HB 372

FISCAL NOTE

STATE OF ALASKA **BILL NO. HB 372**

1998 LEGISLATIVE SESSION

Revision Date:

Title: An Act placing limits on prescribing and providing a contraceptive drug or devise to a minor

Sponsor: DYSON

Requestor: HESS (JUD)

Dept. Affected: Health and Social Services

BRU: Public Assistance Admin

Component: Child Care Benefits

COMPONENT SERIAL NO. 1897

See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	0.0	457.6	457.6	457.6	457.6	457.6
MISCELLANEOUS						
TOTAL OPERATING	0.0	457.6	457.6	457.6	457.6	457.6
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		228.8	228.8	228.8	228.8	228.8
1003 GF Match						
1004 GF		228.8	228.8	228.8	228.8	228.8
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	457.6	457.6	457.6	457.6	457.6

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The proposed legislation restricts the ability of sexually active minors to access contraceptive drugs or devices necessary to reduce the risk of unplanned pregnancies. DPH estimates that 123 teens affected by this legislation will give birth each year. Each year, approximately 40 of these minor parents will become recipients of ATAP. In addition to increased program costs for services to additional minor parents and their dependents, the proposed legislation will make it harder to meet the state's objective to reduce out-of wedlock pregnancies and be one of the 5 states eligible to receive the $20 million bonus from the federal government for reducing out-of wedlock pregnancies.

Teen mothers are less likely to seek prenatal care and are less likely to finish high school. They are more likely to be single parents and poor. The children of teen mothers are at greater risk of low birth weight, dying in its first year of life, being abused or neglected and not receiving sufficient resources for healthy development. Significantly, teen parents and their children have high risk for long-term involvement with social service agencies and reliance on public assistance.

Prepared by: Jim Nordlund

Division: Public Assistance

Phone: 465-2680

Date: 02/13/98

2/24/98

Approved by Commissioner: Karen Perdue, Commissioner

Agency: Department of Health & Social Services

Date: 2/25/98

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FISCAL NOTE - H&SS - CHILD CARE BENEFITS

ANALYSIS (cont.):

Assumptions:

Of the 669 teenagers currently using oral contraceptives, Division of Public Health estimates that 123 will become mothers if unable to gain access to oral contraceptives. DPA estimates that 40 of these new teen mother's will be added to the ATAP caseload each year and will become eligible for PASS I child care assistance. The remaining 83 are potentially eligible for PASS II child care necessary to complete high school or a G.E.D. program or to engage in or pursue employment

1. Legislation is effective 7/1/98

2. The average monthly child care ATAP payment is $310.

3. It is assumed that caseload growth in the first year of implementation will be very low. While 90% or approximately 83 of this population will become pregnant in FY 99. An indeterminate, but smaller percentage will actually give birth and require child care assistance in FY99. For that reason there is no net change for FY 99 expenditures

4. Beginning with FY00 the teen parent ATAP caseload will increase by 40 new cases each year

5. Because minor parents are required to attend school full-time to receive ATAP it is presumed that all minor parents affected by this legislation will require some child care.

6. All other new minor parents affected by this legislation will be eligible for PASS II child care.

Calculations:

40 (number new ATAP cases) X $310 (average monthly child care benefit) = $12,400 x 12 = $148,800 cost per year for new PASS I recipients.

31 (number minor parents eligible for PASS II) x $310 = $25,730 x 12 = $308,780

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. HB 372

Revision Date:
Title: An Act placing limits on prescribing and providing a contraceptive drug or devise to a minor
Sponsor: DYSON
Requestor: HESS (JUD)

Dept. Affected: Health and Social Services
BRU: Public Assistance Admin
Component: Alaska Work Programs
COMPONENT SERIAL NO. 238
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	21.2	85.0	85.0	85.0	85.0	85.0
MISCELLANEOUS						
TOTAL OPERATING	21.2	85.0	85.0	85.0	85.0	85.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	10.6	42.5	42.5	42.5	42.5	42.5
1003 GP Match						
1004 GF	10.6	42.5	42.5	42.5	42.5	42.5
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	21.2	85.0	85.0	85.0	85.0	85.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: 80.0

ANALYSIS: (Attach a separate page if necessary)

The proposed legislation restricts the ability of sexually active minors to access contraceptive drugs or devices necessary to reduce the risk of unplanned pregnancies. DPH estimates that 123 teens affected by this legislation will give birth each year. Each year, approximately 40 of these minor parents will become recipients of ATAP. In addition to increased program costs for services to additional minor parents and their dependents, the proposed legislation will make it harder to meet the state's objective to reduce out-of wedlock pregnancies and be one of the 5 states eligible to receive the $20 million bonus from the federal government for reducing out-of wedlock pregnancies.

Teen mothers are less likely to seek prenatal care and are less likely to finish high school. They are more likely to be single parents and poor. The children of teen mothers are at greater risk of low birth weight, dying in its first year of life, being abused and not receiving sufficient resources for healthy development. Significantly, teen parents and their children have high risk for long-term involvement with social service agencies and reliance on public assistance.

2/26/98

Prepared by: Jim Nordlund
Division: Public Assistance
Phone: 465-2680
Date: 02/13/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/27/98

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ANALYSIS (cont.):

Assumptions:

Of the 669 teenagers currently using oral contraceptives, Division of Public Health estimates that 123 will become mothers if unable to gain access to oral contraceptives. DPA estimates that a total of 40 new teen mother's will be added to the ATAP caseload each year. Considered high-risk, teen-parents require intensive case management and a variety of supportive services to gain self-sufficiency.

1. Legislation is effective 7/1/98

2. The average monthly cost for supportive services is $177.

3. For the purposes of this fiscal note, funding is assumed to be 50% federal receipts and 50% GF match.

4. Increases in these cases during FY99 will be low though most affected teens considered by DPA will become ATAP eligible in the third trimester of their pregnancy . For the purposes of this fiscal note it is assumed that only 50% (n=20) will require welfare to work and other supportive services in the last two quarters of FY 99.

5. Beginning with FY00 the teen parent caseload will increase by 40 new cases each year.

Calculations:

FY00 - FY04

40 (number new ATAP cases) X $177(average monthly cost for supportive services) = $7,080 x 12 = $84,960 cost per year for supportive services.

FY 99

40 X $177 X 6 = $21,240

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. HB 372

Revision Date:
Title: Placing limits on prescribing and providing a contraceptive drug or device to a minor
Sponsor: Dyson
Requestor: House HESS

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-Facility
COMPONENT SERIAL NO. 229
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	851.8	1,007.6	1,242.8	1,494.5	1,763.8	2,051.9
MISCELLANEOUS						
TOTAL OPERATING	851.8	1,007.6	1,242.8	1,494.5	1,763.8	2,051.9
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

	FY99	FY00	FY01	FY02	FY03	FY04
1002 Federal Receipts	509.4	602.5	649.5	781.0	921.8	1,072.3
1003 GF Match	342.4	405.1	593.3	713.5	842.0	979.6
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	851.8	1,007.6	1,242.8	1,494.5	1,763.8	2,051.9

POSITIONS:

	FY99	FY00	FY01	FY02	FY03	FY04
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note assumes that of the 2,471 teen girls (age 15-17) currently eligible for Medicaid, 81 girls who are assumed to be using contraceptives will become pregnant and remain on Medicaid for the birth and delivery of their child as a result of losing access to prescribed contraceptives (based on the YRBS survey, 1995). This estimate is based on state and national data in which teens were surveyed on sexual activity and use of contraceptives. This bill would disproportionately affect access to birth control for low income teens, as the state can only claim federal funding for items that are prescribed. The state has opted to cover over-the-counter birth control products, such as condoms and nonoxynol 9 contraceptive creams, foams, gels and sponges, by prescription in order to provide wider access to these products. The restriction on prescribed contraceptive drugs and devices in HB 372 would limit access to these products for teens.
This fiscal note shows the federal match rate for FY 99-00 at 59.8% and at 52.26% for future years. It assumes that children born each year to teen mothers will remain eligible for Medicaid, as the income eligibility level for children up to age 6 is 133% of the federal poverty level. The teen mothers would themselves remain eligible for Medicaid as children until the age of 21, but this assumption was not included in the fiscal note.

2/20/98

Prepared by: Nancy Weller
Division: Medical Assistance
Phone: 465-3355
Date: 02/19/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/27/98

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Rev 10/96 (fisnote.wk DAS_OMB)

FISCAL NOTE - H&SS - MEDICAID NON-FACILITY

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. HB 372

Revision Date:
Title: An Act placing limits on prescribing and providing a contraceptive drug or devise to a minor
Sponsor: DYSON
Requestor: HESS (JUD)

Dept. Affected: Health and Social Services
BRU: Public Assistance
Component: ATAP
COMPONENT SERIAL NO. 220
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	50.0	199.9	199.9	199.9	199.9	199.9
MISCELLANEOUS						
TOTAL OPERATING	50.0	199.9	199.9	199.9	199.9	199.9
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	25.0	99.9	99.9	99.9	99.9	99.9
1003 GF Match						
1004 GF	25.0	99.9	99.9	99.9	99.9	99.9
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	50.0	199.9	199.9	199.9	199.9	199.9

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: 50.0

ANALYSIS: (Attach a separate page if necessary)

The proposed legislation restricts the ability of sexually active minors to access contraceptive drugs or devices necessary to reduce the risk of unplanned pregnancies. DPH estimates that 123 teens affected by this legislation will give birth each year. Each year, approximately 40 of these minor parents will become recipients of ATAP. In addition to increased program costs for services to additional minor parents and their dependents, the proposed legislation will make it harder to meet the state's objective to reduce out-of wedlock pregnancies and be one of the 5 states eligible to receive the $20 million bonus from the federal government for reducing out-of wedlock pregnancies.

Teen mothers are less likely to seek prenatal care and are less likley to finish high school. They are more likley to be single parents and poor. The children of teen mothers are at greater risk of low birth weight, dying in its first year of life, being abused or negelected and not receiving sufficient resources for healthy development. Significantly, teen parents and their children have high risk for long-term involvement with social service agencies and reliance on public assistance.

3/26/98

Prepared by: Jim Nordlund
Division: Public Assistance
Phone: 465-2680
Date: 02/13/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/27/98

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Rev 10/98/Words etc/OAS_DH55

ANALYSIS (cont.):

Assumptions:

Of the 689 teenagers currently using oral contraceptives, Division of Public Health estimates that 123 will become mothers if unable to gain access to oral contraceptives. DPA estimates that a total of 40 new teen mother's will be added to the ATAP caseload each year.

1. Legislation is effective 7/1/98

2. Increases in these cases during FY99 will be low though most effected teens considered by DPA will become ATAP eligible in the third trimester of their pregnancy . For the purposes of this fiscal note it is assumed that only 50% (n = 20) will receive ATAP in the last two quarters of FY 99.

3. Beginning with FY00 the average annual teen parent caseload will be 40 cases. Of these:

a. DPA estimates an annual average of 24 new minor parent cases with an average monthly ATAP payment of $626.

b. An average of 16 teen parents will be already be receiving ATAP as a dependent on their parent's case. The minor parent's child will add an increment of $102 each month to on-going cases.

4. For the purposes of this fiscal note, funding is assumed to be 50% federal receipts and 50% GF match.

Calculations:

FY99
12 (number new ATAP cases) X $626 (average monthly ATAP benefit) = $7,512 x 6 = $45,072 cost for new ATAP cases.

8 (Number of children added to existing case) X $102 (increment for new child) = $816 X 6 = $4,896

FY00 - 04
24 X $626 X 12 = $180,288 cost per year for new ATAP cases.

16 X $102 X 12 = $19,584 cost per year for additional child added to existing ATAP case.

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REPRESENTATIVE FRED DYSON

HB 372
Sponsor Statement

"An Act placing limits on prescribing and providing a contraceptive drug or device to a minor."

Alaskan families feel besieged as they try to manage and raise their children. The issue of third parties being able to perform medical services to an unemancipated minor is firmly established in our traditions and only recently has it been challenged. The question of providing required emergency services has been settled in law and in court.

The more recent battle grounds have been in the area of birth control services. Last year the legislature passed legislation requiring parental consent for elective abortions and that will be tested in court. HB 372 further defends the rights of parents by asserting, in Alaska State law, that a physician may not issue prescription birth control devices or prescriptions to a minor unless:

(1) the minor is emancipated;
(2) the minor has the written consent of one of a custodial parent or guardian;
(3) a court has ordered that the minor may receive it; or
(4) written notice has been given to a custodial parent or guardian at least five business days prior.

file: PARENTAL CONSENT ON PRESCRIPTION CONTRACEPTION

February 18, 1998

Dear Representative Dyson,

I am fully in support of your parental consent bill, which I recently read about in the Fairbanks News Miner.

President Clinton stated today, "**What parents don't know can hurt their kids**." He was referring to the fact that many eligible families do not sign their children up for federally funded health programs.

On the other hand (or out of the other side of his mouth) President Clinton supports access to *free birth control and abortion* without parental consent or knowledge!

Here in Fairbanks a young woman (well under 18), can go to our public health clinic and receive birth control pills and a *pelvic examination* without her parent's knowledge or consent. This, in my opinion, undermines essential family values that we, as parents, spend our lives trying to instill in our children. The state or federal government should not have the right to casually destroy that foundation.

Aside from the moral issue, there is no way for the public health workers to know *for sure* if this child is taking any other medications prescribed by a family doctor, or doctors. There could be serious health issues involved that the child may not perceive as important to mention at the public health clinic. The strong desire to engage in sexual activity can easily outweigh common sense.

The role of the parents is to love and protect, nurture, and educate. The state, by undermining the family, and in giving encouragement and "privacy" to underage girls in this way is guilty of child abuse: emotional, physical, and sexual.

Sincerely in concern
for our youth,

Carol J. Sanford

Carol J. Sanford
1301 Viewpointe Dr.
Fairbanks, AK 99709
907-479-4674

Jessica Harmon
9024 W. Parkview Ter. Lp.
Eagle River, AK 99577

Mr. Fred Dyson
State Capitol
Juneau, AK 99801182

FEB 2 7 1998

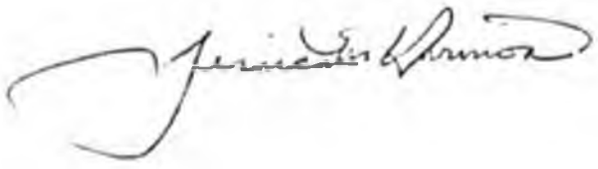
Dear Mr. Dyson,

I am a senior at Chugiak High School and recently read about your proposed bill which would require parental consent for minors to receive prescription drugs or birth control.

I am supportive of your effort to create communication between parents and their kids. I feel that communication is essential in a good parent/child relationship. I personally believe in abstinence, but if some one does make the decision to go ahead and have sex, I believe *both* parties should talk with their parents beforehand. It is the parents' business, because they raised a child and they only care for his or her well being.

I do support your bill because communication is lessening between parents and their children, and we need bills that will promote interaction between kids and their parents.

Very truly yours,



POM for Representative Dyson

H

From: Ms. Alice C Bergland
2210 W 70th Ave
Anchorage, AK 99502 NON constituent

Telephone: 248-5689
Registered Voter: Y

Bill: HB 372 Title: LIMITS ON CONTRACEPTIVES TO MINORS
Message:

PARENTS HAVE A RIGHT AND A NEED TO BE INFORMED ON ABORTION OR ANY FORM OF BIRTH CONTROL FOR UNDER AGED CHILDREN. THIS WILL HELP HOLD THE PARENTS RESPONSIBLE FOR THEIR CHILDRENS ACTIONS.

Entered in ANC on 3/17/98 POMID: 3891 Distribution: 60

POM for Representative Dyson

H

From: Mrs. Debra I. Joslin
PO Box 377
Delta Junction, AK 99737 NON constituent

Telephone: 895-4565
Registered Voter: Y

Bill: HB 372 Title: LIMITS ON CONTRACEPTIVES TO MINORS
Message:

PLEASE PASS THIS BILL.

Entered in DJT on 3/02/98 POMID: 1999 Stored Distribution: 7

POM for Representative Dyson

H

From: Ms. Anita Byers
PO Box 865
Soldotna, AK 99669 NON constituent

Telephone: 262-6188
Registered Voter: Y

Bill: HB 372 Title: LIMITS ON CONTRACEPTIVES TO MINORS
Message:

I SUPPORT AND URGE YOU TO VOTE FOR ITS PASSAGE.

Entered in SOL on 2/24/98 POMID: 1706 Distribution: 12

cc:Mail for: Representative Fred Dyson

Subject: HB372

From: mccalld@customcpu.com (McCall, Dorine/Jim) at CC2MHS1 2/19/98 5:08 PM

To: Representative Fred Dyson at LAA_TRANS

Representative Dyson:

Attention to: Representative Con Bunde

HB372 sounds like a good bill to have in place. It just makes sense and I agree contraceptive drugs and devices should be treated as any other medical procedure or service. Contraceptive drugs and devices are medical procedures and using these things should not be done without permission of a parent. The parents need to be responsible for their children. Allowing 3 additional parental bypasses if the parent/child relationship is not good is a necessary part of this bill. That is good.

SO, I would like to see HB 372 scheduled in House HESS.

Jim and Dorine McCall
18161 Tedrow Dr.
Eagle River, AK 99577

Solea Haight
3784 McGinnis Drive
Juneau, ALaska 99801

(907) 790-3423

I am writing to express my support of **House Bill 372.** Please give this serious consideration.

Thank you,

Solea Haight

cc:Mail for: Representative Fred Dyson

Subject: HB 372
From: erwalker@alaska.net (ENLOW R. WALKER) at CC2MHS1 3/4/98 11:31 AM
To: Representative Con Bunde at LAA_HBUN
To: Representative Joe Green at LAA_TRANS
To: Representative Tom Brice at LAA_TRANS
To: Representative Fred Dyson at LAA_TRANS
To: Representative Allen Kemplen at LAA_TRANS
To: Representative Brian Porter at LAA_TRANS
To: Representative Al Vezey at LAA_TRANS

To all committee members,
I am writing to you in support of HB 372. Please pass this bill and continue to fight for parental rights. It is my sincere belief that parents should be the final athourity over their children(not the state - it doesn't "take a village...") and have a say in every part of their lives until the children reach adulthood(18).
Thank you,
Brian Walker
North Pole, Ak

Support HB 372

3-2-98
To: Representatives Green, Brice, Dyson and Vezey
" Bunde, Kemplen, Porter

From: Jonathan and Ruth Ewig
2325-30th Avenue
Fairbanks, Alaska 99701
907-452-5538 (also a fax line)

RE: PLEASE SUPPORT HB 372 which protects our rights within our families and acknowledges our important role as parents in the lives of our minor children. If something goes wrong when medical decisions are made without our knowledge or permission, we are STILL notified and have to pick up the pieces of a tragedy that we had no part in. The law needs to be consistent in protecting minors. Medical decisions are important, and therefore, need to be made including all parties involved and affected by the result.

Sincerely yours,
Ruth
Ruth Ewig
A parent of minor children

MAR 0 2 1998

cc:Mail for: Representative Fred Dyson

Subject: CONTRACEPTIVES BILL 272
From: lahamer@alaska.net (Lee Ann Hamerski) at CC2MHS1 2/13/98 3:28 PM
To: Representative Fred Dyson at LA _TRANS

Hi Fred:
You have our support and we really appreciate your looking out for kids when so many others, ie makers of contraceptives, health workers, NEA, etc, are seeking to exploit kids under the guise of concern.
Lee Ann Hamerski and family

cc:Mail for: Representative Fred Dyson

Subject: HR 372
From: illguth@ptialaska.net (Tammy Illguth) at CC2MHS1 2/13/98 7:43 AM
To: Representative Fred Dyson at LAA_TRANS

Thank You for supporting HR 372. As a parent it is very important to us to know that I can have a say in items relating to our children.

Erik and Tammy

cc:Mail for: Representative Fred Dyson

Subject: HB 372
From: ajc12@cencentric.net at CC2MHS1 2/12/98 9:34 PM
To: Representative Fred Dyson at LAA_TRANS

I am writing in support of HB 372 to treat contraceptives the same as other medical services or procedures.

HB 372 SS AN ACT PLACING LIMITS ON PRESCRIBING AND PROVIDING A CONTRACEPTIVE DRUG OR DEVICE TO A MINOR

STATISTICS:

According to 1995 reports from the Youth Behavioral Risk Factor Survey (YBRFS)

- 13,422 young women ages 15-17 yrs of age
- 5956 were EVER sexually active
- 3866 were CURRENTLY sexually active
- 669 or 17% were using an oral contraceptive (10% 15 yr. olds—20% 16-17 yr. olds)
- NO young women under 15 were using an oral contraceptive- although 2575 out of 15,571 said they have been and are sexually active.
- About 60% reported they had used a condom the last time they had sex.

According the Alaska Bureau of Vital Statistics

- Between 1980 and 1995 the number of births to young women under 18 grew from 280 to 415.
- This is a 67% increase in 15 years.
- Simultaneously the births to 18-19 year olds held even as births to 20-29 year olds dropped significantly

Issues:

- No one under 15 years of age reported using an oral contraceptive
- Only 17% of 15-17 year olds report using an oral contraceptives
- Births have increased dramatically

Impact:

- If 41% of the 669 young women, ages 15-17, currently using oral contraceptives stop based on having to get their parents involved in the decision we can expect 274 will stop.
- We know that fully 90% of sexually active women will get pregnant within a year if they are not using a contraceptive (246 out of the 274 stopping using oral contraceptives) We will assume 50% will do something else to prevent a pregnancy, leaving us with 123 additional pregnancies in this age group as a result of this bill

Why should we want 15-17 year olds to access prescription contraceptives?

- It is better physically for the girls to be on an oral contraceptive than to carry a child to term (5x more risk to bear a child than use an oral contraceptive)
- The long-term impact on a girl becoming a mother at this age is extremely negative- her own growth and development is impeded, her ability to achieve her own persona

goals are impeded and her long term ability to be economically self-sufficient is greatly diminished.
- The infant is at risk for abuse and neglect based on the mothers own immaturity and if the father is a teen, his immaturity as well

Summary
- Best option is for these young women to not be sexually active
- If they are, preventing a pregnancy is the best option
- Prescription contraceptives offer the best protection from an unwanted pregnancy.

Financial Cost to the State
- A significant number of the young women getting pregnant as a result of their inability to access a prescription contraceptive will need assistance from the Divisions of Medical Assistance and Public Assistance.

Difference Between Father's and Mother's Age
Alaska, 1994-1996

Mother's Age	Father's Age: Younger	Same Age	1-4 Years Older	5-9 Years Older	10-19 Years Older	20+ Years Older	Unknown
13	0	0	1	1	0	0	6
14	0	0	12	1	1	1	27
15	0	4	52	22	6	1	72
16	6	16	131	63	17	1	168
17	14	35	238	95	33	2	219
Total	20	55	434	182	57	5	492
% <17	1.6%	4.4%	34.9%	14.6%	4.6%	0.4%	39.5%
18	47	84	372	152	52	4	230
19	79	117	542	223	73	10	257
Total	126	201	914	375	125	14	487
% 18-19	5.6%	9.0%	40.8%	16.7%	5.6%	0.6%	21.7%
Total	146	256	1348	55	182	19	979
% all teens	4.9%	8.6%	45.2%	1.8%	6.1%	0.6%	32.8%

TO: House H.E.S.S. Committee
REGARDING: HB 372
DATE: March 31, 1998
FROM: Rick Mitcham
PO Box 210124
Anchorage, AK 99521

I am here today in support of House Bill 372, where any medical authority who prescribes contraceptive drugs ~~or devices~~ may not prescribe them to a minor without first in good faith effort obtain relevant medical records for the minor. This is simply for the physical health safety of that person. There is no way to know whether any prescription will have any serious health consequences for that minor. It is always common practice before any doctor prescribes medication for any person to first know if they are on any other medication or is allergic to anything. It is common practice to know of the medical history of the family. It is unlikely that all minors know fully of their medical background or any family history of diseases. Please support this common sense practice and support HB 372. Thank you.

HB372

Testimony by Cynthia Brooke, MD
3/31/98

I am a licensed practicing obstetrician and gynecologist in Anchorage. Currently I am acting as spokesperson for the Alaska Section of the American College of Obstetricians and Gynecologists or ACOG which is a national organization of Board Certified OB/GYN physicians which is a specialty dealing with women's health. Many local ACOG physicians are concerned about recent bills which we feel will have a negative impact on Alaskan women.

ACOG is especially concerned about Dyson's Bill- - HB 372.

Contraceptives save lives. A healthy nonsmoking female who carries a pregnancy to full term is six times more likely to die than if she used oral contraceptives.

And this is just the beginning of the story. Oral contraceptives alone save this country millions of health care dollars every year.

Some people feel this figure is conservative and may extend into the billions of dollars. It does this by preventing about 130,000 hospitalizations annually. This includes hospitalization for women with breast disease,

ovarian cysts, anemia, pelvic inflammatory disease, ectopic pregnancy, rheumatoid arthritis, and uterine and ovarian cancer.

Yes, you read correctly -- in addition to the prevention of death and severe illness from unwanted pregnancies, oral contraceptives also have a profound beneficial effect on many diseases in women, including a 50% reduction in uterine and ovarian cancer.

Multiple medical studies in the last 10 to 20 years have resulted in a new thinking about oral contraceptives, so that now they are commonly used for treatment and prevention of disease, not just prevention of pregnancy. Because of this, ACOG has long supported the view that oral contraceptives should be provided to women by their insurance companies, just as any other prescriptive medication. We defy anyone to name any other medication ever approved by the FDA that has had such a profound and far-reaching positive impact on the lives of so many worldwide. We submit to you that there is no logical reason not to cover contraceptives. The medical facts are overwhelming.

The only reason that can be conceived is that insurance companies do not make preventive care a priority and oral contraceptives are associated with reproductive health benefiting only women. As we well know, women have historically received low priority when it comes to health care dollars.

Dyson's House Bill 372 would limit access of oral contraceptives to minors, by requiring parental permission for minors to receive oral contraceptives. Because teenagers will frequently not admit sexual activity to their parents, the result would be decreased access to teenagers of contraceptives and sexually transmitted disease counseling. In light of the medical benefits of oral contraceptives, it seems that this bill would discriminate on the basis of age . . . . Minors would not have access to the same health care benefits that older women enjoy.

Beyond this, the logic of this bill is not apparent in light of current knowledge regarding teenage pregnancy. Multiple studies have shown that teenage sexual activity is not affected by availability of contraception. Rather, the most successful deterrent to teenage sexual activity is parental openness to discussion of sexual issues with their teenagers.

A recent USA Today article summarized studies from the Centrer for Disease Control., which showed a link between teenagers who delay their first sexual encounter beyond 20 years of age with educational level of their parents. Indeed, two out of three teens with college educated parents report remaining virgins well into young adulthood. This finding is being interpreted as proof that teens with future goals start sexual activity later and obviously their parents are serving as examples.

Whether or not a teenager will have intercourse is determined by an internal moral compass which is most profoundly influenced by his or her parents, personal goals and sense of self-esteem. Teenage pregnancy prevention programs, which address these issues, will be successful. Simply passing a bill, which limits access to contraception, will simply increase the teenage pregnancy rate without addressing the real issues surrounding teenage sexuality.

Research shows that teenage pregnancy costs society about 37 billion dollars annually. This is because "teenage mothers are significantly less likely to receive a high school diploma than women who postpone

childbearing. They are more likely to live in poverty, receive public assistance, and have long periods of welfare dependency. Adolescent fathers finish fewer years of schooling, earn less income annually by age 27, and participate less in the work force than men who delay fathering until age 21. Children of adolescents are more likely to have health and cognitive disadvantages and to be neglected or abused. The daughters of adolescents are more likely to become adolescent mothers themselves, and the sons of adolescents are more likely to be incarcerated." Obviously limiting access of contraceptives to teenagers would increase health care costs significantly and would have a negative impact on all of us.

Include ACOG Fact Sheet, 1998

Adolescent Pregnancy Fact Sheet

In 1994, an estimated 910,600 U.S. teenagers 15–19 years old became pregnant in the United States, resulting in 505,500 live births, 276,380 induced abortions, and 128,730 fetal losses. The same year, nearly 29,000 women under age 15 also became pregnant (1). Compared with other industrialized countries, the U.S. teen pregnancy rate is twice as high as in England, Wales, and Canada, and more than nine times as high as in the Netherlands and Japan (2).

Health Risk Behaviors of Adolescents

Data on trends in health risk behaviors come primarily from the following four sources:

- The 1995 national school-based Youth Risk Behavior Survey (YRBS) conducted by the Centers for Disease Control and Prevention on the sexual behavior of U.S. high school students. More than 16,000 students in grades 9–12 from the 50 states, the District of Columbia, and the U.S. Territories were interviewed for the survey. The survey is a component of the Centers for Disease Control and Prevention Youth Risk Behavior Surveillance System (3). Previous surveys were conducted in 1990, 1991, and 1993.
- The 1995 National Survey of Family Growth (NSFG) conducted by the National Center for Health Statistics on factors affecting pregnancy and women's health in the United States. The data are based upon in-person interviews with a national sample of 10,847 women aged 15–44 years (4). Previous surveys of this type were conducted in 1973, 1976, 1982, 1988, and 1990.
- The 1995 National Survey of Adolescent Males (NSAM) conducted by the Urban Institute and sponsored by the National Institute of Child Health and Human Development and the Office of Population Affairs. To compile data on reproductive and sexual behaviors, a nationally representative sample of over 1,700 males aged 15–19 years were interviewed. The data from the 1995 survey have been compared with a 1988 survey of the same type to analyze trends (5).
- The most recent survey on the health risk behaviors of adolescents is the National Longitudinal Study on Adolescent Health. This study was undertaken by the National Institute of Child Health and Human Development in response to a congressional mandate in 1993. It is a school-based study of more than 90,000 students in grades 7–12 attending 145 schools, the school administrators, and 18,000 parents across the United States designed to assess how individual, family, and school characteristics affect sexual behaviors, contraceptive use, and pregnancy history, among other adolescent health behaviors. Due to its newness, trend data is not available from this survey (6).

Sexual Behavior

According to the YRBS, a small decrease occurred from 1991 to 1995 in the percentage of high school students who reported having had sexual intercourse (Table 1) (3, 7). This trend was confirmed by the NSFG and the NSAM, although it was more pronounced in the latter two surveys. Nearly 50% of adolescent females between the ages of 15 and 19 years reported in the 1995 NSFG that they had had sexual intercourse, compared with 55% in 1990 (4). Similarly, 55% of adolescent males aged 15–19 years reported in the 1995 NSAM that they had had sexual intercourse, compared with 60% in 1988 (5). A slight decrease also occurred in the percentage of high school students reporting in the YRBS that they have had sexual intercourse with four or more partners during their lifetime. There was also a slight increase in the percentage of students reporting that they had sexual intercourse during the 3-month period before the survey (3, 7).

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920

Contraceptive Use

The percentage of high school students who reported in the YRBS that they used birth control pills before last sexual intercourse decreased to 17.4% in 1995 after a steady increase to 18.4% in 1993 (Table 1). Improvements, however, can be seen in condom use (Table 2). In 1995, sexually active African-American teens were most likely to report condom use, as has been the case since 1991. Specifically, 66.1% reported condom use in 1995, which represents an increase of 9.6% from 1993. Reported condom use for all sexually active adolescents has increased as well from 46.2% in 1991 to 54.4% in 1995 (3, 7). Results of the NSFG and the NSAM also indicate increased condom use at first intercourse (4, 5).

Table 1. Youth Risk Behavior Survey—1991, 1993, 1995. Percentage of High School Students Who Reported Selected Sexual Risk Behaviors by Year

Behavior	1991	1993	1995
Ever had sexual intercourse	54.1	53.0	53.1
Have had sexual intercourse with four or more partners ever lifetime	18.7	18.8	17.8
Had sexual intercourse during the 3 months preceding the survey	37.5	37.6	37.9
Used birth control pills prior to last sexual intercourse*	17.8	18.4	17.4

* The wording of the question about birth control pill use in the 1995 Youth Risk Behavior Survey was changed to inquire about birth control use prior to last sexual intercourse, instead of at last sexual intercourse.

Data from the Centers for Disease Control and Prevention. Trends in sexual risk behavior among high school students—United States, 1990, 1991, and 1993. MMWR 1995;44:124–125

Kann L, Warren CW, Harris WA, Collins JL, Williams BI, Ross JG, et al. Youth Risk Behavior Surveillance—United States, 1995. MMWR CDC Surveill Summ 1996;45(No.SS-4):1–84.

Table 2. Youth Risk Behavior Survey: Percentage of High School Students Reporting Condom Use at Last Sexual Intercourse, 1991, 1993, and 1995*

Characteristic	1991	1993	1995
Sex			
Female	39.0	48.0	48.6
Male	54.6	59.2	60.5
Race/Ethnicity			
White	46.6	52.3	52.5
African American	48.0	56.5	66.1
Hispanic	37.6	46.1	44.1
Total	46.2	52.6	54.4

* Only students reporting sexual intercourse during the 3 months preceding the survey are included.

Data from Centers for Disease Control and Prevention. Trends in sexual risk behavior among high school students—United States, 1990, 1991, and 1993. MMWR Morb Mortal Wkly Rep 1995;44:124–125

Kann L, Warren CW, Harris WA, Collins JL, Williams BI, Ross JG, et al. Youth Risk Behavior Surveillance—United States, 1995. MMWR CDC Surveill Summ 1996;45(No.SS-4):1–84.

Early Sexual Intercourse

Teens who are at greatest risk for engaging in early intercourse are those who 1) live in rural areas; 2) have parents who receive welfare; 3) are African American; and 4) are from the South (6). In addition, the likelihood of early first intercourse among females is higher when there is a large age difference between the female adolescent and her partner. A large difference in age of this type is also correlated with the following factors: 1) lower likelihood of contraceptive use at first intercourse; 2) higher likelihood of teen birth; 3) higher number of sexual partners among females during the teen years; and 4) higher likelihood among females of experiencing voluntary, but unwanted, first sexual intercourse (Fig. 1) (8).

Teens who are younger than age 16 years when they have first sexual intercourse are more likely to report that it was nonvoluntary. Specifically, 16% of female adolescents under 16 years of age reported in the NSFG that their first intercourse was nonvoluntary, compared with 7% of those whose first intercourse occurred at age 16 years or older. For those females reporting voluntary first intercourse before the age of 16, 76% stated that their partner was between the ages of 20 and 24 years; 6% stated their partner was 25 years of age or older (4).

Several factors related to schooling have been identified as being associated with a delay in first intercourse: 1) feeling connected to school; 2) attending a parochial school; and 3) attending a school with a high overall average daily attendance. The following family characteristics also protect adolescents from early sexual intercourse: 1) feeling connected to parents and family; 2) perceived disapproval by parents of adolescent sex; and 3) perceived disapproval by parents of adolescent use of contraception (6).

Sexually Transmissible Infections

Each year, 3 million adolescents are infected with sexually transmissible infections. This accounts for 25% of the 12 million new cases of sexually transmissible infections in the United States annually. Rates of sexually transmissible infections for females tend to be higher than those for males. This discrepancy can be attributed partially to the focus of screening programs on females that result in a lack of identification of males with sexually transmissible infections. Also, many sexually transmissible infections are

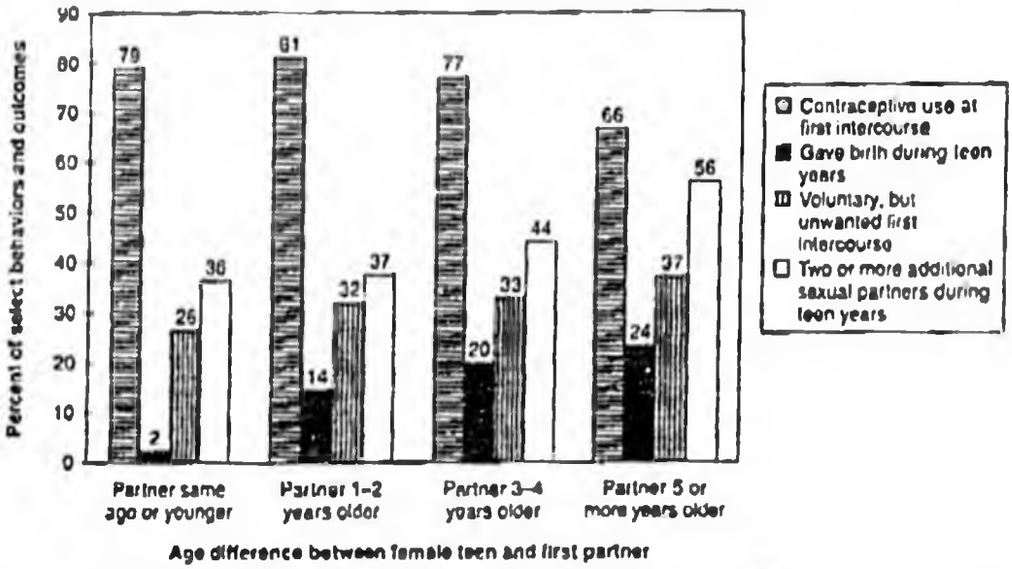


Fig. 1. Percent of select female teen (aged 15–19) behaviors and outcomes by age difference between female teen and first partner. (Data from Moore KA, Driscoll A. Partners, predators, peers, protectors: males and teen pregnancy. Washington, DC: Child Trends, Inc, 1997.)

transmitted more efficiently from males to females than from females to males. The cost to society of sexually transmissible infections to adolescents, as well as adults, was nearly $17 billion in 1994 (9).

Chlamydia

In 1996, 366,406 cases of chlamydial infection were reported to the Centers for Disease Control and Prevention. Adolescent females aged 15–19 years had the highest rates of chlamydial infection, with 2,068.6 cases per 100,000 females in that age group. Of the 306,694 cases in females for whom age data were available in 1996, 8,889 (3%) were of those 10–14 years old; 134,359 (44%) were of those 15–19 years old; and 98,543 (32%) were of those 20–24 years old (10). The Centers for Disease Control and Prevention estimates that the actual annual incidence of chlamydia is 4 million cases—half of which are among females 15–19 years of age—and that as many as 1 in 10 adolescent females tested for chlamydia is infected.

Gonorrhea

Gonorrhea rates have declined fairly steadily overall since 1975 (Fig. 2). In 1996, rates of gonorrhea in 10–14-year-old and 15–19-year-old adolescents decreased to 32.9 cases per 100,000 and 570.8 cases per 100,000, respectively. Even with these decreases, 15–19-year-old females had the highest and 15–19-year-old males had the second highest age-specific rates among females and males, respectively. In addition, the disparity between rates for white and African-American adolescents is considerable. In 1996, African-American females aged 15–19 years had gonorrhea rates of 3,790.9 cases per 100,000; African-American males had rates of 2,357.2 per 100,000. These rates are on average 24 times higher than those for their white counterparts (10).

Herpes

It is estimated that by the mid-1990s, 5.6% of the 12–19-year-old population was infected with the herpes simplex virus type 2. The seroprevalence of herpes simplex virus type 2 among white teenagers between the ages of 12 and 19 was 0.96% in the late 1970s. This rate quintupled to 4.5% by the mid-1990s. Among African Americans, the increase over this period was smaller and did not reach statistical significance. However, the seroprevalence of herpes simplex virus type 2 among African Americans remains higher than that of whites at 8.7% (11).

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome

In 1996, 554 new cases of human immunodeficiency virus (HIV) infection were reported among adolescents 13–19 years old; 1,680 new cases were reported among 20–24 year olds. African-American adolescents are especially vulnerable to HIV. Among youths 13–19 years old with HIV, 64% are African American. In addition, although the

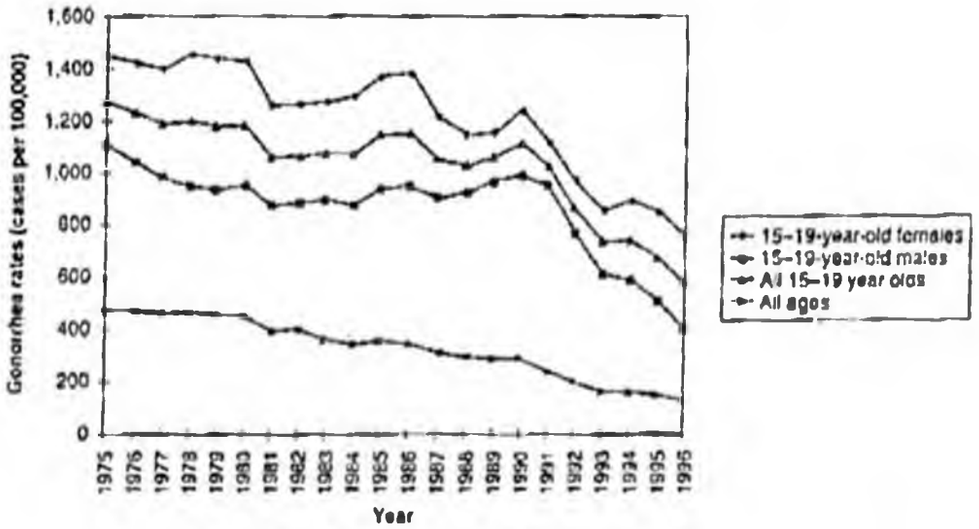


Fig. 2. Gonorrhea rates for adolescents as compared with the entire population: 1975–1996. (Data from numerous editions of Centers for Disease Control and Prevention. Sexually transmitted disease surveillance. U.S. Department of Health and Human Services, Public Health Service. Atlanta, Georgia: Centers for Disease Control and Prevention.)

number of adolescents aged 13–19 with acquired immunodeficiency syndrome (AIDS) is relatively low, it has risen from 1 case in 1981 to 2,754 cases in 1996; 403 of these cases were newly diagnosed in 1996. There were also 2,171 new cases of AIDS diagnosed among those 20–24 years of age (12). This is a decrease from 586 and 3,910, respectively, in 1993 (13). Because infection may occur 10 years or more before AIDS is diagnosed, most of the people aged 20–24 were infected with HIV as either adolescents or preadolescents.

Syphilis

Rates of primary and secondary syphilis in 15–19-year-old adolescents have decreased substantially since 1993. Rates for females 15–19 years of age decreased from 23.5 cases per 100,000 in 1993 to 8.6 per 100,000 in 1996. For males, the rates fell from 10.8 cases per 100,000 in 1993 to 4.3 per 100,000 in 1996. Rates for 10–14-year-old adolescents decreased from 0.9 cases per 100,000 in 1993 to 0.3 cases per 100,000 in 1996. The rates for 10–14-year-old girls decreased from 1.6 cases per 100,000 in 1993 to 0.5 cases per 100,000 in 1996. For boys, the rates fell from 0.3 cases per 100,000 in 1993 to 0.1 per 100,000 in 1996 (10).

Adolescent Pregnancy

The estimates of pregnancies are the sum of live births, induced abortions, and fetal loss outcomes. Although national data on the number of live births are published annually by the National Center for Health Statistics, it is more difficult to assemble timely data on induced abortions and fetal losses. Therefore, the most recent year for which detailed information on teen pregnancy is available is 1994. Pregnancy rates for teenagers remain high in the United States, even though decreases have been occurring in the past few years. In 1994, the pregnancy rate for teens 15–19 years old decreased to 106.1 per 1,000 from 115.0 per 1,000 in 1990 (Table 3) (1, 14).

The most recent comparative state data available on adolescent pregnancy are from 1992. For more recent data on an individual state, contact the state's health department. In 1992, the pregnancy rates for females 15–19 years old decreased in many states from those in 1991. In 1991, pregnancy rates for 15–19 year olds ranged from 54.3 per

Table 3. Pregnancy Rates (per 1,000 Women in Specified Group) by Age

Age (y)	1980	1985	1990	1994
<15	3.2	3.6	3.3	3.2*
15–19	110.0	106.9	115.0	106.1

*Calculation of 1994 rates for adolescents less than 15 years of age is based on data from Henshaw SK. U.S. teenage pregnancy statistics. New York, New York: The Alan Guttmacher Institute, 1997, and U.S. Bureau of the Census. U.S. population estimates, by age, race, sex and Hispanic origin: 1990 to 1996. PPL-97. Suitland, Maryland: U.S. Bureau of the Census, 1997.

Ventura SJ, Taffel SM, Mosher WD, Wilson JB, Henshaw S. Trends in pregnancies and pregnancy rates: estimates for the United States, 1980–92. Monthly vital statistics report; vol 43, no 11 (suppl). Hyattsville, Maryland: National Center for Health Statistics, 1995.

Henshaw SK. U.S. teenage pregnancy statistics. New York, The Alan Guttmacher Institute, 1997.

1,000 in North Dakota to 109.2 per 1,000 in Georgia. In 1992, the rates ranged from 53.7 per 1,000 in Wyoming to 106.9 per 1,000 in Georgia (Table 4). From 1991 to 1992, pregnancy rates for 15–19 year olds decreased significantly in 31 of the 42 states for which age-specific data were available. Among states with decreased pregnancy rates, the percentage decrease generally was greater for whites than for African Americans (15).

In 1991, pregnancy rates for those younger than 15 years of age ranged from 1.8 per 1,000 in Idaho to 10.6 per 1,000 in Georgia. In 1992, the pregnancy rates ranged from 2.0 per 1,000 in Idaho to 10.9 per 1,000 in Mississippi (15).

Table 4. Pregnancy Rates (per 1,000) for Women 15–19 Years Old by State and Race, United States 1991–1992

State	1991			1992		
	White	African American	All Women	White	African American	All Women
Alabama	77.2	139.1	97.0	73.4	134.7	93.2
Arizona	—*	—	106.2	102.3	150.6	103.5
Arkansas	80.4	153.3	98.2	76.7	142.6	90.7
Colorado	—	—	82.3	—	—	79.8
District of Columbia	—	—	226.1	—	—	208.4
Georgia	82.2	165.1	109.2	79.6	162.9	106.9
Hawaii	70.3	—	89.0	64.7	—	86.4
Idaho	63.9	—	63.9	59.4	—	59.7
Indiana	66.3	161.2	75.3	62.9	156.7	72.2
Kansas	73.1	177.2	80.1	77.8	211.9	87.0
Kentucky	82.2	155.0	86.3	75.5	149.9	81.7
Louisiana	86.3	131.4†	92.0	85.3	133.7†	92.6
Maine	64.4	—	64.8	54.9	—	55.2
Maryland	55.6	136.3	79.6	51.0	137.1	76.9
Massachusetts	—	—	74.0	—	—	69.5
Michigan	—	—	82.9	—	—	79.7
Minnesota	—	—	59.5	47.3	218.1	55.2
Mississippi	—	—	105.5	71.9	135.1	100.8
Missouri	65.1	193.0	82.6	60.9	186.0	78.0
Montana	68.9	—	75.6	61.8	—	70.2
Nebraska	—	—	69.4	—	—	63.4
Nevada	108.0	166.6	108.9	101.9	171.2	106.0
New Jersey	52.4	179.1	74.6	41.2	178.7	69.7
New Mexico	101.4	132.7	103.0	102.2	100.8	101.6
New York	76.1	173.2	94.4	77.3	178.9	96.0
North Carolina	86.5	163.2	108.8	83.3	155.3	104.6
North Dakota	47.5	—	54.3	47.8	—	54.2
Ohio	—	—	80.9	—	—	74.9
Oregon	69.5	200.9	89.5	72.4	181.7	81.0
Pennsylvania	59.0	214.9	75.9	53.5	211.5	71.7
Rhode Island	80.7	214.5	89.4	78.0	211.8	88.1
South Carolina	74.2	129.5	94.6	69.6	119.6	89.0
South Dakota	48.4	—	57.5	46.5	—	59.4
Tennessee	85.9	168.4	102.0	77.4	162.4	94.0
Texas	98.2	152.9	104.3	98.2	140.8	103.7
Utah	58.4	—	59.4	54.2	—	55.6
Vermont	77.9	—	78.0	68.4	—	68.7
Virginia	69.2	143.9	84.8	62.9	139.4	79.0
Washington	—	—	91.7	—	—	85.1
West Virginia	62.9	100.3	63.8	64.6	116.9	66.1

* — Pregnancy rate could not be calculated due to a lack of data.

† Rate is for all races other than white.

Centers for Disease Control and Prevention. State specific pregnancy and birth rates among teenagers — United States 1991–1992. MMWR Morb Mortal Wkly Rep 1995;44:678–680.

Table 5. Number (Rate) of Abortions Among Adolescents by Year and Age*

Age (y)	1975	1980	1985	1990	1994
<15	15,260 (1.5)	15,340 (1.7)	16,970 (2.0)	12,580 (1.5)	12,150 (1.3)
15–19	326,780 (31.2)	444,780 (42.8)	399,200 (43.5)	350,970 (40.6)	276,380 (32.2)

* Abortion rate is number of abortions per 1,000 women of specified age group.

Henshaw SK. U.S. teenage pregnancy statistics. New York, New York: The Alan Guttmacher Institute, 1997.

Ventura SJ, Taffel SM, Mosher WD, Wilson JB, Henshaw S. Trends in pregnancies and pregnancy rates: estimates for the United States, 1980–92. Monthly vital statistics report; vol 43, no. 11 (suppl). Hyattsville, Maryland: National Center for Health Statistics. 1995.

Pregnancy Outcome

Abortion

In 1995, 1,210,883 legal abortions for females of all ages were reported to the Centers for Disease Control and Prevention—a 4.5% decrease from the number reported in 1994. These data are preliminary. As a result, abortion data specific to teens less than 15 years of age and to teens 15–19 years of age are not yet available. It is estimated that 243,387 abortions were performed on teens less than 19 years of age (16). The most recent age-specific data indicate that an estimated 276,380 abortions were performed on adolescents 15–19 years old in 1994 (Table 5). The 1994 abortion rate for teens was 32.2 abortions per 1,000 females aged 15–19 years (1). The percentage of pregnancies to adolescents aged 15–19 years ending in abortion has decreased from 46.0% in 1985 to 35.3% in 1994 (Table 6) (1, 17).

Births to Adolescent Mothers

In 1996, 12.6% of all births in the United States were to adolescents 15–19 years old. That year, a total of 494,272 babies were born to females 15–19 years old in the United States—representing a decline in both the number of births and the birth rate from 1990 (Table 7). The 1996 birthrate for 15–19 year olds was 54.7 per 1,000 females. The number of births among African-American teens 15–19 years old steadily declined from 151,613 in 1990 to 131,059 in 1996 (18).

In 1996, 11,242 infants were born to adolescents under age 15, a decrease from 11,657 in 1990, although the birthrate has not declined considerably. A total of 5,227 babies were born to African-American teenagers under age 15 years in 1996; that year, 5,570 babies were born to white teenagers in the same age group (18).

The number of births to adolescent mothers (Table 8) and the birthrates to adolescents vary dramatically by state. From 1991 to 1995, birthrates decreased significantly in all but five states and the District of Columbia. These declines were especially large for teenagers between the ages of 15 and 17 years and among African-American teenagers (19).

Births to Unmarried Adolescent Mothers

Of all births to females 15–19 years old in 1996, a total of 375,805 babies (76% of all births to teenagers) were born to unmarried teenagers (18). The percentage of births to

Table 6. Abortion Ratio Among Adolescents by Year and Age*

	Percentage, by Year				
Age (y)	1975	1980	1985	1990	1994†
<15	55	60	62	52	48
15–19	36	45	46	43	35

* Abortion ratio is the percentage of pregnancies (excluding miscarriages) ending in abortion.

† Calculation of 1994 ratios is based upon data from Henshaw SK. U.S. teenage pregnancy statistics. New York, New York: The Alan Guttmacher Institute, 1997, and U.S. Bureau of the Census. U.S. population estimates by age, race, sex, and Hispanic origin: 1990 to 1996. PPL-57. Hyattsville, Maryland: U.S. Bureau of the Census, 1997.

Moore KA, Snyder NO. Facts at a glance. Washington, DC: Child Trends, Inc. 1996.

Table 7. Number of Babies Born to Adolescent Mothers (Rate) by Age, Race, and Year*

Age and Race	1985	1990	1996
10–14 y			
All races	10,220 (1.2)	11,657 (1.4)	11,242 (1.2)
White	4,101 (0.6)	4,274 (0.7)	5,570 (0.8)
African American	5,860 (4.5)	6,238 (4.9)	5,227 (3.7)
15–19 y			
All races	467,485 (51.3)	521,826 (59.9)	494,272 (54.7)
White	318,729 (42.8)	394,462 (50.4)	348,509 (48.4)
African American	134,270 (97.4)	151,613 (112.8)	131,159 (91.7)

* Rates shown are per 1,000 women in specified age and racial group.

National Center for Health Statistics. Vital statistics of the United States, 1988, vol I, natality. Public use data tape documentation no. (PHS) 90-1113. Washington, DC: U.S. Government Printing Office, 1990.

National Center for Health Statistics. Vital statistics of the United States, 1990, vol I, natality. Washington, DC: Public Health Service, 1994.

Ventura SJ, Peters KD, Martin JA, Maurer JD. Births and Fertility Rates, United States, 1996. Monthly vital statistics report; vol 46, no 11(suppl). Hyattsville, Maryland: National Center for Health Statistics. 1997.

Table 8. Numbers of Babies Born to Mothers Under Age 20, by Age, Race, and State, 1995

State	Number of Births					
	By Age of Mother (y)			By Race of Mother*		
	Total Under 20	<15	15–19	White (Nonmarital %)	African American (Nonmarital %)	Hispanic (Nonmarital %)
Alabama	11,181	324	10,857	5,577 (47)	5,424 (96)	116 (47)
Alaska	1,151	15	1,136	551 (65)	79 (82)	75 (63)
Arizona	10,974	229	10,745	4,030 (73)	470 (93)	5,454 (81)
Arkansas	6,961	191	6,770	4,206 (50)	2,425 (95)	164 (59)
California	68,409	1,645	66,764	15,012 (65)	7,437 (83)	42,089 (64)
Colorado	6,598	134	6,464	3,228 (89)	490 (90)	2,664 (73)
Connecticut	3,603	87	3,716	1,386 (82)	951 (95)	1,270 (85)
Delaware	1,352	51	1,301	620 (81)	598 (98)	124 (82)
District of Columbia	1,471	67	1,404	32 (88)	1,336 (97)	93 (78)
Florida	25,828	738	25,088	11,309 (70)	9,551 (95)	4,601 (69)
Georgia	18,322	595	17,727	8,069 (55)	9,278 (96)	815 (43)
Hawaii	1,862	41	1,841	208 (42)	55 (64)	385 (87)
Idaho	2,531	42	2,489	2,001 (57)	15 (*)	441 (49)
Illinois	24,043	576	23,467	6,615 (77)	9,799 (98)	5,455 (71)
Indiana	12,155	222	11,933	9,221 (74)	2,344 (96)	501 (76)
Iowa	4,067	43	4,024	3,402 (80)	268 (97)	251 (69)
Kansas	4,876	75	4,801	3,387 (69)	768 (94)	553 (71)
Kentucky	8,008	189	8,819	7,697 (56)	1,260 (95)	87 (66)
Louisiana	12,559	351	12,208	4,875 (61)	7,417 (96)	100 (70)
Maine	1,426	20	1,406	1,325 (81)	10 (*)	22 (77)
Maryland	7,437	226	7,211	2,807 (80)	4,114 (97)	345 (75)
Massachusetts	6,116	115	6,001	3,244 (89)	920 (97)	1,734 (88)
Michigan	16,844	377	16,467	8,593 (81)	5,983 (98)	987 (77)
Minnesota	5,327	86	5,241	3,448 (85)	857 (96)	359 (74)
Mississippi	8,162	334	8,848	3,264 (49)	5,799 (97)	27 (56)
Missouri	10,490	214	10,282	7,275 (68)	2,908 (98)	220 (70)
Montana	1,407	12	1,395	958 (70)	7 (*)	62 (73)
Nebraska	2,321	38	2,283	1,573 (76)	297 (96)	295 (73)
Nevada	3,423	72	3,351	1,737 (73)	436 (96)	1,092 (77)
New Hampshire	1,108	5	1,103	979 (84)	10 (*)	34 (71)
New Jersey	9,384	233	9,151	2,508 (83)	3,756 (96)	2,947 (83)
New Mexico	4,954	110	4,844	1,133 (85)	115 (95)	3,059 (82)
New York	25,004	536	24,468	6,657 (74)	7,812 (98)	8,447 (86)
North Carolina	15,473	424	15,049	7,682 (58)	6,599 (96)	720 (63)
North Dakota	811	11	800	586 (73)	3 (*)	25 (72)
Ohio	21,086	455	20,631	14,479 (77)	5,787 (98)	862 (84)
Oklahoma	7,800	161	7,639	5,013 (58)	1,181 (94)	494 (82)
Oregon	5,553	105	5,448	4,103 (75)	233 (98)	999 (64)
Pennsylvania	16,365	386	15,979	9,430 (84)	5,039 (98)	1,684 (87)
Rhode Island	1,291	24	1,267	632 (88)	142 (97)	295 (88)
South Carolina	8,801	283	8,518	3,986 (62)	4,639 (96)	118 (62)
South Dakota	1,190	11	1,179	771 (73)	9 (*)	30 (77)
Tennessee	12,292	274	12,118	7,865 (55)	4,279 (98)	170 (56)
Texas	53,507	1,372	52,135	15,800 (59)	9,183 (83)	27,920 (80)
Utah	4,279	57	4,222	3,398 (59)	47 (83)	623 (70)
Vermont	557	4	553	511 (80)	6 (*)	4 (*)
Virginia	10,538	268	10,270	5,464 (64)	3,764 (95)	575 (70)
Washington	8,882	173	8,709	5,709 (75)	548 (91)	1,852 (67)
West Virginia	3,636	52	3,584	3,405 (53)	211 (95)	11 (*)
Wisconsin	7,112	180	6,932	4,109 (81)	1,873 (96)	627 (77)
Wyoming	949	12	937	735 (81)	13 (*)	137 (68)

* Births are reported by the National Center for Health Statistics by race of mother, not race of child as done prior to 1982.

† Figure does not meet standards of reliability or precision; based on fewer than 20 births.

Data from Division of Vital Statistics, National Center for Health Statistics, 1997.

unmarried teenagers varies considerably by state and race (Table 8). More specific data on births to unmarried teenagers are available only for 1995. The birthrate for white unmarried mothers 15–19 years old decreased slightly in 1995 to 35.5 per 1,000 unmarried females, compared with 36.2 per 1,000 in 1994. It increased from 33.6 per 1,000 in 1993. Among unmarried African-American mothers in the same age group, the rate declined in 1995 to 92.8 per 1,000 compared with 100.9 per 1,000 in 1994 and 102.4 per 1,000 in 1993 (20).

Adoption

More than 90% of teenagers who give birth choose to raise the infant themselves. Teens rarely relinquish their children for adoption (21). Nationwide, 8% of infants born to unmarried adolescents who are 17 years old or younger are placed for adoption (22).

Prenatal Care

Adolescents are more likely to experience higher levels of pregnancy complications than older females and are more likely to have low-birth-weight babies. This occurs primarily because adolescents do not receive prenatal care early in pregnancy. In 1995, 66.3% of teenagers 15–19 years old began prenatal care in the first trimester (Table 9), compared with those 76.0% of 20–24 years old and 88.2% of those 30–34 years old. That same year, 7.6% of teenagers 15–19 years old received late or no prenatal care. Just over 25% began prenatal care during the second trimester (20).

Table 9. Number (Percentage) of Live Births by Month Prenatal Care Began and by Race and Age of Mother, 1995

Age and Race	All Births	Early Prenatal Care (1st–3rd Month)	Late (7th–9th Month) or No Care
< 15 y			
All races	12,242	5,682 (46.1)	1,801 (15.3)
White	5,854	2,988 (52.9)	837 (14.8)
African American	5,927	2,484 (43.8)	874 (15.4)
15–19 y			
All races	499,873	322,348 (66.3)	36,878 (7.6)
White	349,835	234,516 (68.7)	23,596 (6.9)
African American	133,694	78,211 (60.7)	11,721 (9.1)

Ventura SJ, Martin JA, Curtin SC, Mathews TJ. Report of final natality statistics, 1995. Monthly vital statistics report; vol 45, no 11(suppl). Hyattsville, Maryland: National Center for Health Statistics, 1997.

Table 10. Number of Babies Born at Low Birth Weight by Age and Race of Mother, 1995

Age and Race	All Births	Low-Birth-Weight Babies
< 15 y		
All races	12,242	1,647 (13.5)
White	5,854	642 (11.0)
African American	5,927	959 (16.2)
15–19 y		
All races	499,873	46,611 (9.3)
White	349,835	27,785 (8.0)
African American	133,694	17,356 (13.0)

Ventura SJ, Martin JA, Curtin SC, Mathews TJ. Report of final natality statistics, 1995. Monthly vital statistics report; vol 45, no 11(suppl). Hyattsville, Maryland: National Center for Health Statistics, 1997.

Low Birth Weight

In 1995, there were 46,511 low-birth-weight babies (≤2,500 g or less) born to mothers 15–19 years old (Table 10). This figure represents 9.3% of all babies born that year to adolescents in that age group. In that same year, 1,647 low-birth-weight babies were born to mothers under age 15. For both age groups, a larger percentage of low-birth-weight babies were born to African-American mothers than to white mothers (20).

Impact of Teenage Childbearing

Teenage mothers are significantly less likely to receive a high school diploma than women who postpone childbearing. They are more likely to live in poverty, receive public assistance, and have long periods of welfare dependency. Adolescent fathers finish fewer years of schooling, earn less income annually by age 27, and participate less in the work force than men who delay fathering until age 21. Children of adolescents are more likely to have health and cognitive disadvantages and to be neglected or abused. The daughters of adolescents are more likely to become adolescent mothers themselves, and the sons of adolescents are more likely to be incarcerated. Researchers estimate that if all the differences between adolescent and adult childbearers were eliminated, the net gain to society in higher productivity and lower public assistance and social service costs would exceed $37 billion annually (23).

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USA Today 3/4/98 Front page Life section

education dissuades teen sex

College plans may be a factor

By Martin Elias
USA TODAY

Despite all the talk about teens and sex, 2 out of 3 high school students with college-educated parents haven't started sexual activity, suggests a federal survey to be reported Thursday.

The more educated parents are, the more likely their 14- to 17-year-old children are to report being virgins, John Santelli of the Centers for Disease Control and Prevention will tell the Society for Adolescent Medicine meeting in Atlanta. "This shows we shouldn't lump all teens together. Some have started intercourse by middle school, but others are waiting a whole lot longer."

The survey of 3,965 adolescents, a nationally representative sample, was taken through audio headsets, with written response forms provided to make it easier for teens to give candid answers to adult questioners, Santelli says.

It was conducted in 1992, but the figures are the most recent to link teen sex with parental education, and Santelli believes the trend has continued since then. "There's no reason to think there's any change here," he says.

Among the findings:

▶ If at least one parent finished college, 29% of girls had sexual experience, 43% if a parent graduated from high school, 56% if a parent had no high school diploma.

▶ For boys, 31% with a college grad parent had engaged in sex, 47% if a parent finished high school, 59% if a parent had no high school diploma.

Well-educated parents may be able to provide closer teen supervision, Santelli says. Also, teens may delay intercourse if they know they're expected to follow their parents' example in attending college, and they fear early pregnancy.

New studies show adolescents tend to start sex later when parents talk openly about sexuality and convey clear expectations for delayed intercourse, says Debra Haffner, president of the Sexuality Information and Education Council of the United States. "We'd need more research to prove it, but I'd guess college-educated parents are more likely to do this," Haffner says.

There's proof that teens with future goals start sex later, and educated parents may foster [illegible] future planning, she says.

Legislative Affairs Agency
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Delta Junction Legislative Information Office
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Phone: (907) 895-4236 Fax: (907) 895-5017

To: House HES

Fax: 465-3871 Phone: _____

Testimony

Date Sent: 3/31/98 No. of Pages Including Cover Sheet: 2

Thank You,

Tammy Renee' Hall
Information Assistant

Alaska State Legislature

Please enter into the record my testimony to the _____ committee name

committee on HB372, dated 3-31-98
bill/ subject

I urge passage of this Bill based on the reasons already identified by the sponsor as well as the fact that parents are the ones primarily responsible for their minor children and as such should be the ones who give/or don't give their permission for the prescription of contraceptives. If my child is given a prescription for oral contraceptives without my knowledge or consent, who then is responsible should complications arise? The Doctor or the State? I am against the current "Sueing" craze, but would be inclined to sue both under such circumstances. I might also point out that giving contraceptives to minors has NOT reduced the rate of teen pregnancy. If anything, it has had the opposite effect. Check the statistic

Signed: Delma J. Jacobs
Testifier
Republican Party of Alaska, Dist 35 Chairwoman
Representing (Optional)
Box 377 Delta Jct, Ak 99737
Address
(907) 895-4565
Phone No.

TOTAL P.03

31 March, 1998

To: Members of the House HESS
and Interior Delegation

From: Dodie Delaney, nurse practitioner

RE: HB 372

As a nurse practitioner in a family planning clinic and STD (sexually transmitted disease) clinic, I would like you to NOT vote for HB 372 requiring minors to have parental consent to obtain contraceptives.

My personal and religious views are such that I do not believe in sexual relations without marriage. But in the real world this often does not happen. Though I personally would prefer a teen abstain, I am so thankful that ~~they~~ those that come to see me for birth control are taking on that responsibility. Most of the teens I see have been sexually active for a year or more and should be on birth control long before I see them. Yes, I emphasize the need to communicate with their parents and encourage teens to do so.

Many parents have not or will not provide for their child or teach them what they need to know.

Even though I am personally very conservative, I would much rather see a teen who NEEDS birth control be able to obtain it and use it than the misery of an unwanted pregnancy.

Thank you

Dixie Delaney, ANP

1340 Spring Glade
Fairbanks, Ak 99709
March 31, 1998

To: House Health & Social Services committee

Re: HB 372

I urge you to reject HB 372, along with the underlying assumptions it makes. Yes, we all want our teens to delay sexual activity; and yes, we all want open, frank dialogue with our teens; and yes, we as parents want to know what our kids are doing. But the reality is that these are not going to be brought about by legislation. HB 372 simply ensures that these kids who most need birth control — because they are already having sex — will now add the burden of an unplanned →

pregnancy to their lives. I work with adolescents and I have a teen-aged son. I know that what we want for ~~the~~ our kids does not necessarily reflect what they choose to do — and we cannot + should not watch them 24 hours a day.

This is not a perfect world and imperfect decisions will be made. Let us at least permit our kids some measure of safety — and access to caring health-care providers who offer another voice of caution and who share most parent' concerns for the health and well-being of all our kids.

Sincerely

Diana Lingle

Diana Lingle

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the House HES
Committee Name

Committee on HB 372, Contraceptives/minors Dated 3/31/98
Bill / Subject

This bill is the best possible way to INCREASE teen pregnancies in AK.

I urge you to vote "NO."

I can only wonder if the people behind this bill were virgins when they got married? And if not, I certainly hope the first people they told when they decided to have sex...was their parents!

We bombard today's teens with sex in every form of media... and then you propose we take away the tools they need for safety and protection.

I am amazed that a bill like this could even be taken seriously.

May God protect us from people with an agenda like this.

SIGNED: Connie Page
Testifier

Reality
Representing

2211 Penrose Lane Fbnks AK 99709
Address / Phone Number

Lisa Peñalver
President,
FAIRBANKS COALITION FOR CHOICE
P.O. Box 74264, Fairbanks, Ak 99707
457-1458, fx 457-4243
March 30, 1998

Please send the following testimony to the attention of the Alaska State House Health Education and Social Services Committee, Alaska State House of Representatives, Juneau Alaska
(For TELECONFERENCE HEARING - Tuesday, March 31, 3:00pm)
****To be included in the Record of Testimony on HB 372 – Parental Consent for Contraception

Dear Representatives,

I strongly urge you to oppose HB 372. While I appreciate parents' desire to be involved in their teens decisions about sexuality, several thousands of teen pregnancies prove that this is rarely the case. Confidentiality in contraceptive services is one of the few things that has been PROVEN - both in our own country and abroad - to succeed in reducing teen pregnancy and limiting the transmission of sexually transmitted diseases. To breach that confidentially is misguided, and we do it at our own peril!

This is a Truly Bad Idea - if you threaten health care providers and require parental involvement, you might as well be banning the use of any contraceptives by teens. This proposal will NOT stop sexual behavior -but it will GUARANTEE that sex will be more dangerous - even deadly (in the case of AIDS or pregnancy among young girls in immature bodies) - for many of our young people.

- Federal and state lawmakers have long recognized that, while parental involvement is desirable, confidentiality can be crucial to encouraging young people to address sensitive issues such as pregnancy prevention.
- Federally funded Title X family planning programs *have always provided confidential services* to adolescents, and no state (in its right mind) explicitly mandates parental involvement for a minor to obtain contraceptive services.
- Research done by the Alan Guttmacher Institute (AGI) shows that at least 7 in 10 teenage women and their partners currently use a contraceptive method. Restricting access to contraceptives in Alaska could dramatically lower this statistic.
- AGI research reveals that a sexually active teenager who doesn't use contraception has a 90% chance of pregnancy within one year.
- Research done by the Alaska Division of Public Health shows that 74% of births to teenagers are unplanned. The report states "Because a number of serious adverse health and education outcomes to both the mother and infant may result...," These results suggest the potential for a crisis situation. Restricting access to contraceptive services will only make things worse!
- Unwanted childbearing has been linked with costly consequences for families, children and the state.
  Unwanted children:
  - experience more mental handicaps and are twice as likely to receive psychiatric care at government expense;
  - are more than twice as likely as wanted children to have a record of juvenile delinquency;
  - are six times more likely to receive some form of welfare between the ages of 16 and 21;
  - are at increased risk of suffering abuse, neglect, abandonment and removal to foster homes or institutions.
- *Kids Count Alaska* reported in their 1996 Data Book report that teenage, never-married mothers are distinguished from the general population of single parents by their extreme poverty: significantly lower educational attainment, social resources, and potential earnings.
- In 1992, 52% of all the mothers collecting AFDC had their first children as teenagers
- This bill is *sexist* - in that its impact will overwhelmingly be felt by young women who find themselves unable to get protection from either pregnancy and sexually transmitted diseases

Please do not ignore the evidence before your very eyes! I am one of your constituents, as well as President of the Fairbanks Coalition For Choice, representing several thousand pro-choice voters in the Fairbanks area, and ***I urge you to oppose this bill.***

Sincerely,

3-31-98

TO: Member of the House Hess and Interior Delegation

As a nurse practitioner at the Fairbanks Regional Public Health Center, I see a number of teens who are sexually active. There are currently 12 girls who are pregnant at one of our Local High schools. This number is unacceptable and yet - this is with Birth control available without parental consent.

While I routinely encourage parental involvement, there are situations/circumstances where it is unavailable. More important is the availability of Birth control to prevent unwanted pregnancies. Better A teen take responsibility for herself by preventing pregnancy than being forced into a premature responsibility for raising a child.

Please reconsider HB 372. It is an unrealistic answer for an age-old problem. If passed, it will only serve to bring many more children who will not be properly cared for & loved.

Thank you, NS

Nancy Snyder
Family Nurse Practitioner

3-31-98

TO: House Hess Committee and the Interior Delegation
RE: House Bill 372
FROM: Linda Rasmussen ANP
P.O. Box 82053
Fairbanks, AK 99708

Dear Representatives,

I do not support House Bill 372 which would require parental consent for contraceptives for minors. As a Nurse Practitioner who has worked with teens for 15 years I feel strongly that having birth control methods available to teens greatly impacts the number of unplanned pregnancies and "crisis pregnancy abortions".

Almost all of the teens that I see are already sexually active, a fact that dismays me particularly the younger they are. Histories of sexual abuse, dysfunctional parents and families, drug use and peer pressures all are big social problems which contribute to the teens sexual activity.These issues are "out there" to take into consideration. What I see is a teen in the clinic who is currently sexually active and right now needing to prevent further trauma in her life and the life of another child.

Good, open communications among family members on all issues including sexuality issues is an area I stress with all of the teens. In an ideal world I know this level of communication is healthiest for the teen. I also know that some of my patients family situation may inherently not be healthy or not healthy enough at the moment to discuss sexual issues. Because they are already sexually active I need to intervene to help them to not get pregnant while their own world and our world in general is getting "straightened-out".

Requiring parental consent to supply a minor with the birth control which they need would result in an increase in unplanned pregnancies and abortions for this age group. These kids already have enough on their plate without further confounding their lives!

Linda Rasmussen

March 31, 1998

House of Representatives
House HSS Committee
Interior Delegation

Dear Representatives:

We are writing to request your "no" vote with regard to HB 372 requiring parental consent for adolescent prescription contraception.

In an ideal world, parents would accept responsibility for counselling adolescents about sexuality issues and adolescents in turn would choose abstinence. The reality is and (has been since the beginning of time) that young men and women choose to be sexually active and they need education and options to keep themselves safe. To require parental consent would deny many that option. Please help our teens maintain their reproductive rights.

Sincerely,

Kathleen Calling

Becki Shearer

Health and Social Services
House Committee and Interior Delegation.

Date: 3-31-97

RE: HB # 372

Dear Committee members:

HB # 372 will make it illegal for alaska teenagers to receive any prescriptive medicine without parental consent.

I strongly encourage you not to consider the passing of this bill. HB # 372 will have long term effects on our teen populations.

Unfortunately, we have parents + families in our communities that are unable to talk to their teenagers about important health care issues. Many of these issues are life changing and life threatening. Some parents are unaware of the current stresses and situations our teens may face. Likewise many teens can not discuss health issues with their parents.

Providers throughout alaska provide a safe, confidential place for teenagers to obtain up to date information about options and treatments. This information always includes preventive health messages. Options to pregnancy & STD (sexually transmitted diseases) are important. Some of these options require medical treatment that should not be postponed. With early treatment epidemics & chronic health problems can be managed.

HB 372 would only make fast, safe treatment more difficult for teenagers.

Sincerely,

Chris A Bois

To: All members of Health + Social Services
House Committee
+ Interior Delegation

Date: 3/31/98

RE: HB # 372

As the mother of a teen daughter + young adult male, a public health nurse, and a Christian who believes in family values, I recommend the above bill be <u>not</u> considered for passage. <u>All</u> teens need access to free birth control and STD exams without having to seek parental permission. Teens should not have to be parents when they are still children themselves.

Sherry L. Harris, RN
Fairbanks Homeowner
487 Slater Drive
Fbks., Ak. 99701
1-907-452 1952

MEMORANDUM

TO: Health and Social Services Committee,
House of Representatives

DATE: March 31, 1998

FROM: Glenda Lee, Private Citizen (P.O. Box 72274, Fairbanks, AK 99707) Glenda Lee

SUBJECT: House Bill-372

If this bill pass, I personally feel this HB-372 will discourage our young people (ages 12 - 17) from taking steps to prevent pregnancy, Sexual Transmitted Diseases, etc... Majority of our young people would not feel very comfortable at all getting parental consent to get on birth control.

Would you?

I mean really take time out and think about when you were this age, imagine yourself going to your father or mother or guardian and asking permission to use birth control. Most parents cannot deal with their teenagers having sex. **I'm a mother of two teenagers, and I am also a Christian mother. I do not want my teenagers having sex, but I have to come to the reality that my teenagers are human and even though they know right from wrong sometimes hormones overpower their knowledge.** If they had to get consent from their parents before getting on birth control **it would cause them to go through weeks of nervousness, trying to think how to go about this, to the point of, maybe they will forget about it or just decide to take chances and hopefully not get pregnant or come up with a sexual transmitted disease before they will get consent from their parents.**

I deeply oppose this bill. I would rather my teenagers have the freedom to go to the local health provider, physician, outpatient care etc... to take the steps necessary to keep from having other responsibilities that will affect their future. When our young people take responsibility to get on birth control they are not only looking out for themselves, but also for the welfare of their parents.

Thank you in advance for not passing this HB-372.

3-31-98

House of Representatives, HSS Committee
Interior Delagation

Re HB 372

Teen pregnancy is one of the most pressing social issues of the day. Abstinance & open parental discussion are the ideal & to be encouraged. The reality is that many teens are sexually active & in need of birth controll. Without free & confidential access to clinics, the rate of unintended & out of wedlock births would soar in this youngest & most vulnerable group.
Birth control "buys some time" for kids to grow up, get an education / job & straighten out their priorities.

I am opposed to HB 372.

Sincerely,

Janet Lokken, Public Health Nurse - parent, grand parent

1300 Skyline Dr
Fairbanks, AK 99712

Karen Miller
10021 Crest view lane
Eagle River, Alaska 99577
(907) 694-2710

facsimile transmittal

To:	Representative Fred Dyson	Fax:	(907) 465-4587
	[Click here and type name]	Date:	04/01/98
Re:	HB 372 Parental Consent for Contraception	Pages:	two
CC:	Representatives Con Bunde, Chair; Joe Green, Chair, Brain Porter, Al Vezey		

☐ Urgent ☐ For Review x Please Comment ☐ Please Reply ☐ Please Recycle

It is tough to be a teenager, no matter where you live, but it is especially difficult for teens in our Alaskan villages. It is a rebellious time when kids may least want to talk to their parents and in a number of homes reasonable discussion is not possible.

It has been a decade and a half since my daughter was a teenager. Although we were a close family where family conferences, discussions were common, this was one area she didn't want to talk to us about. Whatever her reason I was comfortable and glad that she was able to access a family clinic that addressed her needs.

Confidentiality is crucial in dealing with sensitive health concerns I can not possibly see where requiring parental consent for contraception would have a desirable effect on the quality of family relations I feel funding family clinics and making counselors readily accessible would do far more in improving both the physical and emotional health of our teenagers and strengthening families

Restricting the prescribing of contraceptive drugs and devices by health providers certainly hinders these providers in dealing with teenagers in an open and positive manner Why overburden our present court system with yet another law that they have to administer

Our children need social, emotional and psychological support as they traverse the turbulent years of childhood to adult hood Raising children is very labor- intensive Please do not make this more difficult for both parents and teenagers by creating another layer of government interference

Sincerely,

Karen F Miller

To: Legislature Information Office
Leg 376-6180

3/31/98

To Whom it May Concern:
Re: HB 372

I would like to express my concerns about HB 372 as it limits the access of minors to birth control without parent permission or a court order. I know of very few teenagers who, when faced with the need for birth control are willing, or able, to have the conversation necessary to obtain parent permission. They will be less willing to take the required steps to obtain a court order for that same permission. You can rest assure that they will not delay having sex. By requiring parent permission, you are effectively raising the birth rate of unwed teenage parents. The cost to the state for these babies who will be having babies will be enormous. This proposed House Bill 372 is not the forum in which to debate public morality. I think we all agree that our young people in Alaska need to have a future in which they can reach their greatest potential. HB 372 will be a deterrent to that future.

Sincerely,

Shelley Milton RN

Shelley Milton RN
School Nurse
Palmer Junior Middle School

Alaska State Legislature

Please enter into the record my testimony to the House HESS
committee name

committee on HB 372 , dated 3-31-96 .
bill/subject

I AM BOTH A PEDITRIC NURSE AND A SUBSTITUTE SCHOOL NURSE. I OFTEN HAVE THE PLEASURE OF WORKING WITHIN SENIOR HIGH SCHOOLS. I KNOW THAT THE POSITION OF THE SCHOOLS IS TO ENCOURAGE OR CONDONE ABSTINANCE. UNFORTUNATELY, NOT ALL KIDS HEED THIS ADVICE. I FIND GREAT DIFFICULTY IN SUPPORTING A BILL THAT HAS THE POTENTIAL OF INCREASING TEEN PREGNANCY RATES. THIS BILL HAS HAS THE POTENTIAL TO CREATE A MULTITUDE OF SOCIAL AS WELL AS HEALTH PROBLEMS FOR YOUNG PEOPLE AND SOCIETY AS A WHOLE. AS A HEALTH CARE PROFESSIONAL I STRONGLY URGE YOU CONSIDER THE RAMIFICATIONS THAT WOULD ARISE SHOULD THIS BILL BE PASSED!

Signed: Nicole J. Hobbs, RN BSN
Testifier

Representing (Optional)

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Address

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Phone No.