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●- An examination of the medical care records of 400 patients for a five-year period show that patients receiving ambulatory mental health care have lower utilization of medical services than patients not receiving mental health treatment. By the second post-treatment year, the untreated group used 1.53 as much non-psychiatric medical care as the treated group, and averaged more than \$94 per year in increased non-psychiatric medical costs compared to the treated group (Borus, et al., 1985)

●- A comprehensive analysis of a collection of 58 controlled studies and claims files for the Blue Cross/Blue Shield Federal Employees Plan from 1974 to 1978 concluded that, following mental health treatment, the average 8.7-day inpatient hospitalization was reduced by 1.5 days (Mumford, et al., 1984).

●- Other Blue Cross and Blue Shield data show that following outpatient mental health care, the monthly cost per patient for medical services dropped from \$16.47 to \$7.06. Inpatient and outpatient medical visits decreased by more than 54% (Blue Cross of Western Pennsylvania, 1976).

●- A comparison was made of three groups of persons, all diagnosed as having one of four chronic illnesses, covered by the Blue Cross/Blue Shield Federal Employees Program from 1974 to 1978. One group received 7 to 20 mental health visits within three years, the second was seen for more than 21 visits and the third group had no mental health treatment. By the third year, the 7 to 20-visit group had annual medical charges \$309 lower, and those with more than 21 visits had medical expenses \$284 lower than the no-mental-health-treatment group (Schlesinger, et al., 1983).

●- Corporations are increasingly finding that employee assistance programs that include psychological care can decrease employee medical costs. For example, General Motors had 11,813 referrals to its EAP in 1986. During the same period, sickness payments were reduced by 40% (The New York Times, 8/30/87).

●- Studies of subscribers to the Kaiser-Permanente health insurance plan show that medical bills of heavy users of health services decreases anywhere from 37% to 75% after short-term psychotherapy. (The New York Times, 8/30/87).

●- Mental health services combined with treatment for physical disorders results in decreased hospital costs at least equal to the cost of the mental health services. A recent study of several chronic diseases showed that the use of mental health services "improves the quality and appropriateness of care and also lowers costs of providing it" (Schlesinger, et al., 1983).

●- Demand for mental health services would not rise dramatically with needed, responsible increases in insurance coverage. A recent study showed only 9% of those with generous mental health coverage sought treatment. (Wells, et al., 1982)

Psychologists

Training and Expertise As Health Care Providers

PRESENTED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION

- ❑ No other mental health profession requires as high a degree of education and training in mental health as psychology. Accredited doctoral programs in clinical psychology, including practicums and internships at clinics and hospitals, take an average of 5 1/2 years to complete. Over two-thirds of these clinical internships are in hospital settings.
- ❑ All 50 states and the District of Columbia have enacted laws regulating the practice of psychology. Licensure is required for independent practice. Most state laws require, as a minimum, a doctoral degree from an accredited institution and at least two years of supervised experience by a senior psychologist. To further ensure quality, an ethical code has been adopted as part of all state licensing laws.
- ❑ Accredited clinical psychology programs emphasize a basic core that includes biological, cognitive, emotional, and social bases for human behavior, diagnostic evaluation and assessment, research, as well as intervention and treatment techniques. Among these techniques are individual, child, family and group therapies.
- ❑ Since the mid-1980s, psychologists have provided more outpatient psychotherapy and psychological diagnostic evaluations than any other doctorally-trained mental health professional. In fact, psychology has been in the forefront of the leading psychological and biological research on the mind/body interface, including the diagnosis and treatment of stress disorders, neurological impairments, brain disease and psychosomatic illness.
- ❑ Diagnostic tests performed by psychologists and neuropsychologists are state-of-the-art tools. Increasingly, physicians and other health care professionals turn to psychologists for their diagnostic capabilities.
- ❑ Increasing numbers of psychologists are providing education and training in diagnosis and treatment for residents, interns and students in the field of internal medicine, family practice, neurology, obstetrics, oncology, pediatrics, physical medicine and rehabilitation, as well as trainees in other fields.

Psychologists

In The Health Care System

PRESENTED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION

- There are approximately 50,000 doctorally-trained psychologists licensed to independently diagnose and treat mental and nervous disorders.
- Forty-one states have enacted freedom of choice laws requiring that insurance companies reimburse psychologists for their services if those services are covered by the insurance contract and are within the scope of psychologists' licenses.
- The recognition of psychologists as independent providers increases competition to reduce and control costs. Costs for both psychologists and psychiatrists are significantly lower in all states that have freedom of choice.
- Psychologists are currently recognized in federal programs including the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Veterans Administration, the Federal Employees Health Benefit Plan (FEHBP), HMOs, community mental health centers, comprehensive outpatient rehabilitation facilities (CORFS), and the Medicaid plans in over half of the states. In addition, psychologists are now recognized as independent providers in rendering services to Medicare, HMO enrollees, and to Medicare patients in community mental health centers and in rural health clinics.

Spending to Cut Mental-Health Costs

WSJ 12/13

Employer Finds Quality Care The Best Buy

By RON WINSTON

Staff Reporter of THE WALL STREET JOURNAL

When it comes to surgery for employees, companies can save millions of dollars with a few pointed questions: Is any alternative available? Can it be an outpatient procedure? Can a hospital stay be shortened by a day or two?

But when applied to psychiatric care or treatment for drug and alcohol abuse, such narrow cost-cutting efforts can cost a company millions of dollars. Instead, employers can shrink their bill for mental-health care by taking the long view, even if that means spending more in the early stages of treatment.

That's the conclusion of a four-year study of mental-health treatment at McDonnell Douglas Corp. By assessing individual cases carefully and emphasizing quality care from the outset, the St. Louis aerospace and defense company expects to save more than \$5 million over the next three years—just for people who began care last year.

Prime Target

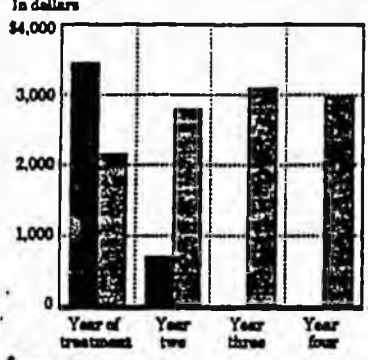
Treatment for such afflictions as depression, marital or job-related stress and drug and alcohol abuse can account for up to 20% of employer health costs. Last year alone, according to benefits consultant Foster Higgins, such expenses jumped 27%, making them a prime target for cost-cutters. Meanwhile, a new study at Westinghouse Electric Corp. suggests that depression is much more prevalent among white-collar workers than previous studies indicated, with worrisome implications for productivity.

"Many companies are wrestling" with mental-health care, says Veronica Vaccaro, manager of mental-health promotion for the Washington, D.C., Business Group on Health. "It's a very squishy area. Benefits managers don't know much about it. There's very little agreement on how long treatments should last."

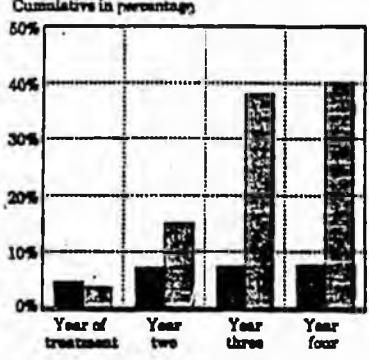
Shrinking the Costs of Mental Illness

Employee Assistance Program (EAP) vs. Alternative Treatment

Excess Family Medical Claims, Employee with Psychiatric Condition



Excess Termination Rate, Employee with Drug or Alcohol Dependency



* Excess is the amount above the average for employees who weren't treated for psychiatric or chemical dependency problems.

Source: Alexander & Alexander Consulting Group; McDonnell Douglas Corp.

Without a consensus, specialists say, a patient may receive, say, 28 days of care in a psychiatric hospital because that's what an insurance policy covers instead of what a diagnosis calls for. With such hospital costs running at \$1,000 a day, employers want to shorten hospital stays or move cases to outpatient care.

"The prevailing winds these days are to cut [mental-health] benefits," says Dr. John J. Mahoney, managing director at Alexander & Alexander Consulting Group, who conducted the McDonnell Douglas study. "But we found the company gets the best mileage by providing the best possible service on the front end."

Different Results

The study compared employees who sought mental-health care on their own with those who chose to use the company's employee assistance program, or EAP. Though coverage was essentially the same in either case, the study found the EAP, which screens troubled patients confidentially and refers them for appropriate treatment, much more cost-effective.

The study, designed to adjust for differences in employees seeking the two kinds of care, is based on medical claims and absentee records for more than 20,000 of McDonnell Douglas's 125,000 employees. It

is particularly unusual in its comparison of the long-term effectiveness of different approaches to treating mental illness.

Already, EAPs are used by 70% of Fortune 500 companies, according to the Employee Assistance Program Association, and about one-third of U.S. employees have access to the programs. Marketers of EAPs are likely to use the study as evidence that they are effective, but researchers caution that the programs vary widely in design and quality.

"This program saved money because it was run in a certain fashion, not because it was an out-of-the-box EAP program," says Dr. Mahoney. Adds Ms. Vaccaro: "Companies are beginning to use their EAPs as cost-management programs, but for that to be effective, it has to be a comprehensive approach."

At McDonnell Douglas, in-house supervisors oversee the program while EAP staff members from outside the company actually meet on a confidential basis with employees—or their dependents—and make an initial assessment of the patient, says Daniel C. Smith, director of employee assistance and human resource risk management services.

"Our approach is to provide whatever level of treatment is warranted by that assessment," Mr. Smith says, "rather than focus on short-term cost-containment objectives." But the company selects only providers with established track records of cost-effective care. And it closely monitors each case, both during treatment and for up to two years after the employee returns to work.

A crucial component of the company's

EAP is insisting that the whole family be included in treatment. That results in higher first-year costs in many cases. "It seems to be a very important aspect of long-term recovery and long-term health cost management," Mr. Smith says.

Family Impact

Indeed, the study offers dramatic evidence of the broad impact of psychiatric problems or substance abuse: Families of employees treated for chemical dependency outside of the EAP consumed an average of \$8,400 more in medical services over four years than families with no mental-health treatment. For psychiatric treatment, the excess medical costs averaged \$11,000. Under the EAP, these added family costs were reduced by more than half.

Among the study's other highlights

—Over four years, employees who used the EAP for chemical dependency treatment missed 44% fewer workdays, had 81% lower attrition and filed \$7,300 less health-care claims than those who did not use the EAP. Savings were somewhat smaller in all categories for psychiatric care.

—Forty percent of employees treated outside the EAP for drug or alcohol abuse left the company within four years, compared with just 7.5% of those who used the EAP. The study didn't factor in costs of replacing an experienced employee, but reducing attrition is a corporate goal because of a decline in the availability of qualified new workers. Mr. Smith says "Retaining valued employees has a who new significance today."

—Employees who sought mental-health care through their health maintenance organizations were four to five times more likely to quit or be fired within four years than those who used the EAP. That "staggering difference in outcomes," Mr. Smith says, indicates that "something is wrong and dramatically wrong," with the quality of mental-health and substance-abuse care that prepaid health plans provide.

McDonnell Douglas says it doesn't plan to require employees seeking care to use the EAP, but it hopes the program's effectiveness will attract people. The company's estimated \$5.1 million in savings over the next three years is based on 1,032 clients who began treatment through the EAP in 1988, comparing their costs with what they would pay had they gone outside the EAP. Of the total, the report says, \$5 million will come from reduced employee medical claims, \$2.3 million from reduced dependent medical claims, and \$800,000 from reduced absenteeism. Savings for employees who began treatment in other years would be cumulative.

COST-SAVINGS AS A RESULT OF PSYCHOTHERAPY

A number of studies have discussed the fact that overall medical costs are dramatically reduced one year after a patient has been in psychotherapy. The following are a few of those studies. Specific references will be provided upon request:

1. Nicholas Cummings, Ph.D., with Kaiser-Permanente mental health programs stated in the October 15, 1982 Psychiatric News that "...Despite two decades of research...showing that brief psychotherapy dramatically reduces utilization of other medical resources, policymakers continue to ignore these findings when designing health care systems...." He found in his study that resolving financial problems of HMO's was done "...by relying on brief psychotherapy to reduce the high incidence of unnecessary medical care...medical utilization declined significantly--and stayed down for the five years studied...[and]...among patient who completed brief psychotherapy, medical utilization dropped 75 percent." This was seen as important when, as he indicated, "...60 percent of all patient care could not be attributed to organic illness but was due, instead, to psychological problems." Patients many times reported not liking their therapists, and that therapy did not help them, but they did dramatically change their overall medical overutilization and no longer had symptoms. There have been over 28 replications of these studies.

2. In 1977 Sten and Young in completing a Masters degree (M.S.W.) thesis at Portland State University found that clinical social work psychotherapy of patients at Kaiser Permanente in Portland, helped to significantly reduce patient over-utilization of other medical services. There was a "...47.1% decrease in physician office visits; a 48.6% decrease in the number of physicians seen for office visits; a 31.2% decrease in telephone contacts; a 48.6% decrease in the number of prescriptions written; a 45.3% decrease in emergency room

visits; a 66.7% decrease in frequency of hospitalizations and a 77.7% decrease in the average length of stay in the hospital...intervention appeared to be positively associated with an over-all change rate of some 53 percent....."

3. Jones and Vischi (1979), in reviewing twenty-five (25) research projects, showed that after an individual was in psychotherapy reductions in medical/surgical expenditures averaged 57% in one study to 62% in out-patient medical visits and 68% in in-patient care.

4. A Kaiser-Permanente study of 152 patients showed that over a five year period there was a reduction in out-patient visits of 62% and 68% for in-patients. The most important aspect of this study is that the matched non-treatment controls, also a psychological distressed group, showed no change in their health care utilization over the same five year period.

5. A West German study utilizing a five year follow-up period after mental health treatment found an 85% reduction in in-patient utilization.

6. Other studies indicated that waiting list, non-treated, groups demonstrated the highest levels of medical care over-utilization, with even increases seen in their request for more doctors appointments and hospitalizations. Other findings revealed that even one psychotherapy session was effective in reducing medical care utilization. However, greater reductions in medical utilization rates were noted with increasing frequency of psychotherapy contacts. Weekly therapy sessions, particularly on a short-term basis of 12 sessions, lead to the greatest psychotherapeutic benefits.

7. Research conducted by Blue Cross/Blue Shield, reported in the New York Times and by the Psychotherapy in Private Practice Journal, with joint sponsorship by the National Institutes of Mental Health, found that "...psychotherapy can

significantly reduce hospital costs for physical ailments among people with heart disease--ischemic and hypertensive, air-flow limitations disease and diabetes." the findings indicated "...that people who had at least 7 visits of out-patient psychotherapy after the diagnosis of one of these 4 diseases incurred costs for medical services that were 66% lower than the costs for those who did not have psychotherapy,...They found that psychotherapy was most effective when it involved moderate amounts of out-patient visits ranging from 7 to 20."

8. A University of Colorado study reported in the September 21, 1984 Psychiatric News reviewed claims for Blue Cross/Blue Shield patients. The findings indicated that psychotherapy significantly reduced medical services, and particularly inpatient services. "...after mental health treatment, inpatient hospitalizations were approximately 1.5 days shorter than those of the control group's average of 3.7 days.....The average change after psychotherapy was -73.4 percent for inpatient and -22.6 percent for outpatient care.....After the initial year, the psychotherapy group had significantly lower inpatient medical care costs in each of the other four years analyzed."

9. Emily Mumford, Ph.D. in the October, 1984 issue of the American Journal of Psychiatry presented her findings of reviewing over 58 research projects on psychotherapy. The results demonstrated that patient costs dropped dramatically after involvement in psychotherapy. Again there were significant reductions in in-patient stays for medical problems for those patients who received psychotherapy. "...following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year....In contrast, the charges of the comparison group increased faster than the inflation rate."

10. A study reported in Psychotherapy Finances in 1983 reported in findings by the U. S. Steel Company that there was a savings of \$5.00 for every \$1.00 spent on mental health services. Polaroid and several other large companies have reported similar results at the same time.

3

11. Federal Employees health insurance programs, which have generous mental health benefits, showed that only 5 - 7% of the total health care costs are for emotional disorders.

12. Studies at the local HMO, SelectCare, in studying 31 Ph.D. and M.S.W. providers, in computer analysis of records demonstrated that the average number of visits over a 3 year period was only 5.4 visits for all providers. A year later it was 4.3 visits. The analysis also indicated that mental health benefits are a very small part of their benefit package, i.e., 7/10th of 1% of their entire budget.

13. In 1977 there were 118,767 patient contacts with 45 physicians at The Eugene Hospital and Clinic. Of these out-patients only 2,900, or 2.44% were diagnosed as having mental or emotional disorders by the physicians.

14. The Group health Association of Washington, D.C., showed a reduction in usage of general medical care by as much as 30.7%, and a 29.8% drop in Lab and X-ray use the year after psychotherapy services were received.

15. Kaiser Plan of California saved 250.00/yr, in the following year, for each patient who received psychotherapy services.

20. Blue Cross of Western Pennsylvania noted a 50% decline in monthly costs per patient in the use of medical-surgical procedures/services for those patients who had received psychotherapy services.

21. Studies of coverage of clinical social work psychotherapy services in private health insurance programs in new York State only costs \$0.00 - \$0.15 per month/premium (NASW in Washington

D.C. study).

22. A 1972 study in West Germany of Insurance coverage for 1,004 patients, also in a five year follow-up study, who had averaged 100 hours of psychotherapy found that 81% felt strongly they were helped by treatment. Further, their hospital usage was reduced to 0.78 hospital days/year. Pre-treatment usage averaged 5.3 days/year, with the general population average being 2.5 days/year. This included hospitalization for any illness.

23. Otto Jones, M.S.W., a clinical social worker, developed a mental health program for employees at Kennecott Copper in Utah. Before the program employees averaged 5.8 working days/month absence, weekly indemnity costs averaged \$70.67/person/month, and hospital/medical/surgical costs averaged \$109.04/person/month. One year after psychotherapy significant reductions were noted: Absenteeism decreased to a 2.93 average working days/month, weekly indemnity costs averaged \$25.33/person/month, and hospital/med/surg. costs averaged \$56.91/person/month. THIS IS A 49.5% REDUCTION IN ABSENTEEISM, A 64.2% REDUCTION IN WEEKLY INDEMNITY, AND A 48.9% REDUCTION IN HQSP.-MED.-SURGERY COSTS!! Those employees not involved in psychotherapy tended to get worse and showed increases of: 2.9% increase in absenteeism, a 28.5% increase in weekly indemnity costs, and a 7.7% increase in hospital, medical and surgical costs.

24. A 1980 letter from Blue Cross of California indicated that psychotherapy coverage for clinical social workers is "...a small part of their total health care package...[and]...have little impact on the total rates for health coverage."

25. A 1979 study reported in Psychiatric News states that "...mental health claims are not a substantial portion of total claims dollars." Again the findings were that only between 5 to 7% of the claims dollars were paid out for mental health care of all types including inpatient services. In general "...costs of mental health care...have lagged behind the increases in other health services."

26. A 1984 NIMH study (AMA News, November 9, 1984); which is the largest and most comprehensive survey to date of mental disorders indicates that 20% of all adult Americans suffers from at least one mental disorder. Such disorders were equally divided between males and females. However, only 1/5th of those so identified ever saw a mental health professional for treatment. The rest were seen by their family physician only and never referred for services.

27. A 1980 article in American Medical News (10/10/84) states that "...A prepaid mental health care program...appears able to cut health expenses...." As a result of this intervention and cost-savings, "...for the first time in three years, Stationers Corp. did not have an increase in its health insurance premiums."

28. McDonnell Douglas (and several other companies like Xerox, Hallmark Cards, Pitney Bowes, and IBM) in providing in-house mental health services for employees "calculates that it saved \$4 million over 10 years...and other companies also report lowered costs for medical and disability insurance, fewer accidents and reduced absenteeism...."

29. A 1980 article in the American Journal of Psychiatry indicates that only 7.3% of insured patients had services for mental health disorders. Of these, over half the claims for such services were submitted by general physicians and not mental health professionals.

30. A 1981 study reported in American Medical News (9/4/81) found that treatment for alcoholism resulted in a savings of \$1.5 million, with "alcoholism rehabilitation programs [having] an 85% success rate." A Stress management and health back programs also saved further money. "...the \$2.7 million estimated savings are "conservative figures..." for New York Telephone employees.



American Psychological Association

Advancing psychology as a science, a profession, and as a means of promoting human welfare

MENTAL HEALTH BENEFITS: NEED AND COST EFFECTIVENESS

NEED

- o 28 million American adults have a serious mental disorder other than substance abuse. These mental illnesses cost society an estimated \$129.3 billion annually, about half of which is attributable to lost productivity in the workplace (Rice et al., 1990).
- o In any one-month period almost 8 million people experience depression at an estimated annual cost of \$15 billion, \$10 billion of which is attributable to absenteeism from the workplace (Regier et al., 1988; NIMH, D/ART Office, 1990).
- o Stress causes American workers to miss an average of 16 days on the job each year, and nearly three-fourths of the corporate medical directors and human resources managers surveyed call stress "very pervasive" or "fairly pervasive." Managers surveyed reported that 13% of their employees suffer from symptoms of depression, including difficulty in concentrating (36%), sleep problems (35%), loss of energy (27%), and loss of interest in work (18%). (American Medical News, Nov. 10, 1989).
- o Mental illness, including depression, can be as functionally disabling as a serious heart condition and more disabling than other chronic physical illnesses such as lung or gastrointestinal problems, angina, hypertension, and even diabetes (Wells et al., 1982).
- o 60% of all health care visits are by people with no physical problem. This figure rises to 80%-90% when stress-related illnesses (e.g., peptic ulcer, ulcerative colitis, hypertension, etc.) are also included (Cummings & VandenBos, 1981).

COST OFFSET AND COST EFFECTIVENESS

The cost of including mental health benefits in health insurance plans must be evaluated in light of the substantial savings that accrue from making qualified mental health services available. A growing body of empirical research demonstrates that mental health care can substantially reduce the utilization and cost of more expensive medical care. This economic effect is known as "cost offset".

- o Three hundred veterans who received abbreviated mental health treatment following a history of excessive medical health utilization were able to reduce outpatient medical visits by 36%. Control groups, who received no psychotherapy, actually increased outpatient medical utilization. (Massad et al., 1990).
- o A comprehensive analysis of 58 controlled studies and claims files for the Blue Cross/Blue Shield Federal Employees Plan from 1974 to 1978 concluded that, following mental health treatment, the average 8.7-day inpatient hospitalization was reduced by 1.5 days. The same study summarized over 60 investigations of psychotherapy effects on medical utilization and found that 85% demonstrated medical utilization decreases following psychotherapy. The average decrease for inpatient utilization was 73.4%, and for outpatient services 22.6%. (Mumford et al., 1984).

o 400 patients who received ambulatory mental health care had lower utilization of medical services than patients not receiving mental health treatment, over a five year period. By the second post-treatment year, the untreated group used 1.53 as much medical care as the treated group, and averaged more than \$94 per year in increased medical costs compared to those who received mental health treatment. (Borus et al., 1985).

o Medicaid patients hospitalized for physical ailments and provided mental health interventions realized average cumulative savings of \$1,500 over a subsequent 2 1/2 year period. The cost of the mental health intervention was entirely paid for (i.e., totally offset) by these savings. Patients hospitalized without physical ailments who received mental health treatment realized savings, ranging from \$296 to \$392 depending on severity of diagnosis. (Fiedler et al., 1989).

o A three year study of over 10,000 Aetna beneficiaries showed that after initiation of mental health treatment, client medical costs dropped continuously over 36 months. The health costs of one mental health treatment group fell from \$242 the year prior to treatment to \$162 two years post-treatment. Other subject groups demonstrated similarly dramatic offset effects, leading the researchers to conclude that a decrease in total health care costs can be expected following mental health interventions even when the cost of the intervention is included. (Holder & Blase, 1987).

o Research on 20,000 enrollees at the Columbia Medical Plan showed that untreated mentally ill persons increased their medical utilization by 61% during a one year period. In contrast, the mentally ill who received psychological treatment increased their medical expenditures by only 11% during the same period. A mentally healthy comparison group averaged a 9% increase. (Hankin, 1983).

o Numerous studies show a decrease from 5 to 80 percent in medical service use following mental health treatment. Of 22 studies examining the impact of alcohol and mental health treatments, 21 presented medical utilization decreases, with average reductions of 46% after alcohol treatment and 26% after treatment for mental illness (Jones & Vischi, 1979).

o Other Blue Cross and Blue Shield data show that following outpatient mental health care, the monthly cost per patient for medical services dropped from \$16.47 to \$7.06. Inpatient and outpatient medical visits decreased by more than 54%. (Blue Cross of Western Pennsylvania, 1976).

o A comparison was made of three groups of persons, all diagnosed as having one of four chronic illnesses, covered by the Blue Cross/Blue Shield Federal Employees Program from 1974 to 1978. One group received 7 to 20 mental health visits within three years, the second was seen for more than 21 visits and the third group had no mental health treatment. By the third year, the 7 to 20-visit group had annual medical charges \$309 lower, and those with more than 21 visits had medical expenses \$284 lower than the no-mental-health-treatment group. (Schlesinger, et al., 1983).

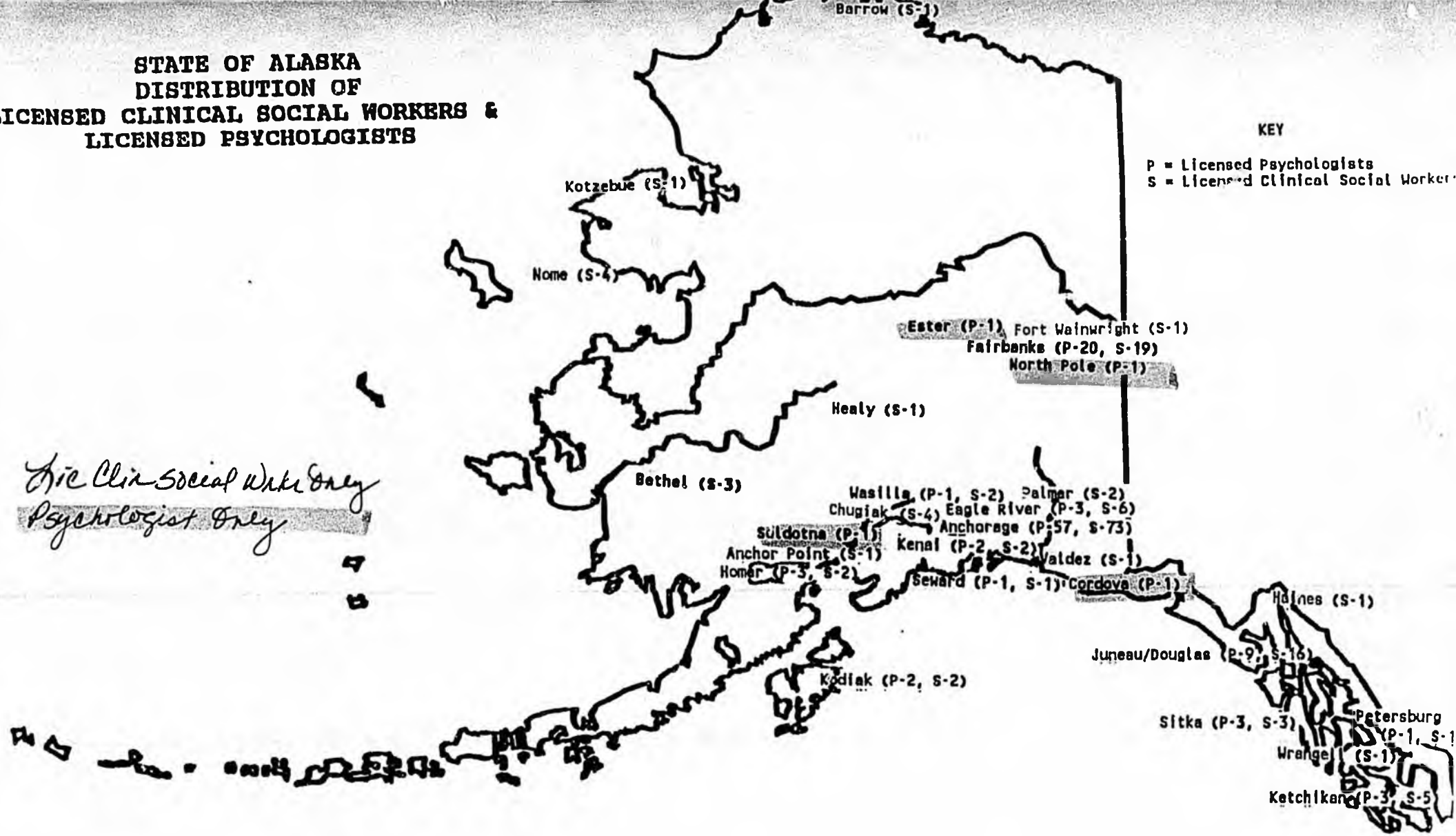
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**STATE OF ALASKA
DISTRIBUTION OF
LICENSED CLINICAL SOCIAL WORKERS &
LICENSED PSYCHOLOGISTS**

KEY

P = Licensed Psychologists
S = Licensed Clinical Social Workers



Handwritten: Lic Clin Social Worker Only
Psychologist Only

TOTALS

STATE OF ALASKA

110 Licensed Psychologists
162 Licensed Clinical Social Workers

OTHER STATES

30 Out-of-State Licensed Psychologists



Information compiled from
State of Alaska
Department of Commerce and Economic Development
Division of Occupational Licensing
Directories of Licensees

Licensed Clinical Social Workers: January, 1991
Licensed Psychologists: October 1990

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SR 156
 (S) Publish Date: 4/10/91

Revision Date: 3/22/91 Department Affec
 Title: An Act requiring the medical assistance program to cover BRU: (1) Medical Assistance Medicaid
psychologist clinical social workers' services Component: Non-Facility
 Sponsor: Senate HESS (2) Medical Assistance Admin. Claims Processing
 Requestor: _____ COMPONENT SERIAL NO. _____

Expenditures/Revenues: Thousands of Dollars

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	104.1	59.2	70.3	83.6	99.3	117.9
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS CLAIMS	392.2	967.9	1,194.4	1,474.0	1,818.9	2,244.5
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	496.3	1,027.1	1,264.7	1,557.6	1,918.2	2,362.4
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

GENERAL FUND	236.3	498.8	614.8	757.9	934.2	1,151.7
FEDERAL FUNDS	259.5	528.4	650.0	799.6	983.9	1,210.7
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	496.3	1,027.2	1,264.8	1,557.5	1,918.1	2,362.4

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

See attached

Changes in CS5B 156 (HESS)
 reflect NO FISCAL CHANGE from the original
 fiscal note. This fiscal note is appropriate.

4/10/91
 date Comte Aide (initial)

Prepared By: [Signature] Phone: 465-3355

Division: Medical Assistance Date: 3/22/91

Approved by Commissioner: Theodore A. Mala, MD, MPH, Commissioner

Agency: Health and Social Services Date: _____

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impact Agency(ies).

SB 156 Analysis

I. Contractual Costs

- a. The Alaska Medical Payments System will require modification to pay psychologists, psychological associates, and licensed social workers as a new service. The contractual costs include such items as the following: provider manuals, training, a new claims form, tables included in the system for psychologists' services for adults and licensed social workers' services, computer programming, computer reports, the addition of collocation codes, and a computer system test. Psychologists services for adults will require only 6 edits, at \$1080/edit (\$6480). Licensed clinical social workers and psychological associates are totally new provider types, each of whom will require \$23,914.
Total one time FY92 cost = 54.3 (27.2 fed, 27.1 SGFM)
- b. The Division of Medical Assistance must pay the claims processing contractor \$6.23 for each claim processed. Estimated claims volume for FY92 is 8,000, assuming a January 1, 1992 start date. FY92 processing costs = 49.8. (36.2 Fed, 13.6 SGFM)

II. New Grants/Claims Costs

- a. There is no accurate method for determining the numbers of Medicaid eligibles who will use this new coverage, the numbers of providers who will choose to enroll, and the initial costs per type of service that they will provide. Cost estimates are based on the following assumptions:
 - (1) 50 psychologists will enroll as providers in the first year.
 - (2) Approximately 24 of these new providers are currently providing services indirectly, supervised by and/or billing through a physician or psychiatrist. About one-half of these are billing Medicaid at a rate 15% lower than the rate charged by psychiatrists. Payments to the 12 now billing at the higher rate will be reduced by \$14,400 (15% reduction X 8,000 current average psychiatrist's Medicaid billing per year, X 12 psychologists = \$14,400 Medicaid savings). However, we assume that 37% of the caseload is children, who could receive psychologists' services through Medicaid under EPSDT regardless of SB 156. Therefore, the net savings related to this legislation is \$9,100 (\$14,400 X 63%).
 - (3) Logic suggests that billings from physicians and psychiatrists who supervise the psychologists now providing services to Medicaid eligibles would decrease if these psychologists were to enroll directly. However, experience in other states that have added psychologists' services has varied so much on this point that we cannot safely assume any decrease in current billings.
 - (4) Approximately 26 psychologists in private practice who are not currently serving Medicaid recipients will enroll. Alaska Psychological Association data indicates these new providers will see an average of 21 patients per week for a total of 34 hours per week, and that they charge \$90 per hour for private sessions.

- (5) We assume that psychologists will not differ from other medical professionals enrolled as Medicaid providers, in that Medicaid patients will, on average, not exceed 15% of their total patient load. We also assume that 37% of their Medicaid billings will be for children, who would be covered by Medicaid under EPSDT regardless; therefore, 63% of the cost of the new caseload would be attributable to SB 156. Cost for the new psychologists' services will be 34 hours per week X 50 weeks X \$90 per hour X 15% X 63% X 26 psychologists = \$375,900.
- (6) The cumulative margin of error in all these assumptions for psychologists services is such that we do not feel it is necessary to separately cost psychological associates' services. We believe that one, two, or possibly three new providers will initially enroll, and the net costs of so few providers can be covered by the funding requested for psychologists.
- (7) 39 licensed clinical social workers will enroll as providers in the first year (The actual number is likely to be higher, but because many licensed clinical social workers do not practice full time, we have assumed 39 "full-time equivalents" to simplify calculations.)
- (8) Approximately 19 of these new providers are currently providing services indirectly, supervised by and/or billing through a physician or psychiatrist. About one-half of these are billing Medicaid at a rate 20% lower than the rate charged by psychiatrists. Payments to the 10 now billing at the higher rate will be reduced by \$16,000 (20% reduction X 8,000 current average psychiatrist's Medicaid billing per year, X 10 licensed clinical social workers = \$16,000 Medicaid savings). We assume no coverage of licensed clinical social workers through EPSDT.
- (9) We have assumed that billings from physicians and psychiatrists who supervise the licensed clinical social workers now providing services to Medicaid eligibles will not decrease if licensed clinical social workers were to enroll directly.
- (10) Approximately 20 licensed clinical social workers in private practice who are not currently serving Medicaid recipients will enroll. We assume that these new providers will see an average of 21 patients per week for a total of 34 hours per week, and that they charge \$85 per hour for private sessions.
- (11) We assume that licensed clinical social workers will not differ from other medical professionals enrolled as Medicaid providers, in that Medicaid patients will, on average, not exceed 15% of their total patient load. Cost for the new licensed clinical social workers' services will be 34 hours per week X 50 weeks X \$85 per hour X 15% X 20 licensed clinical social workers = \$433,500.

(12) Combined new costs for psychologists and licensed clinical social workers = \$809,400 (\$375,000 + \$433,500). Combined savings = \$25,100 (\$9,100 + \$16,000). Net costs = \$784,300 (\$809,400 - \$25,100) for a full year. The time required for data system changes, promulgation of regulations, and provider enrollment activities necessitate a starting date no earlier than January 1, 1992. FY92 costs will therefore be 50% of a full year:

196.1 SGFM
196.1 FED
392.2 Total

(b) Costs for FY93 through FY97 are computed from the FY91 base estimates, adjusted for a full year, and increased annually by 23.4% (4.6% for price increases, 7.0% for increases in the number of eligible recipients, and 11.8% for utilization increases).

Claims processing costs are billed at \$6.23 per claim. For FY93 through FY97, FY92 costs, adjusted for a full year, are increased by 18.8% annually (7.0% for increases in the number of eligible recipients and 11.8% for utilization increases).

THE FOLLOWING DOCUMENT HAS NOT
BEEN FILMED BUT IS AVAILABLE IN THE
ORIGINAL FILE.

PLEASE MICROFILM TOP PAGE ONLY.

The Social Worker as Independent Mental Health Practitioner

Cost effective services
for the community

NASW

7981 Eastern Avenue
Silver Spring MD 20910

PLEASE MICROFILM TOP PAGE ONLY

**DOCUMENTS WHICH HAVE NOT BEEN FILMED BUT ARE
AVAILABLE IN THE ORIGINAL FILE INCLUDE:**

CORRESPONDENCE IN SUPPORT OF SB 156 FROM:

1. NORTON SOUND HEALTH CORPORATION, 4/15/91
2. ALASKA NATIVE HEALTH BOARD, 3/27/91
3. YVONNE MICHELI, KETCHIKAN, 3/15/91
4. JOEL B. WEIMAN, PHD, ANCHORAGE, 3/05/91
5. JOEL B. WEIMAN, PHD, ANCHORAGE, 2/26/91
6. THE FIREWEED THERAPY CENTER, 10/22/90

SB 157

HOUSE COMMITTEE REPORT

(11)

Date Referred: May 2, 1992

FURTHER REFERRALS:

(HES referral waived 5/2/92)

Date of Committee Action: 5/8/92

The FINANCE Committee considered:

CSSB 157(L&C)

CS FOR SENATE BILL NO. 157 (L&C)

OPTOMETRISTS: AUTHORIZED PRACTICES

"An Act relating to optometrists."

RECOMMENDATIONS: [] the same title
 be replaced with _____ [] a new title
 [] have attached amendments(s)
 [] do pass
 [] do not pass
 no recommendations
 [] individual recommendations
 [] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

[] fiscal impact _____

[] fiscal note(s) _____

[] zero fiscal note _____

zero fiscal note(s) DCED 3/18/92

SIGNING <u>DO</u> PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
<i>Mark Boyer</i> Boyer	X	<i>Thomas Koponen</i> Koponen		✓	
<i>Tony Brown</i> Brown	✓	<i>Bob Sharp</i> Sharp		✓	
		<i>Robert Phillips</i> Phillips		✓	
		<i>Ronald Larson</i> Larson		X	
		<i>J. Ulmer</i> Ulmer		X	

Mark Boyer via-chr.
CHAIRMAN'S SIGNATURE

1992 LEGISLATIVE SESSION

Revision Date: _____ Department Affected: Commerce & Economic Development
 Title: An Act relating to optometrists. BRU: Occupational Licensing
 Component: Administration
 Sponsor: Senator Adams
 Requestor: House Finance COMPONENT SERIAL NO.

0	3	5	6
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Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
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REVENUE	0.0	0.0	0.0	0.0	0.0	0.0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary)

The bill amends the optometry statutes to authorize the use of pharmaceutical agents in the practice of optometry. New funds are not required to implement this bill.

Prepared By: Jennifer Strickler Phone: 465-2144
 Division: Occupational Licensing Date: 05/05/92
 Approved by Commissioner: Glenn A. Olds
 Agency: Commerce & Economic Development Date: 54.92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

CS FOR SENATE BILL NO. 157 (L&C)
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered: 3/18/92
Referred: Judiciary

Sponsor(s): SENATOR ADAMS

A BILL
FOR AN ACT ENTITLED

1 "An Act relating to optometrists."

2 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 * Section 1. AS 08.72.175(a) is amended to read:

4 (a) The board may issue a license endorsement authorizing a licensee to prescribe and
5 use the pharmaceutical agents described in AS 08.72.272, if the licensee or applicant for a license
6 passes the written and practical portions of an examination on ocular pharmacology, approved
7 by the board, that tests the licensee's or the applicant's knowledge of the characteristics,
8 pharmacological effects, indications, contraindications, and emergency care associated with the
9 prescription and use of pharmaceutical agents. The endorsement expires at the same time as
10 the license to which it attaches. The endorsement may be renewed upon satisfactory completion
11 of continuing education requirements established by the board by regulation.

12 * Sec. 2. AS 08.72.272 is repealed and reenacted to read:

13 Sec. 08.72.272. USE OF PHARMACEUTICAL AGENTS. (a) A licensee may prescribe
14 and use a pharmaceutical agent in the practice of optometry if

1 (1) the pharmaceutical agent is a drug topically applied to the human eye and its
2 appendages; and

3 (2) the person holds a license endorsement issued by the board authorizing the
4 prescription and use of pharmaceutical agents.

5 (b) A licensee may not purchase, possess, prescribe, or use a pharmaceutical agent unless
6 the licensee has obtained a license endorsement under AS 08.72.175.

7 * Sec. 3. AS 08.72 is amended by adding a new section to read:

8 Sec. 08.72.273. REMOVAL OF FOREIGN BODIES. A licensee may remove superficial
9 foreign bodies from the eye and its appendages. This section is not intended to permit a licensee
10 to perform invasive surgery.

Alaska State Legislature

Senator Al Adams

WHILE IN SESSION
State Capitol
Juneau, Alaska 99801-1182
(907) 465-3707
Fax 463-4867

OUT OF SESSION
P.O. Box 333
Kotzebue, Alaska 99752
(907) 442-3245

Official Business

TO: Representatives Mike Navarre and Eileen MacLean, Co-chairs
House Finance Committee

FROM: Senator Al Adams *APA*

RE: Senate Bill 157, "An act relating to optometrists"

DATE: May 4, 1992

This is to request a hearing on the aforementioned legislation. Accompanying this memorandum is background information for committee review.

Senate Bill 157 expands the authorized pharmaceutical agents available for use in the practice of optometry. It accomplishes this by repealing and rewriting AS 08.72.272.

The Senate Labor and Commerce Committee substitute, which I support, adds a new Section 1 to clarify that the Board of Optometrists may issue a license to optometrists to both prescribe and use the pharmaceutical agents described in AS 08.72.272. This was done to eliminate uncertainty in the use of pharmaceutical agents in the office setting in addition to prescribing use by clients at home. The substitute bill also deletes a prior version's subsection which authorized the use of oral pharmaceutical agents.

An updated fiscal note has been requested from the Department of Commerce.

Thank you.



JEFFREY A. GONNASON, O.D.

My name is Jeffrey A. Gonnason, O.D., a doctor of optometry. I am a life-long Alaskan, president of the Alaska Optometric Association, and past president of the Alaska State Board of Examiners in Optometry. I have been in private practice in Alaska for over 15 years. On behalf of the Alaska Optometric Association representing over 60 of Alaska's Doctors of Optometry, I wish to thank the committee for hearing this issue in the public interest. Documents of support are available from Alaska and across the nation relating the 16 years of experience by other states that allow optometrists the use of therapeutic medications.

The purpose of this legislation is to update the Alaska optometry statutes with regard to the use of pharmaceutical agents. Currently, only diagnostic drugs are used for examining the eye. Passage of this legislation would allow qualified Alaska optometrists to treat the conditions they currently diagnose in a manner consistent with their education and training. Alaska statutes currently require optometrists to "keep informed of and use current professional theories and practices" (AS 08.72.240). In the 30 states where optometrists routinely use drugs to treat eye disease, problems have virtually been non-existent over a 16 year track record. Alaska's O.D.'s do not have this earned and justified privilege.

Optometry as a profession has grown progressively more sophisticated and capable. Most doctors of optometry complete 8 to 9 years of college: 4 years undergraduate and 4 years of graduate training in optometry school, as well as a residency program. Admission requirements and tests are similar to those for medical and dental schools. The biomedical sciences presented in other health professional programs are taught in optometry school with the same quality of instruction. Course work in diagnosis and treatment of eye disease and ocular pharmacology is much more extensive than that presented in medical school. Clinical training occurs in various clinics, HMO's, Public Health, Indian Health, and VA Hospitals. Optometry schools are accredited by the same national agencies that accredit medical schools.

Alaska state education funds would be better spent if these doctors could practice their healing arts in their own native state. It is difficult to get new graduates to come to Alaska because they cannot currently utilize the full extent of their training.



JEFFREY A. GONNASON, O.D.

Optometrists possess an education similar to dentists, podiatrists, and medical doctors. None of these other practitioners, including general medicine, have the extensive training and education specific to eye disease and ocular pharmacology. Yet of these practitioners, only optometry is limited in its use of pharmaceutical agents. We have far more extensive education, as well as training in the use of highly specialized eye instrumentation, than the general medical doctors, nurses, and health aides that are currently allowed to treat eye disease in Alaska.

Last year the American Public Health Association, which represents over 52,000 health professionals, passed a resolution entitled "Access to Treatment for Eye Care". This resolution recommends that legislators update their state optometry practice acts to allow optometrists to use therapeutic pharmaceuticals.

This bill will not allow "grandfathering" of present practitioners. Current statutes already require each Alaska optometrist to pass additional examinations determined by the State Board to receive a license endorsement for pharmaceutical agents. Current regulations for a license already require passing "TREATMENT AND MANAGEMENT OF OCULAR DISEASE", a nationally recognized and standardized examination offered by the International Association of Boards of Examiners in Optometry (IAB), of which Alaska is a member. I can assure you that the Board would exercise the utmost caution in stringent requirements for pharmaceutical endorsement.

The malpractice insurance rate paid by optometrists are the same in states that do allow as those that do not yet allow treatment of eye disease. This is an unbiased reflection of quality, cost-effective care. Malpractice rates have actually been reduced recently. My rate went from \$356 last year down to \$250 this year. This is positive proof of the public safety of optometry, with 16 years of therapeutic experience and one of the lowest litigation rates of the health professions. The courts hold optometrists to the same standards of care applicable to medical doctors and dentists.

Optometrists are classified as physicians under federal Medicare Law, with respect to all services authorized by state law. Medicare patients are denied access to therapeutic eye care from optometrists in Alaska. U.S. Public Health, Indian Health, and military optometrists in Alaska have used medications for many years. If they enter private practice as many have done, they are then restricted by outdated Alaska statutes.



JEFFREY A. GONNASON, O.D.

The only reason for this legislation is to provide much better access to quality, affordable, and cost-effective eye care for Alaskans. This is especially true in our smaller towns and villages. In Alaska, optometrists outnumber ophthalmologists 3 to 1 and are widely distributed throughout the state, while the ophthalmologists are only in the Juneau, Fairbanks, and Anchorage areas (including Soldotna). Time and expense would be saved by the public and the state health payers by reducing unnecessary travel, lost work time, not having to pay more than one doctor, or not having to pay the higher fees of a surgical eye specialist for a common primary care condition. According to the Journal of the American Medical Association, April 1985, "The cost of primary care increases when it is provided by specialists, without necessarily improving its quality...". These cost savings have been well documented. Increased competition and freedom of choice among providers is also a cost containment reality.

The optometrist is often the first contact for a patient suffering from an eye disorder. In most cases, needed treatment can begin immediately, an important aspect in the treatment of many eye diseases. Early diagnosis and treatment allows the optometrist to eliminate patient suffering, and can prevent serious complications.

Optometrists are reasonable, educated, caring professionals with a clean track record nationally. We are state licensed with strict standards. We are regulated by the State Board, by legal liability concerns, by community opinion, and by medicine and the legislature looking carefully over our shoulders. Unlike our other medical and non-medical colleagues with unrestricted license for new educational developments, we practice under a limited license and must return to the legislature for statute changes as optometric education and eye care technology advances. The State Board of Optometry should be allowed to determine the scope of practice by regulation, as is done by other health professions in Alaska to keep current with health care advances.

We are fortunate to have a legislature that will respond to the health care needs of all Alaskans. By lending your approval to expansion of primary eye care services by optometrists, you will be supporting the basic goal of improved quality of life for all Alaskans. Our support is from a broad base: State health administrators, educators, Native organizations, community and regional health groups, insurance providers, medical doctors, dentists, nurses, pharmacists, and mostly by our patients all over the state who choose to trust us with their eye care.

The Impact Of The Use By Kansas Optometrists Of Therapeutic Pharmaceutical Agents

By Stacy Fitch, O.D.

ABSTRACT: From July 15, 1987 through December 31, 1988, the Kansas Optometric Association collected information from Kansas optometrists regarding the number of diagnostic cases seen, their respective therapies, and the number of miles saved. This paper attempts to show the impact of the Kansas therapeutics law on optometrists and their patients.

INTRODUCTION

April 17, 1987 was just a typical day for most of us. But, for Kansas optometrists, it was a milestone. On that day, Kansas became the 17th state to pass a therapeutic law, which has greatly expanded the practice of optometry in Kansas.

The Kansas Optometric Association (KOA) conducted a study for the first year and a half after implementation of this law which asked KOA members to voluntarily keep track of all diagnoses made, therapies, the number of therapeutic encounters, the miles saved, and the referrals made to other doctors. This information was returned to the Kansas Optometric Association.

The Kansas therapeutics law for optometry includes the administering and dispensing of topical pharmaceutical drugs, as well as, the removal of superficial foreign bodies from the cornea and conjunctiva. Any anti-inflammatory agents administered are limited to a 14-day supply and may only be used topically.

RESULTS

Forty-three offices representing 47 optometrists responded to the study. This represents 23% of the 203 optometrists initially certified at SBEO to use therapeutics. Therefore, the results of this study will significantly understate the actual impact. Overall, the total mileage saved by the patients treated by optometrists during the 1½ year period is over 128,000 miles. This represents a major savings of time and out-of-pocket travel expenses for patients.

In Table 1, 23 major diagnoses are listed, with the number of cases of each per month, dating from July 1987 through December 1988. The cases that were referred to another doctor are not included in the table. Two cases of scleritis treated by rural optometrists are not included in the table. A case of scleral melt secondary to cataract surgery is not listed in the table, but is included in the study. This case was co-managed by an optometrist and a surgeon. This case alone saved the patient 1600 miles, encompassing all trips made to the optometrist.

The percentage of cases seen by optometrists practicing in cities versus those practicing in rural areas is considered in Table 2.

Table 3 shows the percentage of cases per month.

DISCUSSION

In Table 2, the greatest percentage of cases were seen by rural optometrists. It would seem that patients are turning to optometrists for their primary eye care in rural areas because of greater convenience. However, it is difficult to draw concrete conclusions in this regard because the majority of optometrists responding to this study are optometrists practicing in rural areas. It may be reasonable to assume that urban optometrists didn't respond because the miles saved would not be great. However, a higher urban OD's response would have reflected significant cost savings over emergency room visits.

In Table 3, the greatest percentage of cases seen per month occurs approximately one year after the implementation of the therapeutics law. There could be several reasons for this. The patients may be more aware of what optometrists can treat now than when the law first passed. Optometrists may also be more confident in treating more sophisticated ocular maladies. Also, as found in the study, optometrists are receiving more referrals from hospitals and general physicians.

CONCLUSION

Prior to April 17, 1987, none of the cases in this study would have been handled by optometrists because the Kansas optometry laws did not allow it.

The mileage saved by the patients became very important in rural areas, which have an optometrist available, but not an ophthalmologist. Since Kansas is largely a rural state, patients are benefiting from the revised optometry laws in time saved, money saved, elimination of unnecessary referrals, as well as improved health care.

ACKNOWLEDGEMENTS

Thanks to Michael P. Malone, O.D. for his assistance in the study and for the use of his optometric office to compile the information, the KOA for supplying the material to write this paper, and the many optometrists who participated in this study.

REFERENCE

Kansas Optometry Laws, 65-1501, 65-1501a.

YOU WILL HEAR

You have heard or will hear a number of reasons why the use of therapeutic drugs by optometrists is dangerous. Let me consider some of these.

YOU WILL HEAR that optometrists are not properly trained to use pharmaceuticals for therapy. This is simply not true. The course of study in this area is the same as that of medicine and more extensive than that of dentistry. Not only are the hours of pharmacology the same for medicine and optometry, but it should be noted that the medical student must study all organs equally, whereas, the optometry student can specialize in the eye once general pharmacology is completed. The drug interactions and systemic effects of the drugs administered for ocular conditions are studied in great detail. Students see numerous patients with pathology which requires pharmaceutical therapy. These students are supervised by ophthalmologists. So when other ophthalmologists say our students do not receive appropriate clinical instruction they are providing misinformation, by reacting emotionally not rationally.

YOU WILL HEAR that a profession which is non-medical should not be allowed to use drugs. Yet dentistry and podiatry are non-medical and use therapeutic drugs, and surgery in the course of their professional practice and no harm has come to the public. The real issue here is not whether optometrists are medical or non-medical; the fact is that optometrists are well trained health-care professionals.

YOU WILL HEAR that these therapeutic pharmaceutical agents can have systemic effects, effects on other parts of the body, and that there could be interactions with other drugs a patient may be taking. These are true statements and optometrists, along with physicians, dentists, podiatrists and pharmacists study these areas and responsibly incorporate it into their practice. The information necessary for responsible use of these agents is in the public domain and accessible to all health professionals, not just to physicians. It was the result of scientific investigations and is not exclusively "medical".

YOU WILL HEAR that there will be public safety problems if optometrists are allowed to use these agents. Very unlikely situations and cases will be put forth, coupled with the assumption of absolutely no professional judgment on the part of the optometrist. These "strawmen" prove nothing. Yet, two states, West Virginia and North Carolina, have had this law for over 10 years and there have been no substantiated problems as a result. The reason I use the word substantiated is that there have been claims of problems but none that have been corroborated, and some have been found to be fraudulent. Twelve states have this law and the safety of the public is just fine. Better access, better quality care and cost containment have been the result.

In conclusion, optometry schools are educating and training optometry students well in the areas of diagnosis of eye pathology and in the responsible use of pharmacological agents. These students will graduate with the appropriate professional judgment to provide high quality eye care to their patients.

EDITORIAL

Lyman C. Norden, O.D., Editor

What makes optometric primary eye care better?

This issue contains another of several letters I've received stating that optometric primary eye care is better, not just less costly than ophthalmologic. Actually, I agree. Now how do we convince others?

It's easy to show that optometric care is less costly. All you have to do is look at financial balance sheets. Look at optometric training sites versus medical. Look at HMOs and governmental agencies in which optometrists provide the primary eye care. It's also easy to show that optometric training in primary vision care is better. All you have to do is look at curriculum. Optometric training involves far more hours in optics, refraction, and psychophysics of vision than does medical — and primary vision care is what most consumers really want from their eye care providers.

Ophthalmology, however, counters with a compelling argument that *medical training* makes its delivery of primary ocular health care superior to optometry's. Of course optometry then has to convince anyone still listening that its training in ocular health care is good enough to do the same. Perhaps we should start with our own compelling argument that optometric training is superior to medical training for the delivery of primary eye care, which includes *both* primary vision care and primary ocular health care. But first we must ask ourselves, "What is there about optometric training that results in better primary ocular health care?" Following are a few observations and opinions from one who has spent some 20 years in multidisciplinary practice settings, optometric training sites, and affiliated medical training sites.

First there is the matter of attitude, developed either in training or prior to training and then nourished by it. Medicine has a long-standing and often-dramatized association with life-and-death issues in patient care and in training for patient care. We see it in the media every day and we hear it in legislative sessions every year. It would be understandably difficult to train in such an environment without being caught up in the egocentrism that can result. This is not saying that egocentrism is bad. It's probably necessary for making clinical decisions about death and serious illness. But let's be realistic. People don't typically seek primary eye care for fear of death, blindness, or any other disabling illness. Most people seek primary eye care because they either want to see better or look better, or both. Optometrists seldom have trouble coming back down to earth when dealing with the vast majority of patients who simply want primary vision care. Similarly, optometrists seldom have trouble coming back down to earth when dealing with legislators and policy makers who simply want what is best for their constituents.

Optometrists are better able to communicate one-on-one with their patients. This is one of the principal reasons why optometry has been able to survive and grow within our medicine-dominated health care system. When given a choice, most people elect to receive their primary eye care from an optometrist. An important reason for this is that optometrists are better able to understand what people really want and need from their primary eye care providers. This ability to communicate effectively with

primary care patients better enables the optometrist to elicit compliance in the pharmacologic management of eye disease.

I believe the development of these communication skills is inherent in optometric training because that training is based upon subjective refraction. In subjective refraction, the doctor in training bases virtually every step of the clinical examination on the patient's response to a question. How many doctors do you go to for health care who actually listen and respond to virtually everything you say for 30 minutes or more? How many doctors do you go to for health care who actually base their diagnoses more upon what you tell them than upon what they see in your tests? Unlike optometric training, fundamental medical training involves numerous clinical decisions based more upon laboratory tests and clinical observations than upon conversation with the patient. Optometrists, however, talk *with* their patients. This is why optometrists are more likely to obtain compliance from patients requiring ocular disease management.

I believe these communication skills are further refined in optometric training because that training involves both the prescription and fitting of prosthetic devices (eyeglasses and contact lenses). By comparison, medical training typically involves the prescription of pharmacologic agents, dispensed by a third party. Prescription medications are purchased and dispensed away from the prescribing doctor's office and quickly forgotten, whether they worked or not. Who wants to pay for another office visit and lose another half day in the doctor's waiting room because they're not sure a prescribed medication really worked? A prosthetic device, however, requires individualized fitting and when it doesn't perform satisfactorily, the patient usually knows it and returns it to its source, at which point the underlying problem must be confronted. Eyeglasses obtained from the prescribing optometrist which don't perform as expected are usually brought to the attention of the doctor in a remarkably efficient feedback loop. This direct feedback system is not a part of ophthalmologic training. Refracting ophthalmologists insulate themselves with opticians (and seem to think they are more virtuous than optometrists for doing so).

Not only must optometrists constantly stand ready to prove themselves to the patients for whom they prescribe, they must do so at virtually every turn within the total health care system. Medicine, because of its status in the eyes of the public, legislators and policy makers, seems always to be assumed right in everything it says until overwhelmingly proven wrong. Optometry on the other hand seems always to be assumed wrong until it proves itself incontrovertibly right.

Being challenged at every turn ultimately makes optometry better at what it does. Optometry has always had ophthalmology nearby, eager to point out any perceived errors in clinical judgement when a case goes bad. This naturally makes optometrists more conscientious and conservative in their treatment of patients. What other health care profession has a more active and therefore more effective quality assurance program?

Nothing in this discussion should be construed as a criticism of medical training. I see nothing wrong with medical training, nor am I in a uniquely credible position to criticize it. But I know what I like, and don't like, in every brand of health care I consume — and so do our patients. The point is that, for the provision of primary eye care, optometric training is better than medical training.

Optometric Education

The growth of the optometric profession is in no small measure due to the remarkable expansion of optometric education during the past thirty years. Because optometry is a relatively young profession, it has been able to benefit from the tremendous expansion in technology during recent years. Many people are not aware of the truly significant changes that have recently taken place in the profession and its educational base.

Fifteen schools and colleges of optometry in the United States now provide an educational experience that is equivalent in length and scope to that which is provided by schools of medicine and dentistry. All medical, dental and optometry programs are four years in length and require the same level of professional training. In fact, a comparison of the current catalogs of the University of North Dakota School of Medicine (UND) and Southern California College of Optometry (SCCO) demonstrates that the admission requirements of SCCO are actually more stringent than those of the UND.

Admission Requirements (Quarter Units)

	UND	SCCO
Calculus	Not required	3-4
Biology or zoology	8	8
Microbiology	Not required	4
Physics	8	12
General chemistry	8	12
Organic chemistry	8	4
Psychology	3	8
English	6	8
College Algebra	3	Not required
Total hours required	90	90

During the first two years of both professional programs, students receive extensive training in basic health sciences, such as pharmacology, anatomy, physiology, neurosciences, and pathology. The second two years are more clinically oriented; the medical student is trained in all aspects of medical care while the optometry student concentrates on the eye and visual system. The result is that the optometry graduate completes his training with much more extensive and in-depth training in the eye and in the diagnosis and treatment of its abnormalities than does the medical school graduate.

After graduation from the four-year professional programs, both the optometrist and the physician are examined and licensed by appropriate agencies of the state. This license allows the physician to practice all aspects of medicine and surgery, including the diagnosis and treatment of eye diseases and the performance of eye surgery. Although most physicians undergo additional training in

one of the medical or surgical specialties, no further testing or licensure is required in order for them to practice as a specialist. Therefore, even though some physicians have undergone several years of additional training to become pediatricians, any physician is permitted to treat diseases of children, and even though some physicians have undergone several years of additional training to become obstetricians, any physician is permitted to deliver babies. Similarly, even though some physicians undergo several years of additional training to become ophthalmologists, any physician may treat diseases of the eye.

For legal and licensure purposes, it is assumed that the training received in the four years of medical school qualifies the graduate to practice all aspects of medicine with reasonable competency. This assumption appears to work very well since there appears to be little pressure for changes to the Medical Practice Act which would require that only specialists be allowed to treat various types of conditions.

This same assumption might well be applied to other health professions as well. If it can be demonstrated that the training a health professional receives in a given area is equivalent to or superior to that received by a physician, there seems to be no logical reason why he should not be allowed to do what the physician does in that area of health care. Since only about 4.5 percent of all physicians are ophthalmologists, it makes good sense to permit the doctor of optometry to provide primary eye care whenever possible.

Benefits of Use of DPAs Continue

Since the use of diagnostic pharmaceutical agents (DPAs) by optometrists was authorized by the 1979 North Dakota legislature, the benefit to the public of this action has continued to be demonstrated. More than 90 percent of North Dakota optometrists have been certified, and most use DPAs routinely in their diagnosis and treatment of vision problems. Contrary to the dire predictions of those who opposed the 1979 legislation, no adverse effects have been reported. In fact, the Optometry Board has not received any formal complaints or reports of problems associated with the use of DPAs by optometrists. Professional liability premiums, perhaps the best indicator of whether or not problems are occurring, have not been affected. The action of the 1979 legislature has proven to have been prudent and in the best interests of the people of North Dakota.

The North Dakota experience is the same as that in the other forty-eight states that currently permit optometrists to use DPAs. In none of these states has significant evidence been brought forth to suggest that any adverse effects are occurring. It is also worthy of special note that in the twelve states which permit optometrists to use therapeutic as well as diagnostic agents, no reports have been made of any problems associated with their use. In fact, it has been well

documented that the therapeutic agents are even less likely to cause complications than are the diagnostic agents. This underscores the fact that the optometrist of today is capable of using both diagnostic and therapeutic pharmaceuticals safely and effectively in his or her practice.

Because of the much broader geographic distribution of optometrists and the fact that fees charged by them are generally less than those charged by ophthalmologists, major savings to the public are realized when optometrists are permitted to practice at their highest level of training. The necessity of referring persons with relatively minor eye injuries or infections to a surgical eye specialist or a hospital emergency room always results in a charge for the second examination and frequently results in the loss of several additional hours from the patient's work and/or the travel of many additional miles.

Optometry IS Primary Eye Care

Analysts of the health-care delivery system have divided it into three broad categories which they have labeled primary care, secondary care, and tertiary care.

Primary care is that level of care delivered by "first contact" providers. These are the doctors first contacted by a person in need of health care, and they are able to diagnose and treat the great majority of persons they see. It has been estimated that from 85 to 95 percent of all health care can be classified as primary care. In general, primary-care providers do relatively little of their work in hospitals. The American Medical Association considers family and general practitioners, pediatricians, internists, and obstetrician/gynecologists to be primary medical care providers. Other primary-care providers include general dentists, optometrists and podiatrists.

Secondary-care providers are generally those who have received additional specialized training beyond that which is required of primary-care providers. Persons with unusual or complicated problems or those who require more than very minor surgery are generally referred to a secondary-care provider by a primary-care provider. Most surgeons are classified as secondary-care providers, and secondary care involves more use of hospitals and specialized facilities than does primary care. Among the medical specialties, orthopedic surgeons, ophthalmologists, anesthesiologists, and cardiologists are examples of secondary-care providers. Non-medical secondary-care providers would include dental specialists, such as orthodontists and periodontists, and optometrists who limit their practice to contact lenses.

Tertiary-care providers are those who specialize in the diagnosis and treatment of rare conditions. Their practice is almost always hospital based and requires additional training beyond the secondary level and use of sophisticated

techniques and instruments. Examples of tertiary-care providers would be open-heart surgeons, brain surgeons, ophthalmologists who repair retinal detachments, and organ transplant specialists.

Because of the additional training and skills required to practice at the secondary and tertiary levels, the care provided is usually more expensive than that provided at primary level. Even in cases where the fees charged are the same, when the costs to society of education and training are considered, the cost of secondary and tertiary care is higher. Since the vast majority of all care can be provided at the primary level, it makes good sense from an economic standpoint to have as much care as possible provided at that level, and in most cases, it is. For example, even though a cardiologist may have more training in the management of high blood pressure, family practitioners are perfectly capable of managing uncomplicated cases. And even though an orthopedic surgeon may have more training in the anatomy and function of the joints, a pediatrician is perfectly capable of treating a child's simple sprained ankle.

Similarly, optometrists, although they do not have the same training as do ophthalmologists, are perfectly capable of managing uncomplicated eye conditions. Their education and training in the diagnosis and treatment of eye problems is much more extensive than that of most physicians, and their past record of conscientious, conservative care is evidence of their ability to recognize and refer to other providers those conditions that require care at the secondary or tertiary level.

Health Care Not Necessarily Medical Care

Although the terms *health care* and *medical care* are often used interchangeably, they do not really mean the same thing.

Health care is a broad term that refers to the entire area of maintenance of physical well-being. *Medical care* is much more limited in that it refers to health care which is provided by medical doctors.

Although the various areas of health care seem to be fairly well defined, many areas overlap. For example, the Medical Practice Act, since it was the first to be enacted, is all-encompassing and permits the physician to practice all aspects of health care regardless of whether or not he or she has any training in that area. Thus, any physician may legally fill teeth or prescribe eyeglasses. On the other hand, certain procedures which would usually be considered the exclusive domain of physicians are done by some other health-care providers. Dentists are permitted to use general anesthetics and prescribe oral antibiotics and potent pain-

DICTIONARY OF VISUAL SCIENCE

— SECOND EDITION —

A modern comprehensive dictionary covering the terminology of the visual sciences, including the fields of ocular anatomy, ocular physiology, ocular pathology, ocular embryology, neuro-ophthalmology, ocular histology, ocular genetics, comparative anatomy of the eye, ocular prosthetics, physiological optics, psychological optics, ophthalmic optics, geometrical optics, ocular refraction, orthoptics, visual training, dispensing, aniseikonia, perimetry, contact lenses, subnormal vision aids, occupational vision, and motorists' vision, and also including the phases of remedial reading, statistics, illumination, and physical optics that relate closely to vision.

Illustrated

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CHILTON BOOK COMPANY

Radnor, Pennsylvania

apparatus

enclose or bind a group
; or as a means of at-
for muscles at their
nserition.

a orbitale.

ris, *a.* Tenon's capsule.

neal (ap'o-plek'se).
of blood into the cor-

nal. Copious hemor-
the retina.

'ilb). A unit of lumi-
d to $\frac{1}{10}$ millilambert.

otlambert.

'ah-ra'tus, -ra'tus). 1.

r group of organs, or
rgans, which collec-
m a common function.
tion of instruments,
implements used for
'k, as an experiment
ion.

re *a.* Those parts of
an, other than the
ve and the receptor
are essential for the
of the organ. In the
ild include all struc-
han the optic nerve
; and cones of the

e *a.* The structures
hich are related to
on; the ciliary ap-
the crystalline lens.
ciliary muscle and
e structures other
stalline lens which
o accommodation;
dy.

e tear-forming and
g system, com-
mal and accessory
's, eyelid margins,
ac, lacrimal lake,
a, canaliculi or lac-
mmon canaliculus
sier, lacrimal sac,
uct, and Hasner's
erior meatus of the

e intraocular and
r musculature of

apparatus

the eye considered collectively.
See under *muscle* for the specific
muscles involved.

nervous a. The sensory and the
motor nerves of the eye and the
orbit considered collectively. See
under *nerve* for the specific
nerves involved.

refractive a. Cornea, aqueous hu-
mor, crystalline lens, and vitreous
humor considered collectively;
the surfaces and the media tra-
versed by light entering the eye
and involved in the production of
the retinal image.

visual a. The two eyes, their ex-
trinsic muscles and other contents
of the orbits, the nerves, the path-
ways, and the visual cortex, con-
sidered collectively. Syn., *visuum*.

apparent height; magnification;
magnitude; movement; posi-
tion; pupil; size; strabismus.
See under the nouns.

apparition (ap''ah-rish'un). 1. A su-
pernatural visual manifestation.
2. A visual hallucination.

appearance. 1. The distinctive char-
acteristics or features of an ob-

apraxia

ject or an individual as noted by
visual observation. 2. The orig-
inating of an experience, particu-
larly visual. 3. An incorrect visual
or other impression.

appendages of the eye (äpen'dih-
jez). The accessory structures or
adnexa of the eye, including the
lacrimal apparatus, the conjuncti-
va, the cilia, the supercilia, the
eyelids, and sometimes the extra-
ocular muscles.

apperception (ap''er-sep'shun). The
action of past experience upon
received sensory stimuli, result-
ing in individual differences of in-
terpretation of the same sensory
stimuli.

applanatio corneae (ap''lah-na'she-o
kor'ne-e). A flattened cornea due
to degenerative changes.

applanation (ap''lah-na'shun). An ab-
normal flattening of a convex sur-
face, especially of the cornea or
the crystalline lens.

apraxia (a-prak'se-ah, ä-prak'-).
The inability to accomplish an
intended or purposeful move-
ment, the nature of which is

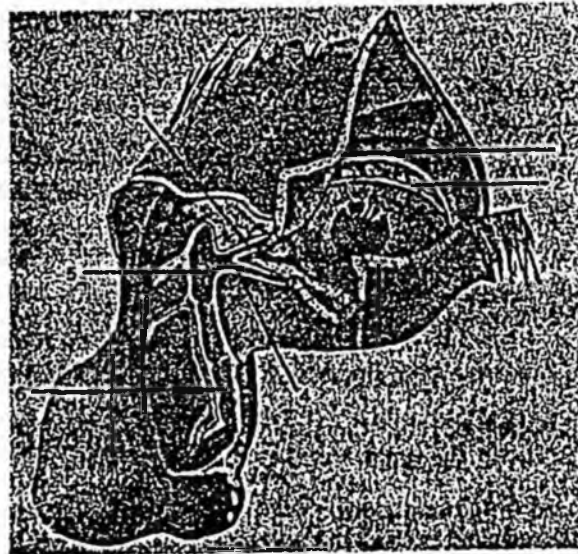


Fig. 3. The lacrimal apparatus. (1) Superior lobe and (2) inferior lobe of lacrimal gland. (3) Superior and (4) inferior canaliculus. (5) Lacrimal sac. (6) Nasolacrimal duct. (From *Text-book of Ophthalmology*, Vol. 1, Duke-Elder, Henry Kimpton, 1942)

APHA recognizes contributions to public health, vision care

ATLANTA— The Vision Care Section (VCS) of the American Public Health Association (APHA) recognized the contributions of a public health leader and a public policy center at the association's 119th annual meeting.

Recognized for his important contributions to public health in general and vision care in particular, was Harris Nussenblatt, O.D., Dr.P.H., of Houston, TX, winner of the section's 1991 Distinguished Achievement Award. Dr. Nussenblatt is a founding member of the Vision Care Section and served as chair from 1982-84. He also served as section councilor, program chair and editor of the section's newsletter for many years. He was also cited for his committee work for the American Optometric Association (AOA) and the Association of Schools and Colleges of Optometry (ASCO) by Les Caplan, O.D., M.P.H., awards chair.

"In summary, Dr. Harris Nussenblatt's record is one of academic excellence with significant contributions to public health and eye care issues. His work has always been attune to changes in health care delivery while being both a leader and team player — all of which has improved the health and well-being of the public," said Dr. Caplan.

The section's Outstanding Paper Award went to Mordachai Soroka, Ph.D., of the Center for Vision Care Policy, State College of Optometry, State University of



Harris Nussenblatt, O.D., Dr. P.H.

New York. The award paper, titled "Comparison of Examination Fees and Availability of Routine Vision Care by Optometrists and Ophthalmologists," was recently published in *Public Health Reports*. Dr. Soroka's national survey determined that ophthalmologists' fees are \$19 more than optometrists' fees for routine eye examination. In addition, he reported that the waiting time for routine examinations with ophthalmologists was 15 days longer than for optometrists, which added a barrier for access to services.

The VCS sponsored numerous papers presented during the conference. The pa-

pers highlighted a patchwork quilt of subjects and their effect upon public health. Panel presentations addressed model diabetes control programs, screening underserved populations, and eye care in underdeveloped countries.

Papers were presented by ODs as well as physicians, nurses, government representatives and scientific researchers, according to Debbie Hettler, O.D., M.P.H.,

SCCO program covers AIDS and vision problems

FULLERTON, CA— "Eye/Vision Problems Associated With AIDS," was the topic of a recent, special edition of the Southern California College of Optometry's (SCCO) Vision and Youcable television program. The program featured SCCO faculty members John Nishimoto, O.D., and Russell Jew, O.D., discussing the devastating effect of AIDS on the eyes. In some cases, eye signs of AIDS are the first to be noticed as the retina is almost always affected by the malady. AIDS can have serious consequences on the patient's vision, the doctors noted.

Dr. Nishimoto and Dr. Jew emphasized that all HIV-positive patients should have an eye examination every three months. Sometimes, the first sign of full-blown AIDS is seen in the eye and treatment to prevent the AIDS virus from multiplying rapidly must be started in order to save at least some vision.

The AIDS virus has been noted in the tear layer of the eye, so optometrists should

Chicago, IL, program chair for the VCS.

"The meeting offered a great opportunity to interact with health professionals from around the world and enhance the role of optometry in the total health care system," said Ian Berger, Ph.D., VCS Action Board representative, Houston, TX.

Frescura, luminary of European optometry, dies at 85

Romeo Frescura, a founding member of the European Optometry Society (SOE), has died at the age of 85 in Imperia, Italy. The second of four generations in the optical field, Frescura was a consultant to the Italian government for eye care and served as president of the optometric trade union there. Active in optometric education in Italy, France and Germany, he served as president of the SOE for nearly 20 years. He is survived by his son, Ugo Frescura, president of the SOE since 1985.

Deaths

ST. LOUIS-- The American Optometric Association derives its great strength and spirit from its people, and mourns all those it loses. The following are those members whose passing has been reported to the *AOA News* as of Dec. 1, 1991

The Evening Sun

A12

Baltimore, Thursday, June 2, 1988



Double vision

Governor Schaefer justified his veto last week of the "eye drops" bill by saying the measure would have "lowered the standard of medical care here." In fact, the governor's action ensures that Maryland, alone in the nation, will retain a double standard of eye care — one for those who have access to an ophthalmologist, and another for those who cannot afford the higher fees or live in rural areas of the state not served by an ophthalmologist.

The "eye drops" battle has been a legislative fixture for so long that it can almost be seen as an duel between lobbyists. But the political fight shouldn't obscure the real issue here, which is rank protectionism for one branch of the medical profession. Maryland's law governing the practice of optometry was adopted in 1954, and since then not one word has been changed. Meanwhile, every other state in the nation has allowed optometrists to use eye drops ("pharmaceutical agents") in order to check patients for disease. This is not a radical idea; optometrists everywhere else in the country routinely use this important diagnostic tool. Maryland optometrists are trained in the use of diagnostic eye drops and are authorized to use them in the state's Veterans Administration Hospitals or in public health facilities, but not in their private offices.

One result of Maryland's backward law is that the number of new applicants taking the state's optometry exam has dropped by half in the last five years. In other words, affordable eye care will become harder to procure — a sign that does not bode well for vision in this state.

Second



Frank Pesci

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Schaefer's veto makes Maryland the only state left which still denies optometrists the right to use eyedrops to dilate patients' pupils. Can you imagine that?

Schaefer said he was swayed by medical authorities and his own ophthalmologist who requested he veto the bill. He said he didn't believe that optometrists' training requirements adequately compare to the training required of ophthalmologists.

Sen. Arthur Dorman, D-21st-Beltsville, an optometrist, didn't buy Schaefer's reasons for the veto.

Dorman would like to know the real reason for the veto.

Dorman knows the real reason. He just doesn't want to say. So I'll say it for him.

The real reason is Bruce Bereano, Annapolis' number one money-making lobbyist. Bereano represents the ophthalmologists, and in 1986 he raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

Two months ago, I ran into Bereano after breakfast at the Maryland Inn. Winking, he spoke about getting a veto of the eyedrop bill if it passes. Do you see a quid pro quo?

I learned a long time ago that the sleaze factor in politics comes in bipartisan doses. The Republicans have their Ed Meese, and in Maryland the Democrats have Schaefer and Bereano.

Frank Pesci of New Carrollton, who writes regularly for this page, is a former member of the Maryland House of Delegates.

AS THE PRINCE GEORGE'S JOURNAL FRIDAY, JUNE 3, 1988

Opinion

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On the side of signing the bill were the governor's own health secretary, optometrists, consumers, the General Assembly, which passed the bill earlier this year, and the fact that every other state in the union allows optometrists to administer eye drops.

On the side of vetoing the bill were ophthalmologists, who stand to lose customers and money if the bill becomes law, and Bruce Bereano, the ophthalmologists' high-powered lobbyist, who also raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

No contest, if you're this governor. Schaefer vetoed the bill.

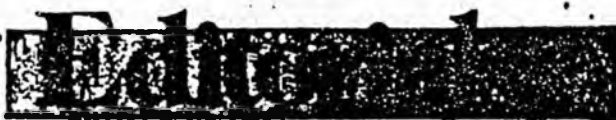
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**DOCUMENTS WHICH HAVE NOT BEEN FILMED BUT ARE
AVAILABLE IN THE ORIGINAL FILE INCLUDE:**

CORRESPONDENCE AND COMMENTS RELATIVE TO SB 157 FROM:

1. CALLISTO MEDICAL CLINIC, KETCHIKAN, 2/18/92
2. STATE OF FLORIDA, DEPT. OF HEALTH AND
REHABILITATIVE SERVICES, 4/23/90
3. THE COMMONWEALTH OF MASSACHUSETTS, DIVISION
OF INSURANCE, 3/26/90
4. IOWA STATE BOARD OF OPTOMETRY EXAMINERS
2/17/90
5. COMMONWEALTH OF KENTUCKY, BOARD OF
OPTOMETRIC EXAMINERS, 4/24/89
6. AMERICAN ASSOCIATION OF RETIRED PERSONS
NEVADA STATE LEGISLATIVE
COMMITTEE, 4/24/89
7. VALLEY EYE AND LASER CENTER, RENTON,
WASHINGTON, 3/13/89
8. NORTHWEST EYE CENTER, SEATTLE,
WASHINGTON, 2/08/89
9. SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
12/21/88
10. COMMENTS OF LESLEY W. WALLS, O.D., M.D. TO THE
VIRGINIA STATE BOARD OF MEDICINE, 12/20/88
11. WEST VIRGINIA BOARD OF OPTOMETRY, 10/16/86

SB 158

SENATE FINANCE COMMITTEE REPORT

DATE: 3/1/91

FURTHER:

Date of 5-Day Notice: 3-13-91 DATE TURNED INTO OFFICE: 4-2-91
(required under Uniform Rule 23) 3-26-91

The Finance Committee considered SB 158

Relating to the interest rate on unpaid and overpaid taxes and to the due dates for and interest on unpaid and overpaid royalties and net profit share payments from state resources; efd.

and recommended:

replace with _____ CS SB 158 (Fix) same title
 or adopt _____ CS _____ new title
 attached amendment(s) technical title change (HB only)
 _____ letter of intent adopted

do pass

do not pass

no recommendation

individual recommendations

further referral to _____

ATTACHES NEW FISCAL NOTE(S):

APPROVES PREVIOUS:

fiscal note(s) Dept/Date: DOR - 3/29/91
Dept. 52.0 Rev.

fiscal note(s) Dept/Date: _____

zero fiscal note(s) _____

zero fiscal note(s) ✓ _____

appropriation-no fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Al Adams
Jim DeLuca
[Signature]

Dick Stally No Rec
Fate Welch (No Rec)

AGO 10050594

1. [Signature] 2. [Signature]
Co-Chairs: Signatures and Recommendations

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. CS SB 158

Revision Date: March 28, 1991

Department Affected: Revenue

Title: "An Act relating to the Interest

BRU:

Rate on Unpaid & Overpaid Taxes..."

Component:

Sponsor: Senate Rules/Governor

Requestor:

COMPONENT SERIAL NO.

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
---------	---	---	---	---	---	---

REVENUE	52,000	72,000	94,000	118,000	145,000	146,000
---------	--------	--------	--------	---------	---------	---------

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

See attached.

Prepared By: Charles L. Logsdon

Phone: 277-5627

Division: Oil & Gas Audit

Date:

Approved by Commissioner:

Agency:

Date:

3-28-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

Page ___ of ___

Fiscal Note Analysis of Bill to Change Interest Rate Statute

This bill would make two fundamental changes in the interest rates on unpaid and overpaid taxes and royalties from state resources. First, instead of a fixed rate of 12 percent the interest rate would be set at 5 percentage points above the rate charged member banks for short term advances by the 12th Federal Reserve District effective the first day of the calendar quarter, or a fixed rate of 11 percent, whichever is greater. Second, instead of simple annual interest, interest will be computed on a quarterly compounded basis as of the effective date. Accrued interest on taxes and royalties due prior to the effective date of this bill would be subject to compounding.

The short term rate quoted by the 12th Federal Reserve District in effect on March 1, 1991 was 6.0%. This means that under this bill, if the current rate does not change on or before July 1, the applicable rate would be 11% for the third quarter of 1991, the first quarter effected by this bill.

Obviously the current floating rate is lower than the current law provides. However, the real impact of the proposed change contained in this bill is in the change from simple to compounded interest. Because the interest on outstanding taxes or royalties due and accrued interest prior to the effective date is charged interest quarterly, the amount of interest due builds at an accelerating rate over time.

The revenue impact outlined in this Fiscal Note assumes an interest rate of 11 percent, \$1000 million in overdue/overpaid taxes or state royalties and accrued interest of \$500 million. This is roughly 50% of current outstanding tax assessments plus interest, a conservative assumption to allow for partial resolution and payments. The following table shows the impact for other higher interest rates possible under this bill.

Analysis of CS SB158
 March 28, 1991
 Page 2

Compound Interest Example for Interest Statute
 (Millions \$)

Amount Overdue/Overpaid = 1000
 Prior Accrued Interest = 500

	CURRENT INTEREST DUE (12% SIMPLE)	PROPOSED INTEREST LAW DUE (FED DIS + 5% COMP QUART)					
		11% Dif	12% Dif	13% Dif	14% Dif		
Year 1	120	172	52	188	68	205	85
2	120	192	72	212	92	233	113
3	120	214	94	238	118	264	144
4	120	238	118	268	148	300	180
5	120	265	145	303	183	341	221
Total	600	1081	481	1210	610	1344	744

As can be seen from the table, the use of compounding can be a powerful additional monetary incentive to speed the resolution of disputes over the correct amount of taxes.

CS SENATE BILL NO. 158 (*Fix*)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

Introduced: 3/1/91
Referred: Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the interest rate on unpaid and overpaid taxes and to the due dates
2 for and interest on unpaid and overpaid royalties and net profit share payments from
3 state resources; and providing for an effective date."

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

5 * Section 1. AS 38.05.135 is amended by adding new subsections to read:

6 (c) Payment of a royalty or a net profit share payment to the state under a lease issued
7 under AS 38.05.135 - 38.05.181 becomes due on the date and in the manner specified in the lease
8 or in a regulation adopted by the commissioner.

9 (d) If a royalty or net profit share payment to which the state is entitled under
10 AS 38.05.135 - 38.05.181 is not paid when it becomes due under (c) of this section, the royalty
11 or payment bears interest in a calendar quarter at the rate of five percentage points above the
12 annual rate charged member banks for advances by the 12th Federal Reserve District as of the
13 first day of that calendar quarter, compounded quarterly as of the last day of that quarter.

14 (e) Interest at the rate and in the manner provided in (d) of this section shall be allowed

See Amend #2

1 and paid on an overpayment of a royalty or net profit share payment made under AS 38.05.135 -
2 38.05.181.

3 * Sec. 2. AS 43.05.225 is amended to read:

Sec. 43.05.225. INTEREST [ON TAXES]. Unless otherwise provided,

4 *See Amend #1* → ~~(1) when a tax levied in this title is not paid by the date prescribed for its~~
5 ~~payment, [BECOMES DELINQUENT] it bears interest in a calendar quarter at the rate of five~~
6 ~~percentage points above the annual rate charged member banks for advances by the 12th~~
7 ~~Federal Reserve District as of the first day of that calendar quarter, compounded quarterly~~
8 ~~as of the last day of that quarter;~~
9

10 (2) the interest rate is 12 percent a year for

11 (A) delinquent fees payable under AS 05.15.095(c);

12 (B) arrearages for child support as provided in AS 25.27.025 unless
13 a lesser rate authorized by that section applies; and

14 (C) unclaimed property that is not timely paid or delivered, as allowed
15 by AS 34.45.470(a).

16 * Sec. 3. AS 43.05.280(a) is amended to read:

17 (a) Interest shall be allowed and paid on an overpayment of a tax under this title at the
18 rate and in the manner provided [PRESCRIBED] in AS 43.05.225(1) [AS 43.05.225].

19 * Sec. 4. AS 43.31.141 is amended to read:

20 Sec. 43.31.141. WHEN TAX DUE, EXTENSION AND INTEREST. The tax imposed
21 by this chapter is due and payable 15 months after the decedent's death [,] and shall be paid by
22 the executor to the department. If the department finds that the payment on the due date of tax
23 or any part of the tax would impose undue hardship upon the estate, the department may extend
24 the time for payment of any part, but no extension may be for more than one year and the
25 aggregate of extensions with respect to an estate may not exceed five years from the due date.
26 In that case, the amount in respect of which the extension is granted shall be paid on or before
27 the date of the expiration of the period of the extension unless a further extension is granted.
28 If the time for the payment is extended, there shall be collected, as part of this amount, interest
29 on the tax as [AT THE RATE] provided in AS 43.05.225(1) [AS 43.05.225] from the due date
30 of the tax to the date the tax is paid.

31 * Sec. 5. AS 43.55.060 is amended to read:

AGO 10050599

1 Sec. 43.55.060. DELINQUENCY. When the tax provided for in this chapter becomes
2 delinquent, it bears interest as provided [AT THE RATE PRESCRIBED] in AS 43.05.225(1)
3 [AS 43.05.225]. If any person fails to make a report required by this chapter, within the time
4 prescribed by law for the report, the department shall examine the books, records, and files of
5 the person to determine the amount and value of the production to compute the tax, and the
6 department shall add to the tax the cost of the examination, together with any penalties accrued.
7 * Sec. 6. APPLICABILITY OF COMPOUNDED INTEREST. Beginning on the effective date of
8 this Act, interest accrues on underpayments and overpayments of royalties, net profit share payments,
9 and taxes, and on any interest accrued on them before the effective date of this Act, at the rates and in
10 the manner specified in AS 38.05.135(d), added by sec. 1 of this Act, and AS 43.05.225, as amended
11 by sec. 2 of this Act.
12 * Sec. 7. This Act takes effect July 1, 1991.

A M E N D M E N T

AA
Adopted
3-26-91
#1

TO: SB 158

Part A
Adopted
A only

Page 2, lines 5 and 6:

Delete all material and insert:

(1) when a tax levied in this title becomes delinquent it bears interest in a calendar quarter at the rate of five

Part B

~~Page 3, line 9:~~

~~Delete all material and insert:~~

~~and taxes, but not on any interest accrued on them before the effective date of this Act, at the rates and in~~

3-26-91
Cotten per
Fisher.

#2
Adopted.

A M E N D M E N T

OFFERED IN THE SENATE

TO: SB 158

Page 1, line 13, after "calendar quarter,"

Insert: "or at the annual rate of 11 percent, whichever
is greater."

Page 2, line 8, after "calendar quarter."

Insert: "or at the annual rate of 11 percent, whichever
is greater."

3/22/91
SFC

SENATE BILL NO. 158

Sectional Analysis

Section 1. Clarifies the date upon which royalties are due. Sets the rate of interest for unpaid royalty payments under AS 38.05.145 - 38.05.181 at five percentage points above the rate charged member banks by the 12th Federal Reserve District, compounded quarterly. Without the amendment, royalty interest is determined under AS 09.30.070 (Interest on Judgments), currently 10.5%, and does not compound. If an interest rate is set in a lease, the contract rate would be unaffected by this provision. Provides that interest on overpayments is the same as interest on underpayments.

Section 2. Sets the rate of interest for unpaid taxes under AS 43 at five percentage points above the rate charged member banks by the 12th Federal Reserve District, compounded quarterly. Without the amendment, the rate is 12% simple interest. This statutory section has historically applied to the charitable gaming program; to the unclaimed property program; and to the child support enforcement program. The amendment retains the old 12% simple interest provision for those programs.

Section 3. Conforming amendment to ensure that interest on overpayments remains the same as interest on underpayments.

Sections 4 and 5. Conforming amendments necessary to refer other sections of the tax laws to the tax portion of the section providing for interest.

Section 6. Applies the new floating interest rate and the compounding provision to the principal of royalties and taxes that were outstanding on the effective date of the act and to interest that has accrued on those royalties and taxes on that date.

Section 7. Provides for a July 1, 1991 effective date.

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029


Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM

March 21, 1991

SUBJECT: May the legislature constitutionally authorize compounding of interest due on delinquent taxes? (SB 158)

TO: Senator Sam Cotten
ATTN: Deborah Vogt

FROM: Jack Chenoweth
Legislative Counsel 

Bill section 2 of Senate Bill 158 amends the manner of computing the interest rate on delinquent taxes from a simple interest to a compounded interest basis. Bill section 6 of the measure directs that, from the measure's effective date, July 1, 1991, interest will compound as well on the interest due and payable on unpaid taxes that has accrued to that date.

There is no question in my mind that the legislature may change the manner of computing interest on unpaid taxes as is proposed by bill section 2. Shifting from a simple to a compound rate (or vice versa) is theoretically and arguably no different than amending or adjusting the interest rate. In the absence of any express prohibition on doing so, the rate may be changed. There is ample authority to support that legislative action.

The change proposed by bill section 6 would also seem to be unobjectionable as a constitutional matter. The ex ction of a penalty or interest, or both, for delinquency in the payment of taxes does not make the penalty or interest payment part of the tax. Penalty and interest are remedial and, generally, may be constitutionally applied to taxes which have already become delinquent at the time of amendment of the statute. League v. Texas, 184 U.S. 156, 46 L.Ed. 478, 22 S.Ct. 475 (1902) (finding a Texas statute providing that delinquent taxes should bear interest from the time of delinquency applicable to taxes already delinquent at the time the statute took effect). In similar manner, the amendment of a tax payment enforcement provision by the change of the penalty or interest, including the manner of determination of the interest, will apply to all taxes, whether levied and due before or after the amend-

AGO 10050615

Senator Sam Cotten
March 21, 1991
Page 2

ment. Henry v. McKay, 3 P.2d 145 (Wash. 1931) (statutory interest rate reduction held applicable to taxes delinquent at the time of the rate reduction).

In my judgment, the legislature may properly and constitutionally require the compounding of interest on the interest due on delinquent or unpaid taxes levied and collected by the state under AS 43 if that interest has accrued before the effective date of the act. The measure proposed a change in the manner of calculation that is uniformly applicable to all taxpayers. Taxpayers who are delinquent on the effective date of the act may not properly claim the right to have the penalty and interest due for the asserted tax delinquency remain unaltered until the delinquency's clearance. See also Webster v. Auditor General, 80 N.W. 705 (Mich. 1899) (statute changing the interest rate on delinquent taxes upheld, the court concluding that the taxpayer in delinquency did not have a vested right to have interest on the delinquency remain unchanged); Plankinton Packing Co. v. Wisconsin Tax Commn., 224 N.W. 121 (Wisc. 1929) (change in the rate of interest applicable to back income taxes held retroactive to taxes assessed on income prior to the bill's passage, it being said by the court that it was well settled that a state may impose retrospective penalties on delinquent taxes); O'Shaughnessy v. Wolfe, 685 P.2d 361 (Mont. 1984) (increased rate of interest on delinquent tax payments given retroactive effect and the retroactive effect of the provision offends no state or federal constitutional due process or equal protection provision).

I trust this is sufficient for your purposes.

JBC:pl
91-198.plm

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM

March 20, 1991

SUBJECT: Retroactive effect given to interest rate increases and compounding of interest on taxes

TO: Senator Sam Cotten

FROM: Jack Chenoweth
Legislative Counsel

It is well settled that a legislature may, constitutionally, enact a statute, retrospective in its effect, to increase the rate of interest due on delinquent taxes. Webster v. Auditor General, 80 N.W. 705 (Mich. 1899); O'Shaughnessy v. Wolfe, 685 P.2d 361 (Mont. 1984); 4 ALR 2d 954, note.

My research disclosed no cases in which a legislature acted by statute, retrospective in its effect, to shift the interest rate applicable to delinquent taxes from a simple interest application to one that provided for compounding. Nevertheless, on the contention that the application of interest to delinquent taxes is an enforcement mechanism, it is difficult for me to understand that a court would favor an interest rate increase but find reason not to favor a shift in the manner of computation. Clearly, the substitution of a compounding feature for what had previously been a simple interest factor results in an increase, and increases have been allowed.

The ability to change, retrospective in effect, the manner of computing interest on delinquent taxes and the rate of interest on those overdue taxes is not without limits. And, as I advised in the debate over retroactive adjustments to the economic limit factor (ELF) in early 1989, the courts will consider the extent of the "reach back." We can only be reasonably certain that the courts would approve a retroactive application to the beginning of the current tax year or, arguably, the current fiscal year, whichever would be earlier. Retroactive application to a date before the earlier of either of those would render the likelihood that the court would sustain the legislature's action more doubtful.

JBC:lmb
91-092.lmb

AGO 10050617

3/22/91
SFC

MEMORANDUM

State of Alaska

Department of Law

TO: Hon. Lee Fisher, Commissioner
Department of Revenue

DATE: March 20, 1991

FILE NO:

TEL. NO: 465-3600

SUBJECT: Re: Proposed amendments
to SB 158

FROM:

J. W. Bush
Jeffrey W. Bush
Assistant Attorney General
Legislation and Regulations Section

Pursuant to your request, we have prepared proposed amendments to Senate Bill 158, relating to the interest rate to be charged on delinquent taxes and royalty payments. I understand that you intend to offer these amendments at the Senate Finance Committee meeting on Friday, March 22.

Please contact me if you need any further assistance on this bill.

JWB:cl

cc w/ enc: ✓ Senator Pat Pourchot, Co-Chair
Senate Finance Committee

Bruce Kendall, Legislative Liaison
Office of the Governor

See Amend. #1.

EFFECT OF A COMPOUND INTEREST PROVISION

Under current Alaska statute (Title 43), a simple interest calculation is used to determine interest owed on tax liabilities. Simple interest assesses interest on principal only; no interest is charged on accrued interest. The attached graphic illustrates the fiscal effect of changing the current statutory simple interest calculation to a compound interest formula—the usual method of financial institutions and modern business transactions. Compounding assesses interest on accrued interest as well as outstanding principal. To illustrate the effect of compounding, a 12 percent interest rate on a tax liability of \$10 million is assumed for all four cases. In each case the tax was due in FY 85 and paid at the end of FY 98. Where applicable, the compounding statute is enacted at the beginning of FY 92.

Case One - Simple Interest

Under the first case, simple interest is used throughout the 14-year period. This case shows the tax and interest liability under current state statute. Using a simple interest formula, the total tax and interest liability is \$26.8 million.

Case Two - Compounding on Only the Tax Portion of Liability Starting in FY 92

This scenario calculates simple interest on the tax liability for the years FY 85 through FY 91. In FY 92 when the compound interest provision becomes effective, compounding applies only to the \$10 million principal owed in FY 85. Compounding does not occur on interest accrued from FY 85 through FY 91. Compounding on principal and interest occurs from FY 92 through FY 98. The total tax and interest liability under this case is \$31.3 million.

Case Three - Compounding the Tax and Interest Liability Beginning in FY 92

The third case calculates the tax liability and interest owed using simple interest from FY 85 through FY 91. In FY 92 when the compound interest provision becomes effective, the outstanding tax liability of principal (\$10 million) and accrued interest (\$8.2 million) are subject to compounding. The tax and interest liability under this case is \$39.4 million.

Case Four - Compounding Retroactive to FY 85

This final case shows the effect of compounding over the entire period of analysis, i.e., if the compound interest provision were retroactive to the initial tax liability date. If the state of Alaska used this more usual form of interest calculation, the total tax and interest liability would be \$52.3 million.

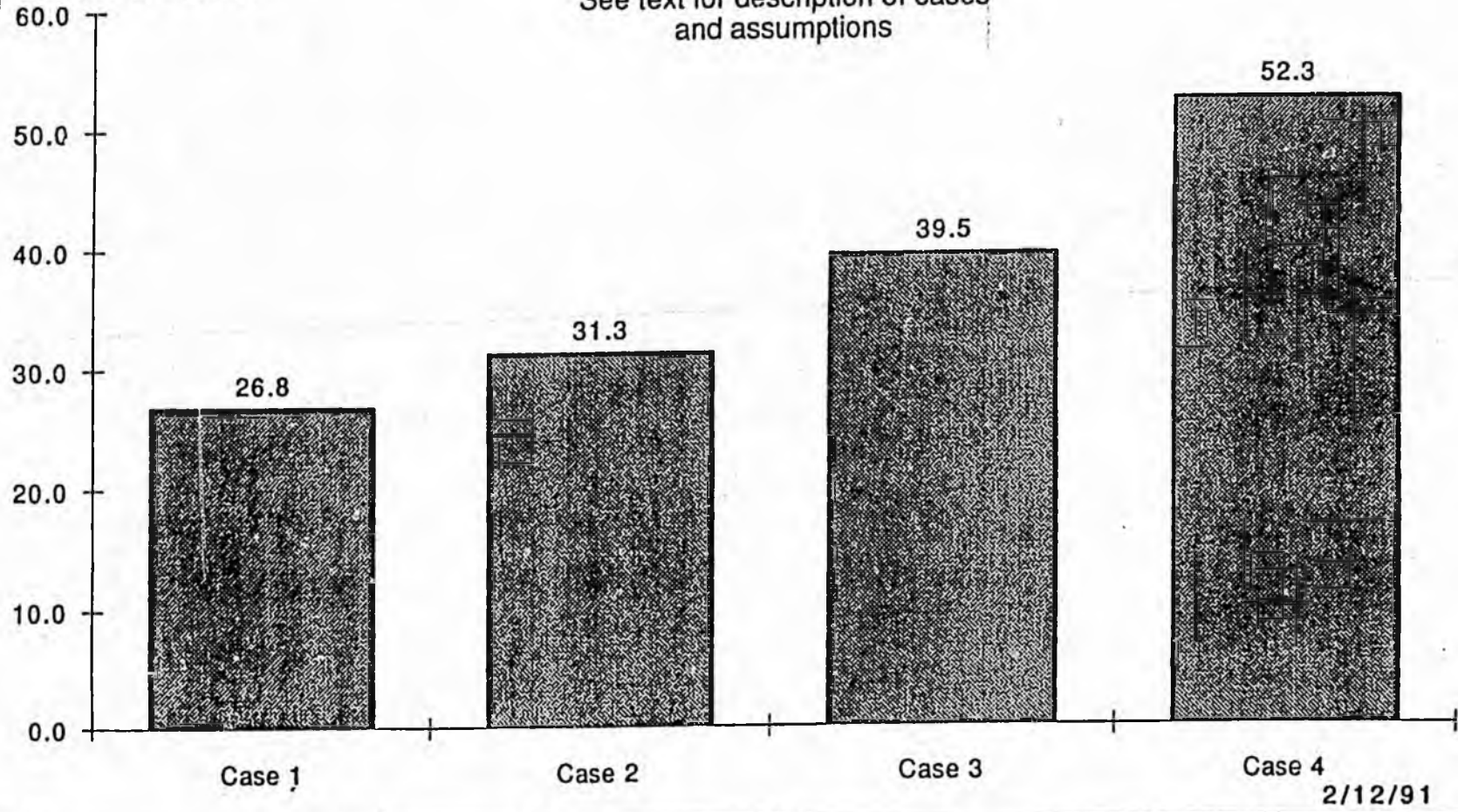
The difference between cases one and four (\$25.5 million) illustrates the financial disincentive to the timely payment of taxes owed under Alaska's current statutes. Essentially, investing the \$10 million would result in a return of \$52.3 million after 14 years under the usual compounding of interest. These proceeds could then be used to pay the tax and interest liability of \$26.8 million assessed using simple interest. The \$25.5 million is the "profit" on the alternative investment.

revised 2/12/91

Fiscal Effects of Compound Interest Provisions on Tax Liability

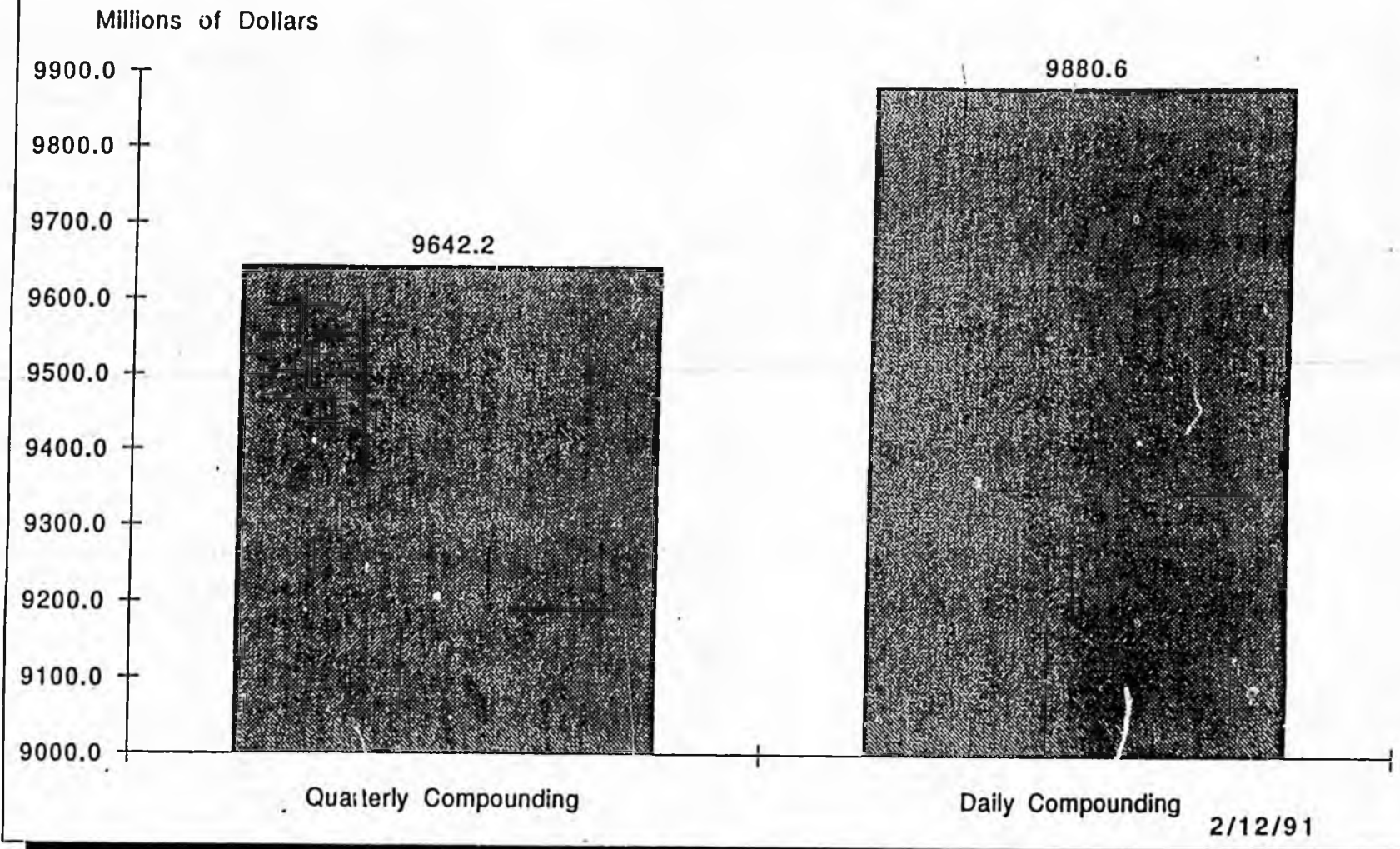
Millions of Dollars

See text for description of cases and assumptions



2/12/91

15-Year Difference Between Daily and Quarterly Compounding



ANNUAL INTEREST RATE CHARGED MEMBER BANKS FOR ADVANCES
BY 12TH FEDERAL RESERVE DISTRICT

<u>Date</u>	<u>Rate</u>	<u>Rate + 5%</u>
1/1/85	8%	13%
4/1/85	8%	13%
7/1/85	7.5%	12.5%
10/1/85	7.5%	12.5%
1/1/86	7.5%	12.5%
4/1/86	7%	12%
7/1/86	6.5%	11.5%
10/1/86	5.5%	10.5%
1/1/87	5.5%	10.5
4/1/87	5.5%	10.5%
7/1/87	5.5%	10.5%
10/1/87	6%	11%
1/1/88	6%	11%
4/1/88	6%	11%
7/1/88	6%	11%
10/1/88	6.5%	11.5
1/1/89	6.5%	11.5%
4/1/89	7%	12%
7/1/89	7%	12%
10/1/89	7%	12%
1/1/90	7%	12%
4/1/90	6.5%	11.5%
7/1/90	6.5%	11.5%
10/1/90	6.5%	11.5%
1/1/91	6.5%	11.5%
Current (2/1/91)	6%	11%

ANNUAL INTEREST RATE CHARGED MEMBER BANKS FOR ADVANCES
BY 12TH FEDERAL RESERVE DISTRICT

<u>Date</u>	<u>Rate</u>	<u>Rate + 5%</u>
1/1/85	8%	13%
4/1/85	8%	13%
7/1/85	7.5%	12.5%
10/1/85	7.5%	12.5%
1/1/86	7.5%	12.5%
4/1/86	7%	12%
7/1/86	6.5%	11.5%
10/1/86	5.5%	10.5%
1/1/87	5.5%	10.5
4/1/87	5.5%	10.5%
7/1/87	5.5%	10.5%
10/1/87	6%	11%
1/1/88	6%	11%
4/1/88	6%	11%
7/1/88	6%	11%
10/1/88	6.5%	11.5
1/1/89	6.5%	11.5%
4/1/89	7%	12%
7/1/89	7%	12%
10/1/89	7%	12%
1/1/90	7%	12%
4/1/90	6.5%	11.5%
7/1/90	6.5%	11.5%
10/1/90	6.5%	11.5%
1/1/91	6.5%	11.5%
Current (2/1/91)	6%	11%

CHART 1

This chart shows the effect of various interest provisions over time on a hypothetical liability of \$10,000,000 that arose in 1982. In all cases, the interest rate used is 12%. Note that S.B. 158 would change the rate to a floating rate tied to the Federal Reserve Bank rate to member banks. The Federal Reserve rate went to 6% on February 1, 1991, making the rate that would be required under the bill 11% (Federal Reserve rate plus 5 percentage points).

Case 1. Simple interest of 12%. This is current law.

Case 2. Simple interest of 12% until July 1, 1992. After July 1, interest compounds on the principal that is outstanding on that date, but does not compound on the interest that has accrued before that date.

Case 3. Simple interest of 12% until July 1, 1991. After that date, interest compounds on the entire liability that is outstanding on that date.

Case 4. Compound interest of 12% beginning in 1982. This shows how the liability would have grown if the compound interest provision had been in effect throughout the period.

CHART 2

This chart starts with actual outstanding liabilities as provided by the Department of Revenue. Currently, outstanding tax assessments total about \$1.77 billion; accrued interest on these outstanding assessments is about \$1.64 billion. The chart shows how liabilities would accrue under various interest provisions. Note that there is no attempt to predict when liabilities will be paid, or what portion of taxes and interest assessed will actually be found to be owed.

Case 1. Simple interest of 12%. This is current law.

Case 2. Interest compounds on the principal that is outstanding as of July 1, 1991 but does not compound on the interest that has accrued before that date.

Case 3. Interest compounds on the entire liability outstanding on July 1.

Chart 1

DEBT ON FY 82 \$10 MILLION LIABILITY

Interest Statute Effective FY 92

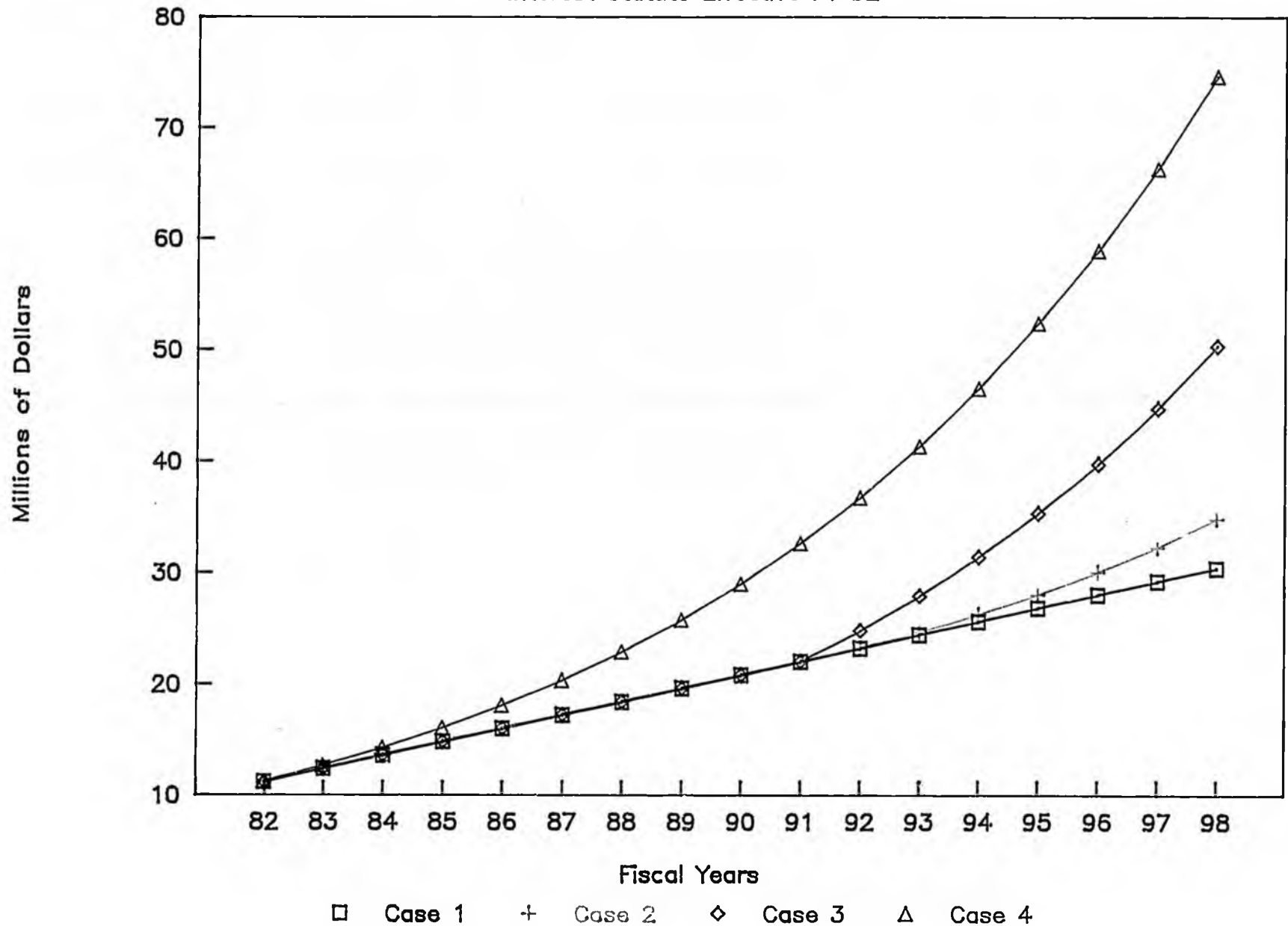
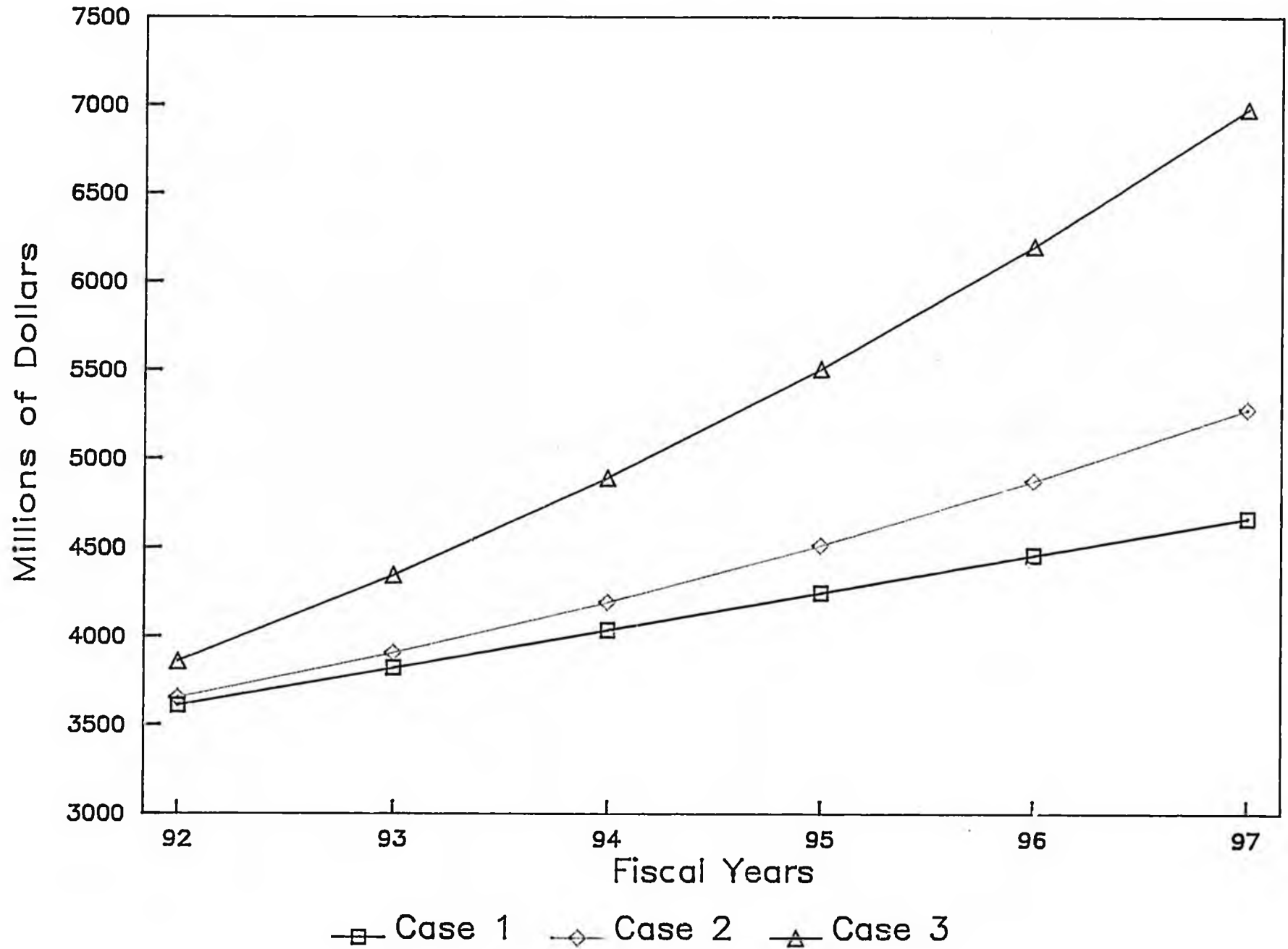


Chart 2

Effect of Interest Provision on Current Outstanding Tax Liabilities



AGD 10050647

Hickel, revenue chief cross wires

Governor's 'vague' style leads Fisher to think he's defying administration

By DAVID POSTMAN
Daily News reporter

JUNEAU — Revenue Commissioner Lee Fisher thought he was defying Gov. Wally Hickel Friday when he called an administration oil-tax proposal an "immoral business practice."

"That's just how independent I am," Fisher said after he testified against a provision in a bill that he and the Senate Finance Committee he was talking to, thought Hickel supported.

But by day's end, what had appeared as a schism in the administration was being written off as confusion.

"The governor and Commissioner Fisher are in complete accord with

each other," said Jeff Logan, the governor's acting deputy press secretary.

Fisher attributed the mix-up to Hickel's trying to be polite to a lunch guest from the Senate who thought Hickel was giving him a commitment.

The bill Fisher was testifying on would change the way interest is accrued to the \$3.9 billion in taxes and interest the state says is owed by the oil industry. The oil companies dispute the amount.

The bill calls for interest to be compounded on the entire debt, back taxes and back interest. Fisher said it should be changed so that interest is not compounded on top of the old interest, which is estimated to be

close to half the \$3.9 billion.

"While I'm advised it is probably legal to do it the way it is presently drafted, I view it as kind of an immoral business practice, in my view at least, and not worth the negative image it would portray," Fisher told the Finance Committee.

Tax officials with BP Exploration (Alaska) and Exxon Corp. testified in favor of Fisher's amendments, agreeing with the revenue commissioner that they should not be charged interest on top of the interest they may already owe.

After Fisher finished his testimony, he was taken aside by Sen. Sam Cotten, D-Eagle River, who was sit-

Please see Page B-3, FISHER

FISHER: Governor, revenue chief cross wires on tax

Continued from Page B-1

ting in on the meeting, for a private chat.

Cotten then asked Senate Finance Co-chairman Pat Pourchot, D-Anchorage, if he could bring Fisher back to the table for more questions.

Cotten said Hickel had told him at lunch on Thursday that he supported the bill as it is written. The senator then asked Fisher what the administration's position was.

Fisher said Chief of Staff Max Hodel had told him the night before that the governor wanted the bill to stay the way it was.

"If the position of the administration is represented by Governor Hickel

on this matter, it is to leave it as it is," Fisher said. "If the position of the administration is to take my advice on it, it is to change it."

Fisher said after the meeting that he would try to change Hickel's mind.

"I've never had the opportunity to argue with him about it and I plan to do that," Fisher said.

But late Friday afternoon, Fisher was laughing about the "brouhaha that is really much ado about nothing."

"I don't think the governor ever supported anything else," he said. "What happened, in a social context, in a lunch with a very persuasive, very articulate senator by the name of Sam Cotten

describing his viewpoint of the legislation, the governor said something like, 'That's right. I support that,' and passed on down the line to the next person, the next subject or the next course of the meal.

"I cannot believe the governor gave any great thought to this in his luncheon conversation."

Fisher said Hodel must also have thought Hickel supported the bill and called "so I wouldn't get blindsided."

Cotten was traveling Friday evening and could not be reached for comment. Neither could Hickel.

"This is all very plausible to me," Pourchot said. "Many of us have been in

meetings with Hickel and he has a conversational style that is in ready agreement with you and then he moves on to the next agenda item. The governor's conversational style is oftentimes vague."

But Pourchot said he was more concerned with why Fisher opposed the bill.

"I'm nervous why he would want to take that position as the prime tax man for the state," he said. "I would expect the tax man to take a very strong, aggressive and fair stance on a major tax issue like this."

In the end, the Finance Committee did not act on the issue and will deal with it again next week.

FISCAL NOTE

Bill Version: SB 158

*R/O SFC
3/26/91*

**STATE OF ALASKA
1991 LEGISLATIVE SESSION**

(S) Publish Date: 3/1/91

*Replaced by
Revenue 3-28-91 note*

Revision Date: _____ Department Affected: Revenue
 Title: Interest Rate on Unpaid and Over- BRU: Oil and Gas Audit Division
paid Taxes and to the Due Dates for and... Component: _____

Sponsor: Hickel

Requester: _____

COMPONENT SERIAL NO.

1	1	5
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Expenditures/Revenue: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE	See Analysis.					
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FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact: See Analysis.

ANALYSIS: (Attach a separate page if necessary.) Although it is not possible to estimate the revenue impact of this bill, it will increase the interest due on outstanding taxes and royalties. It will also increase the cost of both non-compliance and delayed resolution of tax and royalty disputes which may speed up the resolution of outstanding cases.

Prepared By: Charles L. Logsdon Phone: 277-5627

Division: Oil and Gas Audit Division Date: 2-22-91

Approved by Commissioner: _____ Date: 2-22-91

Agency: Revenue

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).