ALASKA LEGISLATURE
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The population of the United States is undergoing significant change. The nation is experiencing a significant bulge in the eligibility for retirement. The older population (65 and over) numbered 35.6 million in 2002, an increase of 3.3 million or 10.2 percent since 1992. However, the number of Americans aged 45-64, increased by 38 percent during this period.[9] Figure 3 shows the falling growth rate of the U.S. workforce. The baby boomer generation is aging and the succeeding generation of workers is significantly smaller.[10]

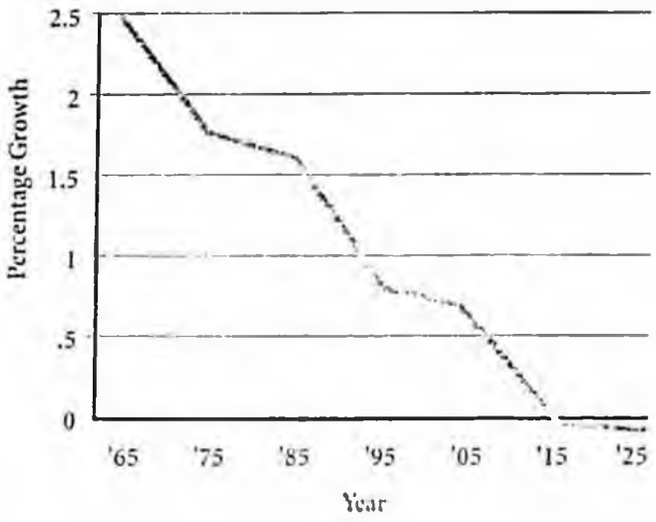


Figure 3

Annual Growth Rate of the U.S. Labor Force

Source: Social Security Administration

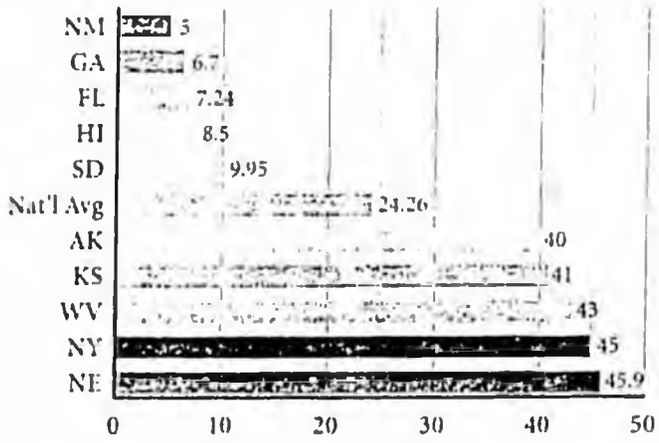


Figure 4

Percent of State Public Health Employees Eligible for Retirement

Source: ASTHO/CSG Survey

Note: The five states with the highest and lowest percentages each are shown.

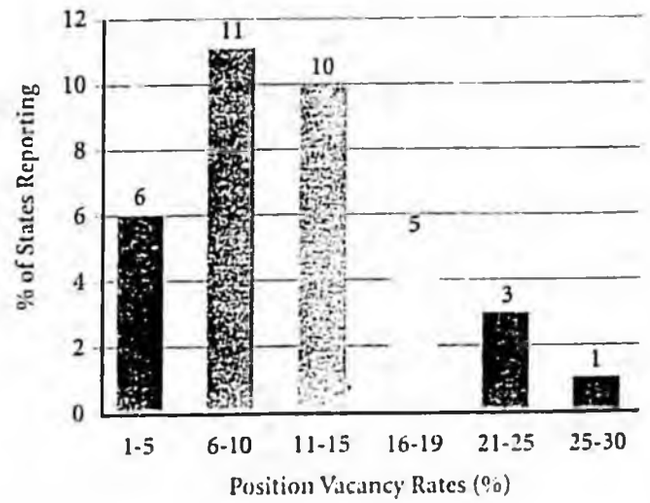
Two: High Percentage of Workers Eligible for Retirement

The "State Employee Worker Shortages: The Impending Crisis" reported that state governments could lose more than 30 percent of their workforce to retirement, private-sector employers, and alternative careers by 2006. The rates for state public health agencies according to the ASTHO/CSG survey are as high as 45 percent (Figure 4). On average, about 24 percent of the public health workforce is eligible for retirement compared to 21 percent reported for all state employees in October 2002.[11]

Figure 5

Position Vacancy Rates in the State Public Health Agencies

Source: ASTHO/CSG Survey



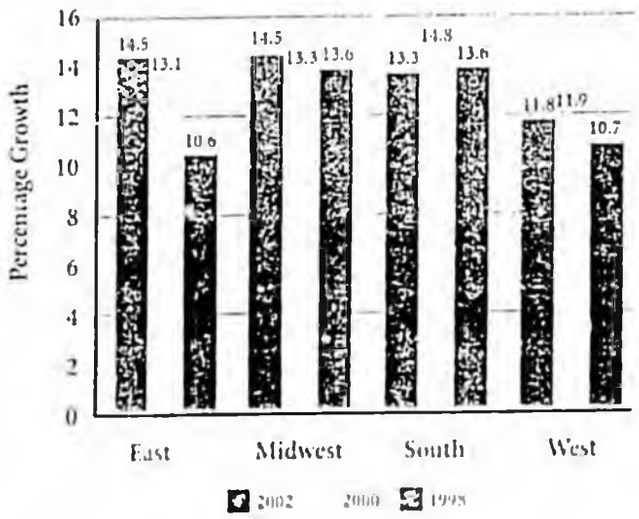
Three: Chronic Shortages in Professional Areas

Four states from the survey show vacancy rates for public health positions of 20 percent or higher. Seventeen out of 35 states reported vacancy rates in the 11-20 percent range. Fourteen states reported that the percentage of state health agency vacancies did not change or had declined in the last five years. The ASTHO/ CSG report shows that around 11 percent of state jobs across all state agencies are vacant.[12]

Figure 6

Turnover Rates for State Public Health Personnel, by Region and Year

Source: ASTHO/CSG Survey



Four: High Turnover Rates

In addition, states must contend with an annual employee turnover rate that averaged 14 percent for the 28 states responding to this question. The high turnover represents a potentially huge loss of institutional knowledge, leadership, and experience for state health agencies. Although in most states the turnover rate for public health is comparable to the turnover rate for all state government agency employees, hiring freezes and shortages will make it hard for state public health agencies to fill vacant positions.[13] The earlier CSG survey documented that 27 states had enforced some type of mandatory hiring freeze.[14]

Public Health Shortage Profiles by Profession

As highlighted in Figure 7, public health professionals such as nurses, laboratory scientists, environmental workers, physicians, nutritionists, educators, and social workers comprise 45 percent of the current public health workforce. The rest of the workforce consists of health officials and administrators (3.5 percent), technicians (9.4 percent), administrative support personnel (12 percent), paraprofessionals (3.5 percent), and other technical and administrative categories.[15]

State and local health agencies are reporting the most significant worker shortages in the areas of nursing, environmental health, epidemiology, and laboratory science.[16] Figure 8 of the ASTHO/CSG survey reflects that the state health agency workforce shortage issue is most noticeable among public health nurses. Thirty out of 37 reporting states identified public health nursing as the field that is and will continue to be the most affected by the personnel shortage. Furthermore, the survey documented considerable shortages for three other public health disciplines including epidemiologists (15 states), laboratory workers (11 states) and environmental health specialists (11 states).

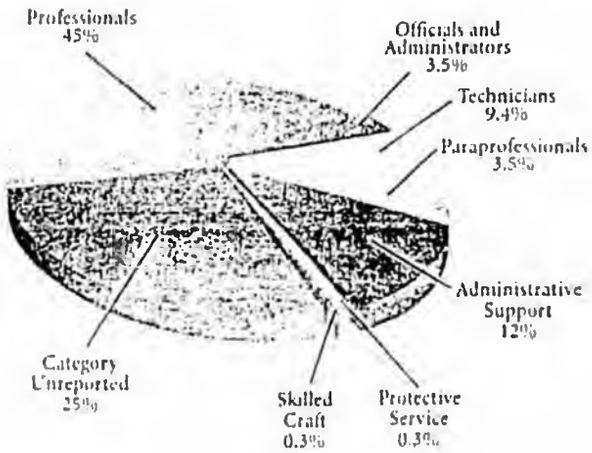


Figure 7

Composition of Total Public Health Workforce

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professionals, National Center for Health Workforce Information and Analysis, The Public Health Work Force: Enumeration 2000, Dec. 2000.

Public Health Nursing

Thirty out of 37 reporting states indicated that nursing is the occupational class most affected by the workforce shortage; shortages are twice that of the next leading class, epidemiologists (Figure 8).

The leaders of state public health nursing average more than 30 years service and are very close to retirement. In one state nearly 40 percent of the public health nursing workforce is eligible for retirement today.[17]

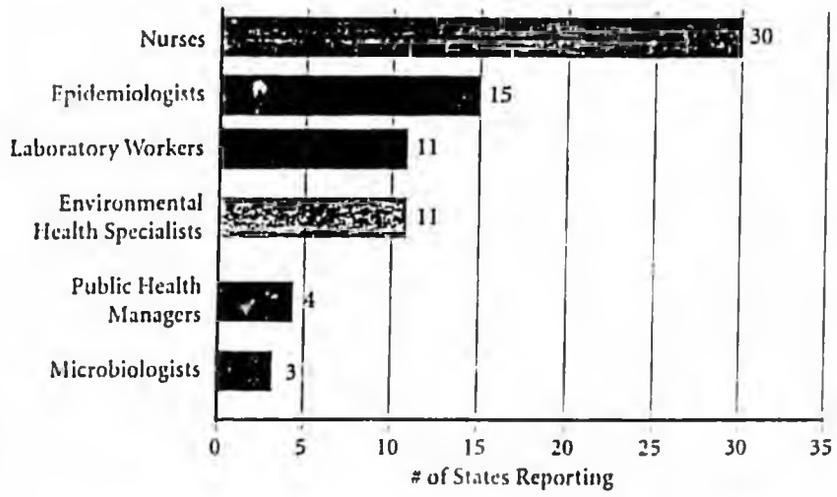
Public health nurses comprise 11 percent of the total public health workforce and 25 percent of all public health professionals.[18] The ASTHO/CSG survey shows the 37 reporting states have a total of 14,733 nurses working for public health agencies. The number of public health nurses varies by state; one state reported six nurses on staff, while another reported having 2,591.

The roles and responsibilities of the public health nurse can also vary by state. They might include, for example, instructing individuals on preventive care, nutrition, and childcare and arranging for immunizations, blood pressure screening, and/or working with community leaders to promote health education.[19]

Figure 8

State Public Health Occupational Classes Most Affected by Worker Shortage

Source: ASTHO/CSG Survey



Health providers across the nation, public and private, are reporting serious deficiencies in the supply of nurses in all health care settings. According to national projections, by the year 2010 there will be a need for one million additional registered nurses in all health fields.[20] The nursing shortage in the private sector adds to the challenge for the public health sector, which must compete for a limited pool of applicants.

Part of the public health nurse recruitment challenge is that young people are increasingly reluctant to enter public health nursing, primarily because of low salaries in the field.[21] Unfortunately, fiscal conditions in many states do not permit the salary increases necessary to allow state health agencies to effectively compete for limited talent.

Women in the past have traditionally filled the vast amount of nursing positions due to limited career paths. However, today's women have greatly expanded career opportunities to choose from when selecting a career leaving behind significant recruiting gaps.

Epidemiology

Epidemiology provides the fundamental public health functions of monitoring health status, diagnosing and investigating health hazards and events, and evaluating the effectiveness of health services.

According to the ASTHO/CSG survey, at least 15 of the 37 reporting states have a shortage of epidemiologists (Figure 8). The U.S. General Accounting Office reports that barriers to recruiting and retaining epidemiologists in the public health field include noncompetitive salaries and a general shortage of professionals.[22] Approximately 42 percent of the current epidemiology workforce in state health departments lacks formal academic training in epidemiology.

The shortage of epidemiologists may be partly explained by the high level of education required for this profession in relation to public salaries. 28.6 percent of epidemiologists have doctoral level training, 40 percent have master's level training, 18.4 percent have bachelor level training and 13 percent have various other types of educational qualifications.[23]

Laboratory Scientists and Technicians

Public health laboratories are often the first line of defense in protecting the American people against diseases and other health threats. Public health laboratories provide diagnostic testing, disease surveillance, applied research, and training. The laboratory workers in state public health constitute 3.1 percent of the total public health workforce.[24]

While several states participating in the ASTHO/CSG survey noted the shortage of laboratory workers, other surveys have also found shortages of laboratory personnel. A report by the Association of Public Health Laboratories that includes data as of December 2002, reveals a severe shortage of qualified laboratory personnel in the states.[25] Thirteen states reported no doctoral-level molecular scientist on staff, and 23 states reported only one. Most states agreed that at least two doctoral-level molecular scientists were needed on staff to ensure emergency readiness.

A shortage of information technology specialists can seriously imperil the ability of states to meet the national goal of timely and effective communication of laboratory results during an emergency.[26] Sixteen states reported no dedicated, full-time information technology specialist to manage laboratory information systems and 18 states reported only one person serving in this capacity.

The primary barrier to hiring adequate laboratory staff is the lack of trained personnel willing to serve in the public sector. In recognition of this, Congress took steps in 2003 to help meet the need of more public health laboratory staff by appropriating $146 million to improve laboratory capacities. However, even though the supplemental funding provides for hiring of a skilled laboratory workforce, the needed workforce simply does not exist. Of 22 states that have not met the August 2003 deadline for preparedness benchmarks from the grant money, 17 cited the difficulty in recruiting new staff as a major problem.[27]

The Association of Public Health Laboratories cautions that policy-makers might erroneously assume that because all of the funds have not been spent, states don't need the money. In fact, intractable vacancy rates and the physical unavailability of professionals willing to work in the public sector are the core of the problem.[28]

Environmental Health Professionals

The term environmental health professional covers a broad array of services in the public health field. For the past 150 years environmental health services have focused on food, water and sanitation. The emergence of new threats – such as cryptosporidium, hantavirus, West Nile virus, SARS, and bio/agro-terrorism – shows the need for a strong environmental public health system and workforce.

Eleven of the 37 reporting states in the ASTHO/CSG survey identified a shortage of environmental health professions. There are slightly more than 20,000 environmental health professionals and technicians in the United States.[29] They comprise about 4.5 percent of the total public health workforce.[30]

Current challenges for recruiting and retaining existing environmental health workers include low pay scales at the state level, minimal advancement opportunities, and competition with the private sector. State environmental programs often serve as a training ground for people to learn needed skills and then move into the private sector at higher salaries.

Keys to Success: State Plans to Address Public Health Workforce Issues

Measuring the extent of the current workforce deficit, projecting future staffing needs, and developing effective strategies to meet these needs present new challenges to State Health Officials. Given current budget constraints at the state level, states are experimenting with new approaches in recruitment and retention. Some of these strategies have been implemented, while others are still in the planning stage.

Workforce Recruitment and Retention

States are considering various strategies to ensure adequate staffing of public health agencies, including:

- Increasing pay and benefits
- Offering flexible work schedules and telecommuting opportunities
- Providing professional training
- Training future public health leaders
- Marketing public health careers at high schools and on college campuses
- Partnering with educational institutions
- Using information technology and the Internet for recruitment

The ASTHO/CSG survey identified six trends that are developing in the approaches to workforce recruitment and retention among the states. These are shown in Figure 9. The CSG/NASPE Survey reported that 34 states are establishing new recruitment and retention strategies and 75 percent of states have developed long-term plans to address the personnel crisis.

Outreach Campaigns

Seven of the 37 reporting states are implementing recruiting strategies that promote public health careers at high schools and higher education institutions. For example, outreach campaigns aimed at universities and colleges, schools of public health and health services; and historically minority colleges. State health agencies are also redefining public service by developing public health career promotion campaigns that showcase state public health agency positions as interesting careers where giving back to the community, detecting new and emerging threats, and keeping America healthy are just part of the job.

All 37 states that participated in the survey have proposed various approaches to alleviating public health worker shortages. For example, some states are developing mid-life career change programs to attract professionals leaving other career paths. Other states are developing reports on the current conditions affecting the workforce to aid policymakers in determining future planning.

Information Technology

Five states reported using information technology and the Internet to expand their outreach and optimize their outreach campaigns. Some states are using the Internet to advertise public health vacancies, taking advantage of commercial partnerships offered by web-based job search engines for augmenting recruitment capabilities and shortening the hiring process. States are also developing clearinghouses for current in-depth information on health careers.

Professional Training

Recognizing the value of institutional knowledge, state health agencies are devising innovative strategies to retain current employees. Fourteen of the 37 reporting states are considering incentives designed to advance the competencies of their public workforce, such as scholarship and loan repayment programs, work-study arrangements, professional training, and distance learning opportunities. Emphasis on the value and attainment of proper qualifications through higher education and continuing education is essential if the public health workforce is to keep up with the escalating demands of new scientific technologies and methodologies.[31]

Eleven of the 37 reporting state public health agencies are considering partnering with various professional educational institutions to design public health programs and curricula. By educating all health professionals about public health skills, states can develop basic public health curriculum units that can be adopted into any baccalaureate or graduate health professional program. This increases the pool of partners for public health organizations that reach out for collaboration in future retention, training, and mentorship.

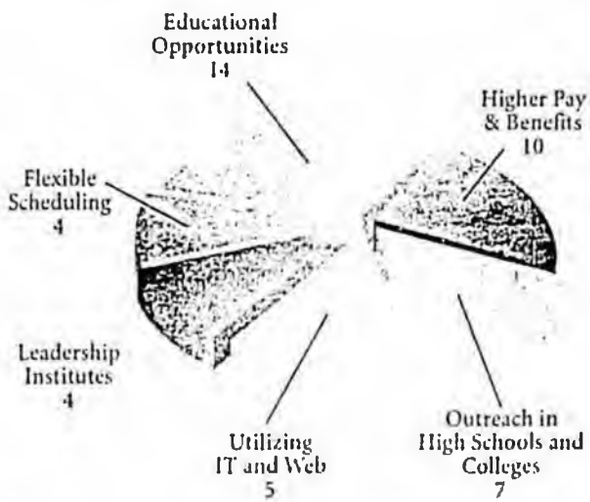


Figure 9
State Public Health Personnel Recruitment and Retention Plans
Source: ASTHO/CSG Survey

Higher Pay and Benefits and Flexibility

States are concerned that considerably lower salaries in governmental public health positions make it difficult to compete with the private sector for employees. Sixteen states are considering offering pay and benefits that are in line with the private sector as a potential solution to public health worker shortages (Figure 10). The ASTHO/CSG report documents that 45 states have faced serious budget difficulties during the past two years that will make it difficult for them to address the state workforce shortage.[32] Despite funding cuts, the ASTHO/CSG survey demonstrates some states are finding vehicles to increase pay to retain employees when the market shrinks for particular high-need occupational categories.

Four of the 37 reporting states are offering telecommuting and other flexible scheduling opportunities to their public health employees. States found flexible schedules improve organizational resilience, promote skills retention for those who might want to move out of state but continue to work on a full-time or part-time basis, lower absenteeism, and reduce the desire to "job hop".

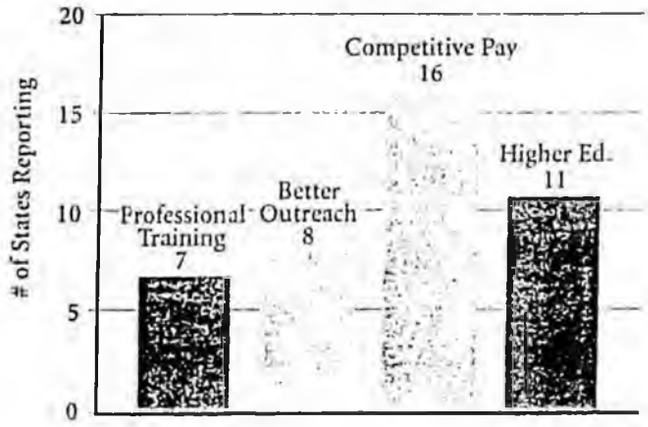
One way to retain the expertise and experience of the aging workforce is to rehire retired employees. Of 36 states that responded to this question in the survey, all but four states reported that they actively seek to rehire retired employees. Of the 33 states responding that are permitted to rehire, 16 provide retirement benefits to the rehired employees. Some states are offering part-time employment to attract public health system retirees.

Tapping the retired worker talent pool offers a significant opportunity to avoid the loss of institutional knowledge and retain highly-skilled employee. It also allows more time for succession planning activities. Currently, Americans age 50 and older make up 28 percent of the population, with 50.6 million people between ages 50 and 70. As the baby-boomers mature, it's predicted that there will be as many Americans of retirement age as there are 20-25 year olds.[33]

Figure 10

Keys to Solving Public Health Workforce Challenges

Source: ASTHO/CSG Survey



Enhancing Leadership Capacity

Four of the 37 reporting states are focused on enhancing the leadership capacity of their public health managers through leadership training institutes. Public health agencies partner with state educational institutions to help future health leaders acquire and develop necessary leadership skills

Conclusion

An adequate supply of competent public health professionals is a vital component of the governmental public health infrastructure. A number of factors are having an adverse affect on the ability of state public health to ensure that there are sufficient numbers of these individuals to fill current and rapidly growing vacancies. Chief among these are that the current workforce is rapidly aging and nearing retirement while there are few students and young professionals who are interested in careers at public health agencies. The combination has resulted in a critical narrowing of the public health workforce pipeline in a majority of the states. If left unchecked, time will exacerbate the crisis.

The ASTHO/CSG survey shows that the greatest worker shortages are in the areas of public health nursing, epidemiology, laboratory science, and environmental health, all of which require advanced specialized training and education. These professionals detect emerging diseases; educate the public about actions to take to prevent exposure, protect the food supply, and help develop public health policy to prevent the spread of disease. A long-term aggressive plan must be implemented to educate, recruit, and retain competent public health professionals.

States are implementing various strategies to improve worker recruitment and retention, such as reaching out to school-aged children to spark interest in the public health profession, using information technology to recruit new public health workers, providing incentives to improve skills, increasing the pay and benefits of the existing public health workforce, and rehiring retired public health employees. The underlying current of tight state budgets, however, affects all of these efforts.

Aside from offering competitive salaries, long-term solutions will require innovative programs for on-the-job training and expensive advanced degree education. Many states said outreach campaigns to new partners, institutes of higher learning, school aged children, and legislatures are critical to building the public health workforce pool. Many states also indicated that scholarship and loan repayment programs could help public health to recruit the best and the brightest America has to offer.

There are a variety of reasons for the public health workforce shortage. The survey provides examples of the practices states are implementing to alleviate the shortages and how the entire public health system must plan for long-term solutions. Both the problems and the solutions are multi-dimensional and will require a well-coordinated effort on the part of the public health agencies, legislatures, institutes of higher learning, and the federal government to help improve the outlook for the future workforce and guarantee the security and health of the American people.

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TIME AFTER TIME

Mandatory overtime in the U.S. economy

by Lonnie Golden and Helene Jorgensen

Over the last two decades, American workers have been clocking more and more hours on the job, and they now work more hours than workers in any other industrialized country. Annual work hours are 4% higher than they were in 1980, amounting to an extra 1 hour and 30 minutes at work per week, on average (ILO 1999). The cumulative rise in time on the job is even higher, of course, for families. In 1998 the typical middle-income, married-couple family worked six more weeks a year than did a similar family in 1989 (Mishel et al. 2001). Workers are also clocking more overtime hours. Almost one-third of the workforce regularly works more than the standard 40-hour week; one-fifth work more than 50 hours. Hourly manufacturing workers, the only group tracked by government statisticians, are putting in 25% more overtime than they were a decade ago.[1] In virtually every industry within the bellweather manufacturing sector, overtime had reached a record by the end of the 1990s.

The growth in overtime work, while helping to drive the healthy growth in output in the U.S., has unhealthy social costs. It is taking its toll not only on workers, but on their families, communities, and, ultimately in many cases, patients, customers, and employers. Families burdened by longer work hours are more likely to find it difficult to balance the conflicting demands of work and family. More hours spent at work mean less time with the family, less time to help a child with homework, less time for play, less time for housework, and less time for sleep. These sacrifices can translate into increased risk for accidents and injuries; greater chronic fatigue, stress, and related diseases; reduced parenting and family time; and diminished quality of goods and services – a serious public concern particularly in the health care sector. The social costs associated with the growth in work hours and persistent overtime are particularly worrisome when the long hours are involuntary.

The tenuous balance between work, family, and other non-work activities is thrown off most when overtime is mandatory (also referred to as "compulsory" or "forced"). Mandatory overtime hours are those above the standard work week (usually 40) that the employer makes compulsory with the threat of job loss or the threat of other reprisals such as demotion or assignment to unattractive tasks or work shifts. Given that overtime can have detrimental effects on workers and their families, mandatory overtime is a serious public policy concern, yet current law does not address it. The Fair Labor Standards Act of 1938 (FLSA), which regulates overtime, currently imposes no limits on overtime hours, nor does it prohibit dismissal or any other sanction for declining overtime work. Rather, the FLSA merely requires that payroll employees (who are not "exempt" from the overtime requirements of the FLSA) be paid an overtime premium of at least one-half of regular rate of pay for each hour worked over 40 during a work week.

With the rise in household work hours and overtime, there is a growing need for limits on involuntary overtime. Labor laws such as the FLSA need to be amended to protect workers against excessive work hours and mandatory overtime and to protect the public from the dangers of an overburdened, stressed workforce. Employees should have the legal right to refuse overtime after having worked a certain number of hours – without fear of job loss or other sanctions. Furthermore, an employee should be asked to work beyond some legislated upper limit only during exceptional circumstances such as a temporary health or public safety emergency. Amendment of the FLSA can preserve the right of workers to work long hours if they choose to do so, but ensure workers the right to refuse mandatory overtime.

The need for limits on mandatory overtime

In the United States, unlike in most European countries, employment is "at will," meaning that the employer can dismiss an employee for any reason or for no reason – except gender, race, age, or disability. Thus, employees who refuse to work overtime can lose their jobs or face other reprisals such as demotion or assignment to unattractive work or to less desirable shift times such as nights or weekends. Faced with the legal threat of these kinds of sanctions, many employees often work more hours than they would like and, in some cases, work an extreme number of hours well beyond the standard 40 a week.

The only disincentive to the unbridled use of overtime by employers is the FLSA requirement that payroll employees covered by the act be paid time-and-a-half for hours worked above 40 in a week. The Department of Labor estimates that about 74 million workers were covered under the FLSA overtime provision in 2000. [2] There is evidence that the required overtime pay premium for these "non-exempt" workers is effective – about 44% of "exempt" workers (i.e., most executives and supervisors, certain administrative and professional employees, and outside salespeople) work longer than 40 hours per week, compared to only about 20% of non-exempt workers. However, the share of the workforce exempted from the FLSA has been growing slightly (Hamermesh 2000) over time, despite recent court decisions reaffirming FLSA coverage over occupations such as journalists, paralegals, some computer technicians

(those positions that are not highly paid or highly skilled), and most on-call positions. Moreover, business interests continue to push Congress to broaden the exemptions to include "inside sales employees" and licensed funeral directors and embalmers. They also are lobbying to create a new classification of "knowledge workers," such as computer and network systems analysts and degreed clerical personnel, who would be exempt from the overtime regulations (see U.S. GAO 1999; Labor Policy Association 2000).

Long hours and risks to worker and public safety and health

Long hours can detrimentally affect workers, their co-workers, their families, consumers, and the public. Indeed, there is evidence that, despite the short-term benefits that make overtime attractive to employers (Easton and Rossin 1997), it may in the longer term create offsetting harm to an organization by decreasing quality, increasing mistakes (Babbar and Aspelin 1998; Hirschman 2000), and reducing productivity (Shepard and Clifton 2000). A study on the effects of overtime work on autoworkers found that overtime resulted in impaired performance in attention and executive functions. Workers also reported feeling more fatigued and depressed after working more than eight hours a day (Proctor et al. 1996). It is not surprising, then, that accident rates increase during overtime hours (Kogi 1991). For example, researchers have identified overtime as a factor contributing to safety incidents at nuclear power plants (Baker et al. 1994), confirming what researchers had previously found at manufacturing plants (Schuster 1985) and among anesthetists (Gander et al. 2000). Workers who work overtime face a greater risk of injury and illness (Aakerstedt 1994; Duchon et al. 1994; Rosa 1995; Smith 1996). For a typical example, a German study found that, after nine hours at work, the accident rate begins to rise; in the 12th hour the accident rate was twice as high as the rate for the first nine hours (Hanecke et al. 1998). Long work hours also multiply repetitive motions and exposure to harmful chemicals.

Further, frequent overtime and compressed work schedules that produce long workdays can be a major cause of the stress and chronic fatigue reported by many workers, as well as the ensuing occupational burnout or serious health conditions (Sparks et al. 1997; Spurgeon et al. 1997; Martens et al. 1999; Barnett et al. 1999; Shields 1999; Fenwick and Tausig 2001). Stress can result in increased blood pressure and cardiovascular diseases, which in some cases can have fatal consequences. The Japanese, known for long work hours, even have a word – *karoshi* – to describe death from overwork (Hayashi et al. 1996; and Sokejima and Kagamimori 1998).

In the U.S., job stress is estimated to cost industry $150 billion per year in absenteeism, health insurance premiums, diminished productivity, compensation claims, and direct medical costs (Donatelle and Hawkins 1989). Longer work hours can only contribute further to this drain. A study by Northwestern National Life (1991), which investigated employee burnout, found that seven out of 10 employees experiencing job stress said they frequently suffered health ailments. Frequent mandatory overtime was one of the leading five factors that caused increased stress. Employees who worked overtime on a regular basis were twice as likely (62% vs. 34%) to report that they found their jobs to be highly stressful.

Overtime work and the crowding-out of non-work-time activities

While hours spent at work have increased, work responsibilities at home have not decreased much.

Therefore, working families more and more find themselves squeezed for time. Overtime, and in particular forced overtime without advanced notice, is a challenge to working families. Being told at the end of the workday to stay and finish a work assignment or work a second shift can leave working parents – especially single parents – scrambling to make arrangements for child care at the last minute. Some parents can rely on other family members to care for their children at these times, but of course not all parents have this option, and therefore must depend on child care centers or babysitters to watch their children, a costly option, or perhaps even have to leave children unattended or unsupervised. Further, overtime work can interfere with after-work classes in which workers have enrolled and with community volunteering and social activities that require advance planning.

Overtime often comes at the expense of sleep: three in four people say they suffer fatigue during the day (Atkinson 1999). A poll by the National Sleep Foundation found rampant sleep deprivation, with one-third of respondents reporting less than seven hours of sleep per night and 63% getting less than the eight hours recommended for superior health, performance, and safety. In the last five years, adults who spend more time at work than sleeping has just about caught up to those who spend the reverse. Those who work sleep significantly less than those who do not, particularly those who work over 40 hours (and 38% in this poll reported working 50 hours or more per week), and they report more sleepiness during awake time and insomnia. Job-related work ranked as the activity least likely to be given up among adults who reported a lack of time (National Sleep Foundation 2001).

When workers cut back on sleep, their work performance suffers. The National Commission on Sleep Disorders estimates that companies lose up to $150 billion per year due to employee fatigue. A study conducted by the American Journal of Public Health in 1992 found that nurses in Massachusetts who work variable schedules (including mandated overtime shifts) were twice as likely to report an accident or error and two-and-one-half times as likely to report near-miss accidents (MassNurse News 2000). It concluded that these conditions were associated with "frequent lapses of attention and increased reaction time, leading to increased error rates on performance of tasks." An Australian study found that sleep deprivation has the same effects as being drunk. As the number of hours increased without sleep, the study's testers took a longer time completing a task, made more mistakes, and had problems with concentration and memorizing information. After 17-19 hours without sleep, the testers' performance and alertness suffered notably, and "performance levels were low enough to be accepted in many countries as incompatible with safe driving" (Williamson and Feyer 2000, 653-4). Sleep deprivation poses a serious safety risk for workers not only at work, but also when driving home after a long day at work. And for workers who work late into the evening, commuting by car may be the only option, since carpools and public transportation are geared to workers on daytime schedules.

Since overtime can have detrimental effects on workers and their families, no worker should be forced to work overtime. Indeed, the public health considerations associated with long work hours suggest that excessive overtime hours should be legally capped.

Levels of overtime and trends

An analysis of the number of hours usually worked by wage and salary employees shows that overtime work is widespread in most industries.[3] In the industries of agriculture, mining, manufacturing, transportation, communication, and some professional services, more than 25% of all employees reported that they worked more than 40 hours per week on a regular basis, and often considerably more. In fact, workers who clocked extra hours (both exempt and non-exempt workers) on average worked nearly 12 hours more than the standard work week of 40 hours in 2000 (see **Table 1**).

There has been a slight, gradual, yet detectable upward trend in this percentage over the last decade. According to data from establishments by the Bureau of Labor Statistics (2000), average overtime in manufacturing escalated over the 1990s, from 3.3 hours to a peak of 4.9. More than half of the 20 industries within manufacturing had increases of at least 1 hour over the 1991-98 period (Hetrick 2000). In fact, many of these industries had set records for their overtime series by early 1997. The National Study of the Changing Workforce (NSCW) survey, in its sample of almost 3,000 individuals, found that the employed put in six hours more than they are scheduled to work (Galinsky and Bond 1998).[4]

Moreover, there is evidence of substantial non-compliance with the existing FLSA rules and regulations regarding overtime hours and pay or exemptions. By misclassifying workers or evading overtime pay rules, employers presumably have employees work longer hours than if the employer followed overtime rules regarding computation of hours and exemptions. Violations are higher in certain major industries (see **Table 2**). Non-compliance appears to be highest in the construction industry, where non-exempts dominate the workforce. While the rate of compliance in services is high, there has been a dramatic decline in two of the industry's components – nursing homes and residential living facilities – in the proportion of firms that are in compliance with the FLSA.[5] The level of compliance in nursing homes dropped from 70% to 40% of surveyed firms, and is 57% in residential living facilities. The vast majority of violations (84% and 92%, respectively) were non-compliance with the industry's overtime pay rules. The most common violations in the nursing care and residential living industries are the failure of employers to pay for all the hours that an employee works and the misclassification of workers as exempt.[6]

Estimates of mandatory overtime

The last attempt to directly measure the extent of mandatory overtime with specific survey questions in a nationally representative sample was the 1977 Quality of Employment Survey (QES) of the University of Michigan. These estimates can form a baseline to estimate the current degree of mandatory overtime. The QES asked workers who worked overtime hours whether overtime was "mostly up to the worker" or "mostly up to the employer" and, separately, if they could refuse overtime without some kind of penalty. About 45% responded that overtime work was "mostly up to their employer" (vs. 44% who that said it was up to them; the rest said "both"). About 19% reported they would suffer a penalty. About one in six workers, 16%, said their overtime was both up to their employer and they would suffer a penalty if they refused it (Ehrenberg and Schumann 1984); this portion represents the most conservative estimate of the extent of mandatory overtime. In the entire QES sample, from the "merged" 1974-77 panels, 21% of men were subject to such mandatory overtime work, and 35% worked overtime voluntarily. Workers in blue-

TABLE 1
Hours worked, part-time and overtime, by industry, 2000 (employed individuals at their main jobs)

Industry	Number of workers	Average weekly hours	Percentage working part-time *(less than 35 hours)*	Percentage working more than 40 hrs/week	Percentage of workers with variable weekly hours*	Average hours worked if working more than 40	Average no. of overtime hours if working more than 40
Agriculture	1,862,667	40.3	15.0%	25.2%	15.0%	54.5	14.5
Mining	495,340	48.0	2.0	40.0	9.7	59.0	19.0
Construction	7,238,868	41.2	5.7	18.9	9.0	51.8	11.8
Manufacturing - durable	11,733,130	42.2	3.0	28.0	4.4	50.4	10.4
Manufacturing - non-durable	7,508,890	41.2	5.7	22.5	5.5	50.5	10.5
Transportation	5,729,608	41.6	10.6	25.1	10.3	53.6	13.6
Communications	1,978,388	41.9	4.7	25.3	4.0	50.8	10.8
Utilities and sanitation	1,430,893	41.3	3.1	17.3	4.1	50.8	10.8
Wholesale trade	4,838,551	42.2	6.9	30.1	5.6	51.4	11.4
Retail trade	20,595,385	35.3	30.7	15.4	8.9	51.4	11.4
Finance, insurance, and Real Estate	7,685,257	40.4	9.6	20.8	5.1	51.1	11.1
Private households	922,179	29.7	42.7	8.7	18.3	56.7	16.7
Business and repair services	7,898,715	40.3	11.4	22.2	6.0	51.3	11.3
Personal services	2 '99,577	37.3	22.2	13.2	8.7	53.6	13.6
Entertainment and recreation services	2,269,862	34.2	31.3	13.1	9.4	52.4	12.4
Hospitals	5,021,226	38.7	15.8	12.2	5.9	54.3	14.3
Medical services	5,961,670	37.0	22.5	11.5	6.2	52.0	12.0
Educational services	10,971,126	37.3	21.5	18.0	5.8	51.9	11.9
Social services	2,979,796	35.7	25.4	9.6	4.8	52.0	12.0
Other Service professions	5,334,002	40.0	15.4	27.4	6.7	52.4	12.4
Forestry and fisheries	98,284	42.6	8.4	17.6	12.0	61.8	21.8
Public administration	6,024,910	40.3	6.0	14.4	4.0	51.1	11.1
All workers							
Weighted averages across all industries	121,378,123	*39.1*	*15.4%*	*19.4%*	*6.9%*	*51.8*	*11.8*
Standard deviation among industries		*3.7*	*11.0*	*7.6*	*3.7*	*2.9*	*2.9*

* Workers with "variable hours" are those whose work week is so variable week to week that they cannot specify its usual length. A significant portion of these workers may, on average, actually work longer than a 40-hour week.

Source: Authors' analysis of the monthly Current Population Survey of households, 2000.

TABLE 2
FLSA coverage and overtime compensation by industry, FY 1996

Industry	Employees under executive, administrative, professional	Non-exempt employees	Estimated percent exempt from overtime	Rate of employer compliance with FLSA overtime regulations
All	31,729	74,044	39.5	90%
Private	25,495	61,899	39.9	88
Agriculture	252	12	99.4	90
Mining	35	3	17.2	92
Contract construction	736	4,584	15.1	73
Manufacturing	3,230	166	19.2	91
Transportation and public utilities	1,413	2,777	55.6	83
Wholesale trade	1,580	4,069	37.2	96
Retail trade	3,049	15,445	28.6	91
Finance, insurance, and real estate	2,706	3,493	49.4	86
Services	12,434	6,154	54.4	93
(not including private households)				
Private households	0	459	50.6	96
Public sector	6,234	12,144	37.5	
Federal government	1,233	1,472	46.6	
State and local government	5,002	10,672	36.1	100
Nonclassified				
Correlation coefficient: percent exempt with percent compliance				0.133

Source: U.S. Department of Labor, Wage and Hour Division, 1998.

collar positions had a greater likelihood of facing mandatory overtime, as did workers who had medical or pension plans, while unionized workers had a lower likelihood (Idson and Robbins 1991).

More recent attempts to infer the extent of mandatory overtime are far from satisfactory. Given the long-term rise in average weekly overtime hours (at least in manufacturing), however, one might suspect that the incidence of *mandatory* overtime has risen more or less commensurately (Smith 1996). A particularly informative study by Cornell University's Institute for Workplace Studies (1999) surveyed 4,278 unionized hourly workers, concentrated mainly in the Northeast and consisting of six industries, primarily construction (craft workers), manufacturing (auto workers), and services (emergency medical technicians; mail handlers; and workers in utilities, transportation, nursing homes, and retail). In this sample, 60% worked some overtime in the previous month, with about a third of these workers putting in 11 or more hours of overtime per week. About a third of the overtime workers reported being compelled by their employer to work overtime (a proportion the authors concluded was surprisingly low). Workers employed in the transportation and emergency health services faced more employer pressure than workers in other industries.

Almost one in five workers, 18%, reported working more overtime hours than they preferred. This amounted to half the proportion satisfied with their number of overtime hours and even less than half of

the proportion actually wanting more overtime. Thus, there appears to be a maldistribution; if hours could be redistributed within all industries away from those who work overtime involuntarily and toward those who wanted more overtime (presumably to build their incomes) this would reduce the latter group by up to 40% of its current size.

Involuntarily scheduled overtime work may further worsen the negative well-being, safety, and health outcomes of overtime per se. The Institute for Workplace Studies (1999) survey found that the proportion of workers who reported high levels of work/family conflict jumped dramatically for those who put in more than 50 hours a week. In addition, respondents who faced supervisory pressure to work overtime reported negative effects. For example, 19% of all workers reported feeling depressed more than "once in a while," but among the 8% of workers who reported high levels of supervisory pressure to work overtime, the percentage jumped up to 23%. Similarly, as supervisory pressure to work overtime increased, workers reported significantly higher levels of somatic stress, higher levels of job-escape drinking, and higher absenteeism due to illness. Supervisory pressure to work overtime was also significantly associated with injuries at work. Among the 66% of workers who reported no supervisory pressure to work overtime, 9% experienced multiple injuries at work during the prior year; among workers reporting low, moderate, or some levels of supervisory pressure, the share was 14%; for workers reporting high levels of supervisory pressure to work overtime, the share was 16%. Yet, financial demands and feelings of job insecurity were cited more frequently than employer pressure as the ultimate motivator of extra work time.

It is important to keep in mind that employees who are not subject to mandatory overtime may still end up working more overtime hours than they would prefer. Many workers have overtime scheduled by their employer, and "choose" overtime because their base wage or salary is insufficient to support their family; some may feel that their chances for a promotion or pay increase improve if they put in extra hours.

Sources of mandatory overtime

The need for mandatory overtime is in part an outcome of the prolonged economic expansion of the 1990s. Low unemployment rates led to labor shortages in certain industries such as health care and telecommunications and in occupations such as nursing. Rather than raising wages to attract new employees, employers opted to have their current workforce work more hours – even if it meant paying an overtime premium. In addition, adjusting hours to the seasonality of demand may be more common, tending to intensify the use of mandatory overtime. Half of all surveyed accounting firms, particularly the larger ones, used mandatory staff overtime for this purpose (Pfau, Quint, and Huttlinger 1997). Further, employers appear to be less willing to invest in training of new employees, and instead prefer to have their current workforce put in more hours; this has been the case in the high tech industry. Overtime continues to be appealing, despite its apparent longer-term harms and risks, because employers can enjoy non-wage cost savings (Cutler and Madrian 1998), while employees gain greater access to higher wage rates (Bell 2000; Hecker 1998) and more flexible daily work schedules (Golden 2000, 2001).

Mandatory overtime in health care: accident risks and compromising of quality

Overtime work is widespread among nurses, medical residents, and doctors, and this pattern of work can lead to situations that jeopardize the health of patients. Understaffing of nurses at hospitals means that nurses sometimes are forced to work a second shift after their first shift ends. High patient load and fatigue from long hours can result in inadequate compliance with procedures and less monitoring of patients. As a result, overtime can compromise patients' health or safety. Medical residents cited fatigue as a cause for their serious mistakes in four out of 10 cases (Boodman 2001), and two studies linked infection outbreaks at hospitals to overtime work (Arnow et al. 1982; and Russell et al. 1983). Indeed, the California Nurses Association reports that more nurses are refusing to work in hospitals with unsafe conditions, in which they include being forced to work unplanned overtime. The American Nurses Association (ANA), in a national survey of 7,300 of its members, found, disturbingly, that 56% of nurses believe that the time they have available for care for each patient has decreased, and 75% feel that the quality of patient care at their own facility has decreased in the last two years. The cited inadequate staffing as the chief reason.

Mandatory overtime in health professions generally is likely high, although no reliable data regarding its extent are available. In the Institute for Workplace Studies (1999) report, health sector workers averaged a little over three hours of overtime per week – not particularly high. In a survey on mandatory overtime, the journal *Nursing2000* reported that 36% said they never worked mandatory overtime. One quarter of the respondents worked mandatory overtime once or twice a month, while another quarter worked it once or twice a week. However, about 14% worked additional mandatory hours every day (*Nursing2000*). Respondents to a poll (2,125 total) administered by the American Association of Critical Care Nurses in May-June 2000 found that 43% of their members' hospitals have a mandatory overtime policy. The same poll found that responding members attributed mandatory overtime mainly (three-quarters of the reasons designated) to both routine short-staffing policies and a nursing shortage. Perhaps it is no coincidence that nurse's aides were second only to truck drivers in the total number of cases of disabling injuries and illness. And not surprisingly, the ANA delegates voted almost unanimously to declare that refusing overtime does not constitute patient abandonment, from which nurses are legally prohibited.

Mandatory overtime provisions in collective bargaining agreements

Generally, union workers are better protected from mandatory overtime than are nonunion workers, since union contracts can specify upper limits on overtime, establish a scheme to make overtime more orderly or voluntary, or establish a system of compensatory leave. In 1977, over one in five union members had collective bargaining agreements that restricted mandatory overtime, according to the QES. But as many unions have lost membership, in particular those in manufacturing and communication industries, workers' bargaining power to obtain such contract provisions may have diminished.[7] Unions may find it increasingly difficult to both oppose mandatory overtime measures in workplaces and negotiate better premiums for overtime work. In addition, unions whose members have experienced declining wage rates are under pressure to preserve overtime work as a way to allow members to prop up their earnings.

In recent years, several unions have successfully negotiated contract language that places limits on mandatory overtime or requires steps to make such arrangements more voluntary in nature.[8] For example, in the health services sector, Tenet Health Care and St. Vincent's Hospital in Worcester, Mass., signed an agreement with 600 nurses that allowed the hospital to mandate overtime but for no more than for a four-hour period twice every three months. (The hospital has the right to assign up to two hours of mandatory overtime, and the nurse can work an additional two hours if she felt capable of doing so safely.) Tenet management had initially demanded that the nurses agree to work mandatory 16-hour shifts with one hour's advance notice.[9] Limits to forced overtime have been implemented in telecommunications and other industries as well. The Communications Workers of America (CWA) strike at Verizon in 2000 resulted in reduced mandatory overtime limits, in some instances cutting them in half, from 15 to 7.5 hours a week; the company is also now required to give at least 2.5 hours notice if overtime work is required, and it must give consideration to those employees requesting to be excused from overtime.[10] Northwest Airlines permits employees to refuse overtime if they provide reasons such as child care responsibilities that cannot be altered on short notice. The American Postal Workers Union and the National Association of Letter Carriers agreed with the U.S. Postal Service to restrict excessive mandatory overtime. The agreement protects those members who sign up on a list of "overtime desired" but want to work only limited overtime, plus those members who are not on the overtime list at all.[11] In the manufacturing sector, the United Steelworkers of America negotiated a cap on mandatory overtime at FMC, a Baltimore, Md., pesticide plant. Newspaper Guild Local 35 (covering Washington-Baltimore) and the Bureau of National Affairs negotiated a voluntary overtime arrangement in which members can be excused from working compulsory overtime unless no other appropriate employee is available.

Policy solutions: legislated mandatory overtime limits, bans, and other remedies

Legislative initiatives at both the federal and state levels would regulate mandatory overtime. Bills have been introduced in the 107th U.S. Congress that would limit the amount of forced overtime that nurses and other licensed health care providers could work. The Safe Nursing and Patient Care Act of 2001 was introduced in the Senate (S-1686) and House (HR 3238). It aims to amend the Social Security Act by limiting the number of mandatory overtime hours a nurse may be required to work among providers of services to which payments are made under the Medicare program Under the Registered Nurses and Patients Protection Act (H.R. 1289, also referred to as the Lantos-McGovern Bill, and a very similar bill with different sponsors, H.R. 1902), licensed health care professionals could not be required to work more than eight hours in a day or 80 hours within a two-week period, unless a written agreement between the employer and the employee specifies otherwise. Nurses associations across the country have endorsed such bills, arguing that it would reduce overtime and improve both patient safety and quality of care. While the latter bill refers only to registered nurses, it would cover all other licensed health care workers in the country (except medical doctors). To date, House leaders have taken no action on it.

These federal proposals as well as a number of similar state initiatives have been important first

The Working Hours Of Hospital Staff Nurses And Patient Safety

Both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours at a stretch.

by Ann E. Rogers, Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges

ABSTRACT: The use of extended work shifts and overtime has escalated as hospitals cope with a shortage of registered nurses (RNs). Little is known, however, about the prevalence of these extended work periods and their effects on patient safety. Logbooks completed by 393 hospital staff nurses revealed that participants usually worked longer than scheduled and that approximately 40 percent of the 5,317 work shifts they logged exceeded twelve hours. The risks of making an error were significantly increased when work shifts were longer than twelve hours, when nurses worked overtime, or when they worked more than forty hours per week.

SEVERAL TRENDS IN HOSPITAL USE and staffing patterns have converged to create potentially hazardous conditions for patient safety. High patient acuity levels, coupled with rapid admission and discharge cycles and a shortage of nurses, pose serious challenges for the delivery of safe and effective nursing care for hospitalized patients.[1] While systematic national data on trends in the number of hours worked per day by nurses are lacking, anecdotal reports suggest that hospital staff nurses are working longer hours with few breaks and often little time for recovery between shifts.[2] Scheduled shifts may be eight, twelve, or even sixteen hours long and may not follow the traditional pattern of day, evening, and night shifts. Although twelve-hour shifts usually start at 7 p.m. and end at 7 a.m., some start at 3 a.m. and end at 3 p.m. Nurses working on specialized units such as

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surgery, dialysis, and intensive care are often required to be available to work extra hours (on call), in addition to working their regularly scheduled shifts. Twenty-four-hour shifts are becoming more common, particularly in emergency rooms and on units where nurses self-schedule.

No state or federal regulations restrict the number of hours a nurse may voluntarily work in twenty-four hours or in a seven-day period.[3] Even though state legislatures in approximately nineteen states have considered bans on mandatory overtime for nurses and other health care professionals, bills prohibiting mandatory overtime for nurses have passed only in California, Maine, New Jersey, and Oregon. No measure, either proposed or enacted, addresses how long nurses may work voluntarily.[4] The recent Institute of Medicine (IOM) report, *Keeping Patients Safe*, explicitly recommends that voluntary overtime also be limited.[5]

The well-documented hazards associated with sleep-deprived resident physicians have influenced changes in house staff rotation policies.[6] In contrast, although shift-working nurses have been the focus of numerous studies, it is not known if the long hours they work have an adverse effect on patient safety in hospitals.[7] The purpose of this paper is to examine the work patterns of hospital staff nurses and to determine if there is a relationship between hours worked and the frequency of errors.

Study Data And Methods

■ **Sample.** A cover letter explaining the study and eligibility criteria was mailed to a random nationwide sample of 4,320 members of the American Nurses Association (ANA) during the winter of 2002; 1,725 nurses expressed interest by returning their completed demographic questionnaire to the Survey Research Institute at Temple University in Philadelphia. Two logbooks covering a two-week period each, instructions for completing the logbooks, and postage-paid envelopes were mailed to 891 eligible subjects (unit-based hospital staff nurses working full time). Three hundred sixty-two subjects returned both logbooks, and thirty-one completed only one of the two logbooks, for a return rate of approximately 40 percent. The Institutional Review Board at the University of Pennsylvania approved this study, and subjects were paid $140 for their participation.

■ **Subjects.** The sample of 393 registered nurses (RNs) was predominantly female (92 percent), Caucasian (79 percent), middle-aged (mean age 44.8 ±8.8 years, range 22–66), and experienced (mean 17.2 ±10.0 years). Only 26.3 percent of the participants reported less than ten years' experience, while 41.9 percent reported twenty or more years. All participants worked full time (at least thirty-six hours per week) as hospital staff nurses. Half reported working in hospitals with more than 300 beds; only 11 percent reported working in a hospital with less than 100 beds. The majority of participants were employed at hospitals located in urban (56 percent) or suburban (19 percent) areas. The remaining participants worked in hospitals located in small towns (18 percent) or rural areas (7 percent). The characteristics of

nurses in the study sample did not differ significantly from those of nurses in the 2000 National Sample Survey of Registered Nurses (NSSRN) in terms of sex, age, marital status, and work environment (hospital size, urban/rural location, and type of hospital unit).[8] Our sample has slightly more nurses who identified their ethnicity as Asian (10.7 percent) than among participants in the NSSRN (3.8 percent).

■ **Instruments.** Spiral-bound logbooks were used to collect information about hours worked (both scheduled and actual hours), time of day worked, overtime, days off, and sleep/wake patterns. Subjects completed seventeen to forty items per day; all forty questions were completed only on days the nurses worked. Questions regarding errors and near errors were included, and space was provided for nurses to describe any errors or near errors that might have occurred during their work periods. On days off, nurses were asked to complete the first seventeen questions about their sleep/wake patterns, mood, and caffeine intake. All items in the logbook and the logbook format itself were pilot-tested before this study began.

Logbooks (both paper and electronic) have been used to collect data during field studies of pilots' cockpit alertness for more than ten years, and from various other groups of subjects including air traffic controllers, flight controllers during space shuttle missions, and emergency room physicians.[9] Data recorded about sleep patterns in these logbooks compare well with data recorded using objective measures such as wrist actigraphy or ambulatory polysomnography.[10]

Although logbooks are not often used to collect information about medical errors, there is some evidence that daily, anonymous, end-of-shift reporting of errors in a logbook is a valid approach to ascertaining the nature and prevalence of nursing errors. During a one-month study period of medication errors at a large military hospital, nurses completed formal incident reports on only 6 percent of the medication errors and 15 percent of the near errors that they reported using daily, anonymous coupons.[11] Another study found that resident physicians also were more likely to report potential injuries to patients using a confidential e-mail system with daily prompts about reporting than they were to complete traditional incident reports.[12]

■ **Analysis.** Data from demographic questionnaires and logbooks were summarized using descriptive statistics and frequency tables. The duration of scheduled and actual work hours per shift was calculated and aggregated per nurse and per week. Cutpoints for classifying shift durations were chosen as 8.5 hours and 12.5 hours because "eight-hour" and "twelve-hour" shifts are usually scheduled to allow for a half-hour handover period at the end of the shift. A work shift was classified as an overtime shift if the actual work hours were longer than the scheduled hours or if the nurse reported that the shift was "scheduled overtime."

A binary response for making an error during a worked shift was used as the primary outcome in analyses. When a nurse caught him/herself before making an error during a shift, a binary near-error variable was reported and treated as the secondary outcome. Errors and near errors were codified into categories by study

investigators, based on the descriptions provided in logbooks (for example, medication administration, procedural, transcription). The univariate associations between the risk of making an error or a near error and (1) the actual duration of the shift, and (2) overtime were estimated separately using logistic regression models. The effect of overtime was also examined by stratifying shifts by their expected duration. Since multiple work shifts from the same nurse contributed to this analysis, procedures based on Generalized Estimating Equation (GEE) were used to determine the odds ratio (OR) while accounting for the nonindependence between repeated measurements.[13] Significance tests were two-sided with alpha = .05. Multivariate analyses also were conducted to evaluate the adjusted associations between errors (or near errors), work hours, and overtime, while controlling for other variables including age, hospital size, and type of hospital unit. For the week-level data, logistic regression models were performed to assess if working more than forty hours or fifty hours would increase the probability of making one or more errors (or near errors) in a week.

Study Results

Data collected on 5,317 work shifts revealed that hospital staff nurses worked longer than scheduled daily, and generally worked more than forty hours per week. Half of the shifts worked exceeded ten and a half hours. Although 31 percent of the scheduled shifts were scheduled for durations greater than or equal to 12.5 hours, there were 2,057 shifts (39 percent) where nurses worked at least 12.5 consecutive hours (Exhibit 1). Fourteen percent of the respondents reported working sixteen or more consecutive hours at least once during the four-week pe-

EXHIBIT 1
Description Of Work Patterns Of Full-Time Hospital Staff Nurses, 2002

Variable	Number of shifts	Percent
Number of shifts	5,317	100.0
Scheduled shifts[a]		
Up to 8.5 hours	2,452	46.6
8.5–12.5 hours	1,183	22.5
12.5 or more hours	1,623	30.9
Actual shifts[b]		
Up to 8.5 hours	771	14.5
8.5–12.5 hours	2,484	46.8
12.5 or more hours	2,057	38.7
Number of overtime shifts	4,292	81.4
Number of mandatory overtime shifts	360	6.8

SOURCE: Authors' analysis of survey results.

[a] Scheduled shift hours were missing from 59 shifts. Mean length (hours): 10.3 (standard deviation, ±2.3); range: 1.0–22.5 hours.

[b] Actual work hours were missing from 5 shifts. Mean length (hours): 10.8 (SD, ±2.5); range: 1.2–23.7 hours.

riod. The longest shift worked was twenty-three hours, forty minutes.

Nurses reported leaving work at the end of their scheduled shift less than 20 percent of the time during the study period. Although overtime was reported at the end of all types of shifts, the proportion of shifts involving overtime was significantly higher ($p = .0001$) when eight-hour shifts (85 percent) were compared to shifts scheduled for eight to twelve hours (79 percent) and twelve hours or longer (78 percent). Overall, our participants worked, on average, fifty-five minutes longer than scheduled each day, and all participants worked beyond their scheduled work shift (overtime) at least once during the twenty-eight-day data-gathering period. Almost two-thirds of the nurses worked overtime ten or more times during that period, and a third reported working overtime each day they worked during that period. There were 360 shifts where nurses reported being mandated to work overtime and another 143 shifts where they described being "coerced" to work voluntary overtime. Even though nurses worked approximately four days per week, averaging 40.2 (±12.9) hours per week (range 8–97.2 hours per week), one-quarter worked more than fifty hours per week for two or more weeks of the four-week period.

There were 199 errors and 213 near errors reported during the data-gathering period. More than half of the errors (58 percent) and near errors (56 percent) involved medication administration. Other errors included procedural errors (18 percent), charting errors (12 percent), and transcription errors (7 percent). Approximately 6 percent of the errors and 29 percent of the near errors reported lacked sufficient information for categorization. Thirty percent of the nurses reported making at least one error, and 32 percent reported at least one near error. One nurse reported eight errors, while another nurse reported nine near errors.

Our analysis showed that work duration, overtime, and number of hours worked per week had significant effects on errors. The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting of 12.5 hours or more (odds ratio = 3.29, $p = .001$) (Exhibit 2). Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled (OR = 2.06, $p = .0005$). Our data also

EXHIBIT 2
Association Of Errors Or Near Errors With Nurses' Work Duration, 2002

Work duration (hours)	Number of shifts	Shifts with one or more errors			Shifts with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
Up to 8.5	771	12	1.6	1.00	20	2.6	1.00
8.5–12.5	2,484	77	3.1	1.85 (.06)	94	3.8	1.44 (.18)
12.5 or more	2,057	103	5.0	3.29 (.001)	97	4.7	1.80 (.04)
Total	5,312	192	3.5		211	4.0	

SOURCE: Authors' analysis of survey results.

NOTES: Five shifts with four errors cannot be classified because of missing work durations. OR is odds ratio.

suggest that there is a trend for increasing risks when nurses work overtime after longer shifts (OR = 1.34, 1.53, and 3.26 for scheduled eight-hour, eight-to-twelve-hour, and twelve-hour shifts, respectively), with the risks being significantly elevated for overtime following a twelve-hour shift ($p = .005$) (Exhibit 3). Although the effects of working prolonged shifts were clearly associated with errors, there was no interaction between scheduled shift duration and overtime ($p = .17$). Finally, working more than forty hours per week and more than fifty hours per week significantly increased the risk of making an error (Exhibit 4). Results were somewhat similar for near errors (Exhibits 2–4).

Nurse and employment characteristics were also examined as potential confounders in the multivariate models. Our results suggest that the relationships of errors or near errors and work hours and overtime were not affected by age, hospital size, or type of hospital unit.

Discussion

This study represents one of the first nationwide efforts to quantify hospital staff nurse work hours and work patterns, and to determine whether extended staff nurse work hours contribute to errors and near errors. Our findings confirm that the work schedules of hospital staff nurses are unpredictably prolonged. All nurses reported working longer than scheduled at least once, and the majority reported working longer than scheduled ten times or more in a twenty-eight-day period, as well as working more than forty hours per week. Almost one-sixth of the sample reported working sixteen or more consecutive hours at least once during the period, which suggests that double shifts (or longer) are not confined to rare emergencies. Mean daily overtime durations were slightly higher than those

EXHIBIT 3
Association Of Errors Or Near Errors With Nurses' Scheduled Work Duration And Overtime, 2002

Scheduled work duration (hours)	Number of shifts	Shifts with one or more errors			Shifts with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
Up to 8.5							
No OT	377	8	2.1	1.00	15	4.0	1.00
OT	2,075	65	3.1	1.34 (.42)	76	3.7	0.90 (.74)
8.5–12.5							
No OT	246	6	2.4	1.00	3	1.2	1.00
OT	937	36	3.8	1.53 (.36)	42	4.5	2.32 (.08)
12.5 or more							
No OT	360	6	1.7	1.00	8	2.2	1.00
OT	1,263	70	5.5	3.26 (.005)	67	5.3	2.34 (.03)
Total	5,258	191	3.6		211	4.0	

SOURCE: Authors' analysis of survey results.
NOTES: Fifty-nine shifts with five errors and two near errors cannot be classified because of missing scheduled work durations. OR is odds ratio. OT is overtime.

EXHIBIT 4
Association Of Errors Or Near Errors With The Number Of Hours Worked Per Week By Nurses, 2002

Hours worked	Number of weeks	Weeks with one or more errors			Weeks with one or more near errors		
		Number	Percent	OR (*p* value)	Number	Percent	OR (*p* value)
More than 40							
No	743	64	8.6	1.00	75	10.1	1.00
Yes	681	101	14.8	1.96 (<.0001)	92	13.5	1.42 (.03)
Total	1,424	165	11.6		167	11.7	
More than 50							
No	1,110	112	10.1	1.00	120	10.8	1.00
Yes	314	53	16.9	1.92 (.0001)	47	15.0	1.46 (.03)
Total	1,424	165	11.6		167	11.7	

SOURCE: Authors' analysis of survey results.
NOTE: OR is odds ratio.

reported in two small observational studies (fifty-five minutes, compared with forty-two and forty-five minutes, respectively).[14]

Although the occurrence of errors did not increase significantly until shift durations exceeded 12.5 hours per day, risks began to increase when shift durations exceeded 8.5 hours. Since errors are relatively rare, it is possible that this study lacked sufficient power to detect the effects of work hours or overtime on errors when nurses were scheduled to work shorter shifts (less than 12.5 hours). Certainly the trend toward increasing errors with longer work durations is consistent with other studies that have demonstrated that extended work periods are associated with increased accidents and neuropsychological deficits among nurses and have contributed to at least two hospitalwide epidemics of Staphylococcus aurous.[15] Investigations of these epidemics showed that nurses, who were fatigued and stressed by high patient caseloads and understaffing, made frequent mistakes and procedural errors. Despite the lack of information about accident rates involving nurses, probed performance tests reveal that nurses working twelve-hour simulated shifts make more frequent errors on grammatical reasoning tasks and medical record reviewing.[16]

There are already hints that the fatigue associated with working twelve-hour shifts is contributing to absenteeism and job dissatisfaction among RNs. Fatigue related to length of shift or the potential of overtime at end of shift, or both, was identified as the cause of approximately 12 percent of the absences reported by a random sample of Canadian hospital staff nurses. Not only did RNs report an unusually high number of sick days year (7.4 days, compared with 3.2 for other workers), but also nurses working twelve-hour shifts reported significantly higher absenteeism rates than nurses working traditional eight-hour shifts. Nurses who worked twelve-hour shifts also expressed lower levels of job satisfaction than nurses working eight-hour shifts.[17]

Inasmuch as the probability of making an error because of long work hours or

"The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety."

overtime was not altered significantly by the age or experience of the nurses, or by the type of unit or hospital size, other factors may be important. More specifically, physiological factors such as fatigue, system variables such as increased work intensity, or a combination of fatigue and increased work intensity may contribute to the errors and near errors we observed. It is also possible that heavy workloads themselves may increase the risk of making an error.

The use of mandatory overtime to cover staffing vacancies is a controversial and potentially dangerous practice.[18] More than one-quarter of nurse participants (28.7 percent) reported working mandatory overtime at least once during the data-gathering period, a percentage that is quite similar to that reported in two surveys of more than 47,000 nurses and in a "Quick Poll" posted on the American Association of Critical Care Nurses Web site.[19]

Mandatory overtime is generally defined as nurses' being told that they could be fired, be subjected to disciplinary proceedings, or lose their nursing license if they refused to stay beyond their regularly scheduled shift or come in to work on their day off.[20] Although not actually threatened with job loss or disciplinary proceedings, many nurses also report feeling that there will be repercussions if they refuse to work extra hours or that overtime "is voluntary but feels like it is required."[21] Perhaps that is why approximately 60 percent of the participants in the American Nurses Association Staffing Survey (N = 4,258) reported being "forced to work voluntary overtime."[22]

Our data are derived from the self-reports of a relatively small number of hospital staff nurses and may not be representative of the work schedules and clinical practices of other U.S. hospital nurses. However, the demographic characteristics of our nurse sample and our findings about hours worked are consistent with data reported by hospital staff nurses in the NSSRN, a probability-based sample.[23] In addition, the percentage of staff nurses who identified twelve-hour shifts as their usual shift pattern (60.6 percent) is quite similar to Marlene Kramer and Claudia Schmalenberg's report that almost two-thirds of the 279 staff nurses they interviewed worked twelve-hour shifts.[24]

Although our response rate was lower than that usually reported for surveys of nurses, this study required more effort than the usual survey; subjects were asked to respond to between seventeen and forty items every day for twenty-eight days.[25] Given the subject burden, it is possible that responders were more invested than nonresponders were in documenting a relationship between the hours they worked and effects on patient safety. However, the amounts of overtime reported varied, with some nurses indicating minimal overtime and others reporting extremely long shift durations or working more than fifty hours per week, or both.

Perhaps more important, the major unit of analysis for this study was the actual work shift (N = 5,317) rather than the nurse (N = 393).

The definition of *error* was not specified in the survey instrument. Nevertheless, all incidents described by participants were obvious deviations from current standards of practice. Reported medication errors clearly fell into the categories familiar to all nurses: wrong patient, wrong medication, wrong dose, wrong route (such as intravenous, oral), wrong time, and errors of omission.[26] Nurses were asked whether they made an error, not to assess whether it led to harm.

By not collecting data that could identify where participants worked, we reduced the fears usually associated with reporting errors. Studies have shown that nurses typically underreport errors because they fear repercussions, including disciplinary action by employers and regulatory agencies. As a result, only those errors considered potentially life-threatening, or approximately 5 percent of significant errors, are usually reported.[27] Errors that are considered "minor" or are intercepted before reaching the patient are almost never reported.[28] In fact, near errors are now considered nonreportable events by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[29]

The errors nurses reported in this study occurred in the context of well-documented deficiencies in nurses' practice conditions in U.S. hospitals, deficiencies that nurses have been reporting for well over a decade.[30] The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety. As advocated by the IOM report on medical errors, safer patient care is more likely to result from changes in the environment in which health care is provided than from blaming health care professionals, who may be providing the best care possible under poor circumstances.[31]

Hospital staff nurses' long hours may have adverse effects on patient care; we found that both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours. Because more than three-fourths of the shifts scheduled for twelve hours exceeded that time frame, routine use of twelve-hour shifts should be curtailed, and overtime—especially that associated with twelve-hour shifts—should be eliminated. Additional research with larger samples, inclusion of other variables such as workload and patient acuity, and more precise measurements of error is suggested.

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ANA Calls for Action on Legislation to Limit Mandatory Overtime

Cites New Study that Shows Link between Patient Safety and Nurses' Work Hours

Washington, DC - The American Nurses Association (ANA) praised a new study released yesterday that shows a strong link between medical errors and the long work hours of nurses and called on Congress to take action on the Safe Nursing and Patient Care Act (H.R. 745, S. 373), which would strictly limit the use of mandatory overtime for nurses.

The study, published in the July/August issue of *Health Affairs*, found that the risk of making an error greatly increased when nurses had to work shifts that were longer than 12 hours, when they worked significant overtime or when they worked more than 40 hours per week. It reinforced findings of the 2003 Institute of Medicine Report, "Keeping Patients Safe: Transforming the Work Environment of Nurses," which said that nurses' long working hours pose a serious threat to patient safety.

"This study is more evidence that patient safety is closely linked to nurses' working conditions," said ANA President Barbara Blakeney, MS, APRN,BC, ANP. "The growing trend of mandatory overtime for nurses is one of the greatest threats to patients' and nurses' safety. We call on Congress to protect the public by taking action to limit mandatory overtime for nurses. Doing so will help protect patients from preventable errors and retain nurses in the workforce."

To date, 10 states have taken action to limit mandatory overtime for nurses, and similar measures have been proposed in 20 other states.

The study, "The Working Hours of Hospital Staff Nurses and Patient Safety," by Ann Rogers, PhD, RN, and colleagues at the University of

Pennsylvania School of Nursing, was funded by the Agency for Health Care Research and Quality. Researchers examined logbooks kept by 393 registered nurses around the country who worked full-time in hospitals. Data collected on 5,317 work shifts revealed that in nearly 40 percent of the cases, nurses worked at least 12.5 consecutive hours. More than 25 percent of the participants in the study reported working mandatory overtime at least once during a one-month period.

According to a 2001 ANA health and safety survey, 67 percent of respondents reported working some form of mandatory or unplanned overtime every month. The ANA has long warned that mandatory overtime is dangerous for patients and nurses, and that the practice has been driving nurses away from the profession, thus exacerbating an emerging nursing shortage that is expected to worsen dramatically over the next 10 years.

"Poor working conditions are a major contributor to the nursing shortage," said Blakeney. "As this study shows, nurses are consistently working long and unpredictable hours, often caring for a large number of critically ill patients. To improve the quality of care and patient safety, we must value nurses' contributions more and make a greater investment in nursing," she said.

To counter staffing insufficiencies that are already occurring, many health care facilities across the nation have increasingly imposed mandatory overtime as a common practice.

Typically, an employer may insist that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment, a charge that could lead to a loss of license for the nurse. At the same time, ethical nursing practice prohibits nurses from engaging in behavior that they know could harm patients, thus leading to a dilemma for many nurses.

The Safe Nursing and Patient Care Act would prohibit health care facilities from forcing exhausted nurses to work extra shifts, an unsafe practice that puts both patients and nurses at risk.

The Safe Nursing and Patient Care Act would:

- Prohibit health care facilities that receive Medicare funding from requiring a registered nurse (RN) or licensed practical nurse (LPN) to work beyond an agreed-to, predetermined, regularly scheduled shift.

  In no instance could a nurse be required to work more than 12 hours in a 24-hour period or for more than 80 hours in a two-week period - a provision that would prevent an institution from altering shift schedules in a way that would undermine the law.

- Include nondiscrimination protections for nurses who refuse overtime and for nurses who provide information and/or cooperate with investigations about the use of overtime.

- Include an exception in the case of a declared national, state or local emergency. Such an emergency would be in response to an unpredictable disaster, not in response to a staffing deficiency resulting from management practices.

- Provide for a study by the Department of Health and Human Services on the maximum number of hours that may be worked by a nurse without compromising patient safety.

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The American Nurses Association is the only full-service professional organization representing the nation's 2.7 million registered nurses (RNs) through its 54 constituent member associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

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Nurses say working long hours is dangerous

OVERTIME: Workers seek to limit number of double shifts.

By TIMOTHY INKLEBARGER
The Associated Press

(Published: June 27, 2005)

Nurses at the Alaska Psychiatric Institute in Anchorage and other state-run health care facilities in Alaska are joining a movement to limit mandatory overtime at hospitals. Nurses often work 12- to 16-hour shifts to fill holes in schedules. *(Photo by AL GRILLO / The Associated Press)*

JUNEAU -- Nurses in Alaska are joining a movement in states across the nation to limit forced overtime at hospitals, a practice they contend is dangerous both for them and their patients.

Nurses at state-run health care facilities, such as the Alaska Psychiatric Institute in Anchorage and the state's six Pioneer Homes for seniors, and at health clinics in rural areas often work 12- or 16-hour shifts to help fill holes in round-the-clock schedules.

Dianne O'Connell of the Alaska Nurses Association said nurses sometimes are called in two or three times a week to work double shifts.

They feel obligated to fill the empty shifts over fear of retribution or the possibility of losing their nursing license for abandoning their patients, O'Connell said.

API nursing director Jane Barnes said nurses who leave their posts irresponsibly without alerting other staff could be reported to the Alaska Board of Nursing.

"But we haven't had nurses do that irresponsibly," she said.

Barnes said it is unlikely that nurses would be reported or have their licenses revoked for declining a mandatory overtime shift because of fatigue. She said API takes the circumstances of each situation into account and has tried to work with nurses to accommodate their needs.

Nurses who refuse mandatory overtime shifts without good reason, though, would be subject to disciplinary action, Barnes said. She said any potential disciplinary action would be made known up front before a nurse decides whether to work the shift.

O'Connell said the mandatory overtime issue has been a problem at the Psychiatric Institute for years because the facility does not have enough nurses on staff.

"If somebody calls in sick, they don't have a pool of people to call upon," she said.

There are 8,670 licensed nurses in Alaska. According to a 2000 nationwide survey, Alaska had 782.9 registered nurses per 100,000 residents, close to the national average. But it lagged in licensed practical nurses.

The Alaska State Employees Association, which represents about 90 nurses statewide, and the

Alaska Nurses Association are pushing Alaska lawmakers to pass a bill that would prevent hospitals from requiring nurses to accept overtime hours if they believe it would jeopardize their safety or the safety of their patients. The bill, by Rep. Peggy Wilson, R-Wrangell, would not apply in emergencies.

Nurses would not be allowed to work more than 12 hours without an eight-hour break. Health care facilities that violate the law would have to pay nurses three times their regular pay for the mandatory overtime hours worked. A second offense within 12 months would result in a fine of $500, and a third violation within a year would mean a fine of $2,500 to $5,000.

J.W. Pound, a nurse who has worked at API for 14 years, said nurses at the hospital are attacked by patients on a regular basis. Many of the patients admitted to the institute are straight out of jail, Pound said.

"You have to be on your guard all the time," he said. "You have people who are pretty paranoid. A lot of them are angry and delusional."

Pound, 55, said he works the night shift when attacks are more common.

He said nurses at API often sign up for scheduled overtime shifts to get their names removed from a list of mandatory overtime shifts that can be required if other nurses are sick or unable to work.

He said some of the overtime shifts can make for 16-hour days at the hospital.

ASEA business agent Doug Carson said the assaults can become more of a safety issue for nurses after they've worked double shifts.

"If you're tired, you make yourself more vulnerable," he said.

API director and chief executive officer Ron Adler said the hospital does not compromise its workers' or patients' safety.

"There is a noted incongruence between the data and staff perceptions," Adler said.

Adler said the quality improvement program at API monitors staff safety, which he said is showing a trend of fewer employee and patient injuries.

He said mandatory overtime is a "lightning-rod issue" and the hospital is implementing a nursing management software program that will help identify peak times of the year when mandatory overtime shifts increase.

"It really gives us data and information to staff the hospital in a more precise way than we're doing," he said. "I think we can staff up with seasonal, part-time and on-call employees."

He said the hospital wants to accommodate employees and give them the time off to spend with their families.

Carson said ASEA filed a grievance against the hospital earlier this year, arguing that API cannot call nurses in on their days off. He said the grievance is pending.

Adler declined to comment on the grievance, directing questions to state labor negotiator Art Chance. Chance did not return phone calls requesting an interview.

The Legislature does not meet again until January, but Wilson, who also serves as chairman of the House Health, Education and Social Services Committee, said she plans to hold hearings sometime later this year.

Wilson, who has worked as a nurse for 32 years, said she has never had to work mandatory overtime shifts but wants to give those who have a chance to discuss the issue in a public forum.

She said the issue also is a problem for nurses at state corrections facilities.

"I think what hospitals are going to have to do is start paying nurses more," she said, noting that state health care facilities pay nurses significantly less than private facilities, which makes it difficult to retain employees.

Carol Cooke, a spokeswoman for the American Nurses Association, said the move to establish laws limiting mandatory overtime is playing out in many states as well as in Congress.

She said nine states have passed laws limiting the practice and another 23 have introduced legislation.

A bill by U.S. Rep. Pete Stark, D-California, and U.S. Rep. Steven LaTourette, R-Ohio, would limit mandatory overtime to emergency situations and give the U.S. Department of Health and Human Services the authority to issue $10,000 fines to facilities that are in violation. A companion bill in the U.S. Senate has been introduced by Sen. Ted Kennedy, D-Mass.

Adler acknowledged the trend and said API is hoping to move away from mandatory overtime with its new scheduling system and seasonal and part-time employees.

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March 15, 2006

Representative Mike Hawker
House Finance Committee
State Capitol Building
Juneau, Alaska

Subject: HB271, prohibiting mandatory overtime

Dear Representative Hawker:

The Alaska Nurses Association (AaNA) appreciates an opportunity to address you, as Chairman for Dept. Health & Social Services (DH&SS) Budget Subcommittee, regarding the issue of mandatory overtime for nurses and related funding issues in the FY07 budget.

AaNA supports HB271, sponsored by Rep. Peggy Wilson, as a prohibition for health care facilities to rely upon the use of mandatory overtime by nurses. The practice of mandatory overtime becomes a hazard to the safety of patients and nurses when it becomes a chronic method for managing nursing-shortages. HB271 is currently pending in the House Finance Committee, and we hope you will agree that the bill establishes good public policy by the State of Alaska for all health care facilities.

During House HESS Committee hearings last summer on HB271, both the Division of Personnel and DH&SS provided a great deal of information showing difficulties recruiting and keeping nursing staff. Salary levels paid to public nurses employed by the State are not competitive with the private sector.

The discussion of nursing shortages within DH&SS arose out of problems faced at API. Psychiatric nurses at API testified that mandatory overtime was being used at the facility in order to cover nursing shifts. This was further causing some nurses to leave the facility, which further exacerbated the problem.

In December, Governor Murkowski requested authorization in the FY07 DH&SS budget to increase wages for DH&SS nurses. During their budget presentations to the members of your Subcommittee, DH&SS testified that salaries would increase by one range – which represents approximately a 7% wage increase per nurse.

Please allow me to express appreciation and thanks to you for the work of the DHSS Subcommittee. Included in the Subcommittee's report was a recommendation to fund Governor Murkowski's request for $2.11 million to provide for a wage increase for Nursing positions in the department.

AaNA Alaska Nurses Association

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Anchorage, AK 99507
www.aknurse.org

While the funding to increase DH&SS nurse salaries may have largely resulted from the discussion and testimony on HB271, AaNA felt strongly that the bill should move forward as a long-term protection against mandatory overtime.

Mandatory overtime is a nationwide issue. The American Nurses Association has encouraged all states to look at the problem and, if necessary, pass legislation (like HB271).

While the legislation focuses on the nurse, please understand that this bill is based first and foremost towards a concern for patient safety. Hospitals and care facilities nationwide are learning more and more about the high costs and tragic consequences from human errors during treatment when the nurse is fatigued.

Nationwide – and especially in Alaska – the numbers show a shortage of healthcare workers, and nurses in particular. There are a number of ways this situation can be addressed, but HB271 is a bill that says that we shouldn't be putting patients safety at risk in order to achieve a short-term fix for a large multi-faceted problem.

As the President of the AaNA, I want to thank all legislators for making the effort as elected public officials to learn about an important issue within our profession. Please take a look at this bill and this issue. We are willing to work with all legislators and with the Administration at resolving these issues.

Sincerely,

Debbie Thompson

Debbie Thompson, BSN, RN, CNOR
President
Alaska Nurses Association

CC: House Finance Committee
Rep. Peggy Wilson

HB

272

IOUSE COMMITTEE REPO

(11)
Date Referred to Committee: April 27, 2005 FURTHER REFERRALS:

Date of Committee Action: 4/29/05

The FINANCE Committee considered: HB 272

HOUSE BILL NO. 272 CARD ROOMS & OPERATIONS

"An Act relating to card rooms and card operations."

Recommends it be replaced with [ ] HCS *or* [✓] CS for HB 272 (FIN)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ [✓] Same Title [ ] New Title

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW FISCAL NOTES *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
Rev			✓	

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	FOSTER	X			
Kelly Mitch Kelly	Kelly		X		
	Hord			X	
Rick Wightman	Wightman			X	
Paul E. Moses	MOSES	X			
Chair:	Meyer			X	
Chair:	Oberbillig			X	

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSHB 272 (JUD)
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Revenue 04
Title: Card Rooms & Operations
RDU: Treasury and Tax
Component: Tax Division
Sponsor: Representative Kott
Requester: (H) FIN
Component No.: 2476

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	-	-	-	-	-	-
CAPITAL EXPENDITURES	-	-	-	-	-	-
CHANGE IN REVENUES ( )	-	-	-	-	-	-

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
10[illegible]	-	-	-	-	-	-
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type - Do not abbreviate)						
TOTAL	-	-	-	-	-	-

Estimate of any current year (FY2005) cost: 0 0
Check this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal: [ ]

POSITIONS

Full-time	-	-	-	-	-	-
Part-time	-	-	-	-	-	-
Temporary	-	-	-	-	-	-

ANALYSIS: *(Attach a separate page if necessary)*

Revenue Discussion

This bill would legalize non-banked card rooms in Alaska, subject to voter rat[illegible]cal or local ordinances authorizing card rooms and with the caveat that "the total number of owner's licenses issued in a municipality may not exceed the total population of the municipality divided by 30,000." A non-banked card room is one in which players compete against each other rather than against the house and the house has no stake in the outcome of a game; Texas Hold-Em poker is an example of a game that might be played in a non-banked card room. There are two issues associated with estimating the maximum number of card rooms that would be allowed under this bill. First, it is not clear if "the most recent federal census information" refers to the Decennial Census or the most recent estimate by the U.S. Census Bureau for purposes of estimating the number of card rooms allowed. Second, the term "municipality" is not defined in the bill.

(continued on next page)

Prepared by: Larry Meyers & Brett Fried
Phone 465-2320
Division: Tax Division
Date/Time 4/29/05 8:10 AM
Approved by: Dan Dickinson, Director of Tax
Date 4/29/2005
Agency: Revenue

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FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. CSHB 272 (JUD)

ANALYSIS CONTINUATION

Revenue Discussion, Continued

For our reference case, we used the definition of "municipality" in AS 29.71.800 (cities and boroughs) and the April 1, 2000 U.S. Census to estimate that a maximum of 13 card rooms would be possible under this bill: 8 in Anchorage, 2 in the Fairbanks North Star Borough, 1 in Juneau, 1 in the Kenai Peninsula Borough and 1 in the Matanuska-Susitna Borough. If we were instead to use the July 1, 2004 annual estimates of population from the Census Bureau, then 15 card rooms would be possible: 9 in Anchorage, 2 in the Fairbanks North Star Borough, 1 in Juneau, 1 in the Kenai Peninsula Borough and 2 in the Matanuska-Susitna Borough. The most restrictive interpretation would be if "municipality" referred only to cities. Using this definition and the April 1, 2000 U.S. Census, a maximum of 10 card rooms would be possible: 8 in Anchorage, 1 in Fairbanks and 1 in Juneau. It is important to note that these estimates, including our reference case, assume all eligible municipalities will quickly ratify ordinances authorizing card rooms. Clearly, if a municipality such as Anchorage were not to authorize card rooms this would dramatically reduce card room operations in the state.

In addition to the voter ratification and population rules, there are three other reasons why we did not include a revenue or cost estimate on the front page of this fiscal note. First, the decision to open and operate a card room is a business decision. Second, under this bill the department is given authority to set many rules and regulations that will affect this business decision. These rules and regulations will be formulated after receiving recommendations from the five member governor-appointed advisory board created under this bill. Third, the fees imposed on card rooms in different states and localities vary widely and make comparisons to Alaska difficult. For example, the state of Montana charges a processing fee to cover the cost of determining whether to issue a license plus $250 for the first table and $500 for each additional table. Washington charges $3,650 for up to 5 tables and $1,060 per additional table up to a maximum of 15, plus any investigation costs exceeding the license fees. CSHB 272 imposes an owner's license fee of $25,000 to apply for a five-year license plus an annual $10,000 per table fee. Operators are also responsible for investigation costs that exceed the portion of the $25,000 fee that is assessed for the investigation, providing of a $500,000 cash bond and biannual occupational licensing fees to be set by the department.

Based on several assumptions, we estimate that one card room in Alaska could generate about $201,000 in fees for the state in the first year. During years 2 through 5, we estimate a card room in Alaska could generate between $150,000 and $167,000 in annual fees for the state. These estimates assume that the average card room will have 15 tables (15 is the maximum allowed in Washington and in California the average is 14.3). The card room is assumed to pay its owner's license fee in the first year with no transfer of ownership over the 5 year license period. This estimate also assumes an occupational licensing system similar to Washington, where annual licenses are $175 initially and $84 for renewals (for Alaska's biannual licenses this would translate into $175+$84=$259 initially and $84+$84=$168 for renewals). We assume that Washington's average of 6.7 card room occupational licenses per table will hold in Alaska and that after the first year, all of the licenses will be renewals. We assume that, like in Washington, all gaming employees will be covered but non-gaming employees such as bartenders will not require licenses. A significant variable affecting revenues would be the actual number of tables card rooms would have. This is difficult to estimate, as in California non-banked card rooms range from a single table to 243 in the Commerce Casino in Los Angeles with the average being 14.3 tables per card room. One or more very large card rooms in Alaska could significantly boost revenues.

One provision of this bill instructs the department to set maximum wagers for card rooms; this restriction along with any maximum rake could have an effect on the revenue generated by potential card rooms. In Washington, non-banked card room wagers are capped at $25 per player per round, and rakes are capped at $10 per player per hour or $1 per player per hand or 10% of the pot up to $5. Annual gross revenue to card rooms per non-banked table in Washington is $162,000. In California, there are no maximums placed on rakes or wagers, and the annual gross revenue per non-banked table is about $409,000.

This bill stipulates that card rooms must hold at least one card tournament per quarter with gross proceeds donated to a nonprofit group. There are many variables that would help determine the total amount generated for charities, including the number of card rooms, the number of tables and rules and regulations adopted by the department. Also, "gross proceeds" is not defined in the bill so it is unclear if prizes or any expenses would be included in this calculation. In Michigan the average Texas Hold Em' tournament generates $2,920 in revenue and $1,059 in profit for charities, with a $500 per person per day prize limit. Any prize limits in Alaska would be determined by the department and may influence the profitability of tournaments. In a 2005 article in the Boston Globe, card tournament supplier Mike Sheehy estimated that "A well run tournament will attract up to 200 players, each of whom pays a $100 entrance fee [...] A tournament of that size can offer pots of $5,000 for the first place player and a few thousand for the second and third and still generate $10,000 for the charity after expenses."

Cost Discussion

The costs of implementing this bill are difficult to estimate because we do not know the number nor size of potential card rooms. Given the assumptions in our revenue discussion, we anticipate $312,000 in personnel costs and related expenditures would be necessary to investigate, license and regulate up to 15 card rooms. Also about $5,930 in RSAs to Public Safety for fingerprint background checks would be required for each card room (assuming 15 tables times 6.7 employees per table times $59 per employee). The personnel costs are for an Investigator IV, four Investigator IIIs and an Administrative Clerk III. Based on the experience of other states and our own experience, this staff should be sufficient to investigate, license and regulate up to 15 card rooms with an average of 15 tables each. Also having two teams of investigators would ensure that teams could be available during all hours of card room operations (assumed to be 12:00 noon to 2:00 am). If the card rooms are larger on average than the assumed 15 tables, we would require additional staff and resources for investigation and regulation. We did not include any additional costs that would be incurred by municipalities as a result of this bill.

Sources: California Division of Gambling Control, Michigan State Charitable Gaming Division, Montana Gambling Control Division, Washington State Gambling Commission, American Gaming Association "2004 State of the States"

adopted 4/29/05
N/D

24-LS0916\F
Kurtz
4/28/05

CS FOR HOUSE BILL NO. 272( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE KOTT

A BILL

FOR AN ACT ENTITLED

"An Act relating to card rooms and card operations."

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

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. This chapter is intended to benefit the people of Alaska by promoting tourism and assisting economic development. The public's confidence and trust will be maintained only through the comprehensive law enforcement supervision and strict regulation of card rooms and card operations under AS 05.18.

* **Sec. 2.** AS 05 is amended by adding a new chapter to read:

Chapter 18. Card Rooms.

Article 1. Card Games and Card Rooms.

Sec. 05.18.010. Card rooms. (a) Notwithstanding AS 11.66, a person may establish and operate a card room in the state if the person complies with the licensing and other requirements of this chapter, as well as the statutory requirements applying to businesses generally.

(b) The following non-banking card games may be played in a card room, according to rules prescribed in regulation by the department:

(1) poker;

(2) pan;

(3) rummy;

(4) bridge; and

(5) cribbage.

Sec. 05.18.020. Presence of department employees in card rooms. Employees of the department have the right to be present in a card room or any adjacent facilities under the control of a licensed owner.

Sec. 05.18.030. Wagers. (a) The department shall determine minimum and maximum wagers on card games.

(b) A licensed owner may not permit any form of wagering on card games except as permitted under this chapter.

(c) Wagers may be received only from a person present in a licensed card room. A person present in a card room may not place or attempt to place a wager on behalf of another person who is not present in the card room.

(d) Wagering may not be conducted with money or other negotiable currency.

(e) All tokens or chips that are used to make wagers must be purchased from the owner of the card room while the purchaser is in the card room or at a facility that is adjacent to the card room and has been approved by the department. The tokens or chips may be purchased by means of an agreement under which the licensed owner extends credit to the patron.

Sec. 05.18.040. Persons under 21 years of age. (a) A person who is under 21 years of age may not be present in a card room.

(b) A person who is under 21 years of age may not make a wager under this chapter.

Article 2. Administration.

Sec. 05.18.110. Administration, regulation, and enforcement. (a) The department shall administer, regulate, and enforce the provisions of this chapter. The department:

(1) shall have all powers and duties specified in this chapter;

(2) shall have all powers necessary to execute this chapter;

(3) shall exercise jurisdiction and supervision over the following:

(A) all authorized card operations in the state;

(B) all persons in card rooms where card operations are conducted;

(4) shall investigate and reinvestigate applicants and license holders and determine the eligibility of applicants for licenses and to require applicants and license holders to reimburse the department for the costs of the investigation and reinvestigation;

(5) shall select from among competing applicants the applicants that promote the most economic development and that best serve the interests of the citizens of the state;

(6) shall take appropriate administrative enforcement or disciplinary action against a licensee under this chapter that violates the provisions of this chapter;

(7) shall investigate alleged violations of this chapter;

(8) shall establish fees for the review and investigation of applications for the licenses that are authorized under this chapter;

(9) may conduct hearings;

(10) may issue subpoenas to compel the attendance of witnesses and subpoenas duces tecum for the production of books, records, and other relevant documents;

(11) may administer oaths and affirmations to witnesses;

(12) shall prescribe a form to be used by a licensed owner as an application for employment by potential employees of the card room and licensees of the department;

(13) may revoke, suspend, or renew licenses issued under this chapter;

(14) may hire employees to gather information, conduct investigations, and carry out other tasks under this chapter;

(15) may take any appropriate action to enforce this chapter, including the issuance of notices of violations of this chapter or regulations of the department.

orders to cease and desist, and closure orders;

(16) may adopt regulations for the implementation and enforcement of this chapter;

(17) shall adopt regulations governing the conduct of card games that may be played in card rooms;

(18) shall adopt regulations specifying the form and amount of charges a card room may impose on players for playing card games in the card room;

(19) may, through the office of the attorney general, apply to the courts for injunctive and declaratory relief in aid of any action or decision of the department on any matter within the jurisdiction of the department.

(b) The Department of Public Safety and the attorney general may assist the department in conducting background investigations of applicants. The department shall reimburse the Department of Public Safety for the costs incurred by the department as a result of assistance provided to the department under this section. The department shall make the payment from fees collected from applicants for licenses.

Sec. 05.18.120. Violations; fees; inspections. (a) The department shall

(1) provide for the establishment and collection of license fees imposed under this chapter and deposit the license fees in the state gaming fund;

(2) levy and collect penalties for noncriminal violations of this chapter and deposit the penalties in the state gaming fund.

(b) The department may enter an office, a card room, or other premises of a person holding an owner's license where evidence of compliance or noncompliance with this chapter is likely to be found.

Sec. 05.18.130. Licensing. (a) The department shall adopt standards for the licensing of persons regulated under this chapter.

(b) The department shall require that the records, including financial statements, of a person holding an owner's license must be maintained in the manner prescribed by the department.

(c) The department may not issue a license to a person who has been convicted of a felony in this or another jurisdiction.

(d) An applicant for a license under this chapter shall provide the following

information to the department:

(1) the name, business address, and business telephone number of the applicant;

(2) an identification of the applicant;

(3) the following information for an applicant that is not an individual:

(A) the state of incorporation and any states where the corporation is registered to do business;

(B) the names and addresses of all corporate officers;

(C) the identity of

(i) any entity in which the applicant has an equity interest of at least 20 percent; the identification must include the state of incorporation or registration, if applicable; however, an applicant that has a pending registration statement filed with the United States Securities and Exchange Commission is not required to provide information under this item;

(ii) the shareholders or participants of the applicant; an applicant that has a pending registration statement filed with the United States Securities and Exchange Commission is required to provide only the names of persons holding an interest of more than 20 percent of all shares;

(4) an identification of any business, including the state of incorporation and all states where the business is registered to do business, if applicable, in which an applicant or the spouse or children of an applicant has an equity interest of more than 20 percent of all shares;

(5) if the applicant has been indicted, been convicted, pled guilty or nolo contendere, or forfeited bail concerning a criminal offense other than a traffic violation under the laws of any jurisdiction, the applicant must include the following information under this paragraph:

(A) the name and location of the court, the arresting agency, and the prosecuting agency;

(B) the case number;

(C) the date and type of offense;

(D) the disposition of the charge;

(E) the location and length of incarceration, if any;

(6) a statement of whether the applicant has filed or had filed against the applicant a proceeding in bankruptcy or been involved in a formal process to adjust, defer, suspend, or work out the payment of a debt, including the date of filing, the name and location of the court, and the case and number of the disposition;

(7) a statement of whether the applicant has filed or been served with a complaint or notice filed with a public body concerning a delinquency in the payment of or a dispute over a filing concerning the payment of a tax required under federal, state, or local law, including the amount, type of tax, taxing agency, and times involved;

(8) the name and business telephone number of the attorney who will represent the applicant in matters before the department;

(9) a description of a proposed or an approved card room, including the expected economic benefit to local communities;

(10) the following information from each licensee involved in the ownership or management of card operations:

(A) an annual balance sheet;

(B) an annual income statement;

(C) a list of the stockholders or other persons having at least 20 percent beneficial interest in the card room activities of the person who has been issued the owner's license;

(D) any other information the department considers necessary for the effective administration of this chapter.

(e) The department shall review and approve or disapprove promptly and in reasonable order all license applications.

(f) A party aggrieved by an action of the department denying, suspending, revoking, restricting, or refusing the renewal of a license may request a hearing before the department. A request for a hearing must be made to the department in writing not more than 10 days after service of notice of the action of the department.

(g) Except as provided in AS 05.18.180, the department shall serve notice of the department's actions under this section on a party by personal delivery or by certified mail. Notice served by certified mail is considered complete on the business day following the date of the mailing.

(h) The department shall conduct all requested hearings under this section promptly and in reasonable order.

Sec. 05.18.140. Card room advisory board. (a) The governor shall appoint five individuals to serve on a card room advisory board. Appointments to the board shall be for a period of five years.

(b) The card room advisory board shall make recommendations to the department relating to license applications and policy issues relating to card rooms.

(c) Members of the card room advisory board serve without compensation and are not entitled to per diem and travel expenses authorized by law for boards and commissions under AS 39.20.180.

Sec. 05.18.150. Violations of chapter; fraudulent acts. If a licensee or an employee of a licensee violates this chapter or engages in a fraudulent act, the department may

(1) suspend, revoke, or restrict the license of a licensee;

(2) require the removal of a licensee or an employee of a licensee from the card room;

(3) impose a civil penalty of not more than $5,000 against an individual who has been issued an occupational license for each violation of this chapter;

(4) impose for each violation of this chapter by a licensed owner a penalty of not more than the greater of $10,000 or an amount equal to the licensee's daily gross receipts for each day of the violation.

Sec. 05.18.160. Investigative procedure; complaints. (a) The department shall review and make a determination on a complaint by a person who has been issued an owner's license concerning an investigative procedure that the licensee alleges is unnecessarily disruptive of card operations.

(b) A licensee filing a complaint under this section must prove by clear and

convincing evidence that the investigative procedure

(1) does not have a reasonable law enforcement purpose; and

(2) is so disruptive as to unreasonably inhibit card operations.

(c) For purposes of this section, the need to inspect and investigate a licensee shall be presumed at all times.

Sec. 05.18.170. Transfer of licenses; rules of procedure; prohibitions. (a) A licensed owner or another person shall apply for and must receive the department's approval before an owner's license is transferred, sold, or, purchased or a voting trust agreement or other similar agreement is established with respect to the owner's license. A licensed owner or another person may not lease, hypothecate, or borrow or loan money against an owner's license.

(b) The department shall adopt regulations governing the procedure a licensed owner or another person shall follow to take an action under (a) of this section. The regulations must specify that a person who obtains an ownership interest in a license shall meet the criteria of this chapter and regulations adopted by the department. A licensed owner may transfer an owner's license only in accordance with this chapter and regulations adopted by the department.

Sec. 05.18.180. Suspension of license without notice or hearing; revocation of license. (a) The department may suspend a license issued to the owner of a card room without notice or hearing if the department determines that the safety or health of patrons or employees would be threatened by the continued operation of the card room. The opportunity for a hearing shall be provided within a reasonable time following a suspension.

(b) The suspension of a license under this section may remain in effect until the department determines that the cause for suspension has been abated. The department may revoke the license if the department determines that the owner has not made satisfactory progress toward abating the hazard.

Sec. 05.18.190. Department records. (a) Notwithstanding any other law, upon written request from a person, the department shall provide the following information to the person:

(1) the information provided under this chapter concerning a licensee

or an applicant;

(2) a copy of a letter providing the reasons for the denial of an owner's license;

(3) a copy of a letter providing the reasons for the department's refusal to allow an applicant to withdraw the applicant's application.

(b) The department may assess fees for the copying of information provided by the department to a person requesting information under (a) of this section.

Article 3. Licenses.

Sec. 05.18.200. Owner's licenses. (a) The department may issue to a person a license to own a card room and conduct card games in any municipality of the state with a population of at least 30,000 according to the most recent federal census information. The total number of owner's licenses issued in a municipality may not exceed the total population of the municipality divided by 30,000.

(b) A person applying for an owner's license under this chapter shall pay a nonrefundable $25,000 application fee to the department.

(c) An applicant shall submit the following on forms provided by the department:

(1) the information required under AS 05.18.130;

(2) if the applicant is an individual, two sets of the individual's fingerprints;

(3) if the applicant is not an individual, two sets of fingerprints for each officer and director of the applicant.

(d) The department shall review an application for an owner's license under this chapter and inform each applicant of the department's decision concerning the issuance of an owner's license.

(e) The costs of investigation of an applicant for an owner's license under this chapter shall be included in the application fee paid by the applicant.

(f) An applicant for an owner's license under this chapter shall pay all additional costs that are associated with the investigation of the applicant that exceed the portion of the application fee paid by the applicant that is assessed for the investigation.

(g) The department may not issue an owner's license under this chapter to a person if the person

(1) has been convicted of a felony under the laws of the state, the laws of another state, or laws of the United States;

(2) has knowingly or intentionally submitted an application for a license under this chapter that contains false information;

(3) is an officer, a director, or a managerial employee of a person described in (1) or (2) of this subsection; or

(4) employs an individual described in (1), (2), or (3) of this subsection and that individual participates in the management or operation of card operations authorized under this chapter.

Sec. 05.18.210. Factors considered in granting owner's licenses; submission of design. In determining whether to grant an owner's license to an applicant, the department shall consider

(1) the character, reputation, experience, and financial integrity of

(A) the applicant;

(B) a person that

(i) directly or indirectly controls the applicant; or

(ii) is directly or indirectly controlled by the applicant or by a person that directly or indirectly controls the applicant;

(2) the card room or proposed card room;

(3) the good faith affirmative action plan of each applicant to recruit, train, and upgrade minorities in all employment classifications;

(4) the financial ability of the applicant to purchase and maintain adequate liability and casualty insurance;

(5) whether the applicant has adequate capitalization to provide and maintain the card room for the duration of the license;

(6) the extent to which the applicant exceeds or meets other standards adopted by the department by regulation.

Sec. 05.18.220. Issuance of license; fee; bond. (a) The department may issue an owner's license to an eligible person if the person pays an initial license fee

and posts a bond as required in this section. The annual license fee is $10,000 for each card table. After a license has been issued, additional tables may be added for an initial license fee of $10,000 each; however, the full annual renewal fee for each table must be paid on or before the anniversary of issuance of the owner's license, regardless of when the table was added. The department may suspend or revoke a license if the annual license fee is not paid in a timely fashion.

(b) A licensed owner must post a $500,000 cash bond with the department at least 60 days before the commencement of the construction of a card room or the commencement of a card operation under the license, whichever is earlier.

(c) The principal of the bond shall be placed without restriction at the disposal of the department, but interest earned on the principal shall inure to the benefit of the licensee.

(d) The bond is subject to the approval of the department and must be payable to the department for use by the department in satisfaction of the licensed owner's financial obligations to the local community, the state, and other parties, as determined by regulations of the department.

(e) If, following a hearing held after at least five days written notice, the department determines that the amount of a licensed owner's bond is insufficient, the licensed owner shall, upon written demand of the department, file a new bond.

(f) The department may require a licensed owner to file a new bond with a satisfactory surety in the same form and amount if

(1) liability on the old bond is discharged or reduced by judgment rendered, payment made, or otherwise; or

(2) in the opinion of the department, a surety on the old bond becomes unsatisfactory.

(g) If a new bond obtained under (e) or (f) of this section is unsatisfactory, the department shall cancel the owner's license. If the new bond is satisfactorily furnished, the department shall release, in writing, the surety on the old bond from any liability accruing after the effective date of the new bond.

(h) The total and aggregate liability of the surety on a bond is limited to the amount specified in the bond, and the continuous nature of the bond may not be

construed as allowing the liability of the surety under a bond to accumulate for each successive approval period during which the bond is in force.

(i) A bond filed under this section is released 60 days after the owner's license expires and a written request for release is submitted by the licensed owner.

Sec. 05.18.230. Tournaments. The holder of an owner's license for a card room shall host a card tournament at least once each calendar quarter, with the gross proceeds of the tournament to be distributed to a nonprofit educational institution or group designated by the owner. An application for issuance or renewal of an owner's license must include proposed dates for the tournaments, and specify the nonprofit educational institution or group designated to benefit from each tournament. The licensed owner shall notify the department of any change in the date or beneficiary of a tournament. A nonprofit educational institution or group may be the designated beneficiary of only one tournament each year under this section.

Sec. 05.18.240. Term of a license. An owner's initial license expires five years after the effective date of the license.

Sec. 05.18.250. Revocation of owner's license for delay. The department may revoke an owner's license if

(1) the licensee begins regular operations more than 12 months after receiving the department's approval of the application for the license; and

(2) the department determines that the revocation of the license is in the best interests of the state.

Sec. 05.18.260. Renewal of owner's license; compliance investigations. (a) The owner's license may be renewed for an additional five-year period, provided that the bond required under AS 05.18.220 remains in force, the annual license fees have been paid in a timely fashion, and the requirements of this section are met.

(b) A licensed owner shall undergo a complete investigation by the department every five years to determine whether the licensed owner remains in compliance with this chapter.

(c) Notwithstanding (b) of this section, the department may investigate a licensed owner at any time the department determines necessary to ensure that the licensee remains in compliance with this chapter.

(d) The licensed owner shall bear the cost of an investigation or reinvestigation of the licensed owner and an investigation resulting from a potential transfer of ownership.

(e) An owner's license may be renewed only if, during the initial license period, the voters of the municipality in which the card room is located vote in favor of renewal of the license. A municipality in which a card room is located shall place the question on a general or special election ballot before the expiration of the initial license period asking the voters whether they favor or disfavor renewal of the license.

Sec. 05.18.270. Schools for training occupational licensees. This chapter does not prohibit a licensed owner from operating a school for the training of occupational licensees.

Sec. 05.18.280. Nature of license. An owner's license is a revocable privilege granted by the state and is not a property right.

Sec. 05.18.290. Occupations requiring license. The department shall determine the occupations related to card games and card rooms that require a license under this chapter. The department shall require that an individual applying for an occupational license may manage card operations for only one licensed owner.

Sec. 05.18.300. Occupational license; requirements; fees; duration; renewal; compliance investigations. (a) The department may issue an occupational license to an individual if

(1) the individual has applied for the occupational license and provided the information required under AS 05.18.130;

(2) a nonrefundable application fee set by the department has been paid on behalf of the applicant in accordance with (b) of this section;

(3) the department has determined that the applicant is eligible for an occupational license; and

(4) an annual license fee set by the department has been paid on behalf of the applicant in accordance with (b) of this section.

(b) A licensed owner or an applicant for an owner's license shall pay the application fee of an individual applying for an occupational license to work at the licensed owner's card operation and any renewal fees on behalf of an employee or

potential employee. The licensed owner or applicant for an owner's license may seek reimbursement of the application fee or annual license fee from an employee who is issued an occupational license by the department.

(c) A license issued under this section is valid for two years after the date of issuance.

(d) Unless an occupational license is suspended, expires, or is revoked by the department, the occupational license may be renewed biennially upon the payment of a license renewal fee by the licensed owner on behalf of the licensee, or by the licensee in an amount established by the department and a determination by the department that the licensee is in compliance with this chapter.

(e) The department may investigate the holder of an occupational license at any time the department determines necessary to ensure that the licensee is in compliance with this chapter.

(f) A licensed owner or an applicant for an owner's license shall pay the cost of an investigation or reinvestigation by the department of a holder of an occupational license who is employed by the licensed owner. The licensed owner or applicant for an owner's license may seek reimbursement of the cost of an investigation or reinvestigation from an employee who holds an occupational license.

Sec. 05.18.310. Qualifications for occupational license. The department may not issue an occupational license to an individual unless the individual

(1) is at least 21 years of age;

(2) has not been convicted of a felony under the laws of this state, the laws of another state, or the laws of the United States;

(3) has demonstrated a level of skill or knowledge that the department determines is necessary to operate card games; and

(4) has met standards of character and fitness adopted by the department for the holding of an occupational license.

Sec. 05.18.320. Application for occupational license. (a) An application for an occupational license shall be made on forms prescribed by the department and contain all information required by the department.

(b) An applicant for an occupational license shall provide the following

information in the application:

(1) a statement of whether the applicant has held any other licenses related to card rooms;

(2) if the applicant has been licensed in another state under any other name, the name under which the applicant was licensed in the other state;

(3) the applicant's age.

(c) An applicant for an occupational license shall submit with the application two sets of the applicant's fingerprints. The applicant must submit the fingerprints on forms provided by the department. The department shall charge each applicant the fee set by the Department of Public Safety for state and national fingerprint record searches.

Sec. 05.18.330. Restrictions on issuance of occupational license. The department may refuse to issue an occupational license to an individual who

(1) is unqualified to perform the duties required of the applicant;

(2) does not disclose or states falsely any information required by the application;

(3) has been found guilty of a violation of this chapter; or

(4) has not met standards of character and fitness adopted by the department for the holding of an occupational license.

Sec. 05.18.340. Suspension, revocation, or restriction of licenses. The department may suspend, revoke, or restrict an occupational licensee for

(1) a violation of this chapter;

(2) a cause that, if known to the department, would have disqualified the applicant from receiving the occupational license;

(3) a default in the payment of an obligation or a debt due to the state; or

(4) any other just cause.

Sec. 05.18.350. Schools for training occupational licensees. (a) This chapter does not prohibit a licensed owner from entering into an agreement with a school approved by the department for the training of an occupational licensee.

(b) Training offered by a school described in (a) of this section must be in

accordance with a written agreement between the licensed owner and the school and approved by the department.

Sec. 05.18.360. Training locations. Training provided for occupational licensees may be conducted in a card room or at a school with which a licensed owner has entered into an agreement under this chapter.

Sec. 05.18.370. Convicted felons; rehabilitation; waiver. (a) An individual applying for an occupational license who is disqualified under AS 05.18.310 due to a conviction for a felony may apply to the department for a waiver of that disqualification, and the department may issue a license to the person if the department determines that the individual has demonstrated by clear and convincing evidence the individual's rehabilitation.

(b) In determining whether the individual applying for the occupational license has demonstrated rehabilitation under (a) of this section, the department shall consider

(1) the nature and duties of the position for which the individual has applied;

(2) the nature and seriousness of the offense or conduct;

(3) the circumstances under which the offense or conduct occurred;

(4) the date of the offense or conduct;

(5) the age of the individual when the offense or conduct was committed;

(6) whether the offense or conduct was an isolated or a repeated incident;

(7) a social condition that may have contributed to the offense or conduct;

(8) evidence of rehabilitation, including good conduct in prison or in the community, counseling or psychiatric treatment received, acquisition of additional academic or vocational education, successful participation in a correctional work release program, or the recommendation of a person who supervises or has supervised the individual;

(9) the complete criminal record of the individual;

(10) the prospective employer's written statement that

(A) the employer has been advised of all of the facts and circumstances of the individual's criminal record; and

(B) after having considered the facts and circumstances, the prospective employer will hire the individual if the department grants a waiver of the requirements of this chapter.

(c) The department may not waive the requirements of this chapter for an individual who has been convicted of committing any of the following:

(1) a felony in violation of federal law, as classified in 18 U.S.C. 3559;

(2) a felony of fraud, deceit, or misrepresentation under the laws of this state or another jurisdiction; or

(3) a felony of conspiracy to commit a felony of fraud, deceit, or misrepresentation under the laws of this state or another jurisdiction.

Article 4. Crimes.

Sec. 05.18.400. Crimes. (a) A person commits a class A misdemeanor if the person knowingly

(1) makes a false statement on an application submitted under this chapter;

(2) operates a card operation in which wagering is conducted or is to be conducted in a manner other than the manner required under this chapter;

(3) permits a person under 21 years of age to make a wager;

(4) aids, induces, or causes a person under 21 years of age who is not an employee of the card room to enter or attempt to enter the card room;

(5) makes a false statement on an application submitted to the department under this chapter; or

(6) enters or attempts to enter a card room and is not an employee of the card room and is under 21 years of age.

(b) A person commits a class C felony if the person knowingly

(1) offers, promises, or gives anything of value or benefit

(A) to a person who is connected with the owner of a card room, including an officer or an employee of a licensed owner or holder of an

occupational license; and

(B) under an agreement to influence or with the intent to influence

(i) the actions of the person to whom the offer, promise, or gift was made in order to affect or attempt to affect the outcome of a card game; or

(ii) an official action of the department;

(2) solicits, accepts, or receives a promise of anything of value or benefit

(A) while the person is connected with a card room, including an officer or employee of a licensed owner or a holder of an occupational license; and

(B) under an agreement to influence or with the intent to influence the actions of the person to affect or attempt to affect the outcome of a card game or an official action of the department;

(3) uses, or possesses with the intent to use, a device to assist in projecting the outcome of a card game;

(4) cheats at a card game;

(5) manufactures, sells, or distributes any cards, chips, or device that is intended to be used to violate this chapter;

(6) alters or misrepresents the outcome of a card game on which wagers have been made after the outcome is made sure but before the outcome is revealed to the players;

(7) places a bet on the outcome of a card game after acquiring knowledge that is not available to all players and that concerns the outcome of the card game that is the subject of the bet;

(8) aids a person in acquiring the knowledge described in (7) of this subsection for the purpose of placing a bet contingent on the outcome of a card game;

(9) claims, collects, takes, or attempts to claim, collect, or take money or anything of value in or from a card game with the intent to defraud or without having made a wager contingent on winning a card game;

(10) claims, collects, or ta'.es an amount of money or thing of value of greater value than the amount won in a card game;

(11) uses or possesses counterfeit chips or tokens in or for use in a card game;

(12) possesses a key or device designed for opening, entering, or affecting the operation of a card game, a drop box, or an electronic or mechanical device connected with the card game or removing coins, tokens, chips, or other contents of a card game; this paragraph does not apply to a licensee or an employee of a licensee acting in the course of the employee's employment;

(13) possesses materials intended to be used in a manner that violates this chapter.

Sec. 05.18.410. Possession of cheating devices; presumption. The possession of more than one of the devices described in AS 05.18.400(b) as cheating devices creates a rebuttable presumption that the possessor intended to use the devices for cheating.

Article 5. General Provisions.

Sec. 05.18.500. State gaming fund. There is created in the general fund the state gaming fund. The state gaming fund consists of all revenue received from card room activities under this chapter and all other money credited or transferred to the fund from another fund or source.

Sec. 05.18.900. Definitions. In this chapter,

(1) "card game" means a non-banking card game listed in AS 05.18.010(b);

(2) "card operation" means the conduct of card games in a licensed card room;

(3) "card room" means a structure in which card games authorized under this chapter are conducted by an owner licensed under this chapter;

(4) "cheat" means to alter the selection of criteria that determine the result of a card game or the amount or frequency of payment in a card game;

(5) "department" means the Department of Revenue;

(6) "gross receipts" means the total amount of money exchanged for

the purchase of chips or tokens by card room patrons;

(7) "intentionally" has the meaning given in AS 11.81.900;

(8) "knowingly" has the meaning given in AS 11.81.900;

(9) "license" means a license issued by the department under this chapter;

(10) "licensed owner" means a person that owns a card room who is licensed under this chapter;

(11) "licensee" means a person holding a license issued under this chapter;

(12) "owner's license" means a license issued under this chapter that allows a person to own and operate a card room.

* **Sec. 3.** AS 11.66.280(2) is amended to read:

(2) "gambling" means that a person stakes or risks something of value upon the outcome of a contest of chance or a future contingent event not under the person's control or influence, upon an agreement or understanding that that person or someone else will receive something of value in the event of a certain outcome; "gambling" does not include

(A) bona fide business transactions valid under the law of contracts for the purchase or sale at a future date of securities or commodities and agreements to compensate for loss caused by the happening of chance, including contracts of indemnity or guaranty and life, health, or accident insurance;

(B) playing an amusement device that

(i) confers only an immediate right of replay not exchangeable for something of value other than the privilege of immediate replay; and

(ii) does not contain a method or device by which the privilege of immediate replay may be cancelled or revoked; or

(C) an activity authorized by the Department of Revenue under AS 05.15 or AS 05.18;

* **Sec. 4.** AS 44.64.030(a)(2) is amended to read:

(2) AS 05.15 and AS 05.18 (charitable gaming; card rooms);

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSHB 272 (JUD)
() Publish Date:

Revision Date/Time (Note if correction):
Title: Card Rooms & Operations
Dept. Affected: Revenue 04
RDU: Treasury and Tax
Component: Tax Division
Sponsor: Representative Kott
Requester: (H) FIN
Component No.: 2476

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	•	•	•	•	•	•
CAPITAL EXPENDITURES	•	•	•	•	•	•
CHANGE IN REVENUES ( )	•	•	•	•	•	•

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
10	•	•	•	•	•	•
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type - Do not abbreviate)						
TOTAL	•	•	•	•	•	•

Estimate of any current year (FY2005) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time	•	•	•	•	•	•
Part-time	•	•	•	•	•	•
Temporary	•	•	•	•	•	•

ANALYSIS: *(Attach a separate page if necessary)*

Revenue Discussion

This bill would legalize non-banked card rooms in Alaska, subject to voter ratification of local ordinances authorizing card rooms and with the caveat that "the total number of owner's licenses issued in a municipality may not exceed the total population of the municipality divided by 30,000." A non-banked card room is one in which players compete against each other rather than against the house and the house has no stake in the outcome of a game; Texas Hold-Em poker is an example of a game that might be played in a non-banked card room. There are two issues associated with estimating the maximum number of card rooms that would be allowed under this bill. First, it is not clear if "the most recent federal census information" refers to the Decennial Census or the most recent estimate by the U.S. Census Bureau for purposes of estimating the number of card rooms allowed. Second, the term "municipality" is not defined in the bill.

(continued on next page)

Prepared by: Larry Meyers & Brett Fried
Phone 465-2320
Division: Tax Division
Date/Time 4/29/05 8:10 AM
Approved by: Dan Dickinson, Director of Tax
Date 4/29/2005
Agency: Revenue

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. CSHB 272 (JUD)

ANALYSIS CONTINUATION

Revenue Discussion, Continued

For our reference case, we used the definition of "municipality" in AS 29.71.800 (cities and boroughs) and the April 1, 2000 U.S. Census to estimate that a maximum of 13 card rooms would be possible under this bill: 8 in Anchorage, 2 in the Fairbanks North Star Borough, 1 in Juneau, 1 in the Kenai Peninsula Borough and 1 in the Matanuska-Susitna Borough. If we were instead to use the July 1, 2004 annual estimates of population from the Census Bureau, then 15 card rooms would be possible: 9 in Anchorage, 2 in the Fairbanks North Star Borough, 1 in Juneau, 1 in the Kenai Peninsula Borough and 2 in the Matanuska-Susitna Borough. The most restrictive interpretation would be if "municipality" referred only to cities. Using this definition and the April 1, 2000 U.S. Census, a maximum of 10 card rooms would be possible: 8 in Anchorage, 1 in Fairbanks and 1 in Juneau. It is important to note that these estimates, including our reference case, assume all eligible municipalities will quickly ratify ordinances authorizing card rooms. Clearly, if a municipality such as Anchorage were not to authorize card rooms this would dramatically reduce card room operations in the state.

In addition to the voter ratification and population rules, there are three other reasons why we did not include a revenue or cost estimate on the front page of this fiscal note. First, the decision to open and operate a card room is a business decision. Second, under this bill the department is given authority to set many rules and regulations that will affect this business decision. These rules and regulations will be formulated after receiving recommendations from the five member governor-appointed advisory board created under this bill. Third, the fees imposed on card rooms in different states and localities vary widely and make comparisons to Alaska difficult. For example, the state of Montana charges a processing fee to cover the cost of determining whether to issue a license plus $250 for the first table and $500 for each additional table. Washington charges $3,650 for up to 5 tables and $1,060 per additional table up to a maximum of 15, plus any investigation costs exceeding the license fees. CSHB 272 imposes an owner's license fee of $25,000 to apply for a five year license plus an annual $10,000 per table fee. Operators are also responsible for investigation costs that exceed the portion of the $25,000 fee that is assessed for the investigation, posting of a $500,000 cash bond and biannual occupational licensing fees to be set by the department.

Based on several assumptions, we estimate that one card room in Alaska could generate about $201,000 in fees for the state in the first year. During years 2 through 5, we estimate a card room in Alaska could generate between $150,000 and $167,000 in annual fees for the state. These estimates assume that the average card room will have 15 tables (15 is the maximum allowed in Washington and in California the average is 14.3). The card room is assumed to pay its owner's license fee in the first year with no transfer of ownership over the 5-year license period. This estimate also assumes an occupational licensing system similar to Washington, where annual licenses are $175 initially and $84 for renewals (for Alaska's biannual licenses this would translate into $175+$84=$259 initially and $84+$84=$168 for renewals). We assume that Washington's average of 6.7 card room occupational licenses per table will hold in Alaska and that after the first year, all of the licenses will be renewals. We assume that, like in Washington, all gaming employees will be covered but non-gaming employees such as bartenders will not require licenses. A significant variable affecting revenues would be the actual number of tables card rooms would have. This is difficult to estimate, as in California non-banked card rooms range from a single table to 243 in the Commerce Casino in Los Angeles with the average being 14.3 tables per card room. One or more very large card rooms in Alaska could significantly boost revenues.

One provision of this bill instructs the department to set maximum wagers for card rooms; this restriction along with any maximum rake could have an effect on the revenue generated by potential card rooms. In Washington, non-banked card room wagers are capped at $25 per player per round, and rakes are capped at $10 per player per hour or $1 per player per hand or 10% of the pot up to $5. Annual gross revenue to card rooms per non-banked table in Washington is $162,000. In California, there are no maximums placed on rakes or wagers, and the annual gross revenue per non-banked table is about $409,000.

This bill stipulates that card rooms must hold at least one card tournament per quarter with gross proceeds donated to a nonprofit group. There are many variables that would help determine the total amount generated for charities, including the number of card rooms, the number of tables and rules and regulations adopted by the department. Also, "gross proceeds" is not defined in the bill so it is unclear if prizes or any expenses would be included in this calculation. In Michigan the average Texas Hold Em tournament generates $2,920 in revenue and $1,039 in profit for charities, with a $500 per person per day prize limit. Any prize limits in Alaska would be determined by the department and may influence the profitability of tournaments. In a 2005 article in the Boston Globe, card tournament supplier Mike Sheehy estimated that "A well-run tournament will attract up to 200 players, each of whom pays a $100 entrance fee [...] A tournament of that size can offer pots of $5,000 for the first-place player and a few thousand for the second and third and still generate $10,000 for the charity after expenses."

Cost Discussion

The costs of implementing this bill are difficult to estimate because we do not know the number nor size of potential card rooms. Given the assumptions in our reference discussion, we anticipate $512,000 in personnel costs and related expenditures would be necessary to investigate, license and regulate up to 15 card rooms. Also about $5,930 in RSAs to Public Safety for fingerprint background checks would be required for each card room (assuming 15 tables times 6.7 employees per table times $59 per employee). The personnel costs are for an Investigator IV, four Investigator IIIs and an Admin Clerk III. Based on the experience of other states and our own experience, this staff should be sufficient to investigate, license and regulate up to 15 card rooms with an average of 15 tables each. Also having two teams of investigators would ensure that teams could be available during all hours of card room operations (assumed to be 12:00 noon to 2:00 am). If the card rooms are larger on average than the assumed 15 tables, we would require additional staff and resources for investigation and regulation. We did not include any additional costs that would be incurred by municipalities as a result of this bill.

Sources: California Division of Gambling Control, Michigan State Charitable Gaming Division, Montana Gambling Control Division, Washington State Gambling Commission, American Gaming Association "2004 State of the States"

adopted 4/29/05

AMENDMENT

OFFERED IN THE FINANCE COMMITTEE BY: Rep. Weyhrauch

TO: CSHB 272 version F

Page 6, Line 13

after attorney, insert

", if any,"

adopted 4/29/05

AMENDMENT 2

OFFERED IN THE FINANCE COMMITTEE BY: Rep. Weyhrauch

TO:

Page 7, Line 3 - 4

delete "on the business day"

replace with

"three business days"

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April 25, 2005

Perry Green
130 W. 4th Avenue
Anchorage, Alaska 99501

Re: Effect of HB 272/SB 165 (Card Rooms) on Indian Gaming in Alaska

Dear Mr. Green:

You have asked what effect, if any, the enactment of HB 272 or SB 165 would have on Indian gaming in Alaska. More specifically, you have asked me to address two questions:

(1) Would the enactment of HB 272 or SB 165 "open the door" to allow Indian tribes in Alaska to operate casino type gaming operations – referred to in the federal Indian Gaming Regulatory Act ("IGRA") as "Class III" games?

The answer is no. As discussed below, all of the card games authorized in HB 272 and SB 165 are Class II games for purposes of IGRA. IGRA authorizes Indian tribes to operate Class III games only if state law does not prohibit them. Alaska law currently prohibits all forms of Class III gaming, and nothing in either bill would authorize Class III games. So long as Alaska law continues to prohibit Class III games, IGRA would not authorize Indian tribes to operate them within Alaska.

(2) Would the enactment of HB 272 or SB 165 "open the door" to additional Class II Indian gaming in Alaska, beyond what is already authorized under existing law?

The answer is no. As discussed below, Alaska currently allows certain organizations and entities to conduct various types of Class II gaming under AS 05.15, including bingo, pull tabs, raffles, lotteries and various lottery type "classics," such as ice classics, rain classics, and salmon classics, among others. In addition, Alaska's criminal [illegible] exempts players engaged in social gambling, including players in social card games, from the criminal prohibitions against gambling in the state. Because Alaska currently allows Class II gaming, including card games, IGRA would allow Indian tribes to operate the types of

Class II card games allowed in HB 272 and SB 165 on Indian lands in Alaska – even if neither of those bills were enacted.

I. Brief overview of the Indian Gaming Regulatory Act.

The federal Indian Gaming Regulatory Act ("IGRA"), 25 U.S.C. 2701 et seq., provides authority for Indian tribes to conduct certain gaming operations on Indian lands.[1] There are three classes of games under the Act.

Class I games include social gaming for minimal prizes and traditional Indian gaming conducted at ceremonies or celebrations. Tribes may conduct Class I games on Indian lands without oversight by the Indian Gaming.

Class II games include bingo, lotto, pull-tabs, punch boards, tip jars and non-banking card games. Non-banking card games are games in which only the players may make wagers on the outcome, in contrast to "banked" card games such as blackjack, baccarat and chemin de fer, where the player effectively plays against the house or another banker and the house or banker collects money from losers and pays winners. Indian tribes may conduct Class II games on Indian lands if the tribe adopts an ordinance authorizing the activity and receives a permit from the Indian Gaming Commission. IGRA imposes various regulatory requirements on Class II gaming and restricts the uses of revenues from Class II gaming operations.

Class III games include casino type gambling, electronic or electromechanical facsimiles of any games of chance, slot machines, pari-mutuel horse and dog racing, and all other forms of gaming that are not Class I or Class II. For states located within the federal Ninth Circuit (including Alaska), Indian tribes may conduct a Class III game only if the state permits the particular type of game that the tribe seeks to operate. *Rumsey Indian Rancheria of Wintun Indians v. Wilson*, 64 F.3d 1250 (9th Cir. 1995). Class III games, if they are allowed by the state, may be conducted only in conformity with a negotiated tribal-state compact entered into by the tribe and the state.

II. Enactment of HB 272 or SB 165 would not "open the door" to Class III Indian Gaming in Alaska.

HB 272 and SB 165 are identical bills that would authorize, under various limitations, the operation of card rooms in Alaska for the purpose of playing one or more

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[1] IGRA restricts Indian gaming to activities conducted on "Indian lands." This is a significant restriction, and is discussed briefly in Part IV of this opinion, beginning on page 4.

specified "non-banking" card games[2]. The specified games are poker, pan, rummy, bridge and cribbage. Since the only games allowed under the bills are non-banking games, they would be considered as Class II games and not Class III games.

IGRA allows Class III Indian gaming activity only if the activity is "located in a State that permits such gaming for any purpose by any person, organization, or entity." Alaska currently does not permit any type of Class III gaming activity, and nothing in either HB 272 or SB 165 would constitute such permission. Kathryn L. Kurtz, Legislative Counsel, recently provided an opinion to Representative Pete Kott in which she concluded that HB 272 would authorize only Class II games and would therefore not provide a basis for any Class III Indian gaming in Alaska. (Memorandum from Kathryn L. Kurtz to Representative Pete Kott, April 21, 2005.) I agree with her analysis, and rather than repeat it here, I have attached a copy of her opinion to this letter.

III. Authority of Indian Tribes to Conduct Class II Card Games under Existing Alaska Law.

IGRA, in 25 U.S.C. 2710(b)(A), allows an Indian tribe to engage in Class II gaming on Indian lands within the tribe's jurisdiction if

> such Indian gaming is located within a State that permits such gaming for any purpose by any person, organization or entity (and such gaming is not otherwise specifically prohibited on Indian lands by Federal law).

AS 05.15 currently allows charitable organizations and municipalities to conduct certain games that would be included within IGRA's definition of Class II games – specifically, bingo, pull tabs, raffles, lotteries and various lottery type "classics" such as the Nenana Ice Classic. Additionally, Alaska's criminal code exempts from prosecution for gambling offenses "a player in a social game." AS 11.66.200. "Social game" is defined in AS 11.66.280(9) as "gambling in a home where no house player, house bank, or house odds exist and where there is no house income from the operation of the game."

There are two alternative bases for concluding that IGRA would permit Indian tribes to operate the types of card games authorized under HB 272 and SB 165, even if neither bill were enacted. The first is that under the authorizing language quoted above, Alaska allows "such gaming" – that is, Class II gaming – of several types. It does not matter that Class II gaming activity is limited to charitable organizations and municipalities. Alaska need only authorize these games for "any purpose by any person,

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[2] Both bills, at page 2, line 1, make it clear that the specified card games are "non-banking." The Senate Labor & Commerce Committee Substitute for SB 165 contains additional language to further emphasize that only "non-banking" games are allowed. The committee substitute, at page 2, lines 18 and 19, provides that wagers may be made only by a player with respect to his or her own game and that players may not make a wager on behalf of another individual.

organization or entity." As noted above, the Ninth Circuit Court of Appeals has ruled that for a Class III game, IGRA authorizes it only if state law permits the same type of game that the tribe seeks to operate. The Court has indicated however, that for Class II games, a less stringent standard will be applied, and a tribe may operate a Class II game if the state permits any person, organization, or entity to operate any Class II game. *See, Rumsey Indian Rancheria of Wintun Indians v. Wilson*, 64 F.3d at 1258 n. 4. Under this analysis, IGRA would authorize Indian tribes to operate Class II card games solely by virtue of current law authorizing charitable organizations and municipalities to operate certain Class II games.

Alternatively, it may be argued that the *Rumsey* analysis should not be applied so broadly where Class II card games are at issue. That is because IGRA makes a distinction in its definition of Class II games between bingo, pull tabs and other bingo-like games on the one hand, and card games on the other. Specifically, IGRA defines Class II card games as games that "are explicitly authorized by the laws of the State" OR that "are not explicitly prohibited by the laws of the State and are played at any location in the State, but only if such card games are played in conformity with those laws and regulations (if any) of the State regarding hours or periods of operation of such card games or limitations on wagers or pot sizes in such card games." 25 U.S.C. 2703(7)(A)(ii)(I) and (II). Current Alaska law meets that definition.

While current Alaska law does not "explicitly" authorize non-banking card games, it clearly does not "explicitly" prohibit them, because of the exemption in AS 11.66.200(b) from prosecution for players in social games. Moreover, since non-banking gambling is allowed in Alaska by players in homes, existing law allows for gambling on card games "at any location in the State."

Thus, Indian tribes are authorized under IGRA to operate non-banking card games under Alaska law as it exists today. Enactment of either HB 272 or SB 165 would not be required as a prerequisite to that authorization.

IV. Territorial Restrictions on Indian Gaming in Alaska.

Even though IGRA would authorize Indian tribes to conduct Class II card games in Alaska under existing state laws, there are additional restrictions in IGRA that may serve to minimize the proliferation of such gaming in Alaska. Indian tribes may conduct Class II and Class III gaming operations only on "Indian lands." Indian lands are defined in IGRA, 25 U.S.C. 2703(4), as:

> (A) all lands within the limits of any Indian reservation; and
>
> (B) any lands title to which is either held in trust by the United States for the benefit of any Indian tribe or individual or held by any Indian tribe or individual subject to restriction by the

United States against alienation and over which an Indian tribe exercises governmental power.

In Alaska, the only lands within an Indian reservation are those within the Metlakatla reservation. The Alaska Native Claims Settlement Act revoked all other reserves set aside for Native use and lands conveyed to regional and village Native corporations are held in fee simple by each corporation. Native corporation lands, then, do not fall within the definition of "Indian lands" because they are not within an Indian reservation, they are not held in trust by the United States, and they are not subject to any restrictions on alienation or sale.

Another category of lands that arguably might constitute "Indian lands" are various Alaska village town sites. While these lands were at one time held in trust, they have since been re-conveyed to the villages in fee simple and are now free of any prior restrictions on the sale of these lands. As a result, village town sites would not qualify as "Indian lands" for purposes of IGRA.

The last category of lands that may constitute "Indian lands" under IGRA are individual Native allotments. There are a number of parcels of land in this category scattered all over the state, and most, if not all, are held by individual Natives and are subject to federal restrictions against alienation. Thus, Native allotments would likely meet two of the three requirements needed to qualify as "Indian lands." What is less clear is whether Native allotments would meet the third requirement that the Tribe must "exercise governmental power" over the lands. This is a complex issue, however, and the result would depend on the facts surrounding the particular parcel in question and the extent to which a recognized tribe actually exercises any governmental powers within the boundaries of that particular parcel.

Please let me know if you have additional questions.

Very truly yours,

Susan A. Burke

Susan A. Burke

SAB:ps

Enclosure

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Juneau, Alaska 99801-1182
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MEMORANDUM April 21, 2005

SUBJECT: Card Rooms and Indian Gaming (HB 272)

TO: Representative Pete Kott

FROM: Kathryn L. Kurtz KK
Legislative Counsel

You asked whether this bill would affect Indian gaming in Alaska. I do not think this bill will open the door to class three gaming.

The federal Indian Gaming Regulatory Act (IGRA), 25 U.S.C. § 2701 et seq., gives Indian tribes the authority to conduct gaming and gambling on Indian lands. The Indian Gaming Regulatory Act divides gaming into three classes:

> (1) Class I gaming includes social gaming for minimal prizes and traditional Indian gaming conducted at ceremonies or celebrations;
> (2) Class II gaming includes bingo, lotto, pull-tabs, punch boards, tip jars and non banking card games, as well as banking card games operated on or before May 1, 1988;[1] and
> (3) Class III gaming includes casino-type gambling, pari-mutual horse and dog racing, lotteries, and all other forms of gaming that are not class I or II gaming.

Class I gaming on Indian lands is within the exclusive jurisdiction of the tribes and is excluded from the provisions of the IGRA. Class II gaming on Indian lands is within the jurisdiction of the tribes but is subject to the provisions of the IGRA, including oversight by the National Indian Gaming Commission. For example, an Indian tribe seeking to conduct bingo games could choose to do so under the authority of state law or could do

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[1] Class II gaming does not include:

> (i) any banking card games, including baccarat, chemin de fer, or blackjack (21), or
> (ii) electronic or electromechanical facsimiles of any game of chance or slot machines of any kind.

25 U.S.C. § 2703(b).

so separately under a permit from the National Indian Gaming Commission. Class III gaming activities are lawful on Indian lands only if authorized by a tribal ordinance or resolution, the activities are conducted on lands located in a state that permits such gaming for any purpose by any person, organization, or entity, and the activities are conducted in conformance with a tribal-state compact entered into by the tribe and state.

The Act provides a framework for negotiation of a tribal-state compact -- the tribe requests the state to enter into negotiations; upon receiving such a request, the state "shall" negotiate with the tribe in "good faith" to enter into such a compact.

There has been a good deal of litigation involving the various provisions of the IGRA since its passage. Some of that has involved the definition of "Indian lands." Although Alaska has only one remaining reservation, it is not safe to assume that there are no other "Indian lands" in Alaska. There certainly are parcels that are held in trust by the United States that might qualify for purposes of IGRA.

This underscores the significance of the difference between class II and class III gaming. If the legislature permitted class III gaming in state law, it would pave the way for tribes to conduct class III gaming on Indian lands under federal law. However, HB 272 permits only non-banking card games, specifically poker, pan, rummy, bridge, and cribbage games. Poker falls under IGRA's definition of class II games. 25 C.F.R. 502.3; National Indian Gaming Commission Opinion dated June 17, 1999, Re: Game Classification Opinion - "Poker Club."[2] House banked card games, such as blackjack and baccarat, as well as player banked games, such as chemin de fer, are class III games, 25 C.F.R. 502.4; National Indian Gaming Commission Bulletin No. 95-1, April 10, 1995, but those types of games are not permitted in card rooms under HB 272.

KLK:med
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[2] According to this National Indian Gaming Commission opinion, "Banking games, as commonly understood and defined in the NIGC regulations, are games in which the banker (usually the house) takes on, that is, competes against, all players, collecting from losers and paying winners. *See* 25 C.F.R. 502.11(c). Conversely, non-banking card games are games where players play against each other. Poker is the typical example of a non-banking card game." The opinion went on to conclude that the proposed poker club would constitute class II, rather than class III gaming: "[A]s proposed, the players in the Nation's Club would play against each other in a non-banking format, not against the house or other banker. Turning Stone and its dealers would not have an interest, financial or otherwise, in the outcome of any poker game. Thus, the poker games to be played at the Club qualify as non-banking card games."

ALASKA STATE LEGISLATURE

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REPRESENTATIVE PETE KOTT

DISTRICT 17 – EAGLE RIVER

Sponsor Statement
for
House Bill 272
An Act relating to card rooms and card room operations

The growing popularity of poker is obvious to who have recently surf TV channels. Many networks, from ESPN to the Travel Channel, are regularly televising Texas Hold 'em tournaments and enjoying sky rocketing ratings and subsequent advertising revenues. Men and woman, old and young are joining the poker trend, which shows no signs of slowing. Due to this growth in interest, the intent of HB 272 is to allow social card games to be played in a tightly controlled public environment. Alaska can address the trend and bring this popular pastime into compliance with the safety and revenue laws of the state.

Under HB 272 card rooms would be limited to boroughs with a population of 30,000 or more and only one card room establishment per 30,000 people. These card rooms would be limited to players 21 years of age or older, and they would only offer non-banked card games such as poker, cribbage, rummy, etc.

In addition to the taxable revenue generated by the card rooms, food and drink purchases, and table charges, the establishments would also pay $10,000 per table annually to the state and would be required to hold quarterly tournaments to benefit a non-profit educational institution or group. As part of the licensing procedure, the card room operators would also be responsible for covering the administrative cost of licensing and subsequent enforcement through a $25,000 application fee.

In addition to the revenue and job creation, regulated card rooms would allow for players to enjoy their hobby in a safe regulated environment rather than playing in an unsavory, and often unsafe "back room." Currently many players, in addition to their friendly home game, play in underground games where the "house" takes in large profits with little assurance of "fair" play. Although not an everyday occurrence, players at these games have in the past been held up at gunpoint with little recourse because of the shady and illegal nature of the game.

By recognizing this trend and the fact that we already allow this type gaming in our homes, Alaska can address the issue head on and make card games a legitimate, safe, social activity that will increase revenue and job opportunities while minimizing the negative effects of underground gambling.

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 272
(H) Publish Date: 4/22/05

Revision Date/Time (Note if correction):
Dept. Affected: Revenue 04
Title: Card Rooms & Operations
RDU: Treasury and Tax
Component: Tax Division
Sponsor: Representative Kott
Requester: (H) L&C
Component No. 2476

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	•	•	•	•	•	•
CAPITAL EXPENDITURES	•	•	•	•	•	•
CHANGE IN REVENUES ( )	•	•	•	•	•	•

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	•	•	•	•	•	•
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type- Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
(see attached)

Prepared by: Larry Meyers & Brett Fried
Phone 465-2320
Division: Tax Division
Date/Time 4/1/2005
Approved by: Jerry Burnett, Special Assistant to the Commissioner
Date
Agency: Department of Revenue

(Revised 9/23/2004 OMB)

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. HB 272

ANALYSIS CONTINUATION

Revenue Discussion

This bill would legalize non-banked card rooms in Alaska, with the caveat that "the total number of owner's licenses issued in a municipality may not exceed the total population of the municipality divided by 30,000". A non-banked card room is one in which players compete against each other rather than against the house and the house has no stake in the outcome of a game. Texas Hold-Em poker is an example of a game that might be played in a non-banked card room. It is not clear if "the most recent federal census information" refers to the Decennial Census or the most recent estimate by the U.S. Bureau of Census for purposes of determining the number of card rooms allowed. We used the April 1, 2000 U.S. Census to determine that a maximum of 13 card rooms would be possible under this bill: 8 in Anchorage, 2 in the Fairbanks North Star Borough, 1 in Juneau, 1 in the Kenai Peninsula Borough and 1 in the Matanuska-Susitna Borough. If we were instead to use the July 1, 2004 annual estimates of population from the Census Bureau, then 15 card rooms would be possible: 9 in Anchorage, 2 in the Fairbanks North Star Borough, 1 in Juneau, 1 in the Kenai Peninsula Borough and 2 in the Matanuska-Susitna Borough. We assume the definition of "municipality" in AS 29.71.800, which includes first-class and home-rule cities and boroughs.

There are three reasons why we did not include a revenue or cost estimate on the front page of this fiscal note. First, the decision to open and operate a card room is a business decision that will be made by potential licensees. Second, under this bill the department is given authority to set many rules and regulations that will affect this business decision. Third, the fees imposed on card rooms in different states and localities vary widely and make comparisons to Alaska difficult. For example, the state of Montana charges a processing fee to cover the cost of determining whether to issue a license plus $250 for the first table and $500 for each additional table. Washington charges $3,650 for up to 5 tables and $1,060 per additional table up to a maximum of 15, plus any investigation costs exceeding the license fees. SB 165 imposes an owner's license fee of $25,000 to apply for a five-year license plus an annual $10,000 per table fee. Operators are also responsible for investigation costs that exceed the portion of the $25,000 fee that is assessed for the investigation, and the department is authorized to set occupational licensing fees.

Based on several assumptions, we estimate that the maximum of 13 card rooms in Alaska would generate about $2.5 million in fees for the state in the first year. During years 2-5, we estimate the maximum of 13 card rooms in Alaska would generate $2.1 million in annual fees for the state. These estimates assume that there will be the maximum of 13 card rooms with an average of 15 tables each (15 is the maximum allowed in Washington and in California the average is 14.3). All card rooms are assumed to pay their owner's license fees in the first year and would not transfer ownership over the 5 year license period. These estimates also assume an occupational licensing system similar to Washington, where annual licenses are $175 initially and $84 for renewals. We assume that Washington's average of 6.7 gaming employees per table will hold in Alaska and that after the first year, two-thirds of the licenses will be renewals. We assume that, like in Washington, all gaming employees will be covered but non gaming employees such as bartenders will not require licenses. Of course, a significant variable affecting revenues is the actual number of tables any individual card room would have. This is difficult to estimate, as in California non-banked card rooms range from a single table to 243 in the Commerce Casino in Los Angeles with the average being 14.3 tables per card room. One or more very large card rooms in Alaska could significantly boost revenues. California and Washington are useful comparisons because both states have data available specifically for non-banked card rooms.

This bill stipulates that card rooms must hold at least one card tournament per quarter with proceeds donated to a nonprofit group. There are many variables that would help determine tournament proceeds, including the number of card rooms, the number of tables, rules and regulations adopted by the department, and other factors. In Michigan the average Texas Hold-Em tournament generates $1,099 in profit for charities, with a $500 per person per day prize limit. Any prize limits in Alaska would be determined by the department and may influence the profitability of tournaments. In an article in the Boston Globe, card tournament supplier Mike Sheehy estimated that "A well-run tournament will attract up to 200 players, each of whom pays a $100 entrance fee [...] A tournament of that size can offer pots of $5,000 for the first-place player and a few thousand for the second and third and still generate $10,000 for the charity after expenses."

Cost Discussion

The costs of implementing this bill are difficult to estimate because we do not know the number nor size of potential card rooms. Given the assumptions in our revenue discussion, we would anticipate $448,600 in total costs with $371,600 in personnel costs and related expenditures and $77,000 in RSAs to Public Safety for fingerprint background checks. The personnel costs are for an Investigator IV, four Investigator III's and an Admin Clerk III. Based on the experience of other states and our own experience, this staff should be sufficient to investigate, license and regulate up to 13 card rooms with an average of 15 tables each. Also having two teams of investigators would ensure that teams could be available during all hours of card room operations (assumed to be 12:00 noon to 2:00 am). If the card rooms are larger on average than the assumed 15 tables we would require additional staff and resources for investigation and regulation. We did not include any additional costs that would be incurred by municipalities as a result of this Bill.

HB 272 - "An Act relating to card rooms and card operations."

Possible gross sales & employee information for card room operations

$4 Rake							
Tables	5	10	15	25	50	100	150
$90/hr avg	$450.00	$900.00	$1,350.00	$2,250.00	$4,500.00	$9,000.00	$13,500.00
9hrs/day avg table use	$4,050.00	$8,100.00	$12,150.00	$20,250.00	$40,500.00	$81,000.00	$121,500.00
Yearly Sales*	$1,478,250.00	$2,956,500.00	$4,434,750.00	$7,391,250.00	$14,782,500.00	$29,565,000.00	$44,347,500.00

*exclusive of non-card game operations

Avg # Employees Per Table	4.5	4.5	4.5	4.5	4.5	4.5	4.5
Total Number of Employees	22.5	45	67.5	112.5	225	450	675

Types of Employees

Dealer (Mimum Wage +Tips)	$250-300/day *
Cashiers (part-time)	$10/hr *
Janitorial/Maintenance	$8/hr *
Security	$10/hr *
Brushperson	$10/hr *
Shift Manager	$45,000/yr *
Card Room Manager	$65,000/yr *
	*Plus Benefits