ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4552 HHES HB 306 - HB 332

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MS workdraft
Hudson* 1/+2

Original sponsors: Gruenberg, Grussendorf, Koponen, et al.

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 306 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to anatomical gifts."

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

* Section 1. AS 13.50.010(a) is amended to read:

(a) A person of sound mind who is 18 [19] or more years of age may make a gift to take effect upon death, of all or a part of the person's body for a purpose specified in AS 13.50.020.

* Sec. 2. AS 13.50 is amended by adding new sections to read:

Sec. 13.50.014. REQUESTS BY HOSPITALS FOR ANATOMICAL GIFTS. (a) When a person dies in a hospital or is pronounced dead after arriving at a hospital, the administrator or a designated employee shall request a gift under AS 13.50.010(b), unless the administrator or employee knows that the person has executed a gift.

(b) Each hospital in the state shall develop procedures for identifying potential donors of gifts, requesting gifts, notifying and coordinating with eye banks, tissue banks, and organ procurement agencies, and assisting in the procurement, removal, storage, and transportation of gifts. The procedures must specify the circumstances under which it is inappropriate to request a gift, such as if the gift is unsuitable, if the request is likely to offend the donor's religious beliefs, or if making the request is likely to cause undue emotional distress to the person who would be asked to make the gift. The procedures must encourage reasonable discretion and sensitivity.

(c) The commissioner of health and social services may exempt from the requirements of this section a hospital that lacks the means

to properly remove, store, or transport gifts.

Sec. 13.50.016. INVESTIGATIONS BY LAW ENFORCEMENT AND MEDICAL PERSONNEL. Law enforcement or medical personnel who respond to the scene of an accident or emergency involving the death of a person and who know that the person executed a gift shall inform appropriate hospital personnel of the gift.

* Sec. 3. AS 13.50.060(a) is amended to read:

(a) The donee may accept or reject the gift. If the donee accepts a gift of the entire body, the donee may, subject to the terms of the gift, authorize embalming and the use of the body in funeral services. If the gift is of a part of the body, the donee, upon the death of the donor and before embalming shall have the part removed without unnecessary mutilation. After removal of the part of the body, custody of the remainder of the body vests in the surviving spouse, next of kin, or a person other than the spouse or next of kin who is authorized to dispose of the body. A person described in AS 13.50.010(b) and the estate of the donor may not be held liable for the cost of an examination under AS 13.50.010(e) or any costs related to the removal, storage, or transportation of a gift.

* Sec. 4. AS 13.50.060(c) is amended to read:

(c) A person who acts in good faith in accordance with the terms of this chapter or the anatomical gift laws of another state or country is not liable for damages for the act in a [ANY] civil action or subject to prosecution in a [ANY] criminal proceeding for the act.

* Sec. 5. AS 13.50 is amended by adding a new section to read:

Sec. 13.50.065. REGULATIONS. The commissioner of health and social services shall adopt regulations for the appropriate training of hospital employees who are designated under AS 13.50.014 to request gifts and for the implementation of this chapter.

* Sec. 6. AS 13.50.070 is amended by adding a new paragraph to read:

(8) "gift" means an anatomical gift of all or part of a person's body.

* Sec. 7. AS 18.65 is amended by adding a new section to read:

Sec. 18.65.311. ANATOMICAL GIFT DOCUMENT. (a) The department shall provide, at the time that an identification card is issued, a form for a document by which the card holder may make an anatomical gift under AS 13.50 (Uniform Anatomical Gifts Act). The document (1) may not be larger than an identification card, (2) must contain sufficient space for the signature of two witnesses to the donor's act of execution of the document, and (3) must provide a means by which the donor may cancel the gift. If the document making an anatomical gift is executed by the applicant, it shall be sealed in plastic and attached to the identification card. A symbol indicating the existence of the anatomical gift document must be displayed in the lower right-hand corner on the face of the identification card.

(b) An employee of the department who processes an identification card application, other than an application received by mail, shall ask the applicant orally whether the applicant wishes to execute an anatomical gift. The department shall, by placement of posters and brochures in the office where the application is taken, and by oral advice, if requested, make known to the applicant the procedure necessary to execute a gift under AS 13.50.

* Sec. 8. AS 28.10.021 is amended by adding a new subsection to read:

Hudson #2

(c) An employee of the department who processes an application for registration or renewal of registration, other than an application received by mail, shall ask the applicant orally whether the applicant wishes to execute an anatomical gift. The department shall make known to all applicants the procedure for executing a gift under AS 13.50

(Uniform Anatomical Gifts Act) by displaying posters in the offices in which applications are taken, by providing a brochure or other written information to each person who applies in person or by mail, and, if requested, by providing oral advice.

* Sec. 9. AS 28.15.061(d) is repealed and reenacted to read:

(d) An employee of the department who processes a driver's license application, other than an application received by mail, shall ask the applicant orally whether the applicant wishes to execute an anatomical gift. The department shall make known to all applicants the procedure for executing a gift under AS 13.50 (Uniform Anatomical Gifts Act) by displaying posters in the offices in which applications are taken, by providing a brochure or other written information to each person who applies in person or by mail, and, if requested, by providing oral advice.

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11/9/87

Original sponsors: Gruenberg, Grussendorf, Koponen, et al.

Ellis

IN THE HOUSE BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

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* Sec. 8. AS 28.15.061(d) is amended to read:

(d) An employee of the department who processes a driver's license application, other than an application received by mail, shall ask the applicant orally whether the applicant wishes to execute an anatomical gift. The department shall, by placement of posters and brochures in the office where the application is taken, and by oral

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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advice, if requested, make known to the applicant the procedure necessary to execute [COMPLETE] a [DOCUMENT OF] gift under AS 13.50 [THE] (Uniform Anatomical Gifts Act) [(AS 13.50)].

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

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May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

HHESS	10-23-87	
HHESS	1-21-88	8:30a.m.

POSITION PAPER

HOUSE BILL 306

"An Act relating to anatomical gifts."

Advances in medical knowledge and technology have greatly increased the feasibility of and demand for transplantation of human tissues and organs. For a number of reasons, demand exceeds supply. HB 306 attempts to facilitate organ and tissue donation by: (1) lowering from 19 years to 18 years the age of persons who may execute gifts of tissues or organs; (2) requiring hospitals to establish procedures for requesting donations from survivors; (3) requiring responders at the scene of an accident to inform the hospital receiving the body of a person killed in the accident if it is known to the responders that the person has executed a donation; (4) clarifying that survivors cannot be held liable for costs associated with an anatomical gift; and (5) requiring employees of the Division of Motor Vehicles to inquire when processing an application for a driver's license whether the applicant wishes to execute an anatomical gift.

It is the department's understanding that legislation similar to HB 306 has been enacted or is under consideration in about half the states. The department also understands that there is similar federal legislation requiring hospital participation in the seeking of organ donations as a condition of participation in the federal Medicare program.

There are strict requirements for assuring the viability of certain types of organs. Therefore, because of distance and lack of fully equipped facilities in certain areas of the state, Alaska may not be able to participate as fully in organ donation as might be hoped. Nevertheless, a more systematic approach to securing organ donation is worthwhile. The success of the effort could probably be enhanced if there were an expanded effort by private or state agencies to educate the public about tissue and organ donation.

Position

The Department of Health and Social Services supports this legislation.

Recommended by: Elizabeth Ward

Elizabeth Ward, M.N.
Director
Division of Public Health

Date: 10/20/87

Approved by: Myra M. Munson

Myra M. Munson, Commissioner
Department of Health and Social Services

Date: 10/20/87

on the issue of one Germany. When West German President Richard von Weizacker's said that, "The Germans in the two German states belong to the same nation," the East German leader replied, "It is dangerous and senseless to mourn the German Reich that perished so shamefully."

Organ Transplants — Proper Priority

AS MEDICAL TECHNIQUES necessary for successful transplantation of human organs improve, particularly in the field of suppressing the immune system's normal (but potentially-fatal) rejection reaction, the need for healthy, available body parts increases. The list of potential recipients grows.

Fairness dictates there should be some orderly method of making such life-giving donations available on a reasonable and balanced basis.

It is the nature of the world we live in that the poignant case attracting national sympathy becomes the one most likely to receive succor. The public will be pulling for the patient it can identify with. That builds pressure to help. But such factors should not dominate what is essentially a straightforward, scientific action.

SO IT IS ENCOURAGING to learn that a little-noticed, new federal law will require hospitals to start identifying patients who could donate their kidneys, livers, hearts or lungs to people in need of them. Many hospitals that do not ask for organ donations will now have to do so.

The new requirements grow out of legislation sponsored by Senator Albert Gore Jr., D-Tenn., and carry out recommendations of a federal advisory group that favored "a single national system for organ sharing" with uniform policies and standards to assure "equitable access to organ transplantation."

Members of that panel had quite properly emphasized that organs should be distributed according to objective criteria, rather than on the basis of who could generate the most publicity or high-level political interest in a particular case.

A FEW NUMBERS can serve to give weight to the need for such a law. A total of 8,960 kidney transplants were preformed last year, compared to 5,358 in 1982.

Yet there are nearly 10,000 people waiting for new kidneys. Some 450 people are waiting for hearts; 300 for livers, and 91 people need heart-lung transplants.

This is a situation that needs to be handled with sensitivity and discretion. But the law represents a humanitarian response to a growing need. And should be recognized as such.

Public Law 98-507
98th Congress

An Act

To provide for the establishment of the Task Force on Organ Transplantation and the Organ Procurement and Transplantation Network, to authorize financial assistance for organ procurement organizations, and for other purposes.

Oct. 19, 1984
[S. 2048]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "National Organ Transplant Act".

National Organ Transplant Act.
42 USC 201 note.
Health.

TITLE I—TASK FORCE ON ORGAN PROCUREMENT AND TRANSPLANTATION

ESTABLISHMENT AND DUTIES OF TASK FORCE

SEC. 101. (a) Not later than ninety days after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this title referred to as the "Secretary") shall establish a Task Force on Organ Transplantation (hereinafter in this title referred to as the "Task Force").

42 USC 273 note.

(b)(1) The Task Force shall—

(A) conduct comprehensive examinations of the medical, legal, ethical, economic, and social issues presented by human organ procurement and transplantation,

(B) prepare the assessment described in paragraph (2) and the report described in paragraph (3), and

(C) advise the Secretary with respect to the development of regulations for grants under section 371 of the Public Health Service Act.

Post, p. 2342.

(2) The Task Force shall make an assessment of immunosuppressive medications used to prevent organ rejection in transplant patients, including—

(A) an analysis of the safety, effectiveness, and costs (including cost-savings from improved success rates of transplantation) of different modalities of treatment;

(B) an analysis of the extent of insurance reimbursement for long-term immunosuppressive drug therapy for organ transplant patients by private insurers and the public sector;

(C) an identification of problems that patients encounter in obtaining immunosuppressive medications; and

(D) an analysis of the comparative advantages of grants, coverage under existing Federal programs, or other means to assure that individuals who need such medications can obtain them.

(3) The Task Force shall prepare a report which shall include—

Report.

(A) an assessment of public and private efforts to procure human organs for transplantation and an identification of factors that diminish the number of organs available for transplantation;

(B) an assessment of problems in coordinating the procurement of viable human organs including skin and bone;

(C) recommendations for the education and training of health professionals, including physicians, nurses, and hospital and emergency care personnel, with respect to organ procurement;

(D) recommendations for the education of the general public, the clergy, law enforcement officers, members of local fire departments, and other agencies and individuals that may be instrumental in effecting organ procurement;

(E) recommendations for assuring equitable access by patients to organ transplantation and for assuring the equitable allocation of donated organs among transplant centers and among patients medically qualified for an organ transplant;

(F) an identification of barriers to the donation of organs to patients (with special emphasis upon pediatric patients), including an assessment of—

(i) barriers to the improved identification of organ donors and their families and organ recipients;

(ii) the number of potential organ donors and their geographical distribution;

(iii) current health care services provided for patients who need organ transplantation and organ procurement procedures, systems, and programs which affect such patients;

(iv) cultural factors affecting the family with respect to the donation of the organs; and

(v) ethical and economic issues relating to organ transplantation needed by chronically ill patients;

(G) recommendations for the conduct and coordination of continuing research concerning all aspects of the transplantation of organs;

(H) an analysis of the factors involved in insurance reimbursement for transplant procedures by private insurers and the public sector;

(I) an analysis of the manner in which organ transplantation technology is diffused among and adopted by qualified medical centers, including a specification of the number and geographical distribution of qualified medical centers using such technology and an assessment of whether the number of centers using such technology is sufficient or excessive and of whether the public has sufficient access to medical procedures using such technology; and

(J) an assessment of the feasibility of establishing, and of the likely effectiveness of, a national registry of human organ donors.

MEMBERSHIP

42 USC 273 note.

SEC. 102. (a) The Task Force shall be composed of twenty-five members as follows:

(1) Twenty-one members shall be appointed by the Secretary of which:

(A) nine members shall be physicians or scientists who are eminent in the various medical and scientific specialties related to human organ transplantation;

(B) three members shall be individuals who are not physicians and who represent the field of human organ procurement;

(C) four members shall be individuals who are not physicians and who as a group have expertise in the fields of law,

theology, ethics, health care financing, and the social and behavioral sciences;

(D) three members shall be individuals who are not physicians or scientists and who are members of the general public; and

(E) two members shall be individuals who represent private health insurers or self-insurers.

(2) The Surgeon General of the United States, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, and the Administrator of the Health Care Financing Administration shall be ex officio members.

(b) No individual who is a full-time officer or employee of the United States may be appointed under subsection (a)(1) to the Task Force. A vacancy in the Task Force shall be filled in the manner in which the original appointment was made. A vacancy in the Task Force shall not affect its powers.

(c) Members shall be appointed for the life of the Task Force.

(d) The Task Force shall select a Chairman from among its members who are appointed under subsection (a)(1).

(e) Thirteen members of the Task Force shall constitute a quorum, but a lesser number may hold hearings.

(f) The Task Force shall hold its first meeting on a date specified by the Secretary which is not later than thirty days after the date on which the Secretary establishes the Task Force under section 101. Thereafter, the Task Force shall meet at the call of the Chairman or a majority of its members, but shall meet at least three times during the life of the Task Force.

(g)(1) Each member of the Task Force who is not an officer or employee of the United States shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including traveltime) during which such member is engaged in the actual performance of duties as a member of the Task Force. Each member of the Task Force who is an officer or employee of the United States shall receive no additional compensation.

(2) While away from their homes or regular places of business in the performance of duties for the Task Force, all members of the Task Force shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under sections 5702 and 5703 of title 5, United States Code.

SUPPORT FOR THE TASK FORCE

SEC. 103. (a) Upon request of the Task Force, the head of any Federal agency is authorized to detail, on a reimbursable basis, any of the personnel of such agency to the Task Force to assist the Task Force in carrying out its duties under this Act. 42 USC 273 note.

(b) The Secretary shall provide the Task Force with such administrative and support services as the Task Force may require to carry out its duties.

REPORT

SEC. 104. (a) The Task Force may transmit to the Secretary, the Committee on Labor and Human Resources of the Senate, and the 42 USC 273 note.

Committee on Energy and Commerce of the House of Representatives such interim reports as the Task Force considers appropriate

Report.

(b) Not later than 7 months after the date on which the Task Force is established by the Secretary under section 101, the Task Force shall transmit a report to the Secretary, the Committee on Labor and Human Resources of the Senate, and the Committee on Energy and Commerce of the House of Representatives on its assessment under section 101(b)(2) of immunosuppressive medications used to prevent organ rejection.

Report.

(c) Not later than twelve months after the date on which the Task Force is established by the Secretary under section 101, the Task Force shall transmit a final report to the Secretary, the Committee on Labor and Human Resources of the Senate, and the Committee on Energy and Commerce of the House of Representatives. The final report of the Task Force shall include—

(1) a description of any findings and conclusions of the Task Force made pursuant to any examination conducted under section 101(b)(1)(A),

(2) the matters specified in section 101(b)(3), and

(3) such recommendations as the Task Force considers appropriate.

TERMINATION

42 USC 273 note.

SEC. 105. The Task Force shall terminate three months after the date on which the Task Force transmits the report required by section 104(c).

TITLE II—ORGAN PROCUREMENT ACTIVITIES

SEC. 201. Part H of title III of the Public Health Service Act is amended to read as follows:

"PART H—ORGAN TRANSPLANTS

"ASSISTANCE FOR ORGAN PROCUREMENT ORGANIZATIONS

Grants.
42 USC 273.

"SEC. 371. (a)(1) The Secretary may make grants for the planning of qualified organ procurement organizations described in subsection (b).

"(2) The Secretary may make grants for the establishment, initial operation, and expansion of qualified organ procurement organizations described in subsection (b).

"(3) In making grants under paragraphs (1) and (2), the Secretary shall—

"(A) take into consideration any recommendations made by the Task Force on Organ Transplantation established under section 101 of the National Organ Transplant Act, and

Ante. p. 2339.

"(B) give special consideration to applications which cover geographical areas which are not adequately served by organ procurement organizations.

"(b)(1) A qualified organ procurement organization for which grants may be made under subsection (a) is an organization which, as determined by the Secretary, will carry out the functions described in paragraph (2) and—

"(A) is a nonprofit entity,

"(B) has accounting and other fiscal procedures (as specified by the Secretary) necessary to assure the fiscal stability of the organization,

"(C) has an agreement with the Secretary to be reimbursed under title XVIII of the Social Security Act for the procurement of kidneys, 42 USC 1395.

"(D) has procedures to obtain payment for non-renal organs provided to transplant centers,

"(E) has a defined service area which is a geographical area of sufficient size which (unless the service area comprises an entire State) will include at least fifty potential organ donors each year and which either includes an entire standard metropolitan statistical area (as specified by the Office of Management and Budget) or does not include any part of such an area,

"(F) has a director and such other staff, including the organ donation coordinators and organ procurement specialists necessary to effectively obtain organs from donors in its service area, and

"(G) has a board of directors or an advisory board which—

"(i) is composed of—

"(I) members who represent hospital administrators, intensive care or emergency room personnel, tissue banks, and voluntary health associations in its service area,

"(II) members who represent the public residing in such area,

"(III) a physician with knowledge, experience, or skill in the field of histocompatability,

"(IV) a physician with knowledge or skill in the field of neurology, and

"(V) from each transplant center in its service area which has arrangements described in paragraph (2)(G) with the organization, a member who is a surgeon who has practicing privileges in such center and who performs organ transplant surgery,

"(ii) has the authority to recommend policies for the procurement of organs and the other functions described in paragraph (2), and

"(iii) has no authority over any other activity of the organization.

"(2) An organ procurement organization shall—

"(A) have effective agreements, to identify potential organ donors, with a substantial majority of the hospitals and other health care entities in its service area which have facilities for organ donations,

"(B) conduct and participate in systematic efforts, including professional education, to acquire all useable organs from potential donors,

"(C) arrange for the acquisition and preservation of donated organs and provide quality standards for the acquisition of organs which are consistent with the standards adopted by the Organ Procurement and Transplantation Network under section 372(b)(2)(D),

"(D) arrange for the appropriate tissue typing of donated organs,

"(E) have a system to allocate donated organs among transplant centers and patients according to established medical criteria,

"(F) provide or arrange for the transportation of donated organs to transplant centers,

"(G) have arrangements to coordinate its activities with transplant centers in its service area,

"(H) participate in the Organ Procurement Transplantation Network established under section 372,

"(I) have arrangements to cooperate with tissue banks for the retrieval, processing, preservation, storage, and distribution of tissues as may be appropriate to assure that all useable tissues are obtained from potential donors, and

"(J) evaluate annually the effectiveness of the organization in acquiring potentially available organs.

Appropriation authorization.

"(c) For grants under subsection (a) there are authorized to be appropriated $5,000,000 for fiscal year 1985, $8,000,000 for fiscal year 1986, and $12,000,000 for fiscal year 1987.

"ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK

42 USC 274.

"SEC. 372. (a) The Secretary shall by contract provide for the establishment and operation of an Organ Procurement and Transplantation Network which meets the requirements of subsection (b). The amount provided under such contract in any fiscal year may not exceed $2,000,000. Funds for such contracts shall be made available from funds available to the Public Health Service from appropriations for fiscal years beginning after fiscal year 1984.

"(b)(1) The Organ Procurement and Transplantation Network shall carry out the functions described in paragraph (2) and shall—

"(A) be a private nonprofit entity which is not engaged in any activity unrelated to organ procurement, and

"(B) have a board of directors which includes representatives of organ procurement organizations (including organizations which have received grants under section 371), transplant centers, voluntary health associations, and the general public.

"(2) The Organ Procurement and Transplantation Network shall—

"(A) establish in one location or through regional centers—

"(i) a national list of individuals who need organs, and

"(ii) a national system, through the use of computers and in accordance with established medical criteria, to match organs and individuals included in the list, especially individuals whose immune system makes it difficult for them to receive organs,

"(B) maintain a twenty-four-hour telephone service to facilitate matching organs with individuals included in the list,

"(C) assist organ procurement organizations in the distribution of organs which cannot be placed within the service areas of the organizations,

"(D) adopt and use standards of quality for the acquisition and transportation of donated organs,

"(E) prepare and distribute, on a regionalized basis, samples of blood sera from individuals who are included on the list and whose immune system makes it difficult for them to receive organs, in order to facilitate matching the compatability of such individuals with organ donors,

"(F) coordinate, as appropriate, the transportation of organs from organ procurement organizations to transplant centers,

"(G) provide information to physicians and other health professionals regarding organ donation, and

"(H) collect, analyze, and publish data concerning organ donation and transplants.

"SCIENTIFIC REGISTRY

"SEC. 373. The Secretary shall, by grant or contract, develop and maintain a scientific registry of the recipients of organ transplants. The registry shall include such information respecting patients and transplant procedures as the Secretary deems necessary to an ongoing evaluation of the scientific and clinical status of organ transplantation. The Secretary shall prepare for inclusion in the report under section 376 an analysis of information derived from the registry. 42 USC 274a.

"GENERAL PROVISIONS RESPECTING GRANTS AND CONTRACTS

"SEC. 374. (a) No grant may be made under section 371 or 373 or contract entered into under section 372 or 373 unless an application therefor has been submitted to, and approved by, the Secretary. Such an application shall be in such form and shall be submitted in such manner as the Secretary shall by regulation prescribe. Grants. 42 USC 274b.

"(b)(1) In considering applications for grants under section 371—

"(A) the Secretary shall give priority to any applicant which has a formal agreement of cooperation with all transplant centers in its proposed service area,

"(B) the Secretary shall give special consideration to organizations which met the requirements of section 371(b) before the date of the enactment of this section, and

"(C) the Secretary shall not discriminate against an applicant solely because it provides health care services other than those related to organ procurement.

The Secretary may not make a grant for more than one organ procurement organization which serve the same service area. Prohibition.

"(2) A grant for planning under section 371 may be made for one year with respect to any organ procurement organization and may not exceed $100,000.

"(3) Grants under section 371 for the establishment, initial operation, or expansion of organ procurement organizations may be made for two years. No such grant may exceed $500,000 for any year and no organ procurement organization may receive more than $800,000 for initial operation or expansion.

"(c)(1) The Secretary shall determine the amount of a grant made under section 371 or 373. Payments under such grants may be made in advance on the basis of estimates or by the way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants.

"(2)(A) Each recipient of a grant under section 371 or 373 shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the undertaking in connection with which such grant was made, and the amount of that Records.

portion of the cost of the undertaking supplied by other sources, and such other records as will facilitate an effective audit.

Audit.

"(B) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of a grant under section 371 or 373 that are pertinent to such grant.

"(d) For purposes of this part:

"(1) The term 'transplant center' means a health care facility in which transplants of organs are performed.

"(2) The term 'organ' means the human kidney, liver, heart, lung, pancreas, and any other human organ (other than corneas and eyes) specified by the Secretary by regulation and for purposes of section 373, such term includes bone marrow.

"ADMINISTRATION

42 USC 274c.

"SEC. 375. The Secretary shall, during fiscal years 1985, 1986, 1987, and 1988, designate and maintain an identifiable administrative unit in the Public Health Service to—

"(1) administer this part and coordinate with the organ procurement activities under title XVIII of the Social Security Act,

42 USC 1395.

Public information.

"(2) conduct a program of public information to inform the public of the need for organ donations,

"(3) provide technical assistance to organ procurement organizations receiving funds under section 371, the Organ Procurement and Transplantation Network established under section 372, and other entities in the health care system involved in organ donations, procurement, and transplants, and

Report.

"(4) one year after the date on which the Task Force on Organ Transplantation transmits its final report under section 104(c) of the National Organ Transplant Act, and annually thereafter through fiscal year 1988, submit to Congress an annual report on the status of organ donation and coordination services and include in the report an analysis of the efficiency and effectiveness of the procurement and allocation of organs and a description of problems encountered in the procurement and allocation of organs.

"REPORT

42 USC 274d.

"SEC. 376. The Secretary shall annually publish a report on the scientific and clinical status of organ transplantation. The Secretary shall consult with the Director of the National Institutes of Health and the Commissioner of the Food and Drug Administration in the preparation of the report.".

TITLE III—PROHIBITION OF ORGAN PURCHASES

Penalties.
42 USC 274e.

SEC. 301. (a) It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

(b) Any person who violates subsection (a) shall be fined not more than $50,000 or imprisoned not more than five years, or both.

(c) For purposes of subsection (a):

(1) The term "human organ" means the human kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin,

and any other human organ specified by the Secretary of Health and Human Services by regulation.

(2) The term "valuable consideration" does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.

(3) The term "interstate commerce" has the meaning prescribed for it by section 201(b) of the Federal Food, Drug and Cosmetic Act. 21 USC 321.

TITLE IV—MISCELLANEOUS

BONE MARROW REGISTRY DEMONSTRATION AND STUDY

SEC. 401. (a) Not later than nine months after the date of enactment of this Act, the Secretary of Health and Human Services shall hold a conference on the feasibility of establishing and the effectiveness of a national registry of voluntary bone marrow donors. 42 USC 273 note.

(b) If the conference held under subsection (a) finds that it is feasible to establish a national registry of voluntary donors of bone marrow and that such a registry is likely to be effective in matching donors with recipients, the Secretary of Health and Human Services, acting through the Assistant Secretary for Health, shall, for purposes of the study under subsection (c), establish a registry of voluntary donors of bone marrow. The Secretary shall assure that—

(1) donors of bone marrow listed in the registry have given an informed consent to the donation of the bone marrow; and

(2) the names of the donors in the registry are kept confidential and access to the names and any other information in the registry is restricted to personnel who need the information to maintain and implement the registry, except that access to such other information shall be provided for purposes of the study under subsection (c).

If the conference held under subsection (a) makes the finding described in this subsection, the Secretary shall establish the registry not later than six months after the completion of the conference.

(c) The Secretary of Health and Human Services, acting through the Assistant Secretary for Health, shall study the establishment and implementation of the registry under subsection (b) to identify the issues presented by the establishment of such a registry, to evaluate participation of bone marrow donors, to assess the imple-

mentation of the informed consent and confidentiality requirements, and to determine if the establishment of a permanent bone marrow registry is needed and appropriate. The Secretary shall report the results of the study to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate not later than two years after the date the registry is established under subsection (b).

Report.

Approved October 19, 1984.

LEGISLATIVE HISTORY—S. 2048 (H.R. 5580) (H.R. 4080):

HOUSE REPORTS: No. 98-575, Pt. 1, accompanying H.R. 4080 (Comm. on Energy and Commerce), No. 98-769 accompanying H.R. 5580 (Comm. on Energy and Commerce), and No. 98-1127 (Comm. of Conference).
SENATE REPORT No. 98-382 (Comm. on Labor and Human Resources).
CONGRESSIONAL RECORD, Vol. 130 (1984):
Apr. 11, considered and passed Senate.
June 20, 21, H.R. 5580 considered and passed House; S. 2048, amended, passed in lieu.
Oct. 3, House agreed to conference report.
Oct. 4, Senate agreed to conference report.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 20, No. 42 (1984):
Oct. 19, Presidential statement.

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B. Organ Procurement

When renal transplantation became an effective form of therapy in the 1960s, it was necessary to develop systems for procuring kidneys from cadaveric donors. Early programs were established to provide centralized services that might include provision for surgical retrieval, tissue typing, maintaining lists and tissue characteristics of potential recipients, and organ distribution (transportation) to cooperating transplant centers.

The United States now operates the largest organ procurement effort in the world. Nationwide there are currently approximately 120 Medicare approved OPAs. Approximately 7,000 cadaveric kidneys were obtained in the United States in 1986. This effort has come about largely through the OPAs funded by the Medicare ESRD program. The number of patients on waiting lists for a kidney transplant totaled 10,000 in 1986.

Each OPA routinely transports organs; for example, more than 40 percent of all transplanted kidneys are obtained in a locale different from the site in which transplantation occurs.

OPAs also procure organs other than kidneys used in transplantion. In 1986, 1368 heart, 924 liver, 45 heart-lung, and 140 pancreas or islet cell transplants were performed in the United States. Virtually all of these organs came from donors identified by the organ procurement system, nearly all of whom also donated kidneys. Waiting lists are much smaller for organs other than kidneys. Approximately 300 people were waiting for donor hearts and 400 waiting for donor livers in 1986. Pediatric patients make up about one-third of the waiting list for liver transplants, but organs are most scarce for this group.

Although OPAs play a central role in locating and placing transplantable human organs, OPAs vary in size, strategies, personnel, and organization.

OPAs currently approved for supplying kidneys for Medicare patients can be divided into two organizationally distinct groups. Nearly half of the OPAs are independently incorporated non-profit entities whose sole function is the procurement of human organs. These independent organ procurement agencies (IOPAs) are approved by HCFA if they comply with our definition of an OPA (42 CFR 405.2102). We prescribe four services that an OPA must perform or coordinate the performance of in order to be approved: Recovery of kidneys, preservation of kidneys, transportation of donated kidneys, and the maintenance of a system to locate prospective recipients for the recovered kidneys. Our instructions to approved IOPAs require them to develop a standard kidney acquisition charge, which is billed to the transplant center at the time an organ is furnished. The transplant center pays the IOPA and bills Medicare for that cost. We have established cost reporting requirements in our regulations and instructions at 42 CFR 413.178 to make adjustments at the end of the cost reporting year.

The remaining OPAs are hospital-based organ procurement agencies (HOPAs). These HOPAs are located within the administrative structure of a hospital approved to perform kidney transplants, usually within the department of surgery or the division of transplantation, or both. The costs of organ procurement activities, of HOPAs are recorded in a kidney acquisition cost center and billed by the hospital separately from the actual transplantation procedure costs that are billed when transplantation occurs (42 CFR 412.90(e)). Medicare cost adjustments, if needed, are made for the HOPA when the hospital's cost report is settled. HOPAs are generally directly responsible to a transplant surgeon and work, for the most part, primarily for that transplant center.

II. Legislation

The National Organ Transplant Act of 1984 (Pub. L. 98-507), created a Task Force on Organ Transplantation, which conducted a comprehensive examination of all aspects of organ procurement and transplantation. In addition to many other findings and specific recommendations, the Task Force concluded that an overriding problem, common to all organ transplant procedures, is the serious gap between the need for organs and the supply of organs available for transplantation. The Task Force found that many opportunities for obtaining organs were lost because of oversights or shortcomings in the present procurement process. One recommendation adopted by the Task Force was that OPAs be strengthened by establishing criteria that they must meet in order to be certified, and that all hospitals, as a condition of participation in Medicare, be required to adopt policies and procedures for routinely identifying potential organ and tissue donors and providing next-of-kin with appropriate opportunities for donation. The Task Force also recommended periodic recertification of the OPAs, requiring the OPAs to meet performance standards and that there be only one agency per service area. (See Organ Transplantation, Report of the Task Force on *Organ Transplantation*, April 1986, pp. 5, 31-34, 59-61, 117-122.)

Congress adopted these recommendations when enacting section 9318 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86), Pub. L. 99-509, which added a new section 1138 to the Act. Section 1138(a) of the Act allows a hospital that otherwise meets the conditions of participation for the Medicare or Medicaid programs to participate in either program only if:

(1) The hospital establishes written protocols to identify potential organ or tissue donors that:

(a) Assure that families of potential donors are made aware that they have an option to donate organs or tissue and an option to decline to donate;

(b) Encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of potential donors; and

(c) Require that an organ procurement agency designated by the Secretary of HHS under 1138(b)(1)(F) be notified of potential donors; and

(2) In the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules of, the Organ Procurement and Transplantation Network (the Network) established in accordance with section 372 of the Public Health Service Act.

This section applies to hospitals participating in the Medicare or Medicaid program as of October 1, 1987.

Section 1138(b) of the Act requires that, on or after October 1, 1987, Medicare and Medicaid pay for organ procurement costs attributable to payments made to an OPA only if the OPA satisfies the conditions below. The OPA:

(a)(i) Is a qualified organ procurement organization (as described in section 371(b) of the Pubic Health Service Act) that is operating under a grant made under section 371(a) of that Act, or

(ii) Has been certified or recertified by the Secretary within the previous two years as meeting the standards to be a qualified organ procurement organization;

(b) Meets the applicable Medicare or Medicaid requirements for organ procurement agencies;

(c) meets performance-related standards prescribed by the Secretary;

(d) Is a member of, and abides by the rules and requirements of, the Organ Procurement and Transportation Network established under section 372 of the Public Health Service Act;

(e) Allocates organs, within its service area and nationally, in accordance with

II

100TH CONGRESS
1ST SESSION

S. 1633

To amend the Public Health Service Act to revise and extend the program of assistance to organ procurement organizations, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 7 (legislative day, AUGUST 5), 1987

Mr. BYRD (for Mr. GORE) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To amend the Public Health Service Act to revise and extend the program of assistance to organ procurement organizations, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Organ Transplant Amendments Act of 1987".

SEC. 2. ASSISTANCE FOR ORGAN PROCUREMENT ORGANIZATIONS.

(a) ADDITIONAL GRANT AUTHORITY.—Section 371(a) of the Public Health Service Act (42 U.S.C. 273(a)) is amended—

(1) in paragraph (2), by inserting "consolidation," after "operation,";

(2) by redesignating paragraph (3) as paragraph (4) and inserting after paragraph (2) the following new paragraph:

"(3) The Secretary may make grants for special projects designated to increase the number of organ donors."; and

(3) in paragraph (4) (as redesignated in paragraph (2) of this subsection)—

(A) by striking "(1) and (2)," and inserting "(1), (2), and (3),"; and

(B)(i) by striking "and" at the end of subparagraph (A);

(ii) by striking the period and inserting ", and"; and

(iii) by adding at the end the following new subparagraph:

"(C) with respect to carrying out paragraph (3), give special consideration to proposals from existing such organizations.".

(b) LIMITATIONS ON ADDITIONAL GRANT AUTHORITY.—Section 374(b)(3) of the Public Health Service Act (42 U.S.C. 274(b)(3)) is amended in the first sentence by striking

"section 371" and all that follows through "organizations" and inserting "paragraphs (2) and (3) of section 371(a)".

(c) DESCRIPTION OF ORGAN PROCUREMENT ORGANIZATION.—Section 371(b) of the Public Health Service Act (42 U.S.C. 273(b)) is amended—

(1) in paragraph (1)(E)—

(A) by striking "size which" and inserting "size such that"; and

(B) by striking "will include" and all that follows through "year" and inserting the following: "the organization can reasonably expect to procure organs from not less than fifty donors each year";

(2) in paragraph (2)(E)—

(A) by inserting "equitably" after "organs"; and

(B) by striking "centers and"; and

(3) in paragraph (2)—

(A) by striking "and" at the end of subparagraph (I);

(B) by striking the period and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(K) assist hospitals in establishing and implementing protocols for making routine inquiries about organ donations by potential donors.".

(d) AUTHORIZATIONS OF APPROPRIATIONS.—Section 371(c) of the Public Health Service Act (42 U.S.C. 273(c)) is amended to read as follows:

"(c) For grants under subsection (a), there are authorized to be appropriated $5,000,000 for each of the fiscal years 1988 through 1990.".

SEC. 3. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK.

(a) DUTIES.—Section 372(b)(2) of the Public Health Service Act (42 U.S.C. 274(b)(2)) is amended—

(1)(A) by redesignating subparagraphs (B) through (H) as subparagraphs (C) through (I), respectively; and

(B) by adding after subparagraph (A) the following new subparagraph:

"(B) establish medical criteria for allocating organs and periodically provide to members of the public an opportunity to comment with respect to such criteria,";

(2) in subparagraph (D) (as redesignated in paragraph (1)(A) of this section), by striking "organs which" and all that follows and inserting "organs,";

(3) in subparagraph (F) (as redesignated in paragraph (1)(A) of this section), by striking "basis," and inserting the following: "basis (and, to the extent practicable, among regions or on a national basis),".

(4)(A) by striking "and" at the end of subparagraph (H) (as redesignated in paragraph (1)(A) of this section);

(B) by striking the period and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(J) carry out studies and demonstrations projects for the purpose of improving procedures for organ procurement and allocation.".

(b) CONSIDERATION OF CRITICAL COMMENTS.—Section 372 of the Public Health Service Act (42 U.S.C. 274) is amended by adding at the end the following new subsection:

"(c) The Secretary shall establish procedures for—

"(1) receiving from interested persons critical comments relating to the manner in which the Organ Procurement and Transplantation Network is carrying out the duties of the Network under subsection (b); and

"(2) the consideration by the Secretary of such critical comments.".

SEC. 4. ADMINISTRATION.

Section 375 of the Public Health Service Act (42 U.S.C. 274c) is amended—

(1) in the matter preceding paragraph (1), by striking "1985, 1986, 1987, and 1988," and inserting "1985 through 1990,"; and

(2) in paragraph (4), by striking "one year" and all that follows through "annual report" and inserting the following: "not later than April 1 of each of the years 1988 and 1990, submit to the Congress a report".

SEC. 5. REPORT.

Section 376 of the Public Health Service Act (42 U.S.C. 274d) is amended by striking "shall annually" and inserting the following: "shall, not later than October 1 of each year,".

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ALASKA HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

TO: Heather Arnett DATE: 10/21/87

FROM: Karla Hart

Here are the organ transplant bills you requested. If we can provide any further assistance, please call.

Karla

P.S. As I mentioned on 10/16, HB1633 is in the committee on Labor and Resources since Aug. 7 and there has been no action on it.

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

...provisions and regulations, transmissions, or agreements for 12, 1942, are hereby revoked.

§ 271. Penalties for violation of quarantine laws

Code of Federal Regulations — Interstate conveyance sanitation, see 21 CFR 1250.3. Communicable disease control procedures, 21 CFR 1240.3.

PART H—ORGAN TRANSPLANTS

§ 273. Assistance for organ procurement organizations

(a) Grant authority of Secretary

(1) The Secretary may make grants for the planning of qualified organ procurement organizations described in subsection (b) of this section.

(2) The Secretary may make grants for the establishment, initial operation, and expansion of qualified organ procurement organizations described in subsection (b) of this section.

(3) In making grants under paragraphs (1) and (2), the Secretary shall—

(A) take into consideration any recommendations made by the Task Force on Organ Transplantation established under section 101 of the National Organ Transplant Act, and

(B) give special consideration to applications which cover geographical areas which are not adequately served by organ procurement organizations

(b) Qualified organizations

(1) A qualified organ procurement organization for which grants may be made under subsection (a) of this section is an organization which, as determined by the Secretary, will carry out the functions described in paragraph (2) and—

(A) is a nonprofit entity,

(B) has accounting and other fiscal procedures (as specified by the Secretary) necessary to assure the fiscal stability of the organization,

(C) has an agreement with the Secretary to be reimbursed under title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.] for the procurement of kidneys,

(D) has procedures to obtain payment for non-renal organs provided to transplant centers,

(E) has a defined service area which is a geographical area of sufficient size which (unless the service area comprises an entire State) will include at least fifty potential organ donors each year and which either includes an entire standard metropolitan statistical area (as specified by the Office of Management and Budget) or does not include any part of such an area,

(F) has a director and such other staff, including the organ donation coordinators and organ procurement specialists necessary to effectively obtain organs from donors in its service area, and

(G) has a board of directors or an advisory board which—

(I) is composed of—

(I) members who represent hospital administrators, intensive care or emergency room personnel, tissue banks, and voluntary health associations in its service area,

(II) members who represent the public residing in such area,

(III) a physician with knowledge, experience, or skill in the field of histocompatability,

(IV) a physician with knowledge or skill in the field of neurology, and

(V) from each transplant center in its service area which has arrangements described in paragraph (2)(G) with the organization, a member who is a surgeon who has practicing privileges in such center and who performs organ transplant surgery,

(II) has the authority to recommend policies for the procurement of organs and the other functions described in paragraph (2), and

(III) has no authority over any other activity of the organization.

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(2) An organ procurement organization shall—

(A) have effective agreements, to identify potential organ donors, with a substantial majority of the hospitals and other health care entities in its service area which have facilities for organ donations,

(B) conduct and participate in systematic efforts, including professional education, to acquire all useable organs from potential donors,

(C) arrange for the acquisition and preservation of donated organs and provide quality standards for the acquisition of organs which are consistent with the standards adopted by the Organ Procurement and Transplantation Network under section 274(b)(2)(D) of this title,

(D) arrange for the appropriate tissue typing of donated organs,

(E) have a system to allocate donated organs among transplant centers and patients according to established medical criteria,

(F) provide or arrange for the transportation of donated organs to transplant centers,

(G) have arrangements to coordinate its activities with transplant centers in its service area,

(H) participate in the Organ Procurement Transplantation Network established under section 274 of this title,

(I) have arrangements to cooperate with tissue banks for the retrieval, processing, preservation, storage, and distribution of tissues as may be appropriate to assure that all useable tissues are obtained from potential donors, and

(J) evaluate annually the effectiveness of the organization in acquiring potentially available organs.

(c) Authorization of appropriations

For grants under subsection (a) of this section there are authorized to be appropriated $5,000,000 for fiscal year 1985, $8,000,000 for fiscal year 1986, and $12,000,000 for fiscal year 1987.

(July 1, 1944, c. 373, Title III, § 371, as added Oct. 19, 1984, Pub.L. 98-507, Title II, § 201, 98 Stat. 2342.)

References in Text. Section 101 of the National Organ Transplant Act, referred to in subsec. (a)(3), is set out as a note under this section.

Title XVIII of the Social Security Act, referred to in subsec. (b)(1)(C), is classified generally to subchapter XVIII (§ 1395 et seq.) of chapter 7 of this title.

Prior Provisions. Section, Act July 1, 1944, c. 373, Title III, § 371, as added July 28, 1956, c. 772, Title II, § 201, 70 Stat. 709, authorizing grants to the Territory of Alaska for an integrated mental health program was repealed by Pub.L. 86-70, § 31(b)(1), June 25, 1959, 73 Stat. 148. Another section 371 of Act July 1, 1944, added by Act Aug. 3, 1956, c. 907, § 1, 70 Stat. 960, is set out as section 275 of this title.

Short Title. Short Title of National Organ Transplant Act, see section 1 of Pub.L. 98-507 set out as a Short Title note under section 201 of this title.

Task Force on Organ Procurement and Transplantation. Title I of Pub.L. 98-507 provided that:

"ESTABLISHMENT AND DUTIES OF TASK FORCE

"Sec. 101(a) Not later than ninety days after the date of the enactment of this Act [Oct. 19, 1984], the Secretary of Health and Human Services (hereinafter in this title [this note] referred to as the 'Secretary') shall establish a Task Force on Organ Transplantation (hereinafter in this title [this note] referred to as the 'Task Force').

"(b)(1) The Task Force shall—

"(A) conduct comprehensive examinations of the medical, legal, ethical, economic, and social issues presented by human organ procurement and transplantation,

"(B) prepare the assessment described in paragraph (2) and the report described in paragraph (3), and

"(C) advise the Secretary with respect to the development of regulations for grants under section 371 of the Public Health Service Act [this section].

"(2) The Task Force shall make an assessment of immunosuppressive medications used to prevent organ rejection in transplant patients, including—

"(A) an analysis of the safety, effectiveness, and costs (including cost-savings from improved success rates of transplantation) of different modalities of treatment;

"(B) an analysis of the extent of insurance reimbursement for long-term immunosuppressive drug therapy for organ transplant patients by private insurers and the public sector;

"(C) an identification of problems that patients encounter in obtaining immunosuppressive medications; and

"(D) an analysis of the comparative advantages of grants, coverage under existing Federal programs, or other means to assure that individuals who need such medications can obtain them.

"(3) The Task Force shall prepare a report which shall include—

"(A) an assessment of public and private efforts to procure human organs for transplantation and an identification of factors that diminish the number of organs available for transplantation;

"(B) an assessment of problems in coordinating the procurement of viable human organs including skin and bone;

"(C) recommendations for the education and training of health professionals, including physicians, nurses, and hospital and emergency care personnel, with respect to organ procurement;

"(D) recommendations for the education of the general public, the clergy, law enforcement officers, members of local fire departments, and other agencies and individuals that may be instrumental in effecting organ procurement;

"(E) recommendations for assuring equitable access by patients to organ transplantation and for assuring the equitable allocation of donated organs among transplant centers and among patients medically qualified for an organ transplant;

"(F) an identification of barriers to the donation of organs to patients (with special emphasis upon pediatric patients), including an assessment of—

"(i) barriers to the improved identification of organ donors and their families and organ recipients;

"(ii) the number of potential organ donors and their geographical distribution;

"(iii) current health care services provided for patients who need organ transplantation and organ procurement procedures, systems, and programs which affect such patients;

"(iv) cultural factors affecting the family with respect to the donation of the organs; and

"(v) ethical and economic issues relating to organ transplantation needed by chronically ill patients;

"(G) recommendations for the conduct and coordination of continuing research concerning all aspects of the transplantation of organs;

"(H) an analysis of the factors involved in insurance reimbursement for transplant procedures by private insurers and the public sector;

"(I) an analysis of the manner in which organ transplantation technology is diffused among and adopted by qualified medical centers, including a specification of the number and geographical distribution of qualified medical centers using such technology and an assessment of whether the number of centers using such technology is sufficient or excessive and of whether the public has sufficient access to medical procedures using such technology; and

"(J) an assessment of the feasibility of establishing, and of the likely effectiveness of, a national registry of human organ donors.

"MEMBERSHIP

"Sec. 102(a) The Task Force shall be composed of twenty-five members as follows:

"(1) Twenty-one members shall be appointed by the Secretary of which:

"(A) nine members shall be physicians or scientists who are eminent in the various medical and scientific specialties related to human organ transplantation;

"(B) three members shall be individuals who are not physicians and who represent the field of human organ procurement;

"(C) four members shall be individuals who are not physicians and who as a group have expertise in the fields of law, theology, ethics, health care financing, and the social and behavioral sciences;

"(D) three members shall be individuals who are not physicians or scientists and who are members of the general public; and

"(E) two members shall be individuals who represent private health insurers or self-insurers.

"(2) The Surgeon General of the United States, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, and the Administrator of the Health Care Financing Administration shall be ex officio members.

"(3) No individual who is a full-time officer or employee of the United States may be appointed under subsection (a)(1) to the Task Force. A vacancy in the Task Force shall be filled in the manner in which the original appointment was made. A vacancy in the Task Force shall not affect its powers.

"(c) Members shall be appointed for the life of the Task Force.

"(d) The Task Force shall select a Chairman from among its members who are appointed under subsection (a)(1).

"(e) Thirteen members of the Task Force shall constitute a quorum, but a lesser number may hold hearings.

"(f) The Task Force shall hold its first meeting on a date specified by the Secretary which is not later than thirty days after the date on which the Secretary establishes the Task Force under section 101. Thereafter, the Task Force shall meet at the call of the Chairman or a majority of its members, but shall meet at least three times during the life of the Task Force.

"(g)(1) Each member of the Task Force who is not an officer or employee of the United States shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule under section 5332 of title 5, United States Code, [section 5332 of Title 5, Government Organization and Employees] for each day (including travel time) during which such member is engaged in the actual performance of duties as a member of the Task Force. Each member of the Task Force who is an officer or employee of the United States shall receive no additional compensation.

"(2) While away from their homes or regular places of business in the performance of duties for the Task Force, all members of the Task Force shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under sections 5702 and 5703 of title 5, United States Code [sections 5702 and 5703 of Title 5, Government Organizations and Employees].

"SUPPORT FOR THE TASK FORCE

"Sec. 103(a) Upon request of the Task Force, the head of any Federal agency is authorized to detail, on a reimbursable basis, any of the person-

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ret of such agency to the Task Force to assist the Task Force in carrying out its duties under this Act [Pub.L. 98-507. See Short Title note under section 201 of this title].

"(b) The Secretary shall provide the Task Force with such administrative and support services as the Task Force may require to carry out its duties.

"REPORT

"Sec. 104(a) The Task Force may transmit to the Secretary, the Committee on Labor and Human Resources of the Senate, and the Committee on Energy and Commerce of the House of Representatives such interim reports as the Task Force considers appropriate.

"(b) Not later than 7 months after the date on which the Task Force is established by the Secretary under section 101, the Task Force shall transmit a final report to the Secretary, the Committee on Labor and Human Resources of the Senate, and the Committee on Energy and Commerce of the House of Representatives. The final report of the Task Force shall include—

"(1) a description of any findings and conclusions of the Task Force made pursuant to any examination conducted under section 101(b)(1)(A),

"(2) the matters specified in section 101(b)(3), and

"(3) such recommendations as the Task Force considers appropriate.

"TERMINATION

"Sec. 105 The Task Force shall terminate three months after the date on which the Task Force transmits the report required by section 104(c)."

Bone Marrow Registry Demonstration and Study. Section 401 of Pub.L. 98-507 provided that:

"(a) Not later than nine months after the date of enactment of this Act [Oct. 19, 1984], the Secretary of Health and Human Services shall hold a conference on the feasibility of establishing and the effectiveness of a national registry of voluntary bone marrow donors.

"(b) If the conference held under subsection (a) finds that it is feasible to establish a national registry of voluntary donors of bone marrow and that such a registry is likely to be effective in matching donors with recipients, the Secretary of Health and Human Services, acting through the Assistant Secretary for Health, shall, for purposes of the study under subsection (c), establish a registry of voluntary donors of bone marrow. The Secretary shall ensure that—

"(1) donors of bone marrow listed in the registry have given an informed consent to the donation of the bone marrow; and

"(2) The names of the donors in the registry are kept confidential and access to the names and any other information in the registry is restricted to personnel who need the information to maintain and implement the registry, except that access to such other information shall be provided for purposes of the study under subsection (c).

"If the conference held under subsection (a) makes the finding described in this subsection, the Secretary shall establish the registry not later than six months after the completion of the conference.

"(c) The Secretary of Health and Human Services, acting through the Assistant Secretary for Health, shall study the establishment and implementation of the registry under subsection (b) to identify the issues presented by the establishment of such a registry, to evaluate participation of bone marrow donors, to assess the implementation of the informed consent and confidentiality requirements, and to determine if the establishment of a permanent bone marrow registry is needed and appropriate. The Secretary shall report the results of the study to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate not later than two years after the date the registry is established under subsection (b)".

Legislative History. For legislative history and purpose of Pub.L. 98-507, see 1984 U.S. Code Cong. and Adm. News, p. 3973.

§ 274. Organ procurement and transplantation network

(a) Contract authority of Secretary; limitation; available appropriations

The Secretary shall by contract provide for the establishment and operation of an Organ Procurement and Transplantation Network which meets the requirements of subsection (b) of this section. The amount provided under such contract in any fiscal year may not exceed $2,000,000. Funds for such contracts shall be made available from funds available to the Public Health Service from appropriations for fiscal years beginning after fiscal year 1984.

(b) Functions

(1) The Organ Procurement and Transplantation Network shall carry out the functions described in paragraph (2) and shall—

(A) be a private nonprofit entity which is not engaged in any activity unrelated to organ procurement, and

(B) have a board of directors which includes representatives of organ procurement organizations (including organizations which have received grants

under section 273 of this title), transplant centers, voluntary health associations, and the general public.

(2) The Organ Procurement and Transplantation Network shall—

(A) establish in one location or through regional centers—

(i) a national list of individuals who need organs, and

(ii) a national system, through the use of computers and in accordance with established medical criteria, to match organs and individuals included in the list, especially individuals whose immune system makes it difficult for them to receive organs,

(B) maintain a twenty-four-hour telephone service to facilitate matching organs with individuals included in the list,

(C) assist organ procurement organizations in the distribution of organs which cannot be placed within the service areas of the organizations,

(D) adopt and use standards of quality for the acquisition and transportation of donated organs,

(E) prepare and distribute, on a regionalized basis, samples of blood sera from individuals who are included on the list and whose immune system makes it difficult for them to receive organs, in order to facilitate matching the compatability[1] of such individuals with organ donors,

(F) coordinate, as appropriate, the transportation of organs from organ procurement organizations to transplant centers,

(G) provide information to physicians and other health professionals regarding organ donation, and

(H) collect, analyze, and publish data concerning organ donation and transplants.

(July 1, 1944, c. 373, Title III, § 372, as added Oct. 19, 1984, Pub.L. 98-507, Title II, § 201, 98 Stat. 2344.)

[1] So in original. Probably should be "compatibility".

Prior Provisions. Section, Act July 1, 1944, c. 373, Title III, § 378, as added July 26, 1956, c. 771, Title II, § 201, 70 Stat. 710, and amended June 25, 1959, Pub.L. 86-70, § 31(b)(2)-(4), 73 Stat. 143, which related to grants to Alaska for special health programs and payment for construction of hospital facilities was omitted in the general revision of this part by Pub.L. 98-507, Title II, § 201, Oct. 19, 1984, 98 Stat. 2345.

Legislative History. For legislative history and purpose of Pub.L. 98-507, see 1984 U.S. Code Cong. and Adm. News, p. 3973.

§ 274a. Scientific registry

The Secretary shall, by grant or contract, develop and maintain a scientific registry of the recipients of organ transplants. The registry shall include such information respecting patients and transplant procedures as the Secretary deems necessary to an ongoing evaluation of the scientific and clinical status of organ transplantation. The Secretary shall prepare for inclusion in the report under section 274d of this title an analysis of information derived from the registry.

(July 1, 1944, c. 373, Title III, § 373, as added Oct. 19, 1984, Pub.L. 98-507, Title II, § 201, 98 Stat. 2345.)

Legislative History. For legislative history and purpose of Pub.L. 98-507, see 1984 U.S. Code Cong. and Adm. News, p. 3973.

§ 274b. General provisions respecting grants and contracts

(a) Application requirement

No grant may be made under section 273 or 274a of this title or contract entered into under section 274 or 274a of this title unless an application therefor has been submitted to, and approved by, the Secretary. Such an application shall be in such form and shall be submitted in such manner as the Secretary shall by regulation prescribe.

(b) Special considerations and priority; planning and establishment grants

(1) In considering applications for grants under section 273 of this title—

(A) the Secretary shall give priority to any applicant which has a formal agreement of cooperation with all transplant centers in its proposed service area,

(B) the Secretary shall give special consideration to organizations which met the requirements of section 273(b) of this title before October 19, 1984, and

(C) the Secretary shall not discriminate against an applicant solely because it provides health care services other than those related to organ procurement.

The Secretary may not make a grant for more than one organ procurement organization which serve the same service area.

(2) A grant for planning under section 273 of this title may be made for one year with respect to any organ procurement organization and may not exceed $150,000.

(3) Grants under section 273 of this title for the establishment, initial operation, or expansion of organ procurement organizations may be made for two years. No such grant may exceed $100,000 for any year and no organ procurement organization may receive more than $200,000 for initial operation or expansion.

(c) Determination of grant amount; advance payments; recordkeeping; access for purposes of audits and examinations

(1) The Secretary shall determine the amount of a grant made under section 273 or 274a of this title. Payments under such grants may be made in advance on the basis of estimates or by the way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants.

(2)(A) Each recipient of a grant under section 273 or 274a of this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the undertaking in connection with which such grant was made, and the amount of that portion of the cost of the undertaking supplied by other sources, and such other records as will facilitate an effective audit.

(B) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of a grant under section 273 or 274a of this title that are pertinent to such grant.

(d) Definitions

For purposes of this part:

(1) The term "transplant center" means a health care facility in which transplants of organs are performed.

(2) The term "organ" means the human kidney, liver, heart, lung, pancreas, and any other human organ (other than cornea and eyes) specified by the Secretary by regulation and for purposes of section 274a of this title, such term includes bone marrow.

(July 1, 1944, c. 373, Title III, § 374, as added Oct. 19, 1984, Pub.L. 98-507, Title II, § 201, 98 Stat. 2345.)

Legislative History. For legislative history and purpose of Pub.L. 98-507, see 1984 U.S. Code Cong. and Adm. News p. 3975.

§ 274c. Administration

The Secretary shall, during fiscal years 1985, 1986, 1987, and 1988, designate and maintain an identifiable administrative unit in the Public Health Service to—

(1) administer this part and coordinate with the organ procurement activities under title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.],

(2) conduct a program of public information to inform the public of the need for organ donations,

(3) provide technical assistance to organ procurement organizations receiving funds under section 273 of this title, the Organ Procurement and Transplantation Network established under section 274 of this title, and other entities in the

health care system involved in organ donations, procurement, and transplants, and

(4) one year after the date on which the Task Force on Organ Transplantation transmits its final report under section 104(c) of the National Organ Transplant Act, and annually thereafter through fiscal year 1988, submit to Congress an annual report on the status of organ donation and coordination services and include in the report an analysis of the efficiency and effectiveness of the procurement and allocation of organs and a description of problems encountered in the procurement and allocation of organs.

(July 1, 1944, c. 373, Title III, § 376 as added Oct. 19, 1984, Pub.L. 98-507, Title II, § 201, 98 Stat. 2346.)

References in Text. Title XVIII of the Social Security Act, referred to in par. (1), is classified generally to subchapter XVIII (§ 1395 et seq.) of chapter 7 of this title.

Section 104(c) of the National Organ Transplant Act, referred to in par. (4), is set out as a note under section 273 of this title.

Legislative History. For legislative history and purpose of Pub.L. 98-507, see 1984 U.S. Code Cong. and Adm. News, p. 3975.

§ 274d. Report

The Secretary shall annually publish a report on the scientific and clinical status of organ transplantation. The Secretary shall consult with the Director of the National Institutes of Health and the Commissioner of the Food and Drug Administration in the preparation of the report.

(July 1, 1944, c. 373, Title III, § 377, as added Oct. 19, 1984, Pub.L. 98-507, Title II, § 201, 98 Stat. 2346.)

Legislative History. For legislative history and purpose of Pub.L. 98-507, see 1984 U.S. Code Cong. and Adm. News, p. 3975.

§ 274e. Prohibition of organ purchases

(a) Prohibition

It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

(b) Penalties

Any person who violates subsection (a) of this section shall be fined not more than $50,000 or imprisoned not more than five years, or both.

(c) Definitions

For purposes of subsection (a) of this section:

(1) The term "human organ" means the human kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin, and any other human organ specified by the Secretary of Health and Human Services by regulation.

(2) The term "valuable consideration" does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.

(3) The term "interstate commerce" has the meaning prescribed for it by section 321(b) of Title 21.

(Pub.L. 98-507, Title III, § 301, Oct. 19, 1984, 98 Stat. 2346.)

Codification. Section enacted as part of the National Organ Transplant Act and not as part of the Public Health Service Act.

Legislative History. For legislative history and purpose of Pub.L. 98-507, see 1984 U.S. Code Cong. and Adm. News, p. 3975.

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"(2) Except as otherwise specifically provided, the amendments made by subsections (a) through (i) [enacting this notice, amending sections 302, 303, 402, 1302, 1352, and 1396a of this title, and section 2020 of Title 7, Agriculture, repealing section 611 of this title, and amending provisions set out as a note under section 1382 of this title] shall become effective on April 1, 1985. In the case of any State which submits a plan describing a good faith effort by such State to come into compliance with the requirements of such subsections, the Secretary of Health and Human Services (or, in the case of the State unemployment compensation program, the Secretary of Labor, or, in the case of the food stamp program, the Secretary of Agriculture) may by waiver grant a delay in the effective date of such subsections, except that no such waiver may delay the effective date of section 1137(c) of the Social Security Act [subsec.(c) of this section] (as added by subsection (a) of this section), or delay the effective date of any other provision of or added by this section beyond September 30, 1986."

Immigration and Naturalization Service to Establish Verification System by Oct. 1, 1987. Section 121(c)(1) of Pub.L. 99-603 provided that: "The Commissioner of Immigration and Naturalization shall implement a system for the verification of immigration status under paragraphs (3) and (4)(3)(i) of section 1137(d) of the Social Security Act [subsec. (d) of this section] (as amended by this section) so that the system is available to all the States by not later than October 1, 1987. Such system shall not be used by the Immigration and Naturalization Service for administrative (non-criminal) immigration enforcement purposes and shall be implemented in a manner that provides for verification of immigration status without regard to the sex, color, race, religion, or nationality of the individual involved."

Studies and Reports by Comptroller General to Congress and Executive Agencies and Departments. Section 121(d) of Pub.L. 99-603 provided that:

"(d) Reports.—

"(1) Report on current pilot projects.—The Comptroller General shall—

"(A) examine current pilot projects relating to the System for Alien Verification of Eligibility (SAVE) operated by, or through cooperative agreements with, the Immigration and Naturalization Service, and

"(B) report, not later than October 1, 1987, to Congress and to the Commissioner of the Immigration and Naturalization Service concerning the effectiveness of such projects and any problems with the implementation of such projects, particularly as they may apply to implementation of the system referred to in subsection (c)(1) [set out as a note above].

"(2) Report on implementation of verification system.—The Comptroller General shall—

"(A) monitor and analyze the implementation of such system,

"(B) report to Congress and to the appropriate Secretaries described in subsection (c)(4)(D)(ii) [set out as a note above] by not later than April 1, 1989, on such implementation, and

"(C) include in such report such recommendations for changes in the system as may be appropriate."

Legislative History. For legislative history and purpose of Pub.L. 98-369, see 1984 U.S. Code Cong. and Adm. News, p. 697. See, also, Pub.L. 99-509, 1986 U.S. Code Cong. and Adm. News, p. 3607.

Library References

Agriculture ⇐2.6(2).
Social Security and Public Welfare ⇐194.2, 194.7, 241.80, 381.
C.J.S. Agriculture §§ 77, 78.
C.J.S. Social Security and Public Welfare §§ 116, 118, 133, 211 to 213.

§ 1320b–8. Hospital protocols for organ procurement and standards for organ procurement agencies

(a) Establishment of protocols; membership in Organ Procurement and Transplantation Network

(1) The Secretary shall provide that a hospital meeting the requirements of subchapter XVIII or XIX of this chapter may participate in the program established under such subchapter only if—

(A) the hospital establishes written protocols for the identification of potential organ donors that—

(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

(iii) require that an organ procurement agency designated by the Secretary pursuant to subsection (b)(1)(F) of this section be notified of potential organ donors; and

(B) in the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network established pursuant to section 274 of this title (in this section referred to as the "Network").

(2) For purposes of this subsection, the term "organ" means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

(b) Organ procurement agency standards

(1) The Secretary shall provide that payment may be made under subchapter XVIII or XIX of this chapter with respect to organ procurement costs attributable to payments made to an organ procurement agency only if the agency—

(A)(i) is a qualified organ procurement organization (as described in section 273(b) of this title) that is operating under a grant made under section 273(a) of this title, or (ii) has been certified or recertified by the Secretary within the previous two years as meeting the standards to be a qualified organ procurement organization (as so described);

(B) meets the requirements that are applicable under such title for organ procurement agencies;

(C) meets performance-related standards prescribed by the Secretary;

(D) is a member of, and abides by the rules and requirements of, the Network;

(E) allocates organs, within its service area and nationally, in accordance with medical criteria and the policies of the Network; and

(F) is designated by the Secretary as an organ procurement organization payments to which may be treated as organ procurement costs for purposes of reimbursement under such subchapter.

(2) The Secretary may not designate more than one organ procurement organization for each service area (described in section 273(b)(1)(E) of this title) under paragraph (1)(F).

(Aug. 14, 1935, c. 531, Title XI, § 1138, as added Oct. 21, 1986, Pub.L. 99-509, Title IX, § 9318(a), 100 Stat. 2009.)

[1] So in original. Probably should be "in".

Effective Date. Section 9318(b) of Pub.L. 99-509 provided that subsec. (a) of this section shall apply to hospitals participating in the programs under subchapters XVIII and XIX of this chapter as of Oct. 1, 1987, and that subsec. (b) of this section shall apply to costs of organs procured on or after Oct. 1, 1987.

Legislative History. For legislative history and purpose of Pub.L. 99-509, see 1986 U.S. Code Cong. and Adm. News, p. 3607.

Part B—Peer Review of Utilization and Quality of Health Care Services

§ 1320c. Purpose

Effective Date. Section 149 of Pub.L. 97-248, as amended Pub.L. 98-369, Title III, § 2354(c)(3)(C), July 18, 1984, 98 Stat. 1102, provided that: "The amendments made by this subtitle [subtitle C of Pub.L. 97-248, comprising sections 141 to 150 of such Public Law which enacted this part, amended sections 1395b-1, 1395g, 1395k, 1395l, 1395s, 1395y, 1395cc, 1395pp, 1396a and 1396b of this title, omitted sections 1320c-14 to 1320c-19, 1320c-21, and 1320c-22 of this title, and enacted provisions set out as notes under this section and section 1305 of this title] shall, subject to section 150 [section 150 of Pub.L. 97-248, set out as a note below], be effective with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Sept. 3, 1982]"

§ 1320c–1. Definition of utilization and quality control peer review organization

The term "utilization and quality control peer review organization" means an entity which—

(1)(A) is composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area, designated by the Secretary under section 1320c-2 of this title, with respect to which the entity shall perform services under this part, or (B) has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured;

Proclamation 5643 of April 29, 1987

National Organ and Tissue Donor Awareness Week, 1987

52 F.R. 15935

By the President of the United States of America

A Proclamation

Spring is a season of promise and renewal, and nothing could be more fitting during this time than to reflect on God's abundant miracles of life and growth.

Organ and tissue donorship presents an opportunity to share in these miracles. Medical technology has made it possible for thousands of Americans to benefit from organ and tissue transplantation. Sometimes this means restored vision or help for severe burns; sometimes, a heart, liver, or bone marrow transplant. But whatever the case, organ and tissue donorship shows the magnificent generosity of the American people.

More and more Americans are aware of organ and tissue donorship, thanks to much education about this worthy cause. The American Council on Transplantation has promoted organ and tissue donorship diligently for the last 4 years. Others, such as the National Kidney Foundation, the Lions Club, the Children's Transplant Association, and the Boy Scouts of America, have joined in the effort.

The results are most encouraging. Millions of Americans now carry organ and tissue donor cards. Many States give people the opportunity to sign donor cards when they complete their driver's license forms. Our schools and our media have also become involved in this cause.

But it is each American family and each citizen who makes organ and tissue donorship work. The generosity of organ and tissue donation is a very private matter between individuals and God, the giver of life. So, as all of us rejoice this springtime on the hope and promise of life, let us also think about signing organ and tissue donor cards. We keep that promise alive by helping others in need.

The Congress, by Senate Joint Resolution 69, has authorized and requested the President to issue a proclamation observing the week of April 26 through May 2, 1987, as "National Organ and Tissue Donor Awareness Week".

NOW, THEREFORE, I, RONALD REAGAN, President of the United States of America, do hereby proclaim the week of April 26 through May 2, 1987, as National Organ and Tissue Donor Awareness Week. I ask health care professionals, educators, the media, public and private service organizations, and all Americans to join in supporting this humanitarian cause.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-ninth day of April, in the year of our Lord nineteen hundred and eighty-seven, and of the Independence of the United States of America the two hundred and eleventh.

Ronald Reagan

THOMAS C. WOOD, M.D., F.A.C.P.
INTERNAL MEDICINE AND NEPHROLOGY

PROVIDENCE MEDICAL OFFICE BUILDING SUITE 661
3340 PROVIDENCE DRIVE, ANCHORAGE, ALASKA 99508
(907) 562-2712

STATEMENT IN TESTIMONY

DATE: October 21, 1987.

TO: Legislative Hearing.

RE: House Bill #306 (Sponsors Gruenberg, Grussendorf, Koponen, et al).

FROM: Thomas C. Wood, M.D., F.A.C.P.

I appreciate the opportunity to present testimony at this legislative hearing. Because of late notification, I was unable to come to this hearing and greatly appreciate the willingness of Kathy Purintun, R.N., to read this statement.

An earlier draft of the bill was submitted to me, and I replied in writing on April 8, 1987. A copy of this letter to Representative Gruenberg and Senator Fischer will be appended to my comments today.

My greatest concern with the bill as submitted is the application of the law to all hospitals within the state except those exempted by the Commissioner of Health & Social Services. At present, only hospitals in major cities are able to remove tissues for organ transplantation, and it seems most appropriate to me to direct the law and subsequent regulations to those specific hospitals in Fairbanks, Anchorage, Juneau, and Ketchikan, where there is the medical expertise for the removal of appropriate organs and tissue and for their transfer to a transplant center.

The identification and support of potential donors is as much a requirement for successful organ donation as is the legal identification of such donors either by the individual himself or his next of kin. Ideally, after brain death has been declared, the heart-beating cadaver is maintained until suitable transfer to the operating room on a respirator, at which time the organs are removed and sent to appropriate receiving institutions for actual use in transplantation. Alternatively, in an unusual circumstance, the entire cadaver can be transported via air ambulance to a major transplant center where multiple organs can be removed and utilized. This situation obviously exists in only the major population and transportation centers of the state.

There are strict medical criteria which are used before accepting a donation. These will include the knowledge of the donor's past medical history, the absence of any infectious disease, willingness of the next of kin to either honor the donor's request for organ donation or provide that consent themselves, and finally the necessary medical support services to insure that appropriate organs can be removed and transported in a viable condition. Even under the very best of circumstances, this requires involvement of many members of the organ transplant team, the coroner, and appropriate hospital personnel.

CONTINUED ON PAGE TWO...

Within Anchorage, only approximately one out of every ten or fifteen identified potential donors is ever utilized for organ donation because of the above conditions. To require personnel in smaller hospitals unfamiliar with the medical and transportation requirements for organ donation is likely to increase emotional distress among the survivors as well as overload the currently available personnel familiar with the transplantation program.

Two final comments include the absolute necessity for insuring that the hospital and appropriate medical personnel do not accrue any liability for either asking permission for organ donation from an inappropriate potential donor or from the failure to identify an appropriate donor. The bill must also be in compliance with the new federal law regarding request for organ donation.

Thank you again for allowing me to present testimony at this legislative hearing.

Respectfully,

Thomas C Wood MD

THOMAS C. WOOD, M.D., F.A.C.P.
Medical Director/Alaska Kidney Center

TCW/ft

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INFECTIOUS DISEASES:
Paul L. Steer, M.D., FACP

NEPHROLOGY:
Steven B. Tucker, M.D.

HEMATOLOGY/ONCOLOGY:
James M. Sprott, M.D.
Mary L. Stewart, M.D.

October 21, 1987

TO WHOM IT MAY CONCERN:

Re: Impending Legislation Regarding Organ Donation

At the present time there are currently more recipients awaiting heart, liver and kidney transplants than there are organs available to satisfy that need.

It is my feeling, therefore, that efforts to increase the availability of organs for appropriate use need be increased.

It is for this reason, therefore, that I support legislation predominantly directed at increasing public awareness of the organ shortage, as well as increasing specific family counselling in appropriate instances.

Alaska has always participated in an organ donation program, predominantly with the University of Washington in Seattle. We are now part of the Northwest Organ Procurement Agency and have been active in this regard.

As outlined, therefore, I am in agreement with the general spirit of the legislation, particularly as it addresses increased involvement at the Division of Motor Vehicles so that new drivers are specifically counselled as to organ donation and would also increase the involvement of the hospital staff to approach patients and their families in circumstances were organ donation may well be appropriate.

I also believe it is vitally important that in a remote area such as Alaska that small rural hospitals where the facilities for appropriate organ donation are not available not be held accountable to this legislation. I likewise think it is imperative that any bill include specific legal language that prevents lawsuits arising from either families who were upset that they were approached and also specifically prevents families from lawsuits where for one reason or another they were, in fact, not approached regarding this subject.

The purpose of this legislation in my opinion is not to open potential legal avenues for suit, but to increase the availability for organs in a situation where there is national shortage. If this legislation will accomplish those ends, it has my ~~full~~ support.

Steven B. Tucker, M.D.
Nephrologist

SBT/lal

NORTHWEST
ORGAN PROCUREMENT
AGENCY

Kathy Purintun R.N.
Organ Donation Coordinator-Alaska
3200 Providence Drive
Anchorage, Alaska 99519-6604
(907) 562-2211 Beeper 352

Dear Ladies and Gentlemen of the Alaska Legislature:

House Bill 306 supports organ donation as an opportunity of voluntary giving. I am in favor of organ donation when it is appropriate and carried out in a sensitive and caring manner. The process can provide solace and something positive in the tragic loss of life to a donating family. It can also improve the quality and longevity of life for a recipient. But the need for organs is greater than the number available, mainly since transplantation success rate have improved.

This morning, (UNOS) United Network of Organ Sharing computer in Richmond,Virginia has identified the following numbers of recipients waiting for organs: 10,100 for kidneys, 462 for hearts, 350 for livers, 95 for heart-lungs, and 50 for pancreas. Closer to home,there are 15 waiting for kidneys and waiting for hearts who are Alaskans. And on the other hand,13 people received kidneys transplants last year and 8 Alaskans received a heart transplant.

The National Transplant Act of 1984 identified the shortage of organs because medical professionals were not identifying potential donors and offering the option to donate to their families/next of kin. Data from the Centers for Disease Control suggest that approximately 20,000 persons die each year under circumstances that make them suitable for organ donation, yet only 3000 organs are donated each year, mostly through approaching families at the very worst hour of the very worst day of their life.

HB 306 is patterned after the Federal Required Request Legislation PL-99-509 (Omibus Budget Reconciliation Act of 1986) requiring hospitals to have organ donation policies whereby potential donors will be identified, families given the option to donate when appropriate, and organ procurement agencies/tissue banks notified to coordinate the process. ~~and x x x x x x x x x x x x x x x x x x x x x x x x x x x~~ This law went into effect October 1, 1987. To my knowledge, at least 32 states have passed state required request legislation since 1985. While this is an important step, current statistics show that tissue donations (cornea, tendons, bone)have increased, organ donations have not. By November 21, the Federal Goverment will assign one OPA per geographic region in the U.S. Currently there are 150 OPA with competition for organs occuring in some areas. Alaska has always been linked to Seattle (NKC/NOPA) for 15 years. This is an independent agency covering the WAMI region to assist hospitals with the organ donation process and provides organs to a variety of transplant centers through the UNOS computer.

The Medical community in Alaska (Anchorage, Fairbanks, Juneau, and Ketichan) support the philosophy of organ donation and we have a very workable system. Out of 28 health care facilities in the state, 7 hospitals have been identified by the OPA as medically able to provide services to evaluate ~~and medically~~ manage organs ~~donors~~ + tissue. I have been working with these hospitals over the last year to provide education and an understanding of the organ donation process. 5 multiple organ donations in AK. (3 hearts, 2 livers, 10 kidneys)

This legislation supports the essential area involving organ donation in Alaska:

1) identifing potential donors is a hospital responsibility

2) request permission of the coroner for recovery of donated organs
3) present the option to donate to the family when it is appropriate
4) encourages discretion and sensitivity in dealing with families - training of the personnel who will be requesting the gifts. It is important to ask, but it is just as important to answer all questions and support their decision. Needs to be done without infringing on people's deeply held values and rights.
5) In Alaska, logistics and medical facilities in rural communities may exempt hospitals from meeting the requirement set forth in this legislation. 6)No cost to the family
7) Law and medical emergency personnel to check for donor cards at the scene of the accident and inform the hospital staff of such
8) Encouraging the MVD to ask all persons orally if they wish to be an organ donor when applying for their identificaton card. (70-80% public favor organ donation, yet statistics show 19% have signified it on their drivers license or ID card) Education of MVD employees concerning organ donation is essential so they can handle the questions.
9) When acting in good faith, the person acting in accordance with the law will not be liable for damages or subject to prosecution.

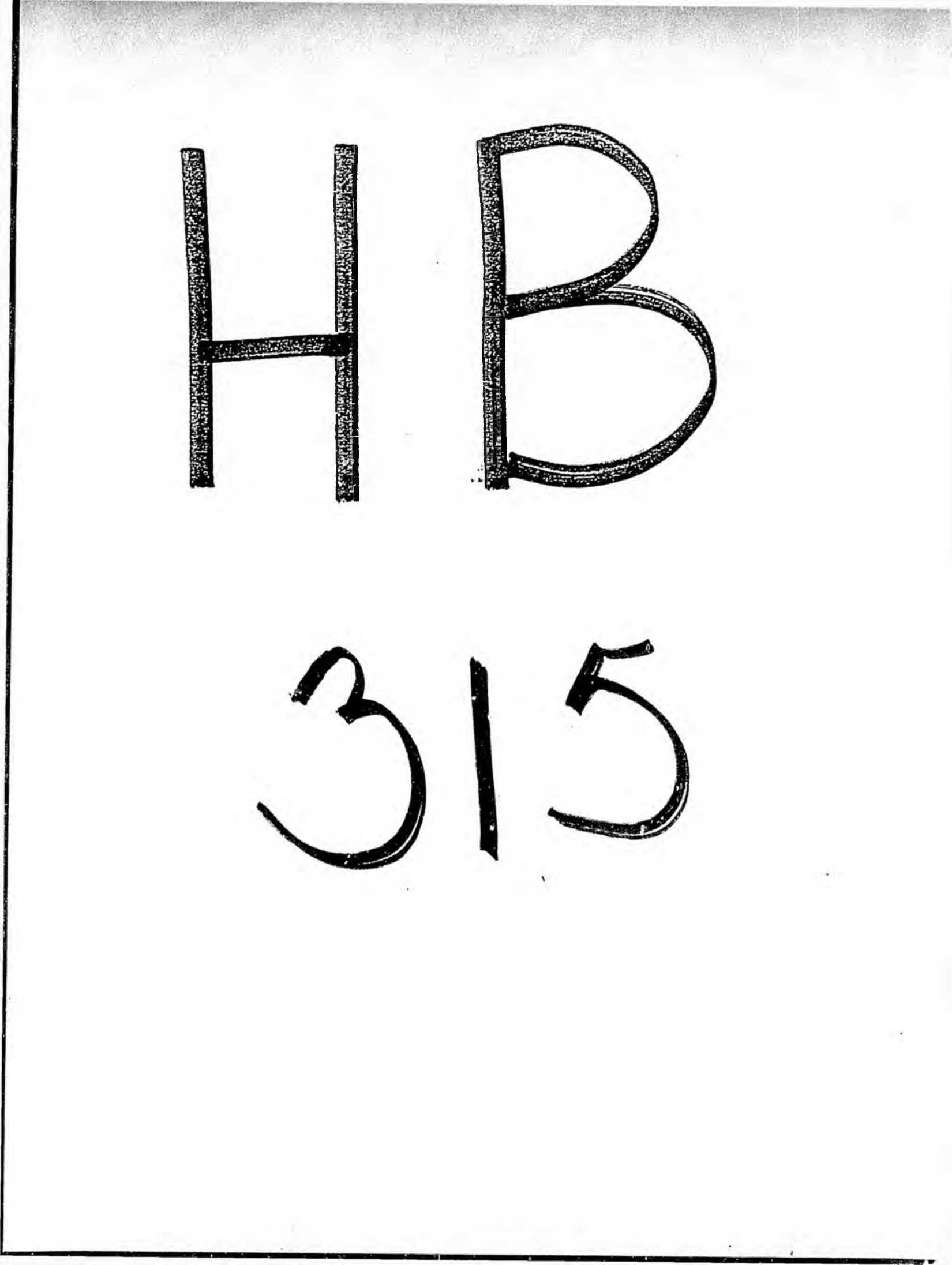
There is,however, that the legislation does not cover:

1) Page 1, Sec 2 (b) The national law identifies two additional situations when it is inappropriate to request a gift - religious beliefs and acutal notice of contrary indications by the deceased or family members.
2) Bottom of page 2 and top of page 3, Sec 4 (a) It is misleading to assume in Alaska for total body donation for the purposes of medical education or research that there would not be a cost to the family/ estate for the transportation of the gift. U. of W. (our closest medical school) provides free transportation for only a 75 mile radius. Therefore, for Alaskans wishing to donate a gift of the entire body, the transportation cost would be there responsibility.

One final point, I would like to make, is that JCAH (Joint Commission Accrediation of Hospitals) has included organ donation policies as a standard for accrediation after January 1988.

I stongly support this legislation because the "gift of life" depends on the recognition of potential organ donors; on the recognition depends on an awareness of the need for organs and a knowledge of the procedure for donation and transplantation. It provides that human connection of encouraging personal decisions about organ donation and following through a process when it is appropriate.

I commend Max Grunberg, Grussendorf, Kopenon for the creative approach of restructuring the Alaska'a Uniform Anatomical Gift Act with this "required request" legislation. Most states have drafted a separate bill, but I feel Alaska approach is also very approriate. Thank you.


HB
315

SB 255

Downtown Rexall Drug

:harge - manufacturer - establishes price
drug wholesaler - 2/3 % markup
Pharmacy -

- very competitive market

Medicaid will only affect pharmacy, not the manufacturer with its fixed price

- independent pharmacys would drop out
- high cost of keeping inventory
- fee doesn't cover overhead

Pharmacy - don't involve federal govt.
- marginal people need the small pharmacies

s - costs shift to private paid clients
"usual and customary" would work but not allowed
must go along with other states

Kodiak

Valdez Drug - agrees w/ previous testimony

Kodiak Drug - wont keep in business, infringe on other customers

Bethel

Swanson's - closure would affect entire area

Binkley - % that are Medicaid eligible
20-25%

Doctor Schrader - will not affect IHS much
IHS rx
15% pop. served is Medicaid eligible
- cross over didn't occur with dental

Seward

Jim Warren - can't afford to discount prices
Seward Drug
- shouldn't subsidize state program

Bill
Pete - Pharmacy consultant for Medicaid in WA
in WA
- nearly complete participation
- variable dispensing fee
$12.12 - average in WA $12.54 - national average
7% of the budget

Sitka

Syb Frye - DHSS cant tell us what the cost will be

White Pharmacy -

Homer

Anch Pt. Pharmacy - we'd lose money
- feds wont pay for some drugs
- can't live w/ wholesale minus
- one wholesaler in Ak

Homer Phar. - 30% are Medicaid eligible

Lynn Chase - support 255
Prov. Hospital - a lot of people in need
- hospital pharmacy already under Medicaid

Dove - supports 255
OAC - no decrease of benefits to senior citizens

Joy Donddeau - can not fill special perscriptions at wholesale plus $5 or $10
$372 - cost
$5 - DHSS fee
- no questions ~~to~~ of hospital costs for drugs

Hensley - why do you anticipate losses
- feds wont allow fair renumeration for special drugs

Halford - do you have to take Medicaid patients
14.8% are Medicaid

Uehling - would ~~would~~ special drugs be available under 255
- probably not

Program is working, Ak has lowest pharmacy budget in the country

Chris Coursey — if 25%, some businesses could fail, others will lay off employees
Ak. Pharm. Assoc.
- have to deal w/ mail order competition now
- average is 20% are Medicaid
- professional fee doesn't cover fixed expenses
- 12 will consider dropping out of program
- Senate Pres. has agreed to examine alternatives or figure out what the costs will be

Hensley — bill has been around — why hasn't communication happened
- have provided input but haven't been able to create an entire package

Dirk White (Sitka) — - $17.71 average for GRH program
- we are not making a killing
- won't treat welfare patients the same if they don't get fair compensation

Halford — can you select sales
- it's all or nothing

Hensley - what would happen to people not served
- I dont know

(co-pay programs)
under GRH patient must pay $1 for each perscription

Harlan Knudsen - Medicaid is a painful program
- nursing homes + hospitals & support 255
'rural system is fragile
↳ $2 million in liability
↳ we need the feds matching dollar in the overall health system

Hallund - what happens to people not served
either go mail order or to hospital

Ron Sedgewick - a 50% difference in methods of reimbursement. Medicaid would give 50% less than GRH

we have ← must maintain provider network
we have ← low cost per recipient $140/yr $243/national
need to work on ← obtain fed matching $

- no more administrative costs for pharmacists

Pharmacist is in Senate budget

Munson

Use same forms
Special fees for sole providers
Generous rates for other programs to make
Pharmacy program only 3%

~~$30~~

- co-payment possible under Medicaid
- considerable variation available certain guidelines
- all states use set fee, no percentage

[90% of usual + customary costs]

2:30

continue to have legislative oversight on what the Dept. does

sunset attribute - reviewed 1 yr. trial balloon
if it doesn't work, it disappears

January program in place, in effect

Munson affirmative action to end
↳ Halfad no

1 year sunset to bill + title

FACTS - MEDICAID PHARMACY PROGRAM
SB 255

-- All medical providers except pharmacists in Alaska participate in the Medicaid program.

-- The majority of pharmacies will continue to serve medicaid and GRM clients. 95% of the pharmacists in Washington State participate in the Medicaid pharmacy program. National statistics show the same high rate of participation.

-- The Medicaid pharmacy program will not force small, independent pharmacists out of business. The majority of pharmacists in Washington state are independent pharmacists and many are sole community providers.

-- Adding Pharmacy as a Medicaid-covered service saves 50% in state funds.

-- If Alaska had adopted a Medicaid Pharmacy Program in FY85, the State would have already saved over 4.5 million.

-- If SB 255 passes it will save a minimum of $5.5 million in state general funds thru FY90.

-- The purpose of SB 255 is to gain federal matching funds not to pay pharmacists less.

-- Native "cross-over" is a non-issue. The majority of IHS - eligibles are already using the pharmacy of their choice - whether it is a private pharmacy or an IHS facility. Nationally, and in Alaska changes in Native utilization patterns have not occurred due to a change in payment sources.

SB 255

-- The changeover to a Medicaid pharmacy program will be invisible to clients.

-- Alaska Pharmacists are the only medical provider in the state and in the nation paid out of 100% state funds for Medicaid clients' services.

-- Alaska is the only state not claiming federal funds for pharmacy services under Medicaid.

-- Legislative Audit has recommended that the Legislature adopt a Medicaid Pharmacy bill.

-- The Alaska Health Association has recommended adoption of a Medicaid pharmacy program.

-- The Governor's Interim Health Care Commission in its final draft has recommended adoption of the Medicaid pharmacy option.

-- The Department will enact no changes in payment to pharmacies without publishing regulations and holding public hearings across the state.

-- The passage of the Medicaid Pharmacy option will not change the paperwork or the billing process for pharmacists.

SB 55

-- A Medicaid Pharmacy Program can pay geographic differentials.

-- A Medicaid Pharmacy Program can pay a differential for "Mom and Pop" pharmacies.

Excerpt from: "A Follow-up Review ON The Department of Commerce and Economic Development, Board of Pharmacy" November 14, 1985

The Division of Legislative Audit

Medicaid Drug Program

During the 1985 legislative session, HB 209 was introduced by the Rules Committee at the request of the Governor. The purpose of the bill was to allow the State to request participation in the Federal Medicaid prescribed drug program. Medicaid offers a program by which it will pay half of the costs of prescribed drugs for covered individuals. Under this program Medicaid allows payment of a dispensing fee in addition to the cost of the prescribed drug. This dispensing fee would be established by the State based on a variety of factors. In effect, under this bill the State would be telling pharmacists how much they can charge for prescribed drugs paid for under the Medicaid program.

We can find no evidence that the Board of Pharmacy formally opposed HB 209. While many pharmacists, including past and present Board members, testified against HB 209 before both the House Finance and the House Health, Education, and Social Services Committees, they have done so on their own behalf and not at the formal request of the Board.

Currently, prescribed drugs for qualified individuals are paid for by the State under the General Relief Medical (GRM) program, which is funded entirely by the General Fund. Under the General Relief Medical program, prescribed drugs are paid for at the price set by the pharmacist. If HB 209 is adopted, the costs would be split with the Federal government. Alaska is only one of two states who do not participate in this program. The Department of Health and Social Services (DHSS) estimates that the cost savings to the State, by enactment of this bill, would be approximately $1.4 million annually.

At the end of the 1985 session, HB 209 had been passed by the House, but not the Senate. In September 1985, DHSS met with pharmacists and tentatively agreed to a collection of alternative cost saving measures in lieu of HB 209. If these measures are implemented, the State's General Relief program would save approximately $700,000.

Although the proposed compromise between DHSS and the Pharmacy Association would reduce the cost of the prescribed drug program to GRM, all expenditures would still be General Fund monies. In our opinion the implementation of HB 209

would be preferable to this compromise. Participation in the Medicaid program would allow the State to provide eligible recipients the same level and quality of service at almost half the cost to the General Fund. Using schedules prepared by DHSS's Division of Medical Assistance, we determined that if the Medicaid Drug program had been in effect during FYs 84 and 85, the State would have saved over $2 million.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: HB 315
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to pharmaceutical medical assistance for needy persons.
Sponsor: _____
Requestor: _____

Agency Affected: Health and Social Services
BRU: HD Administration/Medical Assistance
Components: Claims Processing/General Relief Medical, Medicaid Non-Facility

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL		10.0	10.8	11.7	12.6	13.6
CONTRACTUAL		106.0	99.4	107.3	115.9	125.2
SUPPLIES		1.5	1.6	1.7	1.9	2.0
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		117.5	111.8	120.7	130.4	140.8
CAPITAL						
REVENUE		1,429.3	2,029.5	2,191.8	2,367.2	2,556.5

FUNDING: (Thousands of Dollars)

GENERAL FUND		(1,311.8)	(1,917.7)	(2,071.1)	(2,236.8)	(2,415.7)
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TOTAL		117.5	111.8	120.7	130.4	140.8

POSITIONS:

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED

Prepared by: Kim Busch, Director Kim Busch Phone: 465-3355
Division: Medical Assistance Date: 2-1-88

Approved by Commissioner: Myra Munson Myra M Munson Date: 2-2-88
Agency: Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISCAL NOTE ANALYSIS

HB 315

"An Act relating to pharmaceutical medical assistance for needy persons, and providing for an effective date"

FY89 Governor's Medical Assistance Request

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GENERAL RELIEF MEDICAL Request	9,380.4	9,380.4
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Decrement to Remove Pharmacy	[1,370.6]	[1,370.6]
REVISED	6,639.2	6,639.2

	FED	GFM	Program	Total
MEDICAID NON-FACILITY Request	17,145.4	17,213.2	169.0	34,527.6
C-4 Transfer from GRM	-0-	1,370.6	-0-	1,370.6
Increment for Federal	1,370.6	-0-	-0-	1,370.6
REVISED	18,516.0	18,583.8	169.0	37,268.8

With a move of prescription drugs for Medicaid recipients from the General Relief Medical (GRM) Component to the Medicaid Non-Facility Component, Medicaid funds would become available at a 50/50 federal financial participation ratio. The Governors FY 89 General Relief Medical budget request for Title XIX pharmacy is $3,654.8. This fiscal note assumes an October 1, 1988 implementation date.

The national rate of increase for prescription drug costs in 1987 according to the U.S. Department of Labor was 8%. For purposes of this fiscal note the Department has assumed 8% as the annual rate of inflation for prescription drugs.

Medical Assistance Administration - Claims Processing

The administrative costs except for the $14,000 for computer programming changes will not be necessary if the increment in the Governor's budget is approved as introduced.

Travel:

On-site pharmacy reviews for dispensing fees, validating acquisition costs for drugs, meetings with the pharmacy association, and gathering data for pricing compounded drugs.	$10,000

Contractual:

Professional services contract for pharmacist/ pharmacy services*	$84,000
One time funding for fiscal intermediary to change computer system documentation including provider manuals, change the collocation code table to shift expenditures from GRM to Medicaid, change pricing logic, and add new edits	$14,000
On-going funding for fiscal intermediary for Blue Book update of average wholesale prices into MMIS claims processing system	$ 3,000
Space Rent $1.25/sq. ft. X 200 sq. ft.	$ 3,000
Communications - Long Distance and Printing	$ 1,000
Advertising and Printing	$ 1,000
Supplies:	$ 1,500
Total	$117,500
Federal	$58,750
SGFM	$58,750

Increases from fiscal year to fiscal year are projected at 8%.

* The Department proposes using the services of a contractor to do the initial work of design, development, and implementation of a Medicaid pharmacy program. However, the Department may elect in subsequent years to seek legislative approval of a permanent position for these services.

WE OF THE PHARMACY COMMUNITY IN SITKA APPLAUD YOUR EFFORTS TO ADD HOME HEALTH CARE LANGUAGE AS SPECIFIED IN HB 315. ALREADY IN ALASKA THIS NEW TREND CAUSED BY RISING HOSPITAL COSTS HAS FORCED PEOPLE TO BE CARED FOR OUTSIDE THE HOSPITAL ENVIRONMENT SOONER. MANY CASES DOCUMENT THAT *costs* TO THE FIRST, SECOND OR THIRD PARTY ARE 1/3 OR 1/2 AND IN SOME CASES AS LITTLE AS 1/10TH THE COST OF HOSPITALIZATION, SIMPLY BY PROVIDING HOME CARE THROUGH AN AGENCY AND A DURABLE MEDICAL EQUIPMENT PROVIDER WHILE A PATIENT RECOVERS FROM AN ILLNESS OR AS AN ALTERNATIVE TO LONG TERM CARE IN AN INSTITUTION. WE SEE JUSTIFICATION FOR KEEPING MORE PATIENTS HOME IN ALASKA WHERE THEY RECOVER FASTER AND MORE COMPLETELY THAN EXCURSIONS TO OUT OF STATE HOSPITALS.

AS PROVIDERS FOR BOTH PHARMACY AND DURABLE MEDICAL SERVICES, WE HAVE SOME VERY REAL CONCERNS ABOUT THE FUTURE. ARE WE TO EXPECT TO PROVIDE USUAL AND CUSTOMARY QUALITY FOR OUR PRODUCTS AND SERVICES AND IN TURN BE PAID A USUAL AND CUSTOMARY RETURN? OUR COSTS OF DOING BUSINESS IN OUR AREA CONTINUE TO RISE YET WE ARE BEING TOLD WHAT WE ARE TO BE PAID BASED NOT ON THE QUALITY OF GOODS AND SERVICES BUT ON THE CHEAPEST PRICE IN THE INDUSTRY. WE FEEL AN OBLIGATION TO SERVE OUR PATIENTS WITH THE BEST CARE FOR THE BEST PRICE; HOWEVER, WE STILL MUST MAINTAIN AN INVENTORY OF GOODS AND BE ABLE TO PAY OUR PROVIDERS IN A TIMELY MANNER AND COVER THE OVERHEAD COSTS TO ALLOW US TO DO BUSINESS THE NEXT MONTH WHEN SOMEONE ELSE REQUIRES OUR SERVICES. A GOOD EXAMPLE ARE WHEELCHAIRS AND BEDS. THESE ARE EXPENSIVE ITEMS RUNNING ANYWHERE BETWEEN $250 AND WELL OVER $1000. THERE ARE MANY TO CHOOSE FROM AND MOST PATIENTS REQUIRE SPECIAL NEEDS IN THEIR CHAIRS AND BEDS OR WHY WOULD THEY NEED THE SERVICE IN THE FIRST PLACE. WILL YOU PAY THE $750 FOR THE RECIPIENTS PROPER CHAIR OR ONLY $250 FOR THE "CHEAPEST" CHAIR BECAUSE IT'S AVAILABLE? THE RECIPIENT'S ABILITY TO PAY A FEW DOLLARS ABOVE YOUR MAXIMUM ALLOWABLE COST OF A DRUG IS ONE MATTER WHILE $500 WILL ALMOST CERTAINLY BE A BARRIER TO GOOD MEDICINE.

NOTIFICATION WAS SENT RECENTLY ABOUT A COMPANY IN TENNESSEE BEING AWARDED THE ALASKA MEDICAL PAYMENTS ASSISTANCE (AMPS) CONTRACT. WE ARE TO UNDERSTAND THE TRANSITION WILL OCCUR OVER THE NEXT FEW MONTHS TO BE COMPLETED IN MAY BUT, WE DO NOT UNDERSTAND THE FULL IMPACT OF THE CHANGES THEY INTEND TO MAKE. IT APPEARS THEY INTEND TO PURSUE THE METHOD WHEREBY PHARMACIES GET

REIMBURSED ONLY A PORTION OF THEIR COSTS THROUGH A MAXIMUM ALLOWABLE COST BASIS PLUS A PRE-DETERMINED FEE. WE DO NOT KNOW WHAT THIS FEE IS. SEVERAL YEARS AGO THIS MATTER WAS ADDRESSED AND MANY PHARMACIES STATED THEY MIGHT NOT BE ABLE TO DO BUSINESS WITH AMPS IF USUAL AND CUSTOMARY WAS NOT REIMBURSED. THE STATE, AT THAT TIME INSTITUTED THE ONE DOLLAR CO-PAY TO HEDGE AGAINST RISING COSTS. WE SEEM TO HAVE MISSED NOTIFICATION OF THIS NEW ACTION.

PHARMACY IS NOT ASKING FOR A HAND-OUT. WE ONLY ASK TO BE ALLOWED TO DO BUSINESS AND PROVIDE THE BEST CARE AT THE MARKET VALUED PRICE. LET FREE ENTERPRISE DETERMINE OUR PRICES. HELP US BY GETTING OUR PAYMENTS TO US WITHIN 30 DAYS AND TRY TO MAKE THE SYSTEM SIMPLER BY NOT REQUIRING A REFUSAL FROM MEDICARE WHEN EVERYONE KNOWS THEY REFUSE 100% OF SUCH CLAIMS. GIVE US SOME LEVERAGE TO FALL BACK ON WHEN YOUR CONTRACTED INSURANCE CARRIER DECIDES NOT TO PAY 50% OF YOUR CLAIMS BECAUSE THEY ARE "PENDING". (WE HAVE NEVER BEEN GIVEN A CLEAR DEFINITION OF "PENDING" AS IT IS REFERRED TO BY INSURANCE COMPANIES.) FINALLY, GIVE US A LITTLE RECOGNITION FOR THE JOB WE DO IN OUR COMMUNITIES. ALLOW OUR CONTINUATION OF PROVIDING HIGH QUALITY HEALTH SERVICES.

THANK YOU FOR REQUESTING INPUT ON THIS AND OTHER CONCERNS AFFECTING LEGISLATION THIS SESSION. WE APOLOGIZE FOR NOT SPEAKING WITH YOU PERSONALLY.

SINCERELY,

DAVID E. MOORE R.PH. &
JOHN W. COOPER R.PH.
OF SITKA PHARMACY, INC.

TRISH WHITE R.PH. &
DIRK T. WHITE R.PH
OF WHITE'S, INC.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H HESS 2-2-88 8:30a.m.

POSITION PAPER/Department of Health & Social Services

HB 315

"An Act relating to pharmaceutical medical assistance for needy persons; and providing for an effective date."

I. Purpose of HB 315:

The purpose of HB 315 is to allow the Department of Health and Social Services to increase federal revenue by funding prescribed drugs for Medicaid recipients under the Medicaid Program rather than under the 100% state general funded General Relief Medical Program (GRM).

II. Sectional Analysis:

Section 1 establishes prescribed drugs as a Medicaid service which allows the Department to claim 50 percent federal Medicaid funding. This alone will result in an estimated $1,311.8 million savings of state general funds in FY89.

Section 2 adds prescribed drugs to AS 47.07.035 and provides the Department with legislative direction on the priority of prescribed drugs in the event of a funding shortfall.

Section 3 requires adoption of federal Medicaid procedures for purchasing prescribed drugs.

Section 4 gives "prescribed drugs" the same meaning as in federal Medicaid regulations.

Section 5 provides an effective date of July 1, 1988.

All states, except Alaska, that offer full prescription drug coverage for their Medicaid-eligible citizens, have chosen to fund this coverage through the federal Medicaid program. There is no indication that this has in any way harmed medical assistance recipients or resulted in withdrawal of pharmacies from participation as medical assistance providers.

III. Background

The governor first introduced legislation for the addition of coverage for prescription drugs under the Medicaid program in 1985. If this legislation had been adopted the state would have saved an estimated $4.5 million that could have been claimed in federal funds for those years. Today, pharmacy

remains the single service provided to Medicaid recipients for which the State of Alaska cannot claim federal matching dollars.

Basically, four arguments have been made against adding pharmacy services to the Medicaid program:

Argument: "The Medicaid rules concerning payment for drugs would cause Alaska pharmacies to lose money".

Response: The Medicaid rules concerning payment for drugs were amended last October. The new rules offer the state substantial flexibility including increased freedom from federal rules in setting payment rates for drugs. Under these rules there are two categories of drugs defined as follows:

1. Multiple Source Drugs

These drugs are commonly referred to as "generic" drugs. They are therapeutically equivalent drugs that can be purchased from three or more suppliers. The Health Care Financing Administration (HCFA) publishes a list of these drugs. There are approximately 134 drugs listed. For these drugs only the State cannot pay more in the aggregate than a dispensing fee plus an amount established by HCFA that is equal to 150 percent of the published price for the least costly therapeutic equivalent. According to Region X HCFA, the payment for these drugs in Alaska could be increased in recognition of the cost of shipping and handling. Further, if Alaska can show that the listed drugs are not available at these prices we can pay a higher price using the methodology established for the second category of drugs, "other drugs".

B. Other Drugs

These are all drugs that are not contained on HCFA's list. The State payment for these drugs cannot exceed, in the aggregate, more than the lower of the estimated acquisition cost plus a dispensing fee or the pharmacist's usual and customary charges to the general public. The estimated acquisition cost can be determined through a variety of methods. One method is to obtain a monthly microfiche of wholesale costs from the pharmaceutical distributors in the state.

The dispensing fee can also be established by several methods. One method would be to survey Alaska pharmacies to gather cost data for dispensing drugs. The dispensing fee may allow for geographical differentials and differentials in the volume of business conducted by the pharmacies.

The Department is proposing to either contract with or hire a pharmacist. The pharmacist's role would be to first work with the pharmacies throughout the state to design a program that would be

least disruptive to their businesses and that would ensure continued access for Medicaid and GRM recipients. The pharmacist would also:

- Ensure that Alaska's payments do not in the aggregate exceed the federal limits;
- Set prices above the federal limits for multiple source drugs that are documented as not available in Alaska at the federally listed prices;
- Establish codes and payments for FDA approved compounded drugs (drugs which are not contained in a national drug compendia);
- Work as liason with HCFA to ensure that any future federal changes in Medicaid payments for drugs allow sufficient flexibility for Alaska implementation;
- Work with pharmacies to ensure efficient and rapid processing of claims for payment.

Argument: "Many pharmacies would not participate in a drug program under Medicaid".

Response: In Washington State 1,156 pharmacies which comprise 95+% of the pharmacies in the state participate in the Medicaid drug program. Most states have little problem attracting pharmacies to participate in this program.

Argument: "Medicaid recipients will be forced to use generic drugs which will result in lower quality care".

Response: This legislation will have no impact on current practice regarding whether a generic drug is dispensed. Both Alaska and federal laws state that a generic drug should be dispensed when possible (i.e. available and therapeutically equivalent) but are clear that the ultimate choice always remains with the medical provider.

Argument: "A large number of Alaskan natives would cross over from using Indian Health Service (IHS) pharmacies to using non-IHS pharmacies, costing the state 50 percent where the previous financial participation had been zero".

Response: The shift [illegible]al coverage from the 100% state funded General Relief Medical Program to the 50 percent federally funded Medicaid Program caused no noticeable increase in utilization by natives. In the Department's estimation the majority of natives who wish to purchase drugs at non-Indian health facilities are already doing so through the General Relief Medical Assistance

Program. The shift in funding sources from GRM to Medicaid is unlikely to have any effect on the utilization patterns of most Medicaid-eligible natives. In rural areas, the IHS facility or contractor will remain the pharmacy of choice because it is either the most convenient or the only available provider. In urban areas the cross over has already occurred largely because IHS does not stock many of the drugs commonly prescribed to a large group of these recipients, IHS rules and hours of operation have already made this an unavailable option, and any recipient who wishes to can avoid restriction by not declaring his or her ethnic heritage.

Conclusion:

The Department believes that a Medicaid drug program will continue to result in reasonable payments to pharmacies, will not discourage the participation of this provider group, will not effect the quality of service, and will not result in the state assuming costs formerly borne by the IHS. Most importantly, the Department can assure that the addition of this option will result in a significant annual cost savings to the state without compromising services to Alaskans.

IV. Recommendations

The Department recommends amending Section 5 to change the effective date from July 1 to October 1, 1988. The delay in implementation is necessary to allow the Department time to amend the Medicaid state plan, promulgate and adopt regulations, contract with or hire the pharmacist, and effect changes in the claims processing system.

The Department strongly recommends passage of HB 315 so that the state may begin to receive 50 percent federal financial participation for prescribed drugs through the Medicaid Program. The savings will begin to accrue to the State in October, 1988.

Recommended by: Kim Busch
Kim Busch, Director
Division of Medical Assistance

Date: 2-1-88

Approved by: Myra M Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: 2-2-88

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: HB 315
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to pharmaceutical medical assistance for needy persons.
Sponsor: _____
Requestor: _____

Agency Affected: Health and Social Services
BRU: HA Administration/Medical Assistance
Components: Claims Processing/General Relief Medical, Medicaid Non-Facility

EXPENDITURES/REVENUES: (Thousands of Dollars)

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POSITIONS:

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED

Prepared by: Kim Busch, Director Kim Busch Phone: 465-3355
Division: Medical Assistance Date: 2-1-88

Approved by Commissioner: Myra Munson Myra M. Munson Date: 2-2-88
Agency: Health and Social Services

Distribution (by preparer):
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Decrement to Remove Pharmacy	[1,370.6]	[1,370.6]
REVISED	6,639.2	6,639.2

	FED	GFM	Program	Total
MEDICAID NON-FACILITY Request	17,145.4	17,213.2	169.0	34,527.6
C-4 Transfer from GRM	-0-	1,370.6	-0-	1,370.6
Increment for Federal	1,370.6	-0-	-0-	1,370.6
REVISED	18,516.0	18,583.8	169.0	37,268.8

With a move of prescription drugs for Medicaid recipients from the General Relief Medical (GRM) Component to the Medicaid Non-Facility Component, Medicaid funds would become available at a 50/50 federal financial participation ratio. The Governors FY 89 General Relief Medical budget request for Title XIX pharmacy is $3,654.8. This fiscal note assumes an October 1, 1988 implementation date.

The national rate of increase for prescription drug costs in 1987 according to the U.S. Department of Labor was 8%. For purposes of this fiscal note the Department has assumed 8% as the annual rate of inflation for prescription drugs.

Medical Assistance Administration - Claims Processing

The administrative costs except for the $14,000 for computer programming changes will not be necessary if the increment in the Governor's budget is approved as introduced.

Travel:

On-site pharmacy reviews for dispensing fees, validating acquisition costs for drugs, meetings with the pharmacy association, and gathering data for pricing compounded drugs.	$10,000

Contractual:

Professional services contract for pharmacist/ pharmacy services*	$84,000
One time funding for fiscal intermediary to change computer system documentation including provider manuals, change the collocation code table to shift expenditures from GRM to Medicaid, change pricing logic, and add new edits	$14,000
On-going funding for fiscal intermediary for Blue Book update of average wholesale prices into MMIS claims processing system	$ 3,000
Space Rent $1.25/sq. ft. X 200 sq. ft.	$ 3,000
Communications - Long Distance and Printing	$ 1,000
Advertising and Printing	$ 1,000
Supplies:	$ 1,500
Total	$117,500
Federal	$58,750
SGFM	$58,750

Increases from fiscal year to fiscal year are projected at 8%.

* The Department proposes using the services of a contractor to do the initial work of design, development, and implementation of a Medicaid pharmacy program. However, the Department may elect in subsequent years to seek legislative approval of a permanent position for these services.

Alaska State Legislature

Senate Advisory Council

PO Box V
State Capitol
Juneau, Alaska 99811
Phone (907) 465-3114

MEMORANDUM

TO: Senator Faiks
Alaska State Senate

ATTN: Jens Zehbe

FROM: Maureen Weeks
Senate Advisory Council

DATE : March 25, 1988

SUBJECT SB 255; IR# 88-003261

In a recent memo you asked for statistical data on the type and number of businesses that sell prescription drugs in Alaska; whether Alaska pharmacies are predominantly small "mom and pop" operations or large companies; what percentage of pharmaceutical sales are Medicaid reimbursed; and other pertinent data. I am responding to these questions in the order in which they were asked.

I. THE TYPE AND NUMBER OF PHARMACIES IN ALASKA.

1. Number.

The Board of Pharmacy lists 125 in-state licenses expiring June 30, 1988.

2. Type.

After consulting with the president of the Alaska Pharmacy Association, Chris Coursey, I have divided the types of pharmacies into chains, non-chains, facilities contracting with non-chain pharmacies, facilities contracting with chain pharmacies and state and federal pharmacies. They are listed on Table I below.

Table 1 shows that 24 percent of pharmacies are chain stores and 50 percent are non-chain stores. When facility contracts with non-chain pharmacies are included, 58 percent of Alaska's pharmacies are non-chain pharmacies.

TABLE 1

Types and Number of Alaska Pharmacy Licenses

Type of license	Number	Percent of total (%)
Chain pharmacies:*	30	24
Non-chain pharmacies:	63	50
Facility contracts with non-chain pharmacy:	10	8
Facility contracts with chain pharmacy:	2	2
Facility owns pharmacy:	14	11
State purchases pharmaceuticals:	3	2
Federal government purchases pharmaceuticals:	3	2
Total:	125	

Source: Alaska Board of Pharmacy

* The 30 chain pharmacies are in the Railbelt area and in Juneau. They include 4 in Fairbanks, 20 in Anchorage, 2 in Kenai-Soldotna, 3 in Palmer-Wasilla and 1 in Juneau.

II. PERCENT OF PHARMACY SALES REIMBURSED BY MEDICAID

1. Dittman Poll. Dittman Research is currently conducting a poll for the Alaska Pharmacy Association to determine what percent of pharmaceuticals are Medicaid reimbursed. The poll will be complete next week, according to the association president.

I have asked for a copy for your office. When I receive it, I will send it to you.

2. Informal survey. An informal telephone survey of a small number of pharmacists was conducted from this office. The survey shows the following estimates of Medicaid-reimbursed pharmaceuticals:

Carrs at Gambell in Anchorage:	18-25%
Hewitt's Drug in Spenard:	45%
Ron's Apothecary in Juneau:	10%
White's Pharmacy in Sitka:	15-20%

3. Medicaid reimbursement in pharmacy contracts. Some private pharmacies contract to provide pharmaceuticals to hospitals, long-term care (including all Pioneer Homes) and mental health facilities. Following are reports from two of these pharmacies, selected at random.

* None is Medicaid
It is GRH reimbursed

A. Hewitt's Drugs in Spenard. Owner Dennis Jurgens says Hewitt's contracts with the Anchorage Pioneer Home and with all the mental health intermediate care facilities in Anchorage. Jurgens estimates that 45 percent of his business is Medicaid reimbursed. (If the Pioneer Home is not counted, 30% of Hewitt's business is Medicaid.) Jurgens says chain stores probably aren't interested in competing for high-volume Medicaid business because it is too time-consuming. He said a chain looked at buying him out and declined for that reason.

B. White's Pharmacy in Sitka. Co-owner Trish White says the pharmacy contracts to the Sitka Pioneer Home where 17 of the 112 residents are Medicaid patients. White estimates that 20 percent of the pharmacy's business is Medicaid-reimbursed. (If the Pioneer Home is not counted, 15-20 percent of the pharmacy's business is Medicaid reimbursed.) This is a "mom and pop" pharmacy (White co-owns the pharmacy with her husband). White says in the past two years, the number of non-Pioneer Home Medicaid clients using their pharmacy has doubled. There are two other pharmacies in Sitka.

4. The proportion of Medicaid recipients who use Medicaid each month. Nancy Bennett of the Department of Health and Social Services reports there are 25,000 Medicaid-eligible Alaskans and that out of these, 36 percent (about 9,000) use Medicaid-reimbursed pharmaceuticals. This is about two percent of the Alaska population of 537,800.

III. OTHER PERTINENT DATA.

1. Income of pharmacists

A. Wages paid to registered pharmacist employees. The Alaska Career Information System, published in 1987 by the Alaska Department of Labor, surveyed pharmacists for a report on wages paid to Alaska pharmacists. The results are on Table 2 below.

TABLE 2

Wages Paid to Alaska Pharmacist-Employees -- 1987*

Level	Average per month ($)	Range per month ($)
Entry wage:	2,900	2,400-3,100
After 2 years:	3,200	2,900-3,400
Maximum:		3,300-3,700

Source: Alaska Department of Labor

* There are about 220 licensed pharmacists in Alaska. About 25% are self employed.

B. Income of self-employed pharmacists. Following are three examples of income reported earned in non-chain pharmacies:

1) Ron's Apothecary, Juneau. Co-owner Ron Sedgwick is a volunteer lobbyist for pharmacists and formerly was on contract with the Department of Health and Social Services. He reports his pharmacy netted $52,000 in 1987, after expenses and before wages. Sedgwick and his wife, both pharmacists, are the only employees. Sedgwick says between them, they work 100 hours a week and make $10 an hour each.

2) A Southeast Alaska pharmacy (not in Juneau). This pharmacy reports a net profit of $43,659 in 1987. It is a "mom and pop" pharmacy, owned by a husband and wife pharmacist. They estimate they earn $5.25 an hour. (The pharmacist asked to remain anonymous.)

3) An Anchorage pharmacy. The owner says over the past ten years he has broken even. Last year he earned $42,000 and the business made a profit of $15,000 after paying other employee wages. He said he works 10-12 hours a day and could make the same wages at a chain store in an eight hour day with less headache. He recently sold his business.

C. The price of pharmaceuticals.

Background. Pharmacists say there has been an influx of expensive drugs on the market in the last two years. They say this impacts their business because competition forces them to use a "sliding scale" profit margin, making less margin on expensive drugs. State officials say the cost of Medicaid pharmaceuticals to the State increased by $1 million in the past two years.

1) The average cost of prescriptions. In 1973, the average cost to the consumer of pharmaceuticals statewide was $7. In 1985, the average cost of pharmaceuticals was $16 at McCorkle's Pharmacy and $18.67 at Ron's Apothecary (both stores are in

Juneau). Today the average cost of prescription drugs at Ron's Apothecary is $25.61. McCorkle's went out of business in 1985. (Source: Sedgwick).

2) Expensive prescription drugs. Table 3 shows the wholesale prices of certain costly prescription drugs. The prices were provided by pharmacists during telephone conversations.

TABLE 3

Wholesale Price of Certain Costly Prescription Drugs -- 1988

Name of drug	Cost per month ($)	Quantity
Navane (a psychotrophic drug):	143	200
Loxitane (for mental health patients):	102	100
Tagomet (for ulcers):	64	100
Mevacor (anti-cholesterol)	90	bottle ($2/pill)
AZT (AIDS)	1,000	?

Note: The AZT cost was estimated by R. Sedgwick.

3) Increases in cost of pharmaceuticals. The nationwide cost increase in pharmaceuticals between 1986 and 1988 is as follows:

Cost to druggist: 8% increase
Cost to consumer: 18% increase
Two explanations have been advanced to explain this discrepancy:

(a) Chris Coursey, president of the Alaska Pharmacy Assn., speculates that the discrepancy reflects what paying customers are charged to make up for the federal government's fixed dispensing fee policy.

(b) Ron Sedgwick, pharmacist lobbyist, says the discrepancy reflects the recent influx of new, expensive drugs. He points to his own profit margin, which fell from 51.9% in 1985 to 37% in 1987, while the average price of the pharmaceuticals he sold rose from $18.67 in 1985 to $25.61 in 1987. Sedgwick says his margin fell because the market place will not allow a 50% markup on expensive drugs.

How is the affected by Medicaid.

(Note on markup: Hewitt's Drug in Anchorage marks its prescription drugs up an average 28 to 29 percent. Dennis Jurgens says that some Anchorage pharmacies have higher markups.)

2. Pharmacists' objections to SB 255.

A. "A fixed fee concept will not work on a profit margin system." Pharmacists say pharmacies will get a lower return, forcing them to do one of three things: 1. Charge more to paying customers. 2. Go out of business. 3. Stop serving Medicaid patients. Pharmacists object that they are the only retail merchants asked to support the federal government.

The Department of Health and Social Services says a fixed dispensing fee is adequate. Why should a pharmacist who takes two bottles -- one expensive and one inexpensive-- out of a box and gives them to customers be paid more for handing over the expensive bottle? Remember that the pharmacist is already paid for the cost of the drug. The Department's 2/2/88 position paper says there is "no indication" federal Medicaid coverage in other states has "resulted in withdrawal of pharmacies from participation".

B. "Small pharmacies were forced out of business when the federal government took over Medicaid payments for pharmaceuticals in the late 60's and early 70's." Virtually every Alaska pharmacist interviewed said the professional journals were full of "horror stories"

recounting the "devastation to Mom and Pop pharmacies" after the federal switch over in the Lower 48.

My efforts to check these assertions with the National Association of Retail Druggists as well as the executive directors of pharmacy association in other states have been unsuccessful because those with historical perspective are all in an annual meeting in Phoenix this week. I will have more information on this later.

C. Pharmacists are being asked to buy a "pig in a poke". Pharmacists say they do not want to put their imprimatur on a plan they haven't seen. They say the State has not set a fixed dispensing fee or determined how the base cost would be calculated.

The Department has included funds to hire a pharmacist consultant to design a program that would be least disruptive to pharmacists. A Department official two years ago told pharmacists the fixed dispensing fee would be about $5.

D. "The reimbursement price on expensive items could be less than the wholesale cost of the product." Pharmacists say one popular method used in the Western States to determine base cost is "Average Wholesale Price" minus an 11 percent discount (for bulk buying) OR the pharmacist's usual and customary price -- whichever is lower. They say this is unworkable because small Alaska pharmacies do not get a discount for bulk buying. They cite as an example a bottle of Mevcor, an anti-cholesterol drug, which costs the pharmacist $90 a bottle wholesale. At a 11 percent discount, the reimbursement would be $80.10 plus a dispensing fee. If the dispensing fee were $5, the pharmacist would be paid $85.10 -- which is less than the product cost him.

E. "Alaska is unique."

1) Distance from the market forces Alaska pharmacists to stock inventory for two weeks in order to have a supply. Trish White, co-owner of White's Pharmacy in Sitka, said Alaska pharmacies must stock an inventory two to three times that of pharmacies in the Lower 48. She made that estimate after attending a Pharmacy Management Clinic at the University of North Carolina

in Chapel Hill this year. She said that compared to Lower 48 pharmacies, her pharmacy's turn-over rate is "amazingly low". If pharmacies in Lower 48 cities don't have a bottle on the shelf, "they can run over to a chain store and get it," she said. " We can't."

2) Alaska pharmacists have to pay high freight costs, while those in the Lower 48 have low trucking costs. A small box of prescription drugs costs $10 through the mail (pharmaceuticals are mailed to keep the product fresh). White says that the policy in her store is to absorb the air mail or Gold Streak cost if the pharmacy must special order a drug which is normally stocked.

DHSS Position Paper: this can be compensated thru dispensing fee allowances.

3) Rural paying customers may be charged more for drugs. Eleven rural towns in Alaska have only one pharmacy (list attached). Pharmacists contend that under the new plan, paying customers will surely be charged more in one-pharmacy towns to make up for losses from Medicaid, there being no local competition to keep the prices down.

4) Rural areas may be left without Medicaid service -- or without a pharmacy. Pharmacists contend that in the 12 one-pharmacy towns, pharmacists may be forced by economics to stop serving Medicaid-reimbursed clients. Those pharmacists who feel an ethical obligation to continue serving Medicaid clients may be forced out of business, leaving the entire town without a pharmacy.

5) Region X is unwilling to consider alternative suggestions. Pharmacists contend that Region X does not appear willing to accept alternatives put forth by pharmacists, both in Alaska and other states. Pharmacists say Hawaii, which has problems of distance similar to Alaska's, has tried twice to modify its Medicaid-reimbursement plan (the latest try was this year), with no luck. A long-time Oregon pharmacist and consultant agrees. Stan Hartman of Beaverton says Region X is concerned about "sovietizing" the Medicaid pharmacy plan, but that if the State is "firm" and has back up in the law, it can prove the legality of a proposed alternative and go back to national headquarters to force Region X to accept the plan.

3. An alternative suggestion. In a recent telephone conversation, Stan Hartman, an Oregon pharmacist and author of articles in trade journals, recommended that Alaska use a plan in place in his state. This plan is the Pharmacists Service Group.* It has been in place for four years and sells its services to insurance companies to fulfill health plans. The group competes with national companies providing similar services in Oregon. These companies use a payment plan similar to that used for Medicaid reimbursement: an average wholesale price less 11 percent, plus a $2.70 dispensing fee. But the Pharmacists Service Group uses a usual-and-customary charge plan with a cap at the 90th percentile (the payment is not more than that charged by 90 percent of participating pharmacies).

   In 1987, the plan had 10,000 recipients; it has added the Oregon State Employees as well as other organizations and will number over 150,000 recipients next year.

   Why the plan is "better", according to Hartman:

   A. The plan saves more money than a dispensing fee system.

   B. Pharmacists on this plan show a higher use of generic drugs than pharmacists on competing fixed-fee plans.

   C. The plan cuts down on drug costs by allowing up to a 90-day supply (Alaska has a 30-day supply system, in order to reduce consumer abuse.) Audits show that a 90-day supply of one drug sold for $47 while three 30-day supplies of the same drug cost $19 more. The decreased cost was the result of the economy of scale plus lower administrative costs. Under a fixed fee system, pharmacists are encouraged to dispense smaller amounts of the drug in order to reap more dispensing fees.

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* Information about this plan was supplied by Hartman and by lobbyist Ron Sedgwick. The plan's state director was out of the office this week and I was unable to contact him. I will contact him next week for written information on his plan and when it arrives, I will send it to your office. Should you wish to contact him yourself, his name is Robin Richardson, 503-585-4887. The plan's designer is Dr. Lee Strandberg of the School of Pharmacy at Oregon State University. His telephone number is 503-754-3424.

D. The Oregon plan uses a "co-pays" system (the recipient pays a fee when the prescription is picked up). The aim is to reduce utilization. (In Alaska, the Bristol Bay Hospital, which buys its drugs through the Public Health Service, requires a fixed pick-up fee of $10.) See Table 3.

TABLE 3

Amount charged customer compared to the average per capita prescription cost under the Oregon Pharmacists Service Group plan

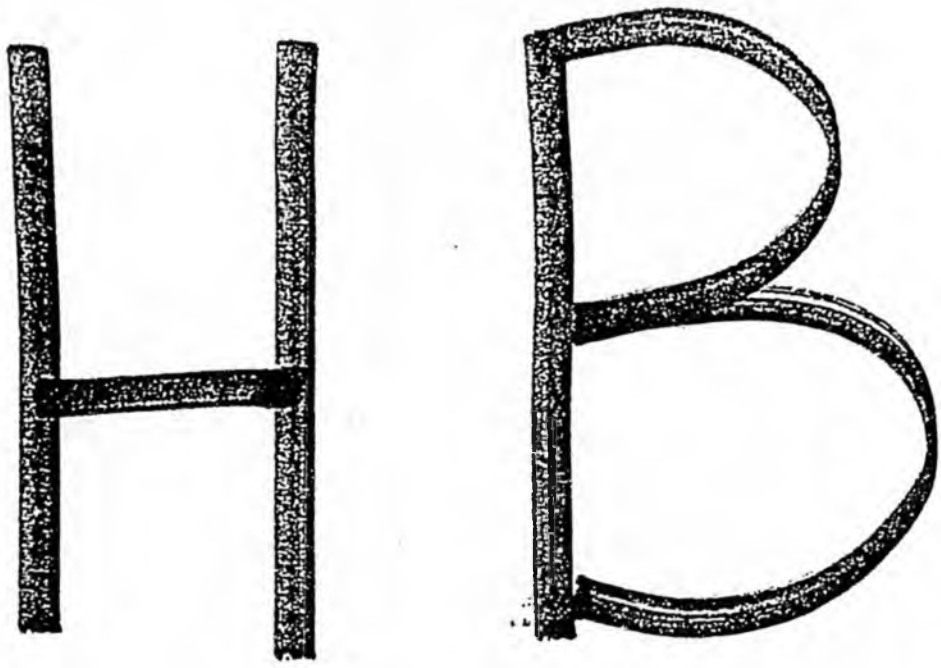
Amount co-paid for prescription	Percent of utilization (%)	Average per capita amount spent monthly on prescription ($)
$2.00	57.5	$4.90
$2.50	48.6	$4.72
$3.00	38.9	$3.19
$4.00	32.4	$2.18
$5.00	35.6	$1.75

Source: Ron Sedgwick

Enclosed for your information is a position paper by Ron Sedgwick explaining these and other pharmacist objections in detail. Also enclosed are the bill's fiscal note and a 2/2/88 position paper by the Department of Health and Social Services entitled "SB 255". Other enclosures include a list of possible reimbursement schemes proposed by pharmacists Ron Sedgwick of Juneau and Bill Larson of Anchorage; the Department of Labor list of pharmacist-employee salaries; a list of Alaska towns with a single pharmacy; the Federal Register with an explanation of new Medicaid regulations concerning pharmaceuticals; and the Board of Pharmacy list of pharmacy licenses which expire in June of 1988.

If you require additional information, please let me know.

Attachments


HB


332

HOUSE COMMITTEE REPORT

(7)

Date referred: 1/11/88 FURTHER REFERRALS: Finance

DATE: 2-11-88

The Health, Education and Social Services Committee has considered HB 332

"An Act relating to the reporting of burn injuries."

RECOMMENDS:

[ ] replace with CS HB 332 (HESS)   [ ] the same title
[ ] attached amendment(s)   [✓] a new title

[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the ______ Committee

ADOPTS: [ ] ______ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[✓] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis
[ ] same as previous fiscal note published ______
[ ] same as previous zero fiscal note published ______

SIGNING DO PASS:

Ellis
Kerttula
Bill Hudson
Gruenberg
Joyce Hanley
Rick E. ...

SIGNING OTHER RECOMMENDATIONS:

Kerttula
Co-Chairman's signature
Ellis

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

HHESS	2-3-88	8:30 a.m.
HHESS	2-10-88	8:30 a.m.
HHESS	2-11-88	8:30 a.m.

BILL NO:

DATE:

TITLE: HB 332

An act relating to the reporting of burn injuries.

CONTACT: January 14, 1988

Gordon Brunton
465-4331

DEPARTMENT OF PUBLIC SAFETY

AS 08.64 would be amended to add a new section requiring physicians to report cases of burn injuries (more than 5 percent of the body with second or third degree burns, or burns to the upper respiratory tract or laryngeal edema due to the inhalation of super-heated air) to the division of fire prevention within 72 hours after treatment. If the physician believes that the victim will die before the division receives the report, the physician must orally notify the Alaska State Troopers or a local law enforcement agency.

This bill would provide another tool to assist in the apprehension of arsonists and would give the Division a better understanding of burn injuries to assist in their prevention.

We suggest the addition of a penalty provision for wilfull failure to report.

The Department of Public Safety Supports passage with the suggested amendment of HB 332.

Daryle A. Hostetter
for Arthur English
Commissioner

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: HB 332
PUBLISH DATE: _____

FISCAL NOTE

REQUEST: _____

Revision Date: _____
Title: An act relating to the reporting of burn injuries.
Sponsor: Rep. Koponen
Requestor: _____

Agency Affected: Public Safety
BRU: Fire Prevention
_____
Components: _____
_____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		0	0	0	0	0
TRAVEL		0	0	0	0	0
CONTRACTUAL		3.1	2.9	3.1	3.2	3.4
SUPPLIES		0.5	0.5	0.6	0.6	0.6
EQUIPMENT		3.5	0	0	0	0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		7.1	3.4	3.7	3.8	4.0
CAPITAL		0	0	0	0	0
REVENUE		0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND		7.1	3.4	3.7	3.8	4.0
FEDERAL FUNDS						
OTHER						
TOTAL		7.1	3.4	3.7	3.8	4.0

POSITIONS:

FULL-TIME		0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

See Attachment.

Prepared by: Gordon E. Brunton
Division: Fire Prevention
Phone: 465-4331
Date: 1/15/88

Approved by Commissioner: _____
Agency: Public Safety
Date: 1-25-88

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISCAL NOTE

HOUSE BILL 332

Assumptions:

An estimated 500 burn injuries will be reported each year.

A 5 percent inflation factor is used for subsequent years.

Personal Services. 100 hours per year, clerical and professional time for case management and data control.	$0.0
Travel.	0.0
Contractual.	
Telephone toll charges to notify law enforcement agencies.	1.3
Printing & distribution of forms & instructions to physicians & law enforcement. (decrease 0.3 after first year)	1.0
Publication of periodic reports.	0.8
Supplies.	
Misc. office supplies, stationery, data storage media.	0.5
Equipment.	
Upgrade microcomputer hard drive/tape backup to increase data storage capacity. (one-time cost)	3.5
Total	$7.1

S.G. Region

December 31, 1987

PRESS RELEASE "For Immediate Release"

Contact: Sylvester (Sam) Neal Director, State Fire Marshal's Office (907) 269-5604

ARSONISTS STEAL FROM US ALL

Conservatively over 7 millon dollars was stolen from Alaskans in 1986 because of Arson. That's over 13 dollars for every man, woman, and child in this state. Insurance companies paid the direct loss for arson fires; but those of us who pay fire insurance for our homes, businesses, and automobiles repay the insurance companies. Nationwide it is estimated that 40 cents of every fire insurance dollar goes to pay for the crime of arson.

Arson is a growing problem in Alaska; but we can do something about it. It is not impossible to dectect, investigate or prosecute arson. Every Alaskan can help improve the chances of an arsonist being caught and convicted. Since one of the most important areas is public involvement,

(more)

ARSONISTS STEAL FROM US ALL (continued)

Alaskans must first realize the magnitude of the arson problem. Second, Alaskans must aid or support the local fire department and law enforcement agencies in efforts to detect arson and suspicious fires and help identify individuals who may have been the arsonist. Public knowledge and observations of a particular fire may provide officials with vitally important information which may otherwise not become known to fire investigators.

If you have knowledge about a suspicious fire, contact your local fire department, law enforcement agency, or the State Fire Marshal's office.

Arson can be stopped, but every Alaskan must be concerned enough to help those agencies who are already fighting the crime which steals from all of us.

FOR MORE INFORMATION, CONTACT YOUR LOCAL FIRE DEPARTMENT OR:

Sylvester (Sam) Neal
State Fire Marshal's Office
5700 E. Tudor Road
Anchorage, Alaska 99507-1225
Phone: (907) 269-5604

-30-

by B. Davis