and community members to address alcohol-related issues.

**The U.S. Surgeon General** should issue a comprehensive advisory on alcohol and cancer risk, modeled on the 1964 advisory on tobacco and cancer. A Surgeon General advisory would significantly raise public awareness of alcohol's carcinogenic properties and catalyze changes in public behavior, healthcare provider practices, and legislative action.

### **Corporations**

**Alcohol manufacturers and distributors** should voluntarily adopt and adhere to responsible advertising standards that go beyond current FTC requirements, committing to not target advertising at individuals under 25 years of age and to include prominent health warnings on all digital, print, and broadcast advertisements. Industry groups such as the Beer Institute ([www.beerinstitute.org](http://www.beerinstitute.org)) and the Distilled Spirits Council ([www.distilledspirits.org](http://www.distilledspirits.org)) should support and fund independent research on alcohol use disorder and prevention.

**Retail corporations, including supermarkets,** convenience stores, and e-commerce platforms, should implement age verification systems that exceed minimum legal requirements and train all employees in responsible alcohol service. Major retailers should reduce prominent placement of alcohol products, particularly near checkout areas and in displays targeted at young shoppers.

**Employers and corporations** of all sizes should adopt comprehensive workplace alcohol policies that include free and confidential employee assistance programs (EAPs), paid leave for alcohol use disorder treatment, and clear policies prohibiting alcohol at workplace events. Large employers should partner with health insurers to ensure that alcohol use disorder treatment is fully covered under employee health plans.

**Technology companies including social media platforms such as Meta** ([www.meta.com](http://www.meta.com)), Alphabet/Google ([www.alphabet.com](http://www.alphabet.com)), and X Corp ([www.x.com](http://www.x.com)) should implement stronger enforcement of minimum age requirements for alcohol advertising, prohibit targeting of alcohol advertisements based on user behavioral data indicating vulnerability to substance use, and remove promotional content for alcohol from youth-oriented platforms.

#### **Private Citizens and Community Organizations**

**Individuals** should be encouraged through public health campaigns to screen themselves using validated tools such as the AUDIT (Alcohol Use Disorders Identification Test), available through the NIAAA, and to seek help from healthcare providers when their alcohol use exceeds recommended guidelines. Communities of faith, civic organizations, and neighborhood associations should host alcohol-free community events and support local members seeking treatment.

**Parents** should be educated through school systems and pediatric healthcare providers about the increased risk of alcohol use disorder among children who begin drinking before age 15 and should be given tools to communicate effectively with their children about alcohol.

**Organizations** such as Mothers Against Drunk Driving (MADD) ([www.madd.org](http://www.madd.org)) and the National Council on Alcoholism and Drug Dependence (NCADD) ([www.ncadd.org](http://www.ncadd.org)) should expand their community outreach and prevention programs.

Healthcare providers, including primary care physicians, nurses, and pharmacists, should routinely screen patients for alcohol use disorder using the AUDIT-C or SBIRT (Screening, Brief Intervention, and Referral to Treatment) protocols and provide brief counseling. Professional organizations including the American Medical Association (AMA) ([www.ama-assn.org](http://www.ama-assn.org)) and the American Academy of Family Physicians (AAFP) ([www.aafp.org](http://www.aafp.org)) should update clinical practice guidelines and training programs to reflect the latest evidence.

#### **Section 4: References**

World Health Organization <https://www.who.int>

Gallup World Poll <https://www.gallup.com>

Centers for Disease Control and Prevention Alcohol Program <https://www.cdc.gov/alcohol>

National Institute on Alcohol Abuse and Alcoholism <https://www.niaaa.nih.gov>

Institute for Health Metrics and Evaluation <https://www.healthdata.org>

## **Section 2 References:**

World Health Organization – Global Status Report on Alcohol and Health 2019:

<https://www.who.int/publications/i/item/9789240005792>

NIAAA – Alcohol Facts and Statistics: <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics>

Bangladesh National Narcotic Control Board: <https://www.narcotics.gov.bd>

Pakistan Narcotics Control Board: <https://www.pncb.gov.pk>

Kuwait Ministry of Interior: <https://www.moi.gov.kw>

Saudi Arabia General Presidency for Promotion of Virtue: <https://www.cpc.gov.sa>

Egypt Tax Authority: <https://www.eta.gov.eg>

Indonesia BPOM: <https://www.pom.go.id>

Indonesia Nahdlatul Ulama: <https://www.nu.or.id>

Indonesia Muhammadiyah: <https://www.muhammadiyah.or.id>

Morocco High Authority of Audiovisual Communication (HACA): <https://www.haca.ma>

Morocco Ministry of Endowments and Islamic Affairs: <https://www.habous.gov.ma>

## **Section 3 References:**

SAMHSA: <https://www.samhsa.gov>

NIAAA: <https://www.niaaa.nih.gov>

CDC Community Preventive Services: <https://www.thecommunityguide.org>

FDA – Alcohol Labeling: <https://www.fda.gov/food/food-labeling-nutrition/alcohol-labeling>

FTC – Alcohol Advertising: <https://www.ftc.gov/business-guidance/resources/alcohol-report>

U.S. Department of Education: <https://www.ed.gov>

Department of Veterans Affairs – Alcohol Misuse: <https://www.va.gov/health-care/health-needs-conditions/mental-health/alcohol-drug-problems>

Beer Institute: <https://www.beerinstitute.org>

Distilled Spirits Council: <https://www.distilledspirits.org>

MADD – Mothers Against Drunk Driving: <https://www.madd.org>

AMA – Alcohol Policy: <https://www.ama-assn.org/delivering-care/substance-use-treatment/ama-policy-alcohol>

AAFP – Alcohol Screening Guidelines: <https://www.aafp.org/pubs/afp/issues/2018/0601/p680.html>

## **Section 5: Draft of a House Bill**

**118th CONGRESS – 2nd SESSION**

**H.R. \_\_\_\_\_**

### **IN THE HOUSE OF REPRESENTATIVES**

A BILL to decrease alcohol use in the United States through evidence-based public health measures, mandatory labeling reforms, taxation, treatment access, advertising restrictions, and coordinated federal, state, local, corporate, and individual responsibilities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

#### **SHORT TITLE.**

This Act may be cited as the "National Alcohol Use Reduction and Prevention Act of 2024" (NAURPA).

#### **SECTION 1. DEFINITIONS.**

As used in this Act:

- (1) Alcohol Use Disorder – The term 'alcohol use disorder' means a medical condition characterized by an inability to control or stop drinking despite adverse social, occupational, or health consequences, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).
- (2) Alcoholic Beverage – The term 'alcoholic beverage' means any beverage containing 0.5% or more alcohol by volume, including beer, wine, distilled spirits, and malt beverages.
- (3) Binge Drinking – The term 'binge drinking' means a pattern of drinking that brings a person's blood alcohol concentration to 0.08 grams percent or above, typically occurring when men consume 5 or more drinks or women consume 4 or more drinks within approximately 2 hours.
- (4) Brief Intervention – The term 'brief intervention' means a short, structured conversation conducted by a healthcare professional intended to motivate individuals to change their alcohol use behavior.
- (5) Evidence-Based Program – The term 'evidence-based program' means a program, policy, or practice that has been evaluated using experimental or quasi-experimental research and has demonstrated effectiveness in reducing alcohol use or alcohol-related harms.
- (6) Fetal Alcohol Spectrum Disorders – The term 'fetal alcohol spectrum disorders' or 'FASD' means a group of conditions that can occur in a person whose mother drank alcohol during pregnancy, including physical, behavioral, and learning problems.
- (7) Minimum Legal Drinking Age – The term 'minimum legal drinking age' means 21 years of age, as established by the National Minimum Drinking Age Act of 1984 (23 U.S.C. § 158).
- (8) Outlet Density – The term 'outlet density' means the number of licensed establishments authorized to sell alcohol per unit of population or geographic area.
- (9) Secretary – The term 'Secretary' means the Secretary of Health and Human Services, unless otherwise specified.

(10) SBIRT – The term 'SBIRT' means Screening, Brief Intervention, and Referral to Treatment, an evidence-based public health approach to identify and address alcohol misuse in primary care and other healthcare settings.

(11) Underage Drinking – The term 'underage drinking' means the consumption of alcoholic beverages by any person under 21 years of age.

## **SECTION 2. ENACTING CLAUSE.**

(a) PURPOSE. – The purpose of this Act is to reduce alcohol consumption, prevent alcohol use disorders, reduce alcohol-related harms including traffic fatalities, domestic violence, and chronic disease, and expand access to evidence-based prevention and treatment services throughout the United States.

(b) FINDINGS. – Congress finds that:

(1) Approximately 95,000 Americans die from alcohol-related causes each year, making alcohol the third leading preventable cause of death in the United States.

(2) Alcohol use costs the United States approximately \$249 billion annually in lost workplace productivity, healthcare expenditures, criminal justice costs, and motor vehicle crash costs.

(3) Only 7.2 percent of people with alcohol use disorder receive treatment in any given year, representing a significant gap in access to care.

(4) Countries that have implemented evidence-based alcohol policies including minimum unit pricing, advertising restrictions, outlet density controls, and increased excise taxes have demonstrated significant reductions in alcohol-related morbidity and mortality.

(5) The International Agency for Research on Cancer (IARC) has classified alcohol as a Group 1 carcinogen causally linked to cancers of the oral cavity, pharynx, larynx, esophagus, liver, colorectum, and female breast.

## **SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES.**

(a) DEPARTMENT OF HEALTH AND HUMAN SERVICES. –

(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall develop and implement a National Alcohol Reduction Strategy that includes measurable goals, timelines, and interagency coordination mechanisms.

(2) SAMHSA shall increase grants for state and community-based prevention programs by not less than 25 percent annually for 5 fiscal years following enactment.

(3) NIAAA shall expand funding for clinical research on pharmacological and behavioral treatments for alcohol use disorder and disseminate findings through updated clinical practice guidelines.

**(b) FOOD AND DRUG ADMINISTRATION. –**

(1) Not later than 18 months after enactment, the FDA shall promulgate regulations requiring updated health warning labels on all alcoholic beverages sold in the United States.

(2) Updated labels shall include warnings about alcohol's relationship to cancer, fetal alcohol syndrome, dependence, and impairment, in rotating format consistent with international best practices established by WHO member states.

**(c) CENTERS FOR DISEASE CONTROL AND PREVENTION. –**

(1) The CDC shall publish annually a state-by-state Alcohol Use and Harm Report documenting consumption levels, binge drinking rates, alcohol-related mortality, and policy implementation status.

(2) The CDC shall expand its Task Force on Community Preventive Services recommendations on alcohol policy interventions and actively assist states in implementing outlet density restrictions, sobriety checkpoint programs, and SBIRT in healthcare settings.

**(d) FEDERAL TRADE COMMISSION. –**

(1) Not later than 1 year after enactment, the FTC shall promulgate rules prohibiting alcohol advertising on any platform or medium where persons under 21 years of age constitute more than 15 percent of the audience.

(2) All alcohol advertisements in any medium shall include a prominently displayed health warning approved by the Secretary.

**(e) DEPARTMENT OF EDUCATION. –**

(1) All federally funded elementary and secondary schools shall implement evidence-based alcohol prevention curricula beginning in grade 5, consistent with SAMHSA's National Registry of Evidence-based Programs and Practices.

(2) Institutions of higher education receiving federal funds shall adopt comprehensive alcohol management plans including SBIRT implementation, 24-hour counseling access, and enforcement of minimum legal drinking age.

**SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS.**

**(a) FEDERAL OFFICIALS. –**

(1) The President shall designate a Senior Advisor on Alcohol Use Reduction within the Executive Office of the President to coordinate interagency efforts and report annually to Congress on progress toward national alcohol reduction goals.

(2) The U.S. Surgeon General shall issue a comprehensive advisory on alcohol and cancer risk, underage drinking, and alcohol use disorder within 1 year of enactment and shall update such advisory every 5 years.

**(b) STATE AND LOCAL OFFICIALS. –**

(1) States receiving federal substance abuse block grants under subpart II of part B of title XIX of the Public Health Service Act shall certify that they have implemented or are actively implementing—

(A) evidence-based alcohol outlet density restrictions in counties or municipalities with above-average rates of alcohol-related harm;

(B) mandatory SBIRT training for all licensed healthcare providers in the state; and

(C) Medicaid coverage for alcohol use disorder treatment, including medication-assisted treatment, outpatient therapy, and residential treatment.

(2) Governors of all 50 states and the District of Columbia shall designate a state-level Alcohol Use Reduction Coordinator within state departments of health who shall coordinate state activities under this Act and submit annual reports to the Secretary.

**SECTION 5. REQUIREMENTS BY CORPORATIONS.**

**(a) ALCOHOL MANUFACTURERS AND DISTRIBUTORS. –**

(1) All alcohol manufacturers and importers shall comply with updated health warning label requirements as promulgated by the FDA under Section 3(b) of this Act within 24 months of the effective date of such regulations.

(2) Alcohol manufacturers with annual gross revenues exceeding \$10,000,000 shall contribute not less than 0.5 percent of annual domestic advertising expenditures to an independently administered National Alcohol Prevention Fund, overseen by the Secretary.

(3) No alcohol manufacturer, importer, or distributor shall engage in advertising or marketing practices that target individuals under 21 years of age, including the use of animated characters, cartoon figures, celebrity endorsements with primary youth appeal, or social media influencer marketing directed at persons under 21.

**(b) RETAIL ESTABLISHMENTS. –**

(1) All retail establishments licensed to sell alcoholic beverages shall implement electronic age verification systems that scan and verify government-issued identification for all purchasers who appear to be under 30 years of age.

(2) Retail establishments shall train all employees involved in the sale of alcoholic beverages in responsible beverage service practices and refusal of sale to intoxicated persons and minors.

**(c) EMPLOYERS. –**

(1) Employers with 50 or more employees shall provide Employee Assistance Programs (EAPs) that include confidential counseling, referral to treatment, and paid leave for alcohol use disorder treatment.

(2) Group health plans and health insurance issuers offering group or individual coverage shall provide coverage for all FDA-approved medications for alcohol use disorder,

SBIRT services, outpatient counseling, and medically supervised detoxification without prior authorization requirements.

**(d) DIGITAL PLATFORMS AND MEDIA COMPANIES. –**

(1) Social media platforms and digital advertising networks with more than 1,000,000 monthly active users in the United States shall implement technical controls to prevent the targeting of alcohol advertising to users who are, or who are likely to be, under 21 years of age, based on all available data signals.

(2) Digital platforms shall report annually to the FTC on actions taken to restrict underage exposure to alcohol advertising.

**SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS.**

**(a) INDIVIDUAL RESPONSIBILITY AND EDUCATION. –**

(1) The Secretary, in coordination with SAMHSA and the CDC, shall develop and widely disseminate a national public education campaign that informs citizens of the health risks of alcohol use, the availability of confidential screening tools such as AUDIT and AUDIT-C, and the access pathways to treatment services.

(2) Healthcare providers shall provide screening for alcohol use disorder to all patients aged 18 and older at least annually and shall offer brief counseling and referral to treatment as appropriate.

**(b) PARENTAL RESPONSIBILITIES. –**

(1) The Secretary shall develop and distribute educational materials to parents, through pediatric healthcare providers, schools, and community organizations, regarding the risk factors for underage drinking, effective communication strategies, and warning signs of alcohol misuse.

**(c) COMMUNITY AND FAITH-BASED ORGANIZATIONS. –**

(1) Community and faith-based organizations receiving federal grants under the Community Services Block Grant program or similar federal funding shall include evidence-based alcohol prevention activities in their program plans.

**SECTION 7. PENALTY CLAUSES.**

(a) CIVIL PENALTIES – LABELING. – Any manufacturer or importer of alcoholic beverages that fails to comply with the labeling requirements of Section 3(b) of this Act after the applicable effective date shall be subject to a civil penalty of not more than \$10,000 per violation per day, as assessed by the FDA.

(b) CIVIL PENALTIES – ADVERTISING. – Any person or entity that violates the advertising restrictions of this Act shall be subject to a civil penalty of not more than \$50,000 per violation, as assessed by the FTC. Each individual advertisement directed at persons under 21 in violation of this Act shall constitute a separate violation.

(c) GRANT REDUCTIONS. – States that fail to certify compliance with the requirements of Section 4(b) of this Act within 3 years of enactment shall be subject to a reduction of not more than 10 percent of their federal substance abuse block grant award.

(d) ENFORCEMENT AUTHORITY. – The Secretary, the FDA, and the FTC shall each have enforcement authority for violations of provisions within their respective jurisdictions under this Act and may promulgate implementing regulations.

## **SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION.**

(a) GENERAL EFFECTIVE DATE. – Except as otherwise provided, this Act shall take effect on the date that is 180 days after the date of enactment.

(b) LABELING REQUIREMENTS. – The FDA labeling regulations required by Section 3(b) shall take effect not later than 24 months after the date of enactment.

(c) IMPLEMENTATION PLAN. – Not later than 1 year after the date of enactment, the Secretary shall submit to Congress a comprehensive implementation plan that identifies lead agencies, interim milestones, performance metrics, and required regulatory actions for each provision of this Act.

(d) ANNUAL REPORTS. – Beginning 2 years after enactment, the Secretary shall submit to Congress and make publicly available an annual report on the status of implementation of this Act, progress toward national alcohol reduction goals, and recommendations for further legislative or regulatory action.

## **SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES.**

### **(a) AUTHORIZATION OF APPROPRIATIONS. –**

(1) There is authorized to be appropriated to SAMHSA \$500,000,000 for each of fiscal years 2025 through 2030 to carry out the prevention and treatment grant programs authorized under this Act.

(2) There is authorized to be appropriated to NIAAA \$150,000,000 for each of fiscal years 2025 through 2030 to expand research on alcohol use disorder prevention, treatment, and health effects.

(3) There is authorized to be appropriated to the CDC \$75,000,000 for each of fiscal years 2025 through 2030 to implement the alcohol use reporting and community prevention technical assistance programs required under this Act.

(4) There is authorized to be appropriated to the FDA \$25,000,000 for each of fiscal years 2025 through 2030 for rulemaking, implementation, and enforcement of updated alcohol labeling requirements.

(b) OFFSETTING PROVISIONS. – Congress finds that increased federal excise taxes on alcoholic beverages, as authorized by separate revenue legislation consistent with the policy goals of this Act, should be considered as a budgetary offset for appropriations authorized herein.

(c) NATIONAL ALCOHOL PREVENTION FUND. – The Secretary shall establish, administer, and provide oversight for the National Alcohol Prevention Fund established under Section 5(a)(2) of this Act. Funds deposited into the National Alcohol Prevention Fund shall be available without further appropriation for evidence-based prevention programs, subject to annual reporting to Congress

## ENDNOTES

The legislative requirements in Sections 3–6 of this Act are informed by policies implemented in multiple countries with demonstrated success in reducing alcohol consumption. The following endnotes identify the source country policies and corresponding reference materials:

1. Minimum unit pricing for alcohol – Scotland's Alcohol (Minimum Pricing) (Scotland) Act 2012; Government of Scotland: <https://www.legislation.gov.uk/asp/2012/4/contents>. Also Australia: National Health and Medical Research Council, Australian Guidelines to Reduce Health Risks from Drinking Alcohol, <https://www.nhmrc.gov.au/guidelines>.
2. Mandatory rotating health warning labels – République française: Loi Évin (Law No. 91-32 of January 10, 1991, amended 2023), <https://www.legifrance.gouv.fr>. Also Canada: Health Canada, <https://www.canada.ca/en/health-canada/services/alcohol/labelling.html>.
3. Outlet density restrictions – England: Licensing Act 2003 (UK), <https://www.legislation.gov.uk/ukpga/2003/17/contents>. Also Norge: Alcohol Act (Alkoholloven), <https://lovdata.no/dokument/NL/lov/1989-06-02-27>.
4. Advertising restrictions on platforms targeting youth – Sverige: Radio and Television Act (SFS 2010:696), <https://www.riksdagen.se>. Also Suomi: Alcohol Act (1102/2017), <https://www.finlex.fi/en/laki/kaannokset/2017/en20171102>.
5. Mandatory SBIRT in healthcare settings – Deutschland: Federal Centre for Health Education (BZgA), <https://www.bzga.de>. Also Nippon: Basic Act on Measures against Alcohol-Related Harm (Act No. 109 of 2013), <https://www.mhlw.go.jp>.
6. Excise tax increases on alcoholic beverages – Norge: Alcohol tax structure, <https://www.skatteetaten.no>. Also Canada: Excise Act 2001, <https://laws-lois.justice.gc.ca/eng/acts/E-14.1/>.
7. Treatment coverage mandates – England: NHS Alcohol Treatment Services, <https://www.nhs.uk/live-well/alcohol-advice/>. Also Australia: Department of Health and Aged Care, <https://www.health.gov.au/topics/alcohol>.
8. Workplace EAP mandates – Deutschland: Workplace Health Promotion Act (Betriebliche Gesundheitsförderung), <https://www.bgw-online.de>. Also République française: Code du Travail, Articles L4121-1 and L4622-1, <https://www.legifrance.gouv.fr>.