

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

March 28, 2017

3:01 p.m.

MEMBERS PRESENT

Representative Ivy Spohnholz, Chair
Representative Bryce Edgmon, Vice Chair
Representative Sam Kito
Representative Geran Tarr
Representative David Eastman
Representative Jennifer Johnston
Representative Colleen Sullivan-Leonard

MEMBERS ABSENT

Representative Matt Claman (alternate)
Representative Dan Saddler (alternate)

COMMITTEE CALENDAR

PRESENTATION: THE ECONOMIC COSTS OF ALCOHOL ABUSE IN ALASKA

- HEARD

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 54

"An Act providing an end-of-life option for terminally ill individuals; and providing for an effective date."

- HEARD & HELD

HOUSE BILL NO. 151

"An Act relating to the duties of the Department of Health and Social Services; relating to training and workload standards for employees of the Department of Health and Social Services; relating to foster care licensing; relating to placement of a child in need of aid; relating to the rights and responsibilities of foster parents; relating to subsidies for adoption or guardianship of a child in need of aid; requiring the Department of Health and Social Services to provide information to a child or person released from the department's custody; and providing for an effective date."

- SCHEDULED BUT NOT HEARD

PREVIOUS COMMITTEE ACTION

BILL: HB 54

SHORT TITLE: TERMINALLY ILL: ENDING LIFE OPTION

SPONSOR(S): REPRESENTATIVE(S) DRUMMOND

01/18/17	(H)	READ THE FIRST TIME - REFERRALS
01/18/17	(H)	HSS, JUD
03/14/17	(H)	HSS AT 3:00 PM CAPITOL 106
03/14/17	(H)	<Bill Hearing Canceled>
03/27/17	(H)	SPONSOR SUBSTITUTE INTRODUCED-REFERRALS
03/27/17	(H)	READ THE FIRST TIME - REFERRALS
03/27/17	(H)	HSS, JUD
03/28/17	(H)	HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

JEFF JESSEE, Program Officer & Legislative Liaison
Alaska Mental Health Trust Authority
Department of Revenue
Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint titled "The Economic Costs of Alcohol Abuse in Alaska."

DONNA LOGAN, Vice President
Anchorage Operations
McDowell Group
Juneau, Alaska

POSITION STATEMENT: Presented a PowerPoint titled "The Economic Costs of Alcohol Abuse in Alaska."

REPRESENTATIVE HARRIET DRUMMOND
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Introduced SSHB 54 as the sponsor of the bill.

KRISTIN KRANENDONK, Staff
Representative Harriet Drummond
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented SSHB 54 on behalf of the bill sponsor, Representative Harriet Drummond.

KAT WEST
National Director of Policy & Programs
Compassion & Choices
Portland, Oregon

POSITION STATEMENT: Answered questions and testified during discussion of SSHB 54.

DAVID COMPTON, MD
Bethel, Alaska

POSITION STATEMENT: Testified in support of SSHB 54.

MARGARET DORE
Attorney
State of Washington

POSITION STATEMENT: Testified in opposition of SSHB 54.

DIANA KRISTELLER, Midwife
APRNs, Voluntary Ending of Life
Fairbanks, Alaska

POSITION STATEMENT: Testified in support of SSHB 54.

CAROL EGNER
Ketchikan, Alaska

POSITION STATEMENT: Testified in support of SSHB 54.

MICHAEL HAUKE DALEN
Anchorage, Alaska

POSITION STATEMENT: Testified in support of SSHB 54.

MARY MCDOWELL
Juneau, Alaska

POSITION STATEMENT: Testified in support of SSHB 54.

NANCIANNA CLONAN
Soldotna, Alaska

POSITION STATEMENT: Testified in support of the SSHB 54.

JOHN FORBES, MD
Anchorage, Alaska

POSITION STATEMENT: Testified in opposition to SSHB 54.

WILLIAM HARRINGTON
Anchorage, Alaska

POSITION STATEMENT: Testified in support of SSHB 54.

SARAH VANCE
Homer, Alaska

POSITION STATEMENT: Testified in opposition to SSHB 54.

DIANA BARNARD, MD
Hospice Care

University of Vermont Medical Center
Burlington, VT

POSITION STATEMENT: Testified during discussion of SSHB 54.

CHRISTOPHER KURKA, Executive Director
Alaska Right to Life
Palmer, Alaska

POSITION STATEMENT: Testified in opposition to SSHB 54.

MICHAEL PAULEY
Alaska Family Council
Anchorage, Alaska

POSITION STATEMENT: Testified in opposition to SSHB 54.

ACTION NARRATIVE

[3:01:07 PM](#)

CHAIR IVY SPOHNHOLZ called the House Health and Social Services Standing Committee meeting to order at 3:01 p.m. Representatives Spohnholz, Sullivan-Leonard, Johnston, and Kito were present at the call to order. Representatives Tarr, Eastman, and Edgmon arrived as the meeting was in progress.

Presentation: The Economic Costs of Alcohol Abuse in Alaska

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CHAIR SPOHNHOLZ announced that the first order of business would be a presentation on the Economic Costs of Alcohol Abuse in Alaska.

[3:02:18 PM](#)

JEFF JESSEE, Program Officer & Legislative Liaison, Alaska Mental Health Trust Authority, Department of Revenue, introduced the PowerPoint presentation of the study contracted with the McDowell Group by the Alaska Mental Health Trust Authority to review the cost of alcohol and drug abuse to the State of Alaska. He reported that many different components, including criminal justice costs, health care costs, car accident costs, lost productivity costs, and child protection costs, were used to help quantify the seriousness of the issue for policy makers. He declared that these were "pretty dramatic numbers" which had been scientifically arrived at using a rigorous methodology. He stated that alcohol abuse in the State of Alaska annually cost the state \$1.8 billion and that drug abuse cost the state an

additional \$1.2 billion each year. He said that he was stunned by the amount of work by the Alaska State Legislature to reduce the cost of government programs and departments which were "arguably trying to contribute something positive to Alaska and Alaskans and yet we are doing very little in this process to look at how we can drive down this \$3 billion cost of alcohol and drug abuse."

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DONNA LOGAN, Vice President, Anchorage Operations, McDowell Group, reported that this was the "fourth edition of the work that we've done for the Trust over the years." She stated that every addition was better, as there was better access to data, which included revised national models and national survey data. She said that there was quite a difference with this current version and the previous 2012 report on 2011 impacts. She pointed out that this report largely focused on the tangible costs, and did not include the intangible costs for pain, suffering, and decreased quality of life. She addressed slide 2, "Why Understanding the Economic Costs Matters," and stated that this was a way to build public awareness for public and private costs, and monitor the relationships between the costs of alcohol and the preventative strategies. She moved on to slides 3 - 5, "Methodology," noting some of the limitations for a lack of timely data, even though the data used was the most recently reported. The report was dependent on national modeling and surveys, even though these did not always capture the Alaska experience of rural health care with a need to bring people into urban settings, and these associated costs. She acknowledged those limitations even as they worked with these models. She said that national statistics for alcohol consumption were used for state to state comparisons and for context to where Alaska fit relative to other states. She pointed to statistics for productivity losses, incarceration, underage drinking, diminished productivity due to absenteeism, and hospitalization, as well as FAS and FASD.

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MS. LOGAN pointed to the complexity of the details and, addressing slide 6, "Alcohol Consumption Patterns (2013 - 2014), shared a context for alcohol consumption, noting that more than half the population consumed alcohol on a "fairly current basis, meaning they've had a drink within the last 30 days." She defined binge drinking as the consumption of five or more drinks in one sitting by a male, and four or more drinks by a female,

and stated that 3 percent of the population were binge drinkers in the past year. She explained that alcohol dependence was defined to include binge drinking with a match to three of nine criteria, whereas alcohol abuse was not as heavy, as it included a match to only one of the nine criteria. She reported that alcohol consumption in Alaska was similar to the rest of the U.S., slide 7, "Alaskan Alcohol Consumption (2013 - 2014)." She listed Alaska, relative to other states, as 31st for binge drinking, 26th for current alcohol use, 21st for alcohol dependence alone, and 20th for combined alcohol dependence and abuse. In response to a question from the Chair, she clarified that of the 39,000 Alaskans who experienced either alcohol dependence or abuse in the past year, 19,000 only experienced alcohol dependence.

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MS. LOGAN moved on to slide 8, "Current Alcohol Use (age 12+), by Age Group," which compared Alaska with the U.S., noting that alcohol use more than doubled from the 12 - 17 years of age group to the 12 - 20 years of age group. She pointed to the 18 - 25 years of age group, and noted that 6 out of 10 Alaskans were drinking, similar to the national levels. She addressed slide 9, "Per Capita (age 14+) Consumption (2013)," and explained that the alcohol content of beer, wine, and liquor had been converted into ethanol counts. She noted that the per capita consumption in Alaska was similar to the U.S., and she reported that the overall consumption had been steady over the last 20 years. She summarized slide 10, "Total Economic Costs of Alcohol Abuse - /\$1.84 B."

MS. LOGAN said that the public-sector costs were reflected on slide 11, "Criminal Justice and Protective Services - \$269.8 M," and pointed out that there were about 9400 arrests in 2014 associated with alcohol, about 25 percent of all the arrests in the state. She relayed that there were 7300 victims of these alcohol related crimes, about 17 percent of all the crime victims. She listed the cost to the justice system, the cost to victims, which included medical costs, lost earnings, and property loss, and the cost for child protective services. These tangible costs totaled almost \$270 million, and, with the intangible costs to victims, the total was more than \$870 million. She noted that theft was the number one crime associated with alcohol, followed by DUI (Driving under the Influence) and assaults. She pointed out that the highest cost per crime to the victims was homicide and assault.

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MS. LOGAN continued with slide 12, "Health Care - \$181.8 M," which measured the hospitalization costs, including inpatient, emergency room, and outpatient services. It did not capture the costs of a primary care clinic or a private doctor. She pointed out that the slide also listed the cost of alcohol and drug treatment, almost \$26 million, of which almost \$12.6 million was associated with Medicaid costs. She noted that it was not possible to capture all the Medicaid costs associated with alcohol. She reported that the 5,000 admissions for drug treatment in 2015 represented 14,500 days of treatment. There were also 2200 admissions for alcohol abuse with 15,800 alcohol related emergency room visits each year. She acknowledged that although nursing homes and long-term care were not a big cost, its \$1.5 million cost had been included. She reported that the \$3 million cost listed for FAS and FASD was underestimated as it only captured those costs related to diagnosis at birth. She pointed out that some of these affects were not labelled until years later. She noted that the costs captured on slide 13, "Public Assistance and Social Services," intuitively seemed low, as they were only about 2.9 percent of the total public assistance and social services paid by the state.

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MS. LOGAN continued with slide 14, "Underage Drinking - \$350 M," which reflected the cost to the Alaska economy due to underage drinking alone. About 48 percent of the underage drinking costs, \$168 million, was related to youth violence and another \$99 million was related to youth traffic accidents.

MS. LOGAN directed attention to the nine categories listed on slide 15, "Traffic Collisions - \$594.3 million," which related to impaired events, and, although the statistics did not differentiate between drug or alcohol related costs, the costs listed on slide 15 were based on a determination that 60 percent of the total costs were alcohol related. She reported that these costs included workplace costs, traffic congestion costs, and property damage. She estimated that \$600 million was related to traffic collision costs.

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REPRESENTATIVE SULLIVAN-LEONARD asked how the data was collected.

MS. LOGAN replied that it was based on widely used national models for producing economic impact analysis. She referenced an earlier study by the Lewin Group. Moving on to slide 16, "Productivity Losses - \$775.1 M," she explained that absenteeism, hospitalization, and incarceration were some of the productivity losses, about 42 percent of the \$1.8 billion. She reported that there were 285 alcohol related deaths in 2015, with liver disease as the number one cause, then suicide and poisoning as the next leading causes. She reported that 33 percent of the 3300 inmates were incarcerated for alcohol offenses. She moved on to report that there had been about 46,700 bed days of lost productivity due to alcoholism.

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MS. LOGAN referred to slide 17, "State Alcoholic Beverages Tax - Volume" which indicated that consumption had remained relatively stable and that slide 18 reflected a change in the law which resulted in an increase in alcohol beverage tax revenue. She added that about half of this increased revenue was placed into an alcohol and drug abuse treatment and prevention fund. She pointed to slide 19, "Local Government Alcohol Tax Sales, 2015," which showed that almost \$5 million had been generated at the local level. She stated that there were almost 2900 jobs associated with the alcohol industry, slide 20, "Jobs and Wages - Alcoholic Beverage Sector, 2014," with a payroll of \$66.4 million.

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MS. LOGAN reviewed slide 21, "In Summary," and stated that there was a cost of \$1.84 billion associated with alcohol abuse, whereas the alcohol beverage industry payroll was \$66.4 million, the alcohol beverage tax revenue was \$37.6 million, and the local government alcohol sales tax revenue was almost \$5 million. She added that during the study on alcohol, they had conducted a cost on drugs, slides 23 - 24, "Illicit Drug Use, 2013 - 2014." She pointed out it was important to note that although drug use was similar to that in the rest of the U.S., marijuana consumption was higher. She added that as it was now a controlled substance, the categorization would change. She reported that 26,000 Alaskans used pain relievers for non-medical purposes in the past year, with 13,000 people dependent on these illicit drugs.

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MS. LOGAN concluded with slide 25, "Total Economic Costs of Drug Abuse - \$1.22 B" and slide 26, "In Conclusion." She declared that there was an economic cost of \$1.84 billion from alcohol, and \$1.22 billion from drug abuse, with a total cost of \$3.1 billion to the economy in Alaska.

[3:38:49 PM](#)

REPRESENTATIVE EDGMON offered his belief that the percentage of inmates in Alaska correctional facilities for alcohol related crimes was higher than 33 percent.

MS. LOGAN replied that the source for this statistic was the Department of Corrections.

REPRESENTATIVE EDGMON offered his belief that the number was much higher.

MS. LOGAN explained that there were different attribution rates applied for different crimes.

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MR. JESSEE added that there were a much higher percentage of inmates who had alcohol and behavioral health issues. He noted that there was a difference between the criminal justice information and a review of the inmates as individuals.

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CHAIR SPOHNHOLZ asked to clarify that although there may be a much higher number of people within the criminal justice system with an abusive or unhealthy relationship with alcohol, that statistic was distinct from the individual crime statistic.

MS. LOGAN relayed that the figures she presented reflected how much of the crime itself was attributable to alcohol.

CHAIR SPOHNHOLZ asked if there was a separate figure for the number of people incarcerated related to illicit drug use.

MS. LOGAN replied that she did not immediately have that figure.

MR. JESSEE added that the Office of Children's Services (OCS) was not able to determine the number of parents with alcohol or behavioral health issues unless it was recorded in the paperwork. He stated that this was the disparity between crime

statistics and the actual assessment of individuals and their actions.

MS. LOGAN, in response to Chair Spohnholz, said that drug related crimes were attributed to 734 inmates.

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REPRESENTATIVE SULLIVAN-LEONARD referenced the comparison of data between Alaska and the U.S., and asked if there was a breakdown of the Alaska data by region.

MS. LOGAN replied that there was only statewide data.

REPRESENTATIVE SULLIVAN-LEONARD asked how this data could be taken into the community to educate, inform, and protect regarding those affected by some of these attributes.

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MR. JESSEE stated that this begins today with the information being presented to the policy makers, in order to deal with the impacts and make decisions regarding the allocation of resources to address this.

REPRESENTATIVE SULLIVAN-LEONARD replied that the information needed to get into the communities, and she expressed concern for the data on underage drinking. She declared that society was okay with alcohol in the establishment, offering examples of events. She suggested that education needed to be started at a younger age, and that families and schools needed to be involved to make a comprehensive change for recognition of the choice not to drink.

MR. JESSEE expressed his agreement. He said that the social norms around alcohol were very complex, and he offered an example of the incongruity for non-profit fundraisers which used alcohol as part of the fund raising to help those devastated by alcohol. He noted that many parents did not pay attention to underage drinking and minor consumption, pointing out that this was a huge impact to the community.

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CHAIR SPOHNHOLZ said that this would be an opportunity for a future hearing as many organizations, departments, and divisions in the state were working on reducing alcohol use and abuse.

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REPRESENTATIVE JOHNSTON offered her belief that the numbers were low, as well, and she asked about the methodology.

MS. LOGAN said that the adult alcohol consumption was from the national survey of drug use and health, with Alaska specific.

REPRESENTATIVE JOHNSTON asked if this was a telephonic survey.

MS. LOGAN replied that it was, and that it was the best data available to make comparisons across the board. She added that the latest information had been inflation adjusted.

REPRESENTATIVE JOHNSTON asked whether the risk survey was opt-out or opt-in, and whether it had been used.

MS. LOGAN replied that they had chosen to go with the national data for the modeling in this report. She added that other reports from the McDowell Group had used other data as it related to underage drinking. In response, she said that a great amount of time had been spent to determine which was the best source.

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REPRESENTATIVE JOHNSTON asked if these two data sets had been compared regarding FASD.

CHAIR SPOHNHOLZ asked to clarify that FAS and FAE had not been included.

MS. LOGAN expressed her agreement, as the data point was not just condition of the infant, but also whether the mother had admitted to drinking.

[3:53:04 PM](#)

REPRESENTATIVE TARR asked whether all the communities with local government alcohol sales tax were listed.

MS. LOGAN replied that these were all the communities they were able to gather.

REPRESENTATIVE TARR asked why Anchorage and Matanuska-Susitna were not on the list. She shared that an approach she supported

to change social norms had highlighted the decrease in teen drinking and the shift toward responsible alcohol use. She asked if there had been a comparison to the tipping points for these problematic behaviors, such as the difference between responsible and irresponsible alcohol use.

MS. LOGAN replied that she was not aware of any comparison of the tipping points, except to define the different levels of abuse and dependency. She reiterated that the national surveys were connected to clinical diagnosis.

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MR. JESSEE added that this was more of a probability analysis than a tipping point for any individual or circumstance, as "the more alcohol you have on board, the more likely something bad is to happen, and the more often you have alcohol on board, the more likely something bad is to happen."

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MS. LOGAN said that the data did track the differences from middle school to high school.

CHAIR SPOHNHOLZ said that she was "heartened by some of the positive social norming that we've been seeing that we believe may be having positive impact on a lot of young people." She reported that 90 percent of young people did not drink, which made it much easier for young people who wanted to make a healthy choice, while also maintaining that "essential part of belonging that's so a part of our growing up, of belonging with their peer group, specifically." She noted that this was an economic report with benchmark data comparing Alaska with other states and did not address social change.

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The committee took an at-ease from 3:59 p.m. to 4:04 p.m.

HB 54-TERMINALLY ILL: ENDING LIFE OPTION

[4:04:29 PM](#)

CHAIR SPOHNHOLZ announced that the next order of business would be SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 54, "An Act providing an end-of-life option for terminally ill individuals; and providing for an effective date."

[4:04:56 PM](#)

REPRESENTATIVE HARRIET DRUMMOND, Alaska State Legislature, paraphrased from a prepared statement, which read [original punctuation provided]:

Thank you chairwoman, Spohnholz. For the record, my name is Harriet Drummond and I am the Representative for House District 18. I would like to thank the committee for hearing this bill today. I know this is not an easy subject for most people. Death is a difficult topic, because it is raw and emotional. No one wants to lose a loved one or think about leaving their family behind. And because no one likes to talk about it, we often don't even start the conversation until someone becomes ill. And by not starting these conversations sooner, talking about something as serious as aid-in-dying becomes personal and painful. We need to change that.

House Bill 54 allows terminally ill patients to ease their pain and suffering by allowing doctors to prescribe medication to aid in dying. This bill allows an Alaskan the right to live, and die, on their own terms according to their own desires and beliefs.

Death is a natural part of life. This bill allows people to be in control of their own care. Providing dignity and peace of mind during a patient's final days with family and loved ones places a much greater focus on a person's life than on the often painful and agonizing process of dying.

My aide will go over the specifics of the bill in just a minute, but I wanted to talk to you about *why* I introduced this legislation.

At the beginning of session, Claire Richardson came to my office and asked when this bill was going to get a hearing.

Her husband, Lisle (pronounced LYLE) was battling ALS, an incurable, progressive nervous system disorder but he wanted to come in and testify on this bill. Some of you may know Lisle. He was born and raised in Juneau. He founded the Gold Town Nickelodeon. He was a social

worker and an avid outdoorsman. Lisle isn't here today. But his words are. He recorded this video when he realized he wouldn't be able to make it to this hearing.

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The committee took a brief at-ease.

[4:08:03 PM](#)

A short video of Lisle Hebert recorded prior to his death was shown to the committee.

[4:12:40 PM](#)

REPRESENTATIVE DRUMMOND continued to read from the prepared statement, which read [original punctuation provided]:

I introduced this bill because of people like Lisle. The people who are no longer here to advocate for themselves.

This is my second time introducing this legislation. And I have heard from a lot of people who have very strong opinions about this bill. During public testimony you will hear from family members who have had to deal with things I hope and pray none of you will ever have to deal with.

I have also been told I am evil for introducing this bill. I have been told I am going to hell, I have been called a Nazi, and I have been told I am playing God. We hook terminally ill patients up to countless machines that prolong death for weeks. We have machines that can breathe, eat, and urinate for people. We administer CPR on sick patients and break their ribs, burrow large IV lines into burned-out veins and plunge tubes into swollen, bleeding airways. God is looking down on us and asking "what are you thinking?!"

Science is not God. Medicine is here to help sick people. And when people are too sick to keep living, medicine should still be able to help people.

We have stopped seeing the person and are only looking at the patient.

I have been told that by introducing this legislation, I am promoting suicide. I resent that. My son was a sensitive, caring, athletic 17-year old the day he took his own life. Stephen was my oldest child. He loved biking and snowboarding. He biked to Denali when he was just an eighth grader. I have spent years going over every minute detail of the days leading up to his death. I have agonized over every decision, every word I said, wondering if there was anything I could have done to prevent it. There isn't a day that goes by when I don't think about how old he would be now or what he might be doing if he was alive today. Suicide is a tragedy. An irrational, self-destructive act that should be prevented at all costs. We don't get to pick and choose which deaths we want to be suicide. Does a patient who decides to quit chemo, or stop undergoing lifesaving dialysis after years of slowly deteriorating count as suicide? Does a Marine who is under attack and jumps on a bomb to save his fellow soldiers count as suicide? Does a Jehovah's Witness who refuses a blood transfusion because of her religious beliefs count as suicide? Suicide is a healthy person who could live but wants to die. Aid-in-dying is about a sick person who wants to live but is dying.

This bill allows patients to have important end-of-life discussions with the doctors they already know and trust. Without this discussion, well-meaning doctors are faced with prescribing painful procedures even when the patient does not want them and there is little hope for success. People in these conditions have already lost their health and often much, much more. This bill at least lets them control the last and most important decision they have left.

I will turn it over to my aide to walk you through the bill and then we will answer any questions the committee may have.

[4:16:33 PM](#)

KRISTIN KRANENDONK, Staff, Representative Harriet Drummond, Alaska State Legislature, spoke from a prepared statement, which read:

For the record my name is Kristin Kranendonk, and I am staff to Representative Drummond. We modeled this legislation off what other states have done.

Oregon enacted the first "death with dignity" law in the U.S in 1994 through a citizen-approved ballot initiative. Washington followed in 2008. Vermont, California, Washington DC, and Canada have all legalized similar legislation as well. What we have learned in the over 20 years since Oregon first passed this legislation is that aid-in-dying has resulted in significant improvements in the care of the terminally ill.

I will now go over the sections of the bill and then answer any questions you might have.

[4:17:20 PM](#)

MS. KRANENDONK referenced the Sectional Analysis of the proposed bill [Included in members' packets], and paraphrased from a prepared statement which read [original punctuation provided]:

Section 1 & 2:

Page 1: Lines 4-10

New subsections are added to AS 11.41.115 (defenses to murder) and AS 11.41.120 (manslaughter) to allow a defense for acting under this new chapter, 13.55.

Provides immunity from criminal liability. (Use of "defense" places the burden on the state to disprove the existence of the defense.)

Section 3:

Pages 1-11: Lines 11-21

Adds a new chapter AS 13.55, which provides the process in which terminally ill individuals may request medication to aid in their peaceful death.

Sec. 13.55.010:

This section lists the criteria an individual must meet to qualify for medication. A person needs to be a resident of Alaska, over 18, suffering from a terminal disease, they must be mentally capable and must voluntarily express a wish to die. It also clearly states that age or disability alone is not sufficient enough to qualify.

Sec. 13.55.020: Authorizes a qualified individual's attending physician to dispense or write a prescription for the necessary medication if the physician complies with the chapter.

This section allows a doctor or pharmacist to prescribe or fill out a prescription. This section is not saying a doctor will ADMINISTER the medication. It is just talking about dispensing medication.

Sec. 13.55.030: Requires a qualified individual to make an oral request to their attending physician to receive the necessary medication. Requires the qualified individual to repeat the oral request at least 15 days after the initial request. Provides alternative request methods for qualified individuals who are not able to speak or not able to sign the request.

If an individual is unable to speak (as sometimes happens with ALS/cancer patients - for example, Stephan Hawking) they can use other means to make their request. (Like an electronic voice box)

Sec. 13.55.040: Directs the attending physician to offer the opportunity to rescind the initial oral request when the qualified individual makes the second oral request. Allows a qualified individual to rescind a request at any time. Prohibits an attending physician from dispensing or prescribing medication unless the physician offers the qualified individual an opportunity to rescind the request.

When a qualified individual makes their second oral request at least 15 days after the initial request for medication, this section directs the attending physician to offer the opportunity to rescind their request. This section also explicitly states an individual can change their mind and rescind a request at any time. It also prohibits an attending physician from dispensing or prescribing any

medication unless they offer a qualified individual a chance to change their mind.

Sec. 13.55.050:

This section lays out the steps a physician needs to take throughout the process. These include determining whether the individual has a terminal disease, is capable, and has made the medication request voluntarily. Also includes providing information to the individual about the medical diagnosis and prognosis, the risks and probable result of taking the medication, and feasible alternatives. Requires the physician to refer the individual to a consulting physician to confirm the diagnosis and to determine that the individual is capable and acting voluntarily. Requires the physician to refer the individual for counseling if appropriate under Sec. 13.55.090. This section requires the attending physician to counsel an individual about where this medication can be consumed (not in public, etc) and talks about the importance of having someone present (nurse, family, etc) at the time medication is to be consumed. Allows the attending physician to sign the death certificate.

Sec. 13.55.060: Before an individual can qualify under the chapter, it requires a consulting physician to examine the individual and confirm the attending physician's diagnosis of a terminal disease, and to verify that the individual is capable, acting voluntarily, and has made an informed decision.

Sec. 13.55.070: Requires the attending or consulting physician to refer the individual for counseling and prohibits the dispensing or prescribing of the necessary medicine until the counselor determines that the individual is not suffering from depression causing impaired judgment.

Sec. 13.55.80: Prohibits the attending physician from dispensing or prescribing medication unless the qualified individual has made an informed decision.

Sec. 13.55.90: Prohibits the attending physician from denying the medication request because the individual declines or cannot notify next of kin.

Sec. 13.55.100: Requires certain waiting periods before medication can be dispensed or prescribed.

Sec. 13.55.110: Requires that the medical record of the qualified individual contains the items listed in the section before the individual receives the medication.

Sec. 13.55.120: Invalidates will or contractual terms that require, prohibit, impose conditions on, or otherwise addresses whether an individual may make or rescind a request under this chapter.

Does not invalidate a will. This simply means you cannot condition a will/contract. (You get this \$\$ on the condition that you agree not to end your life or to end your life.)

Sec. 13.55.130: Provides a person with immunity from civil and criminal liability or professional disciplinary action for participating in good faith compliance with the chapter. States that a medication request by an individual or an attending physician providing medication in good faith compliance with this chapter may not provide the sole basis for the appointment of a guardian or conservator.

Sec. 13.55.140: States that a health care provider has no duty to participate.

Sec. 13.55.150: Under certain conditions allows a health care provider to prohibit another health care provider from participating on the premises in this chapter.

For example, Providence could prohibit a physician from prescribing medication at the hospital and can prohibit qualified individuals from administering medication at the hospital, but they cannot prohibit a doctor from doing these things outside of the hospital (if they have their own private practice for example).

Sec. 13.55.160: Requires a health care provider to notify a physician in writing if they prohibit the administration of medication on the premises.

Sec. 13.55.170 *If a health care provider violates the prohibition (for example, if the physician at*

Providence ignores their policy on this issue) the health care provider can terminate a contract or impose a loss of privileges.

Sec. 13.55.180: Establishes the crime of abuse for coercion, or action without authorization from the qualified individual. Makes the crime a class A felony.

Sec. 13.55.190: States that the chapter does not limit liability for civil damages resulting from a person's negligent conduct or intentional misconduct.

Sec. 13.55.200: Allows a governmental entity to file a claim against an individual's estate to recover expenses incurred if an individual consumes medication to end their life in a public place.

Sec. 13.55.210: Directs the Department of Health and Social Services to review a sample of the records maintained under the chapter every year. Requires a health care provider to file a record of dispensing medication under this chapter with the department. Directs the department to adopt regulations to facilitate the collection of information about compliance with the chapter. Makes the information confidential but requires the department to provide the public an annual statistical report about the information collected.

Sec. 13.55.220: Outlines the qualifications a physician must meet

Sec. 13.55.230: Prohibits construing the chapter to authorize or require health care contrary to applicable generally accepted health care standards. Prohibits construing the chapter as authorizing the ending of life by certain methods, including lethal injection. Establishes that an action allowed by this chapter is an affirmative defense to certain crimes, including murder, manslaughter, and euthanasia.

Sec. 13.55.240: Prohibits a person from conditioning the sale, procurement, issuance, rate, delivery, or another aspect of a life, health, or accident insurance or annuity policy, on the making or

rescission of a request for medication under the chapter.

Sec. 13.55.250: States that a request for medication under this chapter is not an advance health care directive under AS 13.52 and that AS 13.52 (Health Care Decision Act) does not apply to an activity allowed by the chapter.

Sec. 13.55.900: Defines the terms used in the new chapter.

[4:27:56 PM](#)

MS. KRANENDONK paraphrased from a prepared statement to describe Section 4, Section 5, Section 6, and Section 7 of the proposed bill, which read [original punctuation provided]:

Section 4:

Page 11: Lines 22-26

Indicates that the chapter applies to contracts, wills, and life, health, or accident insurance or annuity policies delivered or issued for delivery on or after the effective date.

Section 5:

Pages 11: Lines 27-31

Allows the Department of Health and Social Services to adopt regulations for the new chapter.

Section 6:

Page 12: Line 1

Makes the regulation authority given under Bill Section 5 take effect immediately.

Section 7:

Page 12: Line 2

Makes the Act (except Bill Section 5) effective January 1, 2019.

[4:28:38 PM](#)

REPRESENTATIVE TARR asked for clarification about "acting in good faith compliance" in the immunity section on page 6. She

questioned whether this was referring to an incident if the medication was used inappropriately by the wrong person.

MS. KRANENDONK replied that the section protected a physician who had been acting in good faith, although the stealing of medication was a prosecutable crime.

[4:30:08 PM](#)

REPRESENTATIVE KITO asked how this could be equitably administered in Rural Alaska communities, if the law only applied to people who lived close to a hospital or attending physician. He asked how a request for a prescription by mail was tracked to ensure that it reached the individual. He asked about the obligation if a person had received the medication and decided to rescind, even if this was after the second consultation opportunity to rescind. He asked how this medication would be returned if it was not used.

MS. KRANENDONK, in response, said that the telemedicine component of the section was added to accommodate rural members. Regarding drugs already in the hands of those who had requested, there were current federal regulations to deal with unused medications. She expressed an expectation for the Department of Health and Social Services to cover this in its regulations as described in Section 13.55.201. She pointed out that other states had already addressed this.

REPRESENTATIVE KITO corrected the reference to be for Section 13.55.210.

[4:32:38 PM](#)

KAT WEST, National Director of Policy & Programs, Compassion & Choices, explained that in most homes of terminally ill, dying people, there were large quantities of pain medications, and that Hospice would dispose of these unused medications. She reported that Alaska had a drop off disposal program for safe disposal of medications, as well. She stated that medical aid in dying medications were normally taken one hour in advance to be effective, and that two other medications needed to be administered simultaneously. These two medications allowed for absorption and prevention of regurgitation. She declared that it would be very hard to accidentally overdose on medical aid in dying medications, as they took about two minutes to drink and were quite bitter. She stated that there had not been any

accidental overdoses and no mis-applications of the medication in 30 years.

[4:35:17 PM](#)

REPRESENTATIVE KITO asked if this would not apply to communities without access to regular medical facilities.

MS. WEST offered her belief that it would depend on the telemedicine laws for rural communities. Currently, under proposed SSHB 54, the person choosing medical aid in dying would need to be seen either in person or through telemedicine for an attending physician to make the original eligibility determination for a terminally ill adult, diagnosed with six months or less, and mentally capable of making their own health care decisions. She added that this eligibility had to be confirmed by a second consulting physician, and availability of these physicians could be in person or through telemedicine, dependent upon state law.

REPRESENTATIVE KITO offered a scenario whereby a person in a rural community without an attending physician either dies prior to receiving the medication or is too "far gone" to self-administer. He expressed concern that the medication would not be clearly tracked, accounted for, or identified for disposition. He pointed out that there were not any trooper or police offices in many communities.

MS. WEST pointed out that most dying people had multiple prescriptions which were "just as lethal as a medical aid in dying medication and actually much easier to inject." She added that most often the health care provider disposed of any unused medication.

[4:39:23 PM](#)

MS. KRANENDONK added that hospice in Juneau provided care to communities outside Juneau, and that there were regulations in place to collect the medications. She offered to add an amendment to clarify.

[4:40:23 PM](#)

REPRESENTATIVE DRUMMOND pointed out that it was a very small number of people who requested and obtained the medication. She reported that in the more than 20 years since passage of the aid in dying bill, only 700 - 800 people in Oregon had used this.

She pointed out that these drugs would be dealt with in the same way as drugs to deal with the opioid crisis. She reminded that hospice care was a service, not a building.

[4:41:47 PM](#)

REPRESENTATIVE JOHNSTON asked if there were any issues which could compromise federal funds for health care.

MS. WEST, in response, explained that a 1997 federal law, passed immediately following passage of the Oregon law, prohibited the use of federal funds for medical aid in dying. She pointed out that many states, including California and Oregon, had segregated their state Medicaid funding from the federal Medicaid funding, to make those funds available to people who are eligible and qualified for medical aid in dying. She shared that Oregon offered 23 prescriptions and 15 injections each year.

[4:44:38 PM](#)

CHAIR SPOHNHOLZ opened public testimony. She asked to limit each testimony to two minutes and to maintain respect.

[4:45:52 PM](#)

DAVID COMPTON, MD, stated that he was in full support of the proposed bill both as a physician, a son, and as a human being. He reported that the system had not allowed many of his patients to have their end of life choices accepted. He allowed that although the Hippocratic Oath said that physicians should not participate, he offered his belief that a 5,000-year-old document did not pertain today, as there were many more ethical and moral decision-making tools. He rejected the slippery slope argument, noting that there was 20 years of experience. He opined that the objection was religious in nature, that no one was being forced, and that a physician can choose to participate.

[4:48:33 PM](#)

REPRESENTATIVE SULLIVAN-LEONARD asked about the Hippocratic Oath.

DR. COMPTON replied that the statement most pertinent in this situation was "first do no harm."

[4:49:00 PM](#)

MARGARET DORE, Attorney, reported that assisted suicide was legal in the State of Washington. She added that she was also the President of "Choice is an Illusion," a non-profit corporation opposed to assisted suicide. She stated that it was misleading to discuss aid-in-dying, as a terminal disease was defined as "without treatment." She stated that the bill was "stacked against the patient," noting that she was an inheritance and probate lawyer. She said there was a complete lack of oversight at the death. She opined that there was a slippery slope in Oregon, and she noted that the proposed bill allowed for euthanasia, as a patient may self-terminate with the medication.

[4:51:30 PM](#)

REPRESENTATIVE SULLIVAN-LEONARD asked whether there was anything in the proposed bill for signing prior to follow through with the assisted process.

MS. DORE stated that this was not in the current version of the proposed bill.

[4:52:24 PM](#)

DIANA KRISTELLER, Midwife, APRN, Voluntary Ending of Life, stated her support for the proposed bill and asked for inclusion of advanced practice registered nurses who were licensed independent providers in Alaska with full prescriptive authority in the proposed program.

[4:53:15 PM](#)

ROL EGNER offered a personal story of the suffering by her husband after a severe stroke. She declared her support for the legal availability for medically assisted death for those in dire medical circumstances if they choose. She stated her support for the proposed bill.

[4:55:48 PM](#)

MICHAEL HAUKEDALEN offered a personal story of the death of his wife. He said that the legal system did not allow his wife to terminate her own life. He encouraged passage of the proposed bill.

5:00:26 PM

MARY MCDOWELL shared that she had spent a lot of time with people during the end stages of their lives. She offered her belief that although Alaska valued individual rights and self-determination, the state denied "mentally competent adults who are in the midst of a dying process the right to avail themselves, only if they want to, of a liberty that they have if they reside within a number of other states," the right to some control over the timing and the way of death. She noted that although many people who obtain the prescription have opted not to use it, they have had peace of mind throughout the dying process, knowing they had a way to shorten it if things got that bad, and were not fretting about the loss of dignity or the loss of bodily function. She pointed out that the proposed bill required that an individual have a sound mind to make their own choice. She offered her belief that this was the Alaskan thing to do.

5:03:01 PM

NANCIANNA CLONAN offered a personal story about her husband's death. She asked for passage of the proposed bill.

5:06:16 PM

JOHN FORBES, MD, stated that he was a psychiatrist and had spent six years working for suicide prevention at a national level. He stated his personal opposition to the proposed bill. He declared that the proposed bill was a public health problem and would have unintended effects. He pointed out that there was a "serious problem with suicide" in Alaska, and that this proposed bill would affect suicide rates. He suggested that national studies showed that locales which approved of assisted suicide had higher rates of suicide, as well as higher rates of approval and acceptance of suicide. He said that the acceptability of suicide varied with different groups, and that the World Health Organization (WHO) had included messaging guidelines "to avoid language which sensationalizes or normalizes suicide or presents it as a solution to problems." He declared that physician assisted suicide was "invariably presented as a solution to the problem." He opined that passage of the proposed bill would send a message of the acceptability of suicide as a solution.

5:08:47 PM

WILLIAM HARRINGTON declared that it was a person's right to have access to a self-determined self-termination, and that this should be protected by law. He lauded the bill sponsor for offering the bill in the face of powerful opposition from two groups, the organized cartel of religions and medical professionals. He opined that the chemicals designed to stop the heart and induce death were not medication. He lauded the fifteen day "cooling off period."

[5:11:21 PM](#)

SARAH VANCE asked for clarification regarding how the legality by other states had greatly improved the care for the terminally ill. She asked who paid for the medication, and how much was the medication. She asked to address the cost and the possibility for pharmaceutical companies to take advantage. She declared that it was necessary to respect the sanctity of life, as the end of life was an unsure time. She asked how many doctors had been wrong in the determination of remaining time to live. She declared her opposition to the proposed bill.

[5:13:44 PM](#)

DIANA BARNARD, MD, Hospice Care, University of Vermont Medical Center, pointed out that dying was different than it had been in past generations, as medical advances had allowed for illness prevention and management of diseases and accidents. She acknowledged that there was no cure for dying, and that patients held deeply diverse beliefs about life and death, with very different priorities and needs when facing a terminal condition. She shared her experience that priorities during the final days and weeks became very simple: time with family and a peaceful death at home. She noted that the modern medical health system often made these simple desires go unanswered. She offered her belief that the nearness of death brought patients clarity to regain control of how they live and how they die. She emphasized that medical aid-in-dying was an important option, one tool to meet the needs of some people. She said that her experience indicated it was possible to offer this as a voluntary option.

[5:16:58 PM](#)

CHRISTOPHER KURKA, Executive Director, Alaska Right to Life, stated that this was a dangerous bill, and he urged to vote against it. He said that this was a game of words. He said that Alaska had the second highest suicide rate in the U.S. He

questioned the accuracy of diagnosis for a terminal patient, opining that patients would feel pressure to end their lives.

[5:19:55 PM](#)

MICHAEL PAULEY, Alaska Family Council, stated opposition to the proposed bill for three primary reasons: (1) legalizing physician assisted suicide places the vulnerable in jeopardy, as it contained no mandatory requirement for individuals to seek psychiatric consultation for clinical depression or other treatable mental health issues in order to protect the dignity of terminally ill people; (2) physician assisted suicide corrupts the practice of medicine, and he quoted from the Hippocratic Oath, "I will keep the sick from harm and injustice. I will neither give a deadly drug to anybody who asks for it, nor will I make a suggestion to this effect"; and (3) physician assisted suicide will lead to worse violations of human dignity. He concluded that SSHB 54 was dangerous public policy for Alaska, and he urged opposition to the proposed bill.

[5:22:47 PM](#)

CHAIR SPOHNHOLZ announced that public testimony would be left open, and SSHB 54 would be held over.

[5:24:39 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:25 p.m.