

ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
6810 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

3-6-91

HOUSE COMMITTEE REPORT

(7)

Date Referred: February 4, 1991

FURTHER REFERRALS:

Finance

Date of Committee Action: 3-5-91

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 45

HOUSE BILL NO. 45

INSURANCE COVERAGE FOR MAMMOGRAMS

"An Act relating to insurance coverage for mammograms; requiring the medical assistance program to cover mammograms; and reordering the priorities granted to services covered under the medical assistance program."

RECOMMENDATIONS:

be replaced with [] the same title

[] a new title

[] have attached amendments(s)

[x] do pass

[] do not pass

[] no recommendations

[] individual recommendations

[] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

[] fiscal impact _____ (2) [x] fiscal note(s) DHSS, DOA 2/4/91

[] zero fiscal note _____ [x] zero fiscal note(s) DCED 2/4/91

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

	Check appropriate column:	Do Not Pass	No Rec	Amend
<i>[Signature]</i> LINCOLN				
<i>[Signature]</i> CARNEY				
Beatty Davis	J. G. Gonzales Gonzales		x	
Cheri Davis	Mark Hanley Hanley			x
	Mary Miller			x

[Signature] LINCOLN

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HB 45

Revision Date: 2/21/91
 Title: An Act relating to insurance coverage
mammograms.
 Sponsor: Ulmer, et al.
 Requester: _____

Department Affected: All agencies
 BRJ: _____
 Components: _____
 COMPONENT SERIAL NO.

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
Personal Services	1,593.0	1,593.0	1,593.0	1,593.0	1,593.0	1,593.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants, Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	1,593.0	1,593.0	1,593.0	1,593.0	1,593.0	1,593.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

General Funds	1440.1	1440.1	1440.1	1440.1	1440.1	1440.1
Federal Funds	73.3	73.3	73.3	73.3	73.3	73.3
Other	79.6	79.6	79.6	79.6	79.6	79.6
TOTAL	1593.0	1593.0	1593.0	1593.0	1593.0	1593.0

POSITIONS:

Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

Estimate of current year impact: None

ANALYSIS: (attach a separate page if necessary)
 Costs for political subdivisions and school districts throughout the State will increase an estimate of \$1,812,038. See attached analysis for details.

Prepared By: Gary M. Bader, Director *Gary M. Bader* Phone: 465-4470
 Division: Retirement and Benefits Date: 2/21/91

Approved By Commissioner: _____ Date: _____
 Agency: Administration

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

House Bill 45
Analysis of Financial Impact on
Mandatory Coverage of Mammograms
Prepared by the Division of Retirement and Benefits
Department of Administration
February 21, 1991
Page 2 of 3

This bill will not result in additional operations cost for the Division of Retirement and Benefits. The estimated cost of \$1,593,117 to all agencies the State shown on the attached fiscal note is the result of two components: active State employees and contributions to the retirement funds for retirees.

The bill is estimated to result in an increase of \$1.50 per month per active State employee. It is also estimated to result in a .24% in the PERS contribution rate for the State and a .21% increase in the TRS contribution rate for State.

The total estimated cost to the State is calculated as follows:

Active State Employees

The increase of \$1.50 per month per employee times the number of State employees (15,000) times 12 months equals	\$ 270,000
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Retirement Fund Contributions

The change in the PERS employer contribution rate for the State (.24%) times the estimated FY 92 PERS salaries (\$545,579,183) equals	\$1,309,390
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The change in the TRS employer contribution rate for the State (.21%) times the estimated FY 92 TRS salaries (\$6,537,114) equals	\$ 13,727
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TOTAL COST TO STATE	\$1,593,117
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In addition to the State costs outlined above, there will also be additional costs for political subdivisions and school districts throughout the state. The total estimated cost for these entities is calculated as follows:

Active Political Subdivision and School

District Employees

The increase of \$1.50 per month per employee times the number of employees(1200) times 12 months equals \$ 21,600

Retirement Fund Contributions

The change in the PERS employer contribution rate for Political Subdivisions (.24%) times the estimated FY 92 salaries (\$109,599,379) equals \$983,038

The change in the TRS employer contribution rate for school districts (.21%) times the estimated FY 92 salaries (\$384,476,586) equals \$807,400

TOTAL COST TO
POLITICAL SUBDIVISION AND SCHOOL
DISTRICTS \$1,812,038

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HB No 45

Revision Date: 1/28/91 Department Affected: Health and Social Svcs

Title: An Act Relating to Insurance Coverage for Mammograms Medical Assistance
for Mammograms Component: Medicaid non-facility

Sponsor: ULMGR

Requestor: _____

COMPONENT SERIAL NO.

	2	2	9
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Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	10.0	11.5	13.2	15.1	17.3	19.8
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	10.0	11.5	13.2	15.1	17.3	19.8

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	5.0	5.7	6.6	7.5	8.6	9.9
FEDERAL FUNDS	5.0	5.8	6.6	7.6	8.7	9.9
OTHER	0	0	0	0	0	0
TOTAL	10.0	11.5	13.2	15.1	17.3	19.8

POSITIONS:

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

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)
 See attached analysis

Prepared By: Kimberly B. Busch Phone: 465-3355
 Division: Medical Assistance Date: 1-29-91

Approved by Commissioner: [Signature]
 Agency: HEALTH AND SOCIAL SERVICES Date: 1/29/91

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

HB 45

Currently, Medicaid reimburses enrolled providers for diagnostic mammograms furnished to eligible recipients. Of more than 14,000 mammograms in Alaska in 1990, approximately 400 were provided for Medicaid-eligible women over 35. Each mammogram costs, on average, \$100.

If HB 45 were passed, we do not anticipate any substantial increase in the use of mammograms for screening, in part because radiologists report they do not commonly recommend screening mammograms. We estimate that HB 45 would not add more than 100 new mammograms to Medicaid during FY92, at a total new cost of \$10,000 (100 X \$100 = \$10,000). Funding for this service is 50% Federal, 50% State General Funds.

Costs for FY93 and future years assume a total annual increase of 14.6%, which consists of an increase of 6% in the number of recipients eligible for mammograms, an annual increase of 4% in the rate at which eligible persons will use this service, and an annual increase (typical of past years) of 4.6% in the costs per screening.

No allowance has been made in this estimate for the costs of periodic mammograms for Medicaid-eligible persons (primarily those who are over 65) who receive Medicare benefits. Recent Federal legislation made screening mammograms a Medicare-covered service, and existing Federal law requires Medicaid to pay any Medicare deductibles or co-insurance costs incurred by anyone who participates in both programs.

The department views section 2 of HB 45 as setting only minimum coverage limits, not maximum limits, and that anyone with the appropriate familial and/or personal history may receive payment for any number of mammograms that are medically justified. The Division of Medical Assistance will incur costs in processing claims for this new service and in retrospectively examining these claims to insure that the service was medically necessary, appropriate, and not excessive. However, these costs are anticipated to be so minor as to be absorbed within normal program appropriations and without adding new staff.

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HB 45

Revision Date: _____
 Title: An Act relating to insurance coverage
mammograms.
 Sponsor: Ulmer, et al.
 Requester: _____

Department Affected: All agencies
 BFU: _____
 Components: _____
 COMPONENT SERIAL NO.

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
Personal Services	270.0	270.0	270.0	270.0	270.0	270.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants, Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	270.0	270.0	270.0	270.0	270.0	270.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

General Funds	244.1	244.1	244.1	244.1	244.1	244.1
Federal Funds	12.4	12.4	12.4	12.4	12.4	12.4
Other	13.5	13.5	13.5	13.5	13.5	13.5
TOTAL	270.0	270.0	270.0	270.0	270.0	270.0

POSITIONS:

Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

Estimate of current year impact: None

ANALYSIS: (attach a separate page if necessary)
 See attached.

Prepared By: Gary M. Bader, Director *Gary M. Bader* Phone: 465-4470
 Division: Retirement and Benefits Date: _____
 Approved By Commissioner: *Milton Valer* Date: 11/24/90
 Agency: Administration

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

House Bill 45
Analysis of Financial Impact on
Mandatory Coverage of Mammograms
Prepared by the Division of Retirement and Benefits
Department of Administration
January 28, 1991
Page 2 of 2

This bill will not result in additional operations cost for the Division of Retirement and Benefits.

The bill is estimated to increase the monthly health premium by \$1.50 per employee. This equates to an annual increase of \$270,000.

$$[\$1.50 \times 15,000 \text{ employees} \times 12 \text{ months} = \$270,000]$$

There will be an equivalent cost to school districts and participating political subdivisions and to the retirement funds. Future costs are assumed to remain level but will be determined by the plan's claim experience.

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. HB 45

Revision Date: 1/21/91 Department Affected: Commerce & Economic Dev
 Title: An Act relating to insurance coverage for mammograms BRU: Insurance
 Sponsor: Ulmer, Brown, et al. Component: Operations
 Requestor: _____ COMPONENT SERIAL NO.

0	3	5	4
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Expenditures/Revenues: (Thousands of Dollars)

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

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact on the division.

Prepared By: Joan Brown, Administrative Officer Phone: 465-2597
 Division: Insurance Date: 1/24/91
 Approved by Commissioner: Glenn A. Olds
 Agency: Department of Commerce & Economic Development Date: _____

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



Alaska State Legislature
House of Representatives
 COMMITTEE ON HEALTH, EDUCATION
 AND SOCIAL SERVICES

DATE: March 5, 1991

PLACE: Capitol Room 106

SUBJECT OF MEETING:
 HB 45 INSURANCE COVERAGE OF MAMMOGRAMS

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
✓ Willie Anderson	NEA-AK	105 Municipal Way 302 Tulzall	801		6-3090	<input checked="" type="radio"/> N	HB 45
✓ Dave Walsh	Div of INS ADMIN/	Pouch D Box CR	801		465-2515	<input checked="" type="radio"/> N	HB 45
✓ Mike Coughlin	RET. BENEFIT.	99811		463-3522	465-4471	<input checked="" type="radio"/> N	HB 45
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

DATE 2/21/91

JOINT _____

TAPE # 12

JOINT _____

TIME CALLED TO ORDER 8:35 am/pm

TIME ADJOURNED 10:00A

ROLL CALL:	PRES	ABST	TIME ARRVD	JOINT MEMBERS PRESENT:
Rep. Patrick Carney	✓			
Rep. Georgiana Lincoln	✓			
Rep. Bettye Davis	✓			
Rep. Cheri Davis	✓			came in late. @ 8:30A
Rep. John Gonzales	✓			
Rep. Mark Hanley	✓			
Rep. Mary Miller	✓			

AGENDA:

BILL NO.	SHORT TITLE	ACTION TAKEN
*HB 45	Insurance Coverage for Mammograms	
*HB 24	HIV Testing for Sex Offenders	

OTHER:

SPECIAL ANNOUNCEMENTS:

Mandated Benefits In Health Insurance Policies

Gregory Krohm and Mary H. Grossman, *Benefits Quarterly*, Fourth Quarter 1990

"According to a research bulletin prepared by the Health Insurance Association of America, state governments had enacted over 730 mandates by 1989—up from 343 in 1978 (*MB*, 12/15/89, p. 3). As shown in Table 2 (page 10), Blue Cross and Blue Shield data show that the total number of distinct treatment benefit mandates adopted with any frequency is about 12. The total number of provider mandates is about the same. There are relatively few mandates relating to special populations. The 10 most common mandates account for over 300 of the 730 mandates listed by HIAA.

Almost any benefit added to a health insurance policy increases the cost of the policy. Only those benefits that clearly serve as substitutes for more costly services or treatment actually would decrease costs. Few mandates, however, increase costs significantly.

There have been several state-level studies of the costs of mandated benefits. Table 3 (page 10) summarizes cost data from the studies that have been conducted.

Opponents of mandated benefits frequently point to the exemption from mandates as a primary reason for employers to decide to self-fund their health benefit plans. If that is the case, one would expect to find that self-funded plans provide less coverage for state-imposed mandates than do insured plans.

Continued

Mandated Benefits (continued)

To determine whether this was the case in Wisconsin, insurers that act as administrators for self-funded plans were surveyed, as were third-party administrators and benefit consultants.

The survey showed that, in 1989, the mandates included in the study

Almost any benefit increases the cost of the policy. Few mandates increase costs significantly.

accounted on average for 10.2 percent of the total medical benefits paid for administrative services—only business and 7.9 percent for insured plans. This indicates that self-funded plans provide at least as many of the mandated benefits as insured plans and in some cases provide more generous coverage." MB

Table 2. Health benefit mandates adopted by more than five states, 1989.

	Number of states enacting mandate
Treatment mandates	
Alcoholism	40
Mental health	27
Mammography	25
Drug abuse	22
Maternity	20
Home health	17
Breast reconstruction	11
Ambulatory surgery	8
Hospice	7
In-vitro fertilization	6
Cleft lip and palate	6
Temporomandibular joint disease	6
Provider mandates	
Chiropractors	39
Psychologists	38
Dentists	30
Optometrists	31
Podiatrists	26
Nurse midwives	23
Social workers	16
Nurse practitioners	14
Osteopaths	11
Psychiatric nurses	9
Nurses	8
Nurse anesthetists	7
Physical therapists	6
Speech/hearing therapists	6
Special populations	
Newborns	48
Mentally/physically handicapped dependents	34
Adopted children	15
Preventive care for children	10
Noncustodial children	7
Dependent students	6

Source: Blue Cross and Blue Shield Association; Krohm and Grossman, 1990

Table 3. Percent of claim dollars attributable to state mandated benefits, by state.

	Iowa (1987)	Maine (1988)	Maryland (HIAA) ¹ (1984)	Maryland BC/BS (1984)	Wisconsin (1989)
Mental health	3.7%	2.6%	6.5%	6.5%	4.8%
Alcoholism and drug abuse	1.7	1.3	(²)	0.8	(²)
Other mandates	(Not significant)	(No data)	5.1	3.8	2.3
Total	5.4	3.9	11.6	11.1	7.1

¹ The Maryland HIAA data are based on a percentage of premium. The others are based on a percentage of claim dollars.

² Included in mental health

Source: Blue Cross and Blue Shield Association; Krohm and Grossman, 1990

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* DELIVER TO: LMSCHES
*
* ORIGINAL
* SENT: 02/21/91 TIME: 11:22
* FROM: LTCCFBX
* SUBJECT: 91-02-092,FS,HB45,24;2-21
* PRINT DATE: 02/21/91 TIME: 11:22
*
*****

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SUBJECT LINE TO READ: TC NO.;PL/FS;SHORT SUBJECT;DATE

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T/C NO: 91-02-092
DATE: FEBRUARY 21, 1991
SPONSOR: HOUSE HESS
SUBJECT: HB 45; HB 24
MODERATOR: FRAN
SITE: FAIRBANKS

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FINAL STATS

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TESTIFIED

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NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. BONNIE MCCORQUODALE,	P.O. BOX 71248,FBX,99707	452-5222	HB24
2. VEVA BECKER,	4139 ROSEBUD LN.,FBX,99709	479-6968	HB45
3. MARGARET GRAY,	311 SLATER ST.,FBX,99701	452-3788	HB45
4. MARK TUMED,	1324 SUMMIT DR.,FBX,99712	457-6818	HB24
5. TRISH NEUBERT,	1969 SWALLOW DR.,FBX,99709	479-6538	HB45
6. DORIS LOENING,	665 10TH,FBX,99701	452-4039	HB45

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OBSERVED

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NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. BEVERLY MCCLENDON,	P.O. BOX 04397,FBX,99708	455-6639,	HB24
2. LUCY MCCARTHY,	P.O. BOX 00607,FBX,99708	479-2804	HB45
3.			
4.			
5.			

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TESTIFIED: 6
UNABLE: 0
OBSERVED: 2
TOTAL: 8

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START TIME: 8:30 A.M. END TIME: 10:05 A.M.

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HOUSE COMMITTEE REPORT

2-4-91

(7)

Date Referred: January 21, 1991

FURTHER REFERRALS: Health, Education and Social Services

Finance

Date of Committee Action: 1-31-91

The LABOR AND COMMERCE Committee considered:

HB 45

HOUSE BILL NO. 45

INSURANCE COVERAGE FOR MAMMOGRAMS

"An Act relating to insurance coverage for mammograms; requiring the medical assistance program to cover mammograms; and reordering the priorities granted to services covered under the medical assistance program."

RECOMMENDATIONS:

[] the same title

be replaced with _____ [] a new title

[] have attached amendments(s)

[x] do pass

[] do not pass

[] no recommendations

[] individual recommendations

[] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

(2) [x] fiscal impact (DOA) (DHESS)

[] fiscal note(s)

[x] zero fiscal note (DLED)

[] zero fiscal note(s)

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

	Check appropriate column:	Do Not Pass	No Rec	Amend
Dave Douglas				
Betty Bruckman				
Jim An				
Jim P. Pappell	[Signature]		X	
David M. Finkelstein				

Chairman's Signature

Finkelstein

HB 45 — RELATED TO MAMMOGRAPHY SCREENING
Sectional Analysis

Section 1.(a) Requires Alaska health insurance providers to include low dose mammography screening in every group and individual policy which covers mastectomies and related procedures.

(b) Establishes frequency standards for mammography screening, as recommended by the American Cancer Society.

(c) Requires that payment for mammograms should be not less favorable than for other radiological examinations and may be subject to standard co-payment and deductible provisions.

(d) States that these requirements are not applicable to supplemental contracts covering a specified disease or other limited benefits.

(e) Definition of "low-dose mammography screening".

Section 2. List of statutes that apply to service corporations operating as insurance providers in Alaska; the mammography requirement for insurance providers is included in this list so that the statutes are consistent.

Section 3. Includes mammography screening as a service which may be covered by Medicaid funding.

Section 4. Places mammography screening on the prioritized list of services which will not be funded if funds are not available.

Section 5. States that this act applies to individual and group health insurance policies and to hospital or medical service subscriber contracts entered into or renewed on or after the effective date of the Act.



Medicine

COVER STORIES

A Puzzling Plague

What is it about the American way of life that causes breast cancer?

By CLAUDIA WALLIS



In the bad old days, some 20 years ago, no one had the heart even to talk about it. Breast cancer struck the most evident of a woman's assets, where the motherly and the erotic are joined. And treatment of the disease was a nightmare of pain, dis-

figurement and uncertainty too terrifying to contemplate. A seemingly healthy woman with nothing more than a tiny lump in her breast (and a larger one forming in her throat) could agree to have a biopsy performed and not know whether she would awake from surgery with a small bandage on her breast—or no breast at all.

Much has changed since then. For one

thing, breast cancer is widely discussed. Celebrity after celebrity—a veritable Breast Cancer Hall of Fame—has stepped forward to demystify the disease and soften its stigma, beginning with Shirley Temple Black, Ingrid Bergman and Betty Ford, and more recently including Nancy Reagan and Gloria Steinem. Lessons on cancer detection and the importance of mammo-



One out of every ten American women will get breast cancer. Of those who do, one out of four will die of it.

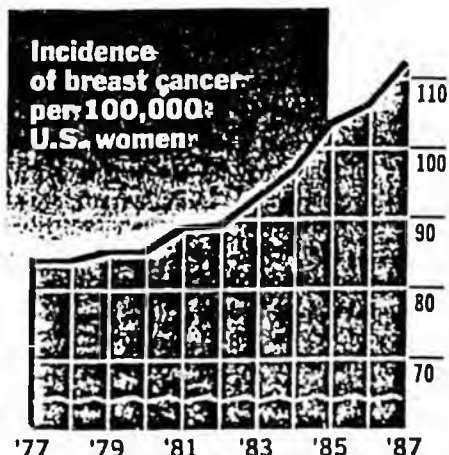
grams are the subject of elaborate public information campaigns.

More important, the surgical and post-surgical options have multiplied. Chastened by better educated and more demanding patients, doctors now wait after a positive biopsy to discuss these options before moving in to amputate. Just last year a consensus meeting convened by the National Institutes of Health formally recommended lumpectomy, the removal of a cancerous lump plus a small amount of surrounding tissue, followed by radiation therapy, as an equally effective alternative to breast removal in many cases. And the success rate for treatment is up—not dramatically, but up. Nowadays, 76.6% of breast-cancer patients survive five years after surgery, and 63% are alive 10 or more years later. In 1970 the five-year survival rate was 68%.

But there is also bad news about breast cancer. The number of cases continues to soar. According to the National Cancer Institute (NCI), the U.S. incidence increased 32% between 1982 and 1987. Only lung can-

cer is rising faster. Cancer is the leading cause of death for women 35 to 50, and breast cancer is the most common malignancy in this age group. All in all, an American woman has a 1-in-10 chance of developing breast cancer over the course of her lifetime, and that risk keeps on rising.

The big question is why. Most experts



TIME Chart. Source: National Cancer Institute. Annual figures are for 1987.

on the disease agree that part of the increase can be attributed to earlier detection of tumors. Some 65% of American women over 40 have had a mammogram, up from about 20% in 1979. The widespread use of this tool, a low-dose X ray of the breasts, has meant that more women are discovering their tumors in the early stages, before a lump can be felt. In past decades, prior to the spread of mammography, such women might have died of other causes before their breast cancer was diagnosed.

Nonetheless, most investigators of the epidemic believe early detection is only part of the story. They look at the fact that breast cancer is far less common in other parts of the world and conclude, ominously, that the answer lies in some facet of the American life-style. "Something in our environment is contributing," contends Dr. Marc Lippman of Georgetown University.

Study after study has explored the possibilities. Could it be the birth control pill? Probably not, since dozens of investigations into that question have produced a quag-

Medicine



The ouch factor: a good mammogram is uncomfortable

Two out of three older women fail to get checked regularly.

mire of contradictions. How about smoking? Again, there is no clear connection. Alcohol? Drinking seems to raise the risk of the disease slightly, but the association is too weak to account for America's prodigious rate. What about the widespread use of estrogen therapy following menopause? Studies show only a mildly elevated risk. And while food additives and even lack of sunlight have come under suspicion, there is little evidence to convict them.

THE FAT FACTOR

Instead, many researchers around the world are pointing to another component of the Western way of life: a diet rich in fat. Researchers have known for more than 40 years that high-fat diets promote the growth of mammary tumors in laboratory animals. They have also observed that the varying rates of breast cancer in various countries correlate neatly with the amount of fat in a nation's diet. The U.S., Britain and the Netherlands, which have some of the world's richest diets, also have among the highest breast-cancer rates. Meanwhile, in countries such as Japan, Singapore and Romania, where the diet is very lean, the incidence of breast cancer is one-sixth to one-half the U.S. rate.

On the theory that genetic factors might be responsible for such national variations, researchers have looked at immigrant groups. They have found that

when Japanese move to the U.S., or Italians to Australia, their previously low breast-cancer mortality rate rises to match the higher rate of their adopted country within a generation or two, as diet and lifestyle change. "The results are too consistent to believe that the association is indirect," says Maureen Henderson, an epidemiologist at the Fred Hutchinson Cancer Research Center in Seattle. When it comes to the breast cancer-fat connection, she says flatly, "I'm sure of it."

Japanese researchers are also convinced. Breast cancer is one of the fastest-growing diseases among Japanese women, with the incidence up 58% between 1975 and 1985. "The largest factor behind the sharp rise is the Westernization of eating habits," says Dr. Akira Eboshida, chief deputy director of the Health and Welfare Ministry's Disease Control Division. "We are eating more animal fat and less fiber." Cancer of the breast is not the only ailment rising with the larding of the Japanese diet. Heart disease is also surging, as is cancer of the colon, ovaries and prostate. All have been linked to a high-fat diet. On the other hand, stomach cancer, historically the most common cancer in Japan, is falling as the nation moves away from its traditional diet of salty, pickled and smoked foods. "If the current trend continues," predicts Eboshida, "breast cancer will replace stomach cancer as the No. 1 killer of Japanese women in the next century."



A color-enhanced mammogram shows a white spot of cancer

The technique reveals pinpoint tumors undetectable by touch.

Despite such evidence, not everyone shares the conviction that fat is the villain. Critics of this theory point out that statistical correlations are not the same as proving cause and effect. Many researchers argue that there are probably several lifestyle factors rather than a single culprit. "The high rates are not due to one bad habit, but to our whole way of life," says Mary-Claire King, a cancer geneticist at the University of California, Berkeley.

According to Dr. Walter Willett at the Harvard School of Public Health, overall calories may play a larger role than fat: Americans may simply be eating too well. Willett points out that breast-cancer rates tend to be highest in prosperous countries where people are well nourished. In such lands of plenty, girls begin to menstruate at an earlier age, women tend to have their children later in life and menopause also comes later. Late menopause (after 50), delayed childbearing (after 30) and early onset of menstruation (before 12) are all acknowledged "risk factors" for breast cancer. For older women, obesity also increases the risk of the disease. King notes that better education and job opportunities for women have furthered the trend toward postponed motherhood and childlessness (also a risk factor). "All the things that cause women to be healthy, well-educated and have careers put them at risk for breast cancer."

Critics of the fat theory also point to

several studies that seem to refute it, including a survey by Willett of 90,000 nurses from 34 to 59. Though the diets ranged from 32% fat content to about 44% (the U.S. average is 42%), the Harvard researcher could find no correlation between fat intake and the incidence of breast tumors. One problem with Willett's study: many researchers believe that dietary fat must be more radically reduced, to about 20% of total calories, to affect the occurrence of breast cancer.

The proof, of course, is in the pudding, or in this case, not eating any. Unfortunately, researchers seeking conclusive evidence of the effects of a very low-fat diet have had little success in obtaining funds. One concern is cost. Another is that women participating in such trials would have trouble adhering to the drastic regimen, which would mean very limited amounts of meat, dairy products and oils of any kind.

To show that it can be done, Henderson in Seattle completed a three-year pilot study, funded by the National Institutes of Health, of 2,000 postmenopausal women who were painstakingly taught how to follow a 20% fat diet. "We give them a Ph.D. in fat," she explains. Her hope was that the pilot would lead to NIH funding of a 10-year effort with 24,000 women. No such luck. A competing proposal for a similar study that would cost \$107 million was on the verge of being financed when an NCI advisory panel decided last month to put it on hold—a crushing disappointment for many researchers.

THE ESTROGEN CONNECTION

If fat does figure in the development of breast cancer, just what role does it play? No one in the research community believes that too many thick shakes and fries can in themselves cause normal, well-behaved cells to mutate into unruly malignant ones. In fact, no one has the faintest notion what causes the initial genetic changes to occur. "In lung cancer we have a reasonable idea that the major cause is cigarette smoking," says Dr. Philip Leder, chairman of Harvard's department of genetics. "In skin cancer we understand that the major cause is ultraviolet light, which is absorbed by DNA and causes it to break. But with breast cancer we don't have any idea what the precipitating factors are."

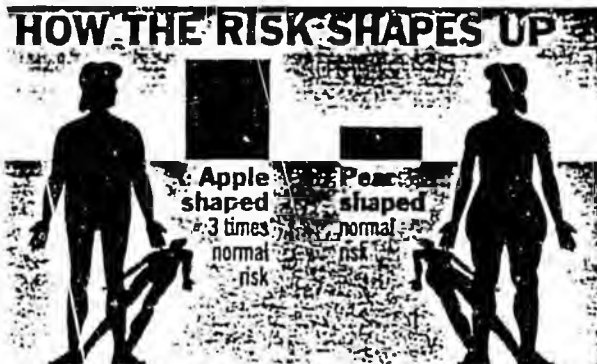
Doctors have long been convinced that some people are genetically predisposed to develop breast cancer. A woman whose mother or sister had the disease before menopause has five to six times the usual risk of developing it. If either one had the

disease in both breasts, then the woman's risk is five to 10 times the norm.

Though scientists do not know how breast cancer begins, they do have some ideas about how it progresses. The female hormone estrogen, which is produced in the ovaries and causes a young girl's breasts to develop, also plays an unmistakable role in promoting the growth of tumor cells. Why do childlessness, late menopause, early onset of menstruation and delayed childbearing all increase the risk of breast cancer? One likely explanation is that all involve a prolonged, uninterrupted

overall levels of estrogen and especially large amounts of the "biologically active" form. Equally significant, endocrinologist David Rose of the Naylor Dana Institute in Valhalla, N.Y., has found that when women switch to a very low-fat diet (20% of total calories), their estrogen levels quickly drop by 20%. Advocates of the dietary-fat theory regard this observation as a crucial bit of supporting evidence. Given estrogen's established role in promoting breast cancer, the fact that fatty foods directly affect estrogen levels means that, as Maureen Henderson puts it, "it's biologically rational that fat can influence cancer."

Considering all the fuss over fish oil and polyunsaturates in the world of heart disease, one might wonder if the type of fat consumed makes any difference. "The data are very confusing on this," admits Rose. Some researchers believe that certain fats are more villainous than others with respect to cancer, but Henderson and others say all fat should be reduced. Drastically.



Obese women who carry excess weight on their upper bodies (apple shaped) are at three times the average risk of getting breast cancer, possibly because they have unusually high levels of certain estrogens. Overweight women who are pear shaped have no increased risk. Apple-shaped women are also more susceptible to heart disease and diabetes.

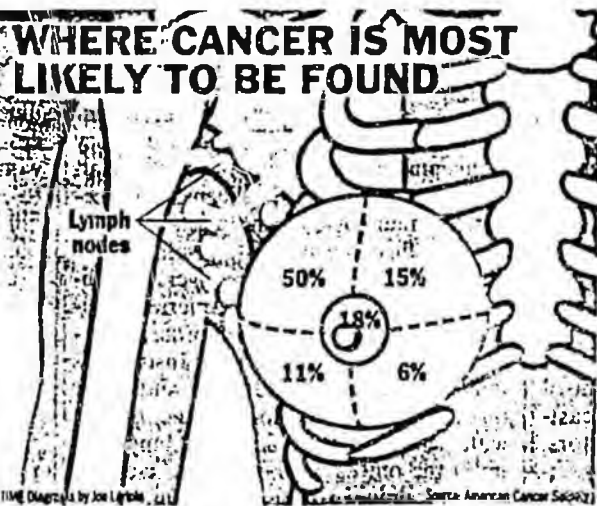
THE MAMMOGRAM MUDDLE

Until the government decides to fund a long-term dietary study and until the work is completed, the value of an ultralow-fat diet in preventing breast cancer will remain open to question. For women 40 or older, however, there is one bit of medical counsel that has almost unanimous approval: Get a mammogram. Now. And do it regularly.

Consider these facts. By the time a breast tumor is large enough to be felt as a lump, it is generally more than 1 cm (0.4 in.) in diameter and contains several billion cancer cells, some of which may have broken loose, circulated through the bloodstream and begun to infiltrate other organs. A mammogram can detect pinpoint tumors that are less than 0.5 cm (0.2 in.) across, often well before the process of metastasis has started. This is not to say that a manual exam by a doctor or the woman herself is a waste of time. Such exams can sometimes turn up tumors missed by X rays. But the early-detection capability of mammography clearly saves lives. A 1987 study found that for women whose tumors were discovered early by mammograms, the five-year survival rate was about 82%, as opposed to 60% for a control group.

And if that is not incentive enough, early detection through mammography can sometimes bring another bonus: surgery that spares the breast. A small, early tumor can often be removed with a lumpectomy procedure rather than a mastectomy.

Why, then, aren't American women running en masse to the mammographer's

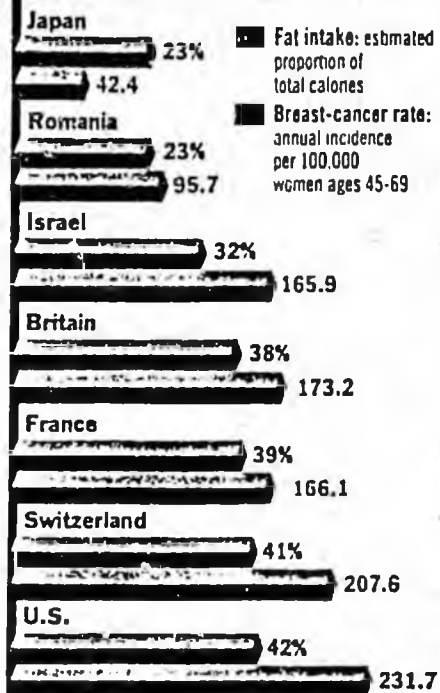


presence of high levels of estrogen in the bloodstream. Doctors have also noticed that women whose ovaries were removed before age 40 rarely get breast cancer.

Researchers focusing on the role of fat in the development of cancer have been particularly intrigued by the estrogen connection. Biologists have long known that estrogen is produced not only in the ovaries but also in fat cells. Obese women have higher levels of estrogen than thin ones—a probable factor in their greater risk of breast cancer after menopause.

But it has been only in the past five years that researchers have found a link between estrogen levels and fat in the diet. Women who eat lots of hamburgers, thick shakes and other fatty foods have higher

DANGER IN THE DIET



An intriguing link with eating habits: a Seattle woman, participating in a study on cancer prevention, prepares a special low-fat meal

office? Why do less than a third of women over 40 have mammograms every one to two years, as experts recommend? One reason may be lingering fears about radiation exposure. Nowadays, however, mammography doses are about one-tenth of what they were 20 years ago—less than one receives from cosmic rays on an airplane flight. A more significant factor, says Dr. Sarah Fox, a UCLA professor of family medicine, is "that physicians aren't making the recommendations." Doctors often feel that mammograms are unnecessary for women who are not in a high-risk category. "Sometimes they'll say, 'You've had a couple of children and you've got no family history, so relax,'" explains Dr. Robert Smith of the Centers for Disease Control in Atlanta. Yet three out of four breast-cancer victims have no known risk factors, says Smith. No woman over 40 should consider herself safe. And certainly her doctor should know better.

The cost of mammograms may also discourage women. Insurance frequently fails to cover the \$50 to \$200 procedure. Medicare just began paying for it this year. Public hospitals do not always offer such screening, and some state Medicaid programs have refused to provide reimbursements, which helps explain why breast cancer is often diagnosed too late among the poor. For black women in particular, the five-year survival rate is only 64%, in contrast to 77% for white women.

Adding to the confusion on mammography is the unfortunate fact that medicine's powerful professional societies cannot agree on what to recommend. The American Cancer Society urges a mammogram every one or two years for women be-

tween ages 40 and 49, and annually thereafter. The American College of Physicians disagrees, claiming that a mammogram is not "cost-effective" for women under 50, since only 20% of malignancies occur in these women.

As if matters were not muddled enough, a storm has erupted in recent years over the uneven quality and accuracy of mammograms around the U.S. "Half the states do not have a licensing procedure for radiologic technologists. It could be the office receptionist pushing those buttons," warns Marie Zininger, a quality-control specialist for the American College of Radiology. Another problem, according to the National Cancer Institute, is that General Electric, Philips and other manufacturers have flooded the market with mammography machines. Many wind up in the offices of doctors who lack the proper training in the use and maintenance of these machines. The College of Radiology has responded with a drive, launched in 1989, to examine and certify mammography facilities. It advises patients to choose a high-volume accredited facility. Another sign that a mammogram is up to snuff: the ouch factor. To get a good picture, the mammography machine must compress the breast. "If you're not uncomfortable," says UCLA's Fox, "you're probably getting a bad mammogram."

A POLITICAL SOLUTION?

In recent years a ground swell of breast-cancer victims, feminists and legislators, inspired by the success of the AIDS lobby in bringing attention and funds to that epidemic, have been pushing for better

regulation of mammography standards, for mandatory insurance coverage of mammograms, and generally for more research into the still mysterious roots of breast cancer. They point out that the U.S. government spends only \$77 million a year investigating ways to prevent the illness, against \$648 billion on heart-disease prevention. Last week Congresswoman Mary Rose Oakar of Ohio sought to redress the shortfall by introducing a bill that would add \$25 million to the NIH budget expressly for basic research on breast cancer. Meanwhile the National Women's Health Network, a lobbying group in Washington, continues to press for federal funding of studies on the effects of diet.

But given the demands on the limited federal research budget, such efforts will probably fail. Perhaps as unfortunate, notes Dr. Geoffrey Howe, a leading researcher on cancer and diet at the University of Toronto, is the fact that "political pressure is the criterion for deciding what scientific research needs to be done."

For patients, the lack of answers and of resources to find them amounts to an all too literal deadlock. "I am scheduled to die because I have metastatic breast cancer," says Elenore Pred, founder of the Breast Cancer Action group in San Francisco. "I'm part of the 44,000 women for whom there is no cure. But I refuse to be written off." Pred is devoting her days to lobbying for more research and better public education on the disease. As the mother of two daughters, she could leave them no healthier legacy. — Reported by J. Madeleine Nash/Chicago and James Willwerth/Los Angeles

The Rough Road to Recovery

Options for therapy have multiplied, but making the right choices can be daunting for both doctors and patients

By CLAUDIA WALLIS

D Colleen Fallscheer, a cheerful 40-year-old mother of two from Waterford, Mich., is living proof that breast-cancer therapy is not the horror show it used to be. A little over a year ago, a mammogram revealed a bright malignant spot, no more than 1.5 cm (about 0.6 in.) across, imbedded in the translucent tissue of her left breast. A surgeon recommended a mastectomy, to be followed by chemotherapy. Fallscheer was appalled. She sought a second opinion from David August, a surgical oncologist at the University of Michigan Medical Center, who told her that her tiny malignancy made her an ideal candidate for a lumpectomy, a less drastic procedure.

Last November, in a two-hour operation, Dr. August's team removed the cancer plus a margin of surrounding tissue, leaving Fallscheer with a 5-cm (about 2-in.) scar in an otherwise normal-looking breast. To catch any residual cancer cells, she received six weeks of daily radiation therapy, which produced a light suntan but left no permanent trace. "A lumpectomy plus radiation does not cure more women than mastectomy," says radiation oncologist Allen Lichter of the University of Michigan, "but it creates fewer physical and emotional scars." Fallscheer concurs: "It was only after I saw Dr. August that I felt I wasn't going to die after all."

Ten years ago, lumpectomy would not have been an option for Fallscheer. Since then, studies have shown that when a tumor is small, confined to a single area and readily accessible to the surgeon's scalpel, lump removal plus radiation is no less effective than removing the entire breast. But as Fallscheer's experience shows, not every surgeon is convinced. Nor does every eligible patient choose the lesser operation. Though about 50% of breast-cancer patients are candidates for lumpectomy, only about half of those elect it. Many, including Nancy Reagan, feel safer if the en-



The "caterpillar stage": Crossley, who received high-dose chemotherapy, gets a checkup

tire breast is removed. "For most women, whether or not they lose their pectorals is not the issue," explains University of Chicago surgeon Monica Morrow. "It's whether or not they lose their lives."

Choice of surgery is only the first of many decisions faced by patients and doctors. None are simple, and women sometimes get the impression that there are as many variations in therapy as there are doctors. The key question following surgery, however, is whether the cancer has spread. It is not localized disease in the breast that kills more than 40,000 U.S. women a year, but the dissemination of the cancer to other, more vital organs, usually the brain, the bones, the liver or lungs.

To determine if the deadly process of metastasis has begun, surgeons performing mastectomies and lumpectomies routinely remove 10 to 25 lymph nodes from under the arm near the affected breast and examine these glandular structures for signs of cancer. A woman with "positive" nodes has a 37% to 75% chance of a cancer relapse within five years, depending on the number of affected nodes and the size of the original tumor. In such cases, chemotherapy or hormone therapy will be urged.

The kind of drug treatment depends on many things, including a woman's age and the biology of her tumors. The cancer cells of postmenopausal patients often require the hormone estrogen in order to grow. If lab tests show the presence of estrogen receptors in a tumor (a sign of a good prognosis), therapy with tamoxifen, an estrogen-blocking drug, is usually recommended. It reduces the risk of disease recurrence by approxi-

mately 20%, with relatively mild side effects.

Younger women and those who have no estrogen receptors usually receive combinations of two to five chemotherapy agents, such as Cytosan and methotrexate, over a period of four months to a year. Because these drugs target rapidly dividing cells, they not only destroy cancer cells but also cells in the hair follicles, the lining of the digestive tract and the bone marrow. That produces the dreaded side effects of chemo: hair loss, nausea and a decline in infection-fighting white blood cells. Premature menopause can be another consequence. Even this harsh treatment provides no guarantee of a cure, though in certain groups of patients, it can increase survival rates as much as 40%.

Today, thanks to the widespread use of mammograms, breast tumors are being discovered earlier, before the cancer has spread. Now 60% of patients are "node negative," up from 50% 10 years ago. Increasingly, cancers are being found at a very early, localized stage, known as "in situ carcinoma" (cancer in place).

While early detection vastly improves the chances of a cure, it also raises questions for doctors. No one is certain how much treatment is right for in situ carcinoma. Nor is it easy to determine therapy for patients whose cancer has begun to spread but has not yet affected the lymph nodes. Experience has shown that up to 30% of these node-negative women will develop a recurrence. The question: Which 30%?

Frequently, doctors use a variety of factors to determine which patients are at highest risk. One major consideration: tumor size. "One centimeter [0.4 in.] is considered the major turning point," says Dr.

Larry Norton at Memorial Sloan-Kettering in New York City. "Over 1 cm, and I lean very strongly toward additional treatment." A close look at the tumor cells will provide other clues, says Dr. William McGuire, chief of medical oncology at the University of Texas Health Science Center at San Antonio. Misshapen cell nuclei, abnormal amounts of DNA or an accelerated rate of cell division are all bad signs, suggesting a need for chemotherapy or tamoxifen. Newer tests include examining tumor cells for extra copies of cancer-causing genes or excess amounts of an enzyme called Capthepsin D, which seems to play a role in metastasis. Says McGuire: "Today we know that if you have a low score on all these markers, your chance of recurrence is less than 10%. If you score high, your chance is greater than 50%."

To have the cancer return even after the trauma of surgery and the misery of chemotherapy is the nightmare of every patient. When this happens, the outlook is grim. But in recent years doctors have been experi-

menting with a controversial treatment for advanced and recurring breast cancer that involves massive doses of chemotherapy and a bone-marrow transplant. Annette Crossley, 45, of Glendora, Calif., is hoping it will save her life. Crossley suffered a cancer relapse just a few months after completing a course of treatment that included a mastectomy, chemotherapy and radiation. Given slim odds of survival, she chose to try the new treatment at the University of Chicago Medical Center. Over a five-day period, she received intravenous chemotherapy in four to seven times the usual doses. Because such treatment destroys the bone marrow, healthy marrow was extracted from Crossley's pelvic bone before she began the toxic therapy. After the sessions and some rest, the marrow was re-injected into her body.

Such high-dose therapy is perilous. Until the transplanted marrow replenishes the patient's supply of white blood cells, she is highly vulnerable to infection. Jacob Bitran, Crossley's oncologist, believes that

the procedure is worth the risk. He and his associates have treated 67 advanced breast-cancer patients in this manner over the past four years. Though 11 have died of complications, mostly infections, 16 are in complete remission, seemingly disease free. "That means 1 in every 4 is a long-term survivor," he says. Others are not persuaded. "I am not convinced that we have the benefits to justify the toxicity," says Harvard oncologist I. Craig Henderson, noting that, regardless of treatment, 10% of women with advanced, metastatic disease will be alive after 10 years. Such doubts have led many insurance companies to refuse to pay for the procedure, which typically costs about \$120,000.

For Annette Crossley, cost is not the main concern. Slowly regaining strength, with little hair left on her head, she remains a picture of hope. "This is the caterpillar stage," she says, grinning gamely, "the ugly stage before the butterfly comes out."

—Reported by J. Madeleine Nash/
Ann Arbor

Restoring Lost Curves and Confidence

Last November, at the age of 43, Carol Beebe lost her left breast to cancer. But when she awoke from mastectomy surgery at New York City's Columbia-Presbyterian Medical Center and gazed down at her chest, nothing appeared to be missing. Beebe, an IBM employee from Point Pleasant, N.J., had chosen to have a reconstruction of her breast immediately following the mastectomy. In a single operation, plastic surgeons shaped a new breast from Beebe's own abdominal tissue, moving it into place minutes after the general surgeons had removed the diseased breast. The technique spares the patient the anguish of amputation. "Our basic philosophy is that you don't leave the hospital without a breast," explains Plastic and Reconstructive Surgery chairman Norman Hugo, who performed the operation.

Rebuilding the breast after mastectomy has become increasingly popular in recent years: more than 34,000 U.S. women chose some form of reconstruction in 1988, up 71% from 1981, according to the American Society of Plastic and Reconstructive Surgeons. Younger patients are particularly drawn to the procedure, though Hugo has reconstructed breasts for women of all ages and types, including a nun.

The majority of reconstructions are done with implants, small bags that are inserted under the muscle of the chest wall and filled with either silicone gel or saline solution. The inflation must be done gradually over a period of weeks to allow time for the muscle and skin to stretch, a process that can cause discomfort and sometimes lead to infections.

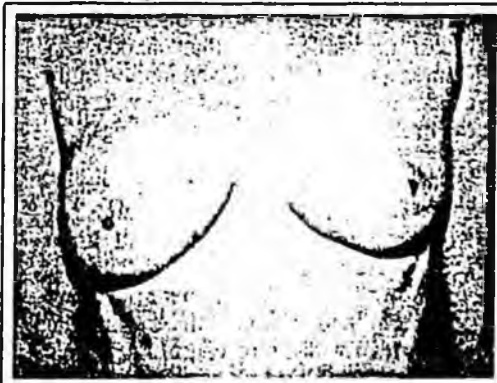
Linda Lehman, 43, a mother of two from Newville, Pa., received two silicone implants last February, three months after undergoing double mastectomies. That summer she went out

and bought a new two-piece swimsuit. "Losing your breasts is a terrible experience," she says. "You mourn the loss. You have the same phantom feelings as when you lose a limb." The implants, she says, have restored her spirit along with her figure. "I wear more revealing clothing than before, and I've never looked better."

Silicone implants are not without drawbacks. Because they sit high on the chest and are compactly curved, the implants most closely reproduce the look of a young woman's breast and can be a poor match for an older patient. They can also make the breast feel hard, interfere with mammography and, on occasion, rupture, causing inflammation if silicone has been used. This spring, as a result of pressure from patient-advocacy groups and members of Congress, the FDA will require implant manufacturers to provide proof of the safety of their products. Still, many surgeons say the risks have been exaggerated.

Reconstruction using a flap of abdominal tissue, as Beebe had, avoids most of the implant problems but is a far more complex operation, lasting upwards of six hours and requiring a longer recovery period.

The plastic surgeon must carve a large, almond-shaped swath from the belly, about 16 cm by 30 cm (6 in. by 12 in.), carefully lifting up the skin, fat and an underlying muscle, without severing the artery that supplies the tissue. The flap is then fashioned into a new breast. A new nipple can be created later by twisting the tissue and tattooing on an areola. For Beebe, there was abdominal pain at first and cramping of the relocated muscle that continued for several weeks following her surgery. But she has no doubt that she made the right choice. "It feels natural and moves naturally," she says. "I don't even feel like I've lost a breast. It's just a little different now."



Breast, left, rebuilt with abdominal tissue

Tantalizing Clues to a Lethal Legacy

Research into the genetic factors is raising hopes of better screening and treatment

By J. MADELEINE NASH CHICAGO



To most women, the notion of undergoing a mastectomy in order to prevent breast cancer smacks of wild paranoia. But for Maria Burkhardt of Covington, La., the unthinkable slowly became the inevitable. Twenty years ago, an aunt was stricken with the disease. Her mother died from it a decade later. In 1986 Maria's younger sister Jo Ann began fighting for her life. Next her older sister Rose developed an aggressive tumor. Maria consulted a doctor and was told she was "a ticking time bomb." Ominously, her tissues were judged too dense for mammograms to scan reliably.

So last summer, at 47, Maria decided to have both breasts removed. Her own graceful curves were replaced with silicone implants that harbored no trace of her family's lethal legacy. A short time later, Maria received a report that vindicated her decision. A postoperative examination of her breast tissue had found precancerous lesions. "I just broke down and cried," she recalls. "I'd done this knowing I might never know if I'd made the right choice."

Families like Maria Burkhardt's are rare, accounting for a tiny fraction of breast-cancer cases. But the malevolent genes they pass down through the generations are beginning to yield important clues to all breast malignancies. "Cancer," declares celebrated molecular biologist James D. Watson, "is a disease of the DNA," the master molecule that encodes the genetic blueprint for every living cell. Tumors develop as the result of rearrangements in DNA, specifically in the genes that govern cell growth.

In most cases, the changes that lead to breast cancer begin accumulating after birth, perhaps triggered by some set of environmental stresses, whether random cosmic rays or a dietary factor. Some women, however, start out with the genetic deck stacked against them. Like Burkhardt and her sisters, they stand a greater risk of developing breast cancer, in both breasts and at an earlier age, than other women.

Recent months have brought a series of discoveries about the genetic mutations involved in breast cancer. "Information is accumulating at an astounding rate," says University of Utah geneticist Mark Skolnick.



"A ticking time bomb": after her sisters Jo Ann, left, and Rose, right, were stricken with aggressive breast tumors, Maria Burkhardt opted for preventive mastectomies. "Half the people I talked to said I'd be crazy, but it's not worth waiting for cancer."

Changes in at least two types of genes play a role: those that direct cells to grow and divide; and those that issue commands to halt growth. Much of the research has focused on a growth-enhancing gene on chromosome 17, often referred to as the *HER-2/neu* oncogene. An estimated 30% of breast-cancer patients have somehow acquired abnormal quantities of this gene—as many as 50, as opposed to the normal two.

The extra copies are a bad omen. Patients that have them suffer three times the rate of cancer recurrence of other patients, says UCLA oncologist Dr. Dennis Slamon. Such patients, he says, should "absolutely" get further treatment. But one genetic abnormality is not enough to transform healthy, law-abiding breast cells into anarchic tumors. "The genes responsible for this disease are like pieces of a patchwork quilt," says geneticist Mary-Claire King of the University of California, Berkeley. The patchwork pattern may vary from one woman to the next, but each case probably involves five or six separate mutations occurring over a period of years.

Researchers at the Cancer Institute in Tokyo have implicated five genes on four different chromosomes. Dr. Yusuke Nakamura speculates that the loss of a growth-suppressing gene on chromosome 17 may be one of the earliest changes on the road to malignancy. Other groups have also pointed to sites on chromosome 17. Last November a team led by scientists at Mas-

sachusetts General Hospital Cancer Center identified one such gene as the likely cause of Li-Fraumeni syndrome, a rare genetic disorder that increases susceptibility to breast cancer and other malignancies. Since then, King and her colleagues at Berkeley have identified another segment of chromosome 17 that is associated with familial breast cancer. Other researchers, including a group in Strasbourg, France, are unraveling the genetics behind the deadly process of metastasis.

The flood of insights into the genetics of breast cancer will ultimately provide physicians with more effective weapons. This year Dr. Slamon and his colleagues hope to begin clinical trials of a genetically engineered antibody that locks onto the protein made by the *HER-2/neu* oncogene, interfering with its function. This antibody has already been shown to inhibit tumor growth in mice.

Researchers like Berkeley's King dream of diagnostic tools powerful enough to identify abnormal genes in breast cells long before they become fully cancerous. Such tools could begin to lift the burden of uncertainty from women who, like Maria Burkhardt, come from cancer-prone families and wonder if they carry the dreaded trait. Someday, if King has her way, tests for breast-cancer genes could become as commonplace as Pap smears. And then, she says optimistically, "no one need die of breast cancer anymore."

—With reporting by

James Wilberth/Los Angeles

Screening Mammography: Increasing the Effort toward Breast Cancer Detection

ABSTRACT

Mammography is the only modality with the potential for detecting a breast cancer while it is non-palpable and at a stage of high curability. Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status, and prognosis is best for small lesions without axillary node metastasis. Many studies have indicated that screening mammography is tremendously underused. This article focuses on the effectiveness of mammography and the importance of detecting a breast cancer at an early stage. Health care providers have a responsibility to inform their clients about the benefits of mammography. In addition, women need to be taught breast self-examination and undergo regular clinical breast examinations by a health care professional. The American Cancer Society guidelines for screening breast cancer are given.

Deborah A. Hamwi, R.N., N.P., M.S.N.

The high incidence of breast cancer among women in the United States has made early diagnosis the focus of screening efforts. It is estimated that in 1990 a total of 150,000 women will be diagnosed with breast cancer, and approximately 44,000 will die of this disease.¹ Many advances have been made in early detection and especially in screening mammography, which has been shown to be effective in detecting breast cancer at preclinical stages. However, more than 90 percent of breast cancers are first detected by women themselves.² The size of breast cancers detected by this method averages about 2.5 centimeters (approximately one inch), and approximately 50 percent of the women have lymph node involvement at the time of discovery.³

Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status, and prognosis is best for small lesions without axillary node metastasis. Small, non-palpable (preclinical) cancers found by screening mammography have a 10-year survival rate of 95 percent and can thus have a major impact.^{2,3} When nodes are involved, the survival rate drops to 53 percent or less. Presently, the majority of breast cancers are detected at this stage.³

In February 1990 a study sponsored by the

National Cancer Institute and the Jacobs Institute of Women's Health was done to determine whether expanded media coverage, national and local information efforts and screening programs had increased the use of mammography. The survey of 980 women age 40 and older showed that 64 percent had had at least one mammogram, up from 37 percent in 1987. The study also indicated that only 31 percent of the women were following mammography guidelines established by the National Cancer Institute, the American Cancer Society and 11 other medical organizations. Nearly three-fourths of the women 40 years of age or older who had had a mammogram reported that they did so because their doctors recommended it — a finding that was consistent across age, race, income and education categories. Forty-five percent of the women who had never had a mammogram reported that their physicians did not tell them to do so. These women were also more likely to be uncomfortable in asking their physicians for a mammogram if their physicians did not mention it first. It is estimated that breast cancer death rates could be decreased by 30 percent if women received mammograms at recommended intervals.⁴

The American Cancer Society (ACS) recommends a baseline mammogram for all women be-

Brief Summary

Contraindications: Patients who have had a severe reaction to NAPROXEN, ANAPROX or ANAPROX DS or in whom asthma or other NSAIDs induce the symptoms of asthma, rhinitis, and nasal polyps. Because anaphylactoid reactions usually occur in patients with a history of such reactions, caution patients with asthma, nasal polyps, urticaria, and hypersensitivity associated with NSAIDs before starting therapy. If such symptoms occur, discontinue the drug. **Warnings:** Serious GI toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAIDs. Remain alert for ulceration and bleeding even in the absence of previous GI tract symptoms. In clinical trials, symptomatic upper GI ulcers, gross bleeding, or perforation occur in about 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. Inform patients of signs and/or symptoms of serious GI toxicity and what steps to take if they occur.

Studies have not identified any subset of patients not at risk in developing peptic ulceration and bleeding, except for a prior history of serious GI events and other risk factors associated with peptic ulcer disease, such as peptic ulcer disease, smoking, etc. No risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration and bleeding less well and most spontaneous reports of fatal GI events are in this population. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity.

Precautions: DO NOT GIVE NAPROXEN (NAPROXEN CONCENTRATE) WITH ANAPROX OR ANAPROX DS (NAPROXEN SODIUM) SINCE THEY CIRCULATE IN PLASMA AS THE NAPROXEN ANION. Acute interstitial nephritis with hematuria, proteinuria, and nephrotic syndrome has been reported. Patients with impaired renal function, heart failure, liver dysfunction, patients taking diuretics, and the elderly are at greater risk of overt renal compromise. If this occurs, discontinue the drug. Use with caution and monitor serum creatinine and/or creatinine clearance in patients with significantly impaired renal function. Use caution in patients with decreased creatinine clearance less than 20 mL/minute. Use the lowest effective dose in the elderly or in patients with chronic alcoholic liver disease or cirrhosis. Borderline elevations of liver tests may occur in up to 15% of patients. Elevations of SGPT or SGOT occurred in controlled trials in less than 1% of patients. Severe hepatic reactions, including jaundice and fatal hepatitis, have been reported rarely. If liver disease develops or if systemic manifestations occur (e.g., eosinophilia or rash), discontinue therapy. If therapy is resumed, the dosage is reduced by eliminating evening therapy, and patients should be closely monitored for adverse effects, including systemic vasculitis and exacerbation of arthritis symptoms. Determine hemoglobin values periodically for patients with initial values of 10 grams or less who receive long term therapy. Peripheral edema has been reported. For patients with restricted sodium intake, note that each tablet contains approximately 25 or 50 mg of 2 mEq sodium. Use with caution in patients with fluid retention, hypertension or heart failure. The drug may reduce fever and inflammation, diminishing their diagnostic value. Conduct continuous studies if any change of occurrence in vision occurs. **Information for Patients:** Side effects can cause discomfort and, rarely, more serious side effects, such as GI bleeding, may result in hospitalization and even fatal outcomes. Physicians may wish to discuss with patients potential risks and benefits of NSAIDs, particularly when they are used for less serious conditions where treatment without NSAIDs may be acceptable. Patients should use caution for activities requiring alertness if they experience drowsiness, dizziness, vertigo or depression during therapy. **Laboratory Tests:** Because serious GI tract ulceration and bleeding can occur without warning symptoms, follow chronically treated patients and inform them of the importance of the follow-up. Drug Interactions: Use caution when giving concomitantly with coumarin type anticoagulants; a nonionized sulfonamide or sulfonylurea; furosemide; lithium; beta-blockers; probenecid; or methotrexate. **Drug/Laboratory Test Interactions:** May decrease catalase, urea nitrogen and prothrombin time or increase urinary values for 17-ketosteroids. **Serumology:** Stop therapy for 72 hours before serum function tests. May interfere with urinary assays of SHUAA, Creatinylsulfate. A 2-year rat study showed no evidence of carcinogenicity. **Precaution:** Subgroup 1: Do not use during pregnancy unless clearly needed. Avoid use during late pregnancy. Nursing Mothers: Avoid use. **Pediatric Use:** Single doses of 2.5-5 mg/kg (1st reported suspension) with total daily dose not exceeding 15 mg/kg/day, are safe in children over 2 years of age.

Adverse Reactions: In a study GI reactions were more frequent and severe in rheumatoid arthritis patients on 1550 mg/day naproxen sodium than in those on 825 mg/day in children with juvenile arthritis. Rash and prolonged bleeding times were more frequent, GI and CNS reactions about the same, and other reactions less frequent than in adults. **Incidence Greater Than 1%:** Probable Causal Relationship: GI: The most frequent complaints related to the GI tract, constipation, heartburn, abdominal pain, nausea, dyspepsia, diarrhea, stomatitis, CNS: headache, dizziness, drowsiness, vertigo, blurred vision, dermatologic: itching (pruritus), skin eruptions, eczematoid, swelling, purpura, SJS-like lesions, toxicoid, benign exanthematous, viral cutaneous. Cardiovascular: severe, dysrhythmia, palpitations, congestive heart failure, hypotension, orthostatic hypotension, cerebrovascular: stroke, transient ischemic attack, myocardial infarction, thrombocytopenia, CNS: depression, cerebral abnormalities, inability to concentrate, insomnia, migraine, myalgia and muscle weakness, dermatologic: photosensitive dermatitis, skin rashes. Special Senses: hearing impairment. Cardiovascular: congestive heart failure, respiratory: eosinophilic pneumonitis. General: anaphylactoid reactions, menstrual disorders, pyrexia (fever) and fever. **Causal Relationship Unknown:** Hematologic: aplastic anemia, hemolytic anemia, CNS: cognitive dysfunction. Dermatologic: epidermal necrolysis, erythema multiforme, Stevens-Johnson syndrome, urticaria. GI: non-peptic GI ulceration, ulcerative stomatitis. Cardiovascular: vasculitis. General: myalgia and muscle weakness, hearing impairment.

Overdosage: May cause drowsiness, numbness, indigestion, nausea, vomiting. Empty stomach and use usual oral or rectal enemas. In animals 0.5 g/kg of activated charcoal reduced plasma levels of naproxen.

Dosage and Administration for Mild to Moderate Pain, Dysmenorrhea and Acute Rheumatoid Arthritis: Recommended starting dose is 550 mg, followed by 275 mg every 8 to 12 hours. Total daily dose should not exceed 1375 mg.

Dosage and Administration for Rheumatoid Arthritis, Osteoarthritis and Juvenile Spontaneous: Recommended dose in adults is 275 mg or 550 mg twice a day. In patients who tolerate lower doses well, the dose may be increased to 1650 mg per day for limited periods when a higher level of anti-inflammatory activity is required. At this dosage, physicians should observe sufficient increased clinical benefit to offset potential increased risk.

Caution: Federal law prohibits advertising without prescription. See package insert for full Prescribing Information. Revised 10/88

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tween the ages of 35 and 39, mammograms every one to two years for women who are 40 to 49 (depending on risk factors), and mammograms every year for all women age 50 and over.⁵ In addition, the ACS recommends the practices of breast self-examination and regular clinical examinations (see Table 1, p. 31).⁶⁻⁷

Screening mammography and clinical breast examination can contribute much to early detection and overall reduction in breast cancer morbidity and mortality. Health care professionals can play a vital role in thoroughly evaluating their clients and making appropriate referrals. In addition, health care professionals can instruct their patients in breast self-examination, which can help them detect abnormalities in between mammographies and regular clinical examinations.

Biology of Breast Cancer

Medical understanding of the biology of breast cancer has changed over time. The spread of cancer was once believed to occur in an orderly progression from the breast to the axillary nodes and then to distant sites via the lymphatics. However, treatment often failed; systemic disease appeared and many patients died after what had appeared to be "successful" local treatment.

The currently held concept is that blood-borne metastases occur early in the majority of patients with breast cancer, and that success in treatment of breast cancer requires successful systemic control in addition to local control. There is also thought to be a relatively long preclinical phase, probably lasting approximately two to three years, during which time a cancer can be detected only by mammography. At this stage, the likelihood of nodal and distant metastasis is low, and screening mammography can have its greatest impact.^{3,8}

Mammography

Mammography—or soft tissue roentgenography of the breast—has been available since the first half of the 20th century. However, its use in clinical medicine did not become widespread until two decades ago.³⁻¹⁰

Mammography now has two main diagnostic uses: first, to screen

essentially healthy asymptomatic women; and second, to evaluate the breast tissue of women with symptoms such as breast lumps, nipple discharge or mastalgia.⁹

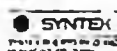
Many studies have demonstrated the efficacy of mammography in early detection of breast cancer. The Health Insurance Plan of Greater New York conducted a study between 1963 and 1970 involving 30,000 women who underwent screening mammography, history and physical examinations. The study demonstrated a 33-percent reduction in breast cancer mortality among all screened women and a 40 percent reduction in mortality in women over age 50.

The Breast Cancer Detection Demonstration Project was a much larger study involving 280,000 women and sponsored by the American Cancer Society and National Cancer Institute. The women underwent history, physical examinations and mammographies. Forty-two percent of the cancers discovered were detected by mammography alone. In addition, mammography appeared to have been effective not only in women older than age 50, but also in women ages 40 to 49. In the latter group, mammography alone detected 35 percent of cancers, and mammography combined with physical examination detected 50 percent of the cancers.

More recently, screening studies from the Netherlands and Sweden have further documented the importance of mammography. In the Swedish report, 163,000 women underwent a single-view screening mammography every two to three years. The seven-year study demonstrated a 31-percent reduction in breast cancer mortality and a 25-percent reduction in the number of advanced breast cancers.^{9,11-12}

Radiation Risk

A concern of many is the radiation risk associated with mammography. In 1976, there was intense debate about whether mammography, which uses X rays, might in itself produce breast cancer. Although not a likely cause of breast cancer, radiation exposure will substantially increase a woman's risk after a 10- to 20-year latency period. This conclusion is based on observations of women exposed to relatively high doses of



Anaprox DS
(NAPROXEN SODIUM)

radiation, such as in the Hiroshima and Nagasaki atomic bomb blasts, multiple fluoroscopies for the treatment of tuberculosis, and X-ray treatment for postpartum mastitis.¹²

However, there appears to be very little increased risk to women exposed to radiation after the age of 40 — the age when mammography is most indicated. The prepubescent breast is sensitive to the carcinogenic effect of radiation, and the breast may become gradually less sensitive to the effects of radiation during adolescence. There are no epidemiologic data demonstrating that routine use of mammography — even repeated mammograms at yearly intervals — is ever associated with an increased risk of breast cancer. In addition, the radiation doses currently used for screening mammography have been significantly reduced from earlier doses to the range of 0.2 rad per breast per examination. Women need to be educated that the dose of radiation from a mammogram is negligible and should not deter them from receiving regular mammograms.¹³

Historically, radiation risk estimates have been taken from studies of women exposed to relatively high doses of radiation such as atomic bomb survivors, patients exposed to multiple fluoroscopic examinations and women treated for postpartum mastitis. These groups received more than 50 rad of radiation and did have an increased incidence of breast cancer. The age at irradiation was identified as a major determinant of risk. Women irradiated when younger than 20

years old had a higher risk of radiation induced breast cancer.^{2,12}

It is not known whether very low doses of radiation, such as those used in current mammographic techniques (0.1 to 0.8 rad), can

Radiologist and Technologist

Competently performing the examination and recognizing the subtle signs of early breast cancer require that the radiologist and

Nearly three-fourths of the women 40 years of age or older who had had a mammogram reported that they did so because their doctors recommended it — a finding that was consistent across age, race, income and education categories.

cause breast cancer. The risk, if it does exist, is so small that it has never been observed but only inferred from the greater incidence of breast cancer seen in women exposed to doses of greater than 50 rad.^{2,10,13}

Currently, mammograms are most often produced by a screen-film technique. The average glandular radiation dose for a two view examination is 0.1 to 0.2 rad. There has been considerable improvement over earlier techniques including a significant reduction in radiation dose and considerable improvement in diagnostic image quality.^{10,12-13}

technologist be qualified and experienced with mammography. The technologist is responsible for positioning the patient properly so that as much of the breast as possible appears on the film and so that the breast is compressed to as thin a layer as possible. In a population of healthy women age 40 to 74, only 2 percent of the women have a pathological lesion. The radiologist interpreting screening mammograms must be familiar with the wide range of mammographic appearances that are present in normal breasts.^{12,14-15}

Cost of Mammography

In 1986, the American Cancer Society sponsored a community-wide low-cost mammographic screening project. The goal of the ACS campaign was to encourage a long-term reduction in the cost of mammographic screening and increase public and physician awareness of the value of mammographic screening. The project provided mammographic examinations at a cost of \$50 each for 18,264 asymptomatic women ages 35 years and over.¹⁶

The mean fee for a screening mammography in 1988 was \$111; however, this fee can vary contingent on facilities' volumes and subsidies. Women have reported the high cost of mammography as one reason for not undergoing mammograms at recommended intervals. This can have a major impact on women in low socioeconomic groups who are unable to pay out-of-pocket expenses. In the past, many insurance companies did not authorize payment for routine

Compression

Adequate compression is an essential factor in reducing the scatter of the X-ray beam, production of a more uniform density of the breast, and preservation of image clarity by prevention of movement. In addition, compression can reduce the radiation dose, since a lesser thickness of breast tissue needs to be penetrated. When the breast tissue is compressed, suspicious lesions are more easily identified.¹¹⁻¹⁵ The importance of adequate compression should be explained to the patient prior to a mammogram so that she is better able to tolerate the minimal discomfort associated with each exposure. Occasionally, women will experience pain. They should be instructed to communicate discomfort immediately to the technologist. In order to reduce chances of discomfort, mammography should be obtained following the menstrual period when the breasts are least likely to be tender.^{3,12,16-15}

TABLE 1
American Cancer Society
Recommendations
for Asymptomatic Women

Women 40 years of age or less:

- Breast self-examination every month.
- Clinical breast examination at least every three years.
- Baseline mammogram between the ages of 35 and 39.

Women between 40 and 49 years of age:

- Breast self-examination every month.
- Clinical breast examination annually.
- Mammogram every one to two years, depending on risk factors.

Women age 50 and over:

- Breast self-examination every month.
- Clinical breast examination annually.
- Mammogram annually.

screening purposes. However, insurance coverage for screening mammograms is increasing. As of July 1990, 29 states require insurance companies to provide some level of coverage for mammography. With the coverage provided by insurance companies and the expected increase in procedural volume, compe-

available and easily accessible to all women. More programs that promote the benefits of early breast cancer detection are needed. The American Cancer Society has made a substantial impact in educating and stimulating interest among women about this procedure.

In a population of healthy women age 40 to 74, only 2 percent of the women have a pathological lesion. The radiologist interpreting screening mammograms must be familiar with the wide range of mammographic appearances that are present in normal breasts.

tition for patients will hopefully result in lower fees. The availability of low-cost screening for women requires the involvement and cooperation of screening centers, health care professionals and third-party payers.^{2,7,16-17}

Limitations and Recommendations

Mammography is the only modality with the potential for detecting a breast cancer while it is non-palpable and at a stage of high curability. However, large screening projects have found that 15 to 20 percent of cancers are not detectable on mammograms. It is known that mammography is most limited in the dense breast and is therefore of little diagnostic value in women under age 35. It should be emphasized that neither palpation nor mammography are 100-percent accurate. Therefore, a patient with a suspicious lesion found on clinical examination and a negative mammogram requires further work-up.²

American College of Radiology Accreditation

Two years ago, the American College of Radiology (ACR) began a voluntary mammography-accredited program to provide quality assurance to consumers through comprehensive assessment of mammography units and facilities. So far, the ACR has accredited more than 770 mammography units in the United States, and 1,500 more units have applied for accreditation. ACR accreditation ensures that a facility has been evaluated by peer radiologists for equipment quality, staff qualifications, quality of the image and the amount of patient exposure to radiation.¹⁸ The American Cancer Society offices have lists of accredited facilities in their areas.

Conclusion

Motivation of women to accept the procedure of mammography is an important factor in successful screening. Use of mammography must continue to increase, and women must return for repeat mammograms at recommended intervals. Efforts in this direction must be ongoing and persistent. Special efforts are needed to ensure that older women and women in lower socioeconomic groups receive mammograms. Screening centers must be readily

Breast cancer is a disease that threatens both femininity and life itself. There must be an increased awareness among women and health care professionals that will facilitate early detection and diagnosis. Vital to this process are mammography to detect small, non-palpable cancers, breast self-examination and clinical breast examinations by a health care professional.¹⁶ Application of these guidelines will result in early diagnosis and the saving of many lives.

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About the author: Deborah A. Hamwi, R.N., N.P., M.S.N., is a nurse practitioner in the department of operating room services at the University of California at Irvine Medical Center.

POSITION PAPER

House Bill 45

"An Act relating to insurance coverage for mammograms; requiring the medical assistance program to cover mammograms; and reordering the priorities granted to services covered under the medical assistance program."

The purpose of this bill is to expand coverage for mammography screening under individual or group disability insurance, and under optional services related to state participation in the 50% federally funded Medicaid program.

This legislation would affect both health insurance coverage provided by private carriers and public funding of medical services provided, in Alaska, through the Division of Medical Assistance in the Department of Health and Social Services.

Health and disability insurance coverage provided by the health insurance industry, which would be affected by Sections 1 and 2 of the proposed legislation, is not within the responsibility of DH&SS, so the department does not take a position in regard to this kind of coverage under those programs, except to note the recognized value of mammography screening under today's medical standards.

Medical services available to eligible recipients of Medicaid, as administered in DH&SS by the Division of Medical Assistance, would be addressed by Sections 3 and 4 of the proposed legislation, and would allow the Department to provide mammography screening as an optional medical service to recipients of Medicaid.

The Department endorses periodic mammography screening as a cost-effective preventive health measure, and believes that payment for this service could be added at the low cost of \$10,000 for FY 92 because we expect little increase in the number of referrals from physicians. Currently, Medicaid does pay for diagnostic mammograms when ordered by a physician.

In the interest of maintaining consistency in the Medicaid statutes, we offer the following comments and recommendations.

As a specific medical service, mammography is just one of several thousand CPT-4 codes used universally to bill for medical services, and CPT-4 codes are usually dealt with in regulation rather than singling specific codes out for special treatment in statutory form. The rest of AS 47.07.130 deals with broad categories of services rather than specific CPT-4 codes. Therefore, it would be inconsistent with existing statute to single out this particular CPT-4 code as HB 45 would do in its current form.

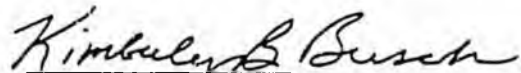
The Department would recommend the following alternative to the present Sections 3 and 4 of the proposed legislation.

In AS 47.07.030(b) we propose changing "low-dose mammography screening" to "adult screening", making an identical change in AS 47.07.035, and defining the proposed term in the existing definitions section, AS 47.07.900, using the definition as stated in the proposed legislation on page 2, lines 14-17.

There is a sensitive issue in the matter of where this new service is to be placed in the priority list of AS 47.07.035. This statute lists the optional services in the order in which they must be suspended or deleted if appropriations are inadequate. Where any service is to be placed on this list is a very subjective matter and invariably arouses strong sentiments among both medical providers and Medicaid recipients. Rather than argue the comparative importance of various medical services, the Department suggests that it may be appropriate to fall back on a principle used by some past legislatures: listing the newest service as first to be suspended. This is defensible on the grounds that the degree to which the public has come to depend on the coverage of any service is, in large measure, a function of how long that services has been covered.

It would therefore be our recommendation that the priority ranking for "adult screening" under AS 47.07.035 be revised to (1).

Recommended by:

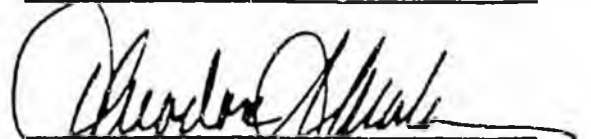


Kimberly B. Busch
Acting Director
Div. of Medical Assistance

Date:

1-29-91

Approved by:


Theodore A. Maia, MD, MPH
Commissioner

Date:

29 Jan 1991

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

January 24, 1991

Representative David Finkelstein, Chair
Labor & Commerce Committee
House of Representatives
P. O. Box V
Juneau, AK 99811

Support: HB 45

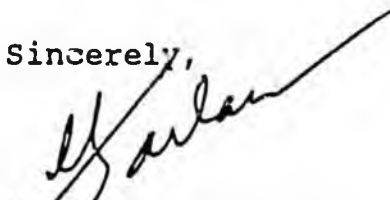
Dear Representative Finkelstein:

The Alaska Hospital & Nursing Home Association would like to lend its support to the passage of HB 45, mandating insurance coverage for mammograms.

Unfortunately I will be out of Juneau on January 29 and will not be able to testify at your Committee hearing on that date.

The bill speaks for itself. It is regretful the Legislature should have to tell either buyers or sellers of health insurance that this type of "preventive" medicine is just good common sense and should be part of an individuals insurance program.

Sincerely,


Harlan R. Knudson
President/CEO

HRK/ma

cc: Members, House Labor & Commerce Committee
Representative Finkelstein
Representative Iverson
Representative Donley
Representative Bruckman
Representative Taylor
Representative Zawacki

✓ Representative Ulmer

WELLSPRING

A WELLHEALTH CENTER

Mary Lou Follett, RNC, ANP
Advanced Nurse Practitioner & Counselor

Constance Trollan, RNC, ANP
Advanced Nurse Practitioner & Counselor

January 26, 1991

Representative Fran Ulmer
Alaska House of Representatives
P. O. Box V
Juneau, Alaska 98211-3100

Dear Representative Ulmer:

Thank you for introducing legislation which will require health insurance carriers in Alaska to provide coverage for mammography screening.

The American Cancer Society states that annually 175,000 new cases and 44,500 deaths will result from breast cancer. This translates into one in nine women in America affected by this disease.

To detect breast cancer in its early, more curable stages, the American Cancer Society recommends breast self-exams every month for women ages 20 and older, a breast exam by a health professional every three years for women ages 20-40, and over 40 years, a clinical exam every year. In addition the American Cancer Society recommends a baseline mammogram for women 35-39 years, a biannual mammogram from 40-49, and an annual mammogram from ages 50 and over.

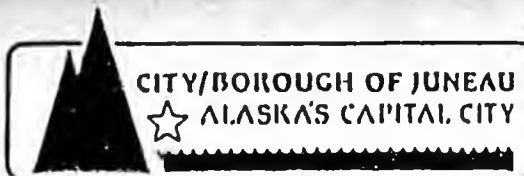
I believe that insurance carriers in Alaska should be required to pay for breast examinations including mammography as delineated by the American Cancer Society. As mammography and radiologist fees are expensive in Alaska, and as these should not be barriers to women seeking adequate women's health care, I suggest that a minimum payment of \$100.00 per woman for mammography be specified in legislation. This will enhance compliance with American Cancer Society guidelines and enable early detection of breast cancer in Alaskan women.

I wholeheartedly support your legislative attempts to require Alaskan insurance carriers to provide coverage.

Sincerely,



Constance Trollan
Women's Health Care ANP



LOOKING TO THE FUTURE

1991 ALASKA CONFERENCE ON AGING

JUNEAU COMMISSION ON AGING

COMMUNITY FORUM -- SENIOR CONCERNS

Assembly Chambers
Juneau, Alaska
January 26, 1991

RESOLUTION IN SUPPORT OF HB 45

RELATING TO MAMMOGRAPHY SCREENING

WHEREAS, breast cancer is the leading cause of premature death in American women; and

WHEREAS, 75% of breast cancers occur in women over age 50, and 40% of breast cancers occur in women over age 65; and

WHEREAS, mammography screening is the most effective means of detecting breast cancer in its curable stage; and

WHEREAS, in over 90% of the breast cancers detected in early stages the patient survives; and

WHEREAS, only 15% - 20% of women who should have a regular mammogram receive one; and

THEREFORE, BE IT RESOLVED, that it is in the interest of senior women to have insurance coverage for mammography screening; and

BE IT FURTHER RESOLVED, that HB 45, relating to insurance coverage for mammography screening, sponsored by Rep. Fran Ulmer, receives the support and endorsement of this organization.

SIGNED

DATE

1-26-91

KAREN S. O'BRIEN

3266 Bluebird Avenue
Fairbanks, Alaska 99709
(907) 479-3422

February 6, 1991

RECEIVED
FEB 8 - P.M.

Rep. Georgianna Lincoln
Post Office Box "V"
Juneau, Alaska 99811

RE: House Bill No. 45

Dear Representative Lincoln:

The Breast Cancer Detection Center in Fairbanks provides an invaluable service for the entire State of Alaska. With the recently proposed cuts, BCDC will be totally eliminated.

Please offer your support for House Bill No. 45 which would enable all individuals to obtain mammograms. Thank you.

Sincerely,



Karen S. O'Brien

NFIB Alaska

National Federation of
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
(NFIB/ALASKA)

TO THE

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ON

HB 45

AN ACT RELATING TO INSURANCE COVERAGE FOR MAMMOGRAMS;
REQUIRING THE MEDICAL ASSISTANCE PROGRAM TO COVER
MAMMOGRAMS; AND REORDERING THE PRIORITIES GRANTED
TO SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.

State Office
9159 Skywood Lane
Juneau, AK 99801
(907) 789-4278



The Guardian of
Small Business

NFIB/ALASKA POSITION PAPER

Mr. Chairman, members of the Health, Education and Social Services Committee, my name is Resa Jerrel, and I represent the National Federation of Independent Business/Alaska - NFIB/Alaska. Before giving my testimony on HB 45, it might be appropriate to briefly describe NFIB/Alaska and its legislative program.

NFIB/Alaska is comprised of 5400 small and independent business owners statewide.

The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our membership on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues. We then share the results of our poll with the Legislature and Administration. There is not enough space on the annual poll to place every possible issue to our membership. Therefore, we also use the three previous years ballots as guidance on issues.

The broad issue of mandated benefits is of great concern to our membership. On the 1990 ballot, we polled our members regarding their views on a similar issue, mandated mental/nervous disorders. The ballot results clearly show that small business owners overwhelmingly - 93% - oppose the government imposing such mandates on them. Any employee benefit package should be worked out between the employer and employee.

In recent years there has been an explosion of states passing laws requiring health insurance policies to cover specific diseases and specific health care services. Mandated health insurance benefits cover services ranging from acupuncture to

naturopaths.

Mandated benefits cover everything from life saving techniques to purely cosmetic devices, such as hair transplants in Minnesota. Collective, these mandates have added considerably to the cost of health insurance and they prevent people from buying no-frills insurance at a reasonable price.

We understand the purpose of this legislation is to act as an incentive for people to utilize this screening service. It is doubtful that will occur, because in Juneau a mammogram cost \$100-\$171. Most health insurance policies have a \$250, \$500 or \$1,000 deductibles. A person is still going to have an out of pocket expense of \$100 - \$171 even if their policy covers the x-ray service or they do not even have health insurance.

Our members believe in the freedom of choice in health insurance. This means being able to buy a health insurance policy tailored to individual, family and employee needs. With this in mind, we would offer an ALTERNATIVE to mandating this coverage: have the insurance companies offer this coverage as an option. With the ability to pick and choose a person can purchase it or choose not to purchase it.

We believe the issue is not whether this benefit and other similar benefits should be extended to employees; rather we believe it is instead, should this benefit be mandated by the Legislature.

Mr. Chairman, Members of the Committee, thank you for the opportunity to present our views on this issue.



Alaska State Legislature
House of Representatives
 COMMITTEE ON HEALTH, EDUCATION
 AND SOCIAL SERVICES

DATE: February 21, 1991

PLACE: Capitol Room 106

SUBJECT OF MEETING:
 HB 45 Insurance Coverage for Mammograms

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
(DO YOU WISH TO TESTIFY?)		(FILL OUT COMPLETELY!)				Y N	
JAN YOUNG	American Cancer Society	PO BOX 34337 JUNEAU, AK 99803	99803	789-3146		(Y) N	HB 45
GORDON LANDES	Div. of Medical Asst.	PO BOX 4-07, JUNEAU 99811	99801	465-775		Y (N)	AVAILABLE FOR QUESTIONS HB 45
Jay Frank	State Farm Allstate	One Sealaska Pl Suite 303 JUNEAU AK	99801		6-5912	(Y) N	HB 45
Dr. Mike Frankie	American Cancer Soc	10301 Diagonal HLU JUNEAU AK	99801	789-0511	789-2910	(Y) N	HB 45
MIKE COUGHLIN	DIV OF RET/BENEFIT	PO BOX CR JUNO AK 99811		465-4470		Y (N)	FOR QUESTIONS IF NEEDED HB 45
DON KOCH	DIV OF INSURANCE	PO BOX D JUNO AK 99811		465-257	465-257	(Y) N	HB 45
Bruce Brannigan	Admin/ Labor Educ	POC-0220, JUNEAU 99811		789-220	465-2441	(Y) N	HB 45
Rese Jemel	NFIB	9159 Skyward JUNEAU	99801	789-4278		(Y) N	HB 45
Gordon Evans	HIAA	318 4th St. JUNEAU	99801	586-3210	same	(Y) N	HB 45
SHERRIE GOLL	ALASKA WOMEN'S LEAGUE	P.O. Box 22156 JUNO AK	99802		463-6744	(Y) N	HB 45

HB

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Alaska State Legislature

HOUSE OF REPRESENTATIVES



REPRESENTATIVE FRAN ULMER

MEMORANDUM

March 6, 1991

TO: Rep. Georgianna Lincoln, Co-chair
Rep. Pat Carney, Co-chair

FROM: Rep. Fran Ulmer

RE: HB 50, relating to the Children's Trust Fund

HB 50 makes a \$4 million appropriation to the Alaska Children's Trust Fund. Established by the legislature in 1988, the Children's Trust Fund is designed to provide a stable stream of income for community-based programs to prevent child abuse and neglect. Income from the interest of the trust could be appropriated annually for that purpose. At current market rates, this \$4 million appropriation would yield approximately \$200,000 in income.

Alaska ranks fourth highest in the nation in the rate of reported child abuse. Alaska's rate of 54 children per 1,000 reported as victims of abuse is more than 60% greater than the national rate (34 per 1,000). Nearly one of every 19 Alaskan children suffer from abuse or neglect. The Division of Family and Youth Services receives 20,000 reports of child abuse and neglect every year.

Alaska's child population grew by 30% during the 1980's. The increase in reports of child abuse and neglect, however, far exceeds those population increases. The number of children receiving protective services has more than tripled since FY 78 and the number of children receiving protection because of sexual abuse has increased 800%.

The increase in child abuse and neglect has been accompanied by an increase in the severity of abuse. As a result, the number of seriously disturbed children entering the state's custody is increasing. Since 1985, the number of adolescent sexual offenders under supervision has increased 700%.

These figures demonstrate how family violence passes from one generation to another. Children in violent homes learn violence as a normal way of solving problems. Studies indicate high correlations between child abuse and deviant behavior among violent juvenile delinquents and

District 4B — Juneau

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adults who commit violent crimes. Sons who witness their fathers' violence have a 1000% greater chance of becoming abusers than those who do not. Most violent criminals were severely abused physically or sexually as children.

Child abuse and neglect can result in death or life-long problems. The degree of harm depends on the child's age, the relationship between the child and the offender, the nature and length of the abuse or neglect, and the assistance the child receives when the abuse is disclosed. Children who experience abuse or neglect often have low self-esteem and alcohol or other drug problems. They run-away or attempt suicide.

All of these problems create long-term social and financial costs for the state. Prevention programs are the most cost-effective means of avoiding those costs. Community-based, intensive counseling services in families' homes protect children while simultaneously helping to prevent on-going neglect and abuse. Education helps parents learn violence-free discipline and positive reinforcement for appropriate behavior. Therapy for abused and neglected children helps to prevent the cycle of abuse from continuing.

The Children's Trust Fund is an appropriate method of preventing the problems resulting from child abuse and neglect. The appropriation made to the trust today will yield income next year and every year. It will still be funding prevention programs 20 years from now when the effects of today's abuse will be felt in the criminal justice system, in the need for increased social services and public assistance, and in the beginning of another cycle of abuse. HB 50 begins a cycle of funding to prevent that cycle of abuse from continuing.

State Facts

Total population	524,000
Education expenditures per pupil	\$ 7,971
Percent population under 18	31.9%
Percent births with early prenatal care	79.1%
Percent population minority	21.1%
Percent of children not covered by health insurance	19.5%
Percent population metropolitan	11.7%
Benefits as percent of poverty (AFDC and Food Stamps)	92.1%
Per Capita Income	\$ 21,636

Alaska

National Composite Rank

38 51

Per Capita Income Rank

5 51

Percent change over time

Trend data

National rank

Indicators	Percent change over time			Trend data		National rank				
	-60	W O R S E	0	B E T T E R	+60	BASE Year	BASE Data	MOST RECENT Year	MOST RECENT Data	National rank (based on most recent available data)
Percent low birth weight babies 1980 1988				7		1980	5.4	1988	5.0	5 51
Infant mortality rate (per 1,000 live births) 1980 1988				6		1980	12.3	1988	11.6	44 51
Child death rate Ages 1-14 (per 100,000 children) 1980 1988				6		1980	48.2	1988	45.6	51 51
Teen violent death rate: Ages 15-19 (per 100,000 teens) 1984 1988				13		1984	113.3	1988	98.3	48 51
Percent teen out-of-wedlock births 1980 1988		-8				1980	5.4	1988	5.8	7 51
Juvenile incarceration rate (per 100,000 juveniles) 1979 1987		-8				1979	225	1987	244	46 51
Percent of children in poverty 1979 1985-89		-13				1979	12.1	1985-89	13.7	9 51
Percent graduating high school 1982 1988				2		1982	64.3	1988	65.5	43 51

Re: HB 50

March 7, 1991

testimony of Saralyn Tabachnick, MEd
Children's Program Director
AWARE, Inc.
Box 20809
Juneau, AK 99802

A 1981 study funded by the National Center on Child Abuse & Neglect found that half of children who came to shelters wre themselves physically or sexually abused. In the state of Alaska, 19,000 women were abused by their partners in 1986; 63% of those women had children who were abused. Further, when children witness abuse in their family, they are learning from their parents that violence is an acceptable way to solve problems. Sons who witness their father's violence have a 1000 % greater chance of becoming abusers than those who do not.

The importance of providing safe shelter for battered women & their children is clear- not only does it prevent women from being abused, it also protects children from violence. And while women & children are in shelter, we facilitate personal safety & education groups to empower them with the skills & support to help them keep themselves safe. By providing appropriate intervention, we can prevent the generational cycle of abuse.

Humans are born defenseless. We are totally dependent upon others to meet our needs, to protect us, keep us safe, care for us, love & nurture us. In fact, this is the job of a parent. Yet when we do not have our basic needs met, when children are humiliated, neglected, threatened, physically & sexually abused by the person who was to have protected & cared for them, the betrayal of trust a child feels leaves a long & deep scar. Child abuse can be & is physically & emotionally life threatening. We need to protect childrens' lives & spirits. We need to work to prevent violence, & prevent child abuse.

To do this, we must have the support of individuals & systems. We must provide prevention information to children so that they can protect themselves. We need to teach them that they can say no to inappropriate touch, learn the importance of telling an adult, & know that they are not to blame, they didn't do anything wrong, because an adult abused them does not mean they are bad.

Last week, the Prevention/Education Specialist at AWARE provided 3, 45 minute presentations to middle school students. After her presentations, 12 students came to speak to her, individually, about personal safety concerns.

We must provide information for parents as well, so that they can offer the loving care a child needs to develop his potential. We must offer parent support groups and intervention when parents are abusing their children, or fear they may do so. By providing information to children and parents, we prevent abuse. By providing safe shelter for battered women & their children, we prevent abuse.

There are no children testifying here today. They don't have the ways or means or words to speak to you. I am here on behalf of children, to advocate for childrens' needs, for their safety & well-being, for their care & protection. Children deserve these things. It's not their fault if they don't have them. It's our responsibility to provide them. We all need to do what we can to advocate for those whose voices are not heard.

Thank you.

Lynn Squires, MA
Tongass Community Counseling Center
March 7, 1991

Testimony on HB 5650

I wear a couple of hats with Tongass Community Counseling Center. I work with both the Family Services Treatment Program and Sex Offender Treatment Program. That may sound contradictory, but most of our offenders were also victims - some studies say that from 1/3 to 2/3 of offenders are also sexual assault victims. Most of them have families that are characterized by high levels of dysfunction. Working with these two groups becomes much more compatible if you keep that in mind.

These particular statistics are personalized for me in that 95% of the men I work with at Lemon Creek Correctional Center are victims of physical or sexual assault. I certainly believe that the key to decreasing the rate of recidivism is treatment. Statistics prove that incarceration itself does not deter sex offenders from re-offending.

How does this tie into the Family Services Treatment Program? Treatment is the key to preventing this inter-generational cycle of violence from perpetuating itself. We know that often the abused become the abusers; that people re-enact their childhood traumas. Women abused as children either become abusers or enter into abusive relationships. Men abused as children become abusers. The victims begin to identify with the victimizers - why not? - that's a much more powerful position than that of a victim.

What goes into prevention? We get referrals for families in crisis. Either the child is acting out, has been abused and taken from the home, or has been sexually assaulted and the social worker feels they would benefit from treatment. There needs to be a number of resources available for a family in crisis. One family receiving services from Tongass's Family Services Treatment Program has a mom who is a recovering alcoholic. She needs, or has needed, services from Juneau Recovery Unit, Natives for Sobriety, Alcoholics Anonymous and Tongass. Dad is a sex offender receiving private therapy services. The son is in school, is involved in Big Brothers/Big Sisters, and individual therapy with Tongass. The daughter is in school, receives treatment from Milam, special tutoring and alcohol programs, and is in a group at Tongass.

Lynn Squires, MA
Testimony on HB 56
Page 2

That's a lot of resources that one family needs, and this situation/family is not atypical. This is indicative of the depth of the crisis.

Why family treatment? Why not just treat the kids? We feel that isolating the children for services perpetuates the problem. We believe you have to intervene at a family systems level. Parenting skills, education, developing a variety of family roles, besides scapegoat and rebel, are essential. We attempt to avoid identifying a child as the problem because that leads to perpetuating feelings of "I'm bad" or worthlessness. Primarily, we do not want these cycles to continue inter-generationally and it must be stopped at a family level.

You must decide which kind of work you want to do: crisis work or prevention. Prevention may take more of an investment in the beginning, but when you realize that every man who molests children has an average of 76 victims, and if even 10 of those victims perpetuate the cycle, it doesn't take long for the crisis to escalate beyond control.

HB 50

TESTIMONY
OF
JANUARY H. SCOTT
NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE
BEFORE THE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
ALASKA STATE LEGISLATURE
MARCH 7, 1991

Madam Chair and Members of the Committee:

My name is January H. Scott. I am with the National Committee for Prevention of Child Abuse in Chicago, Illinois and Director of its Training and Technical Assistance Department.

Why is it critical that the Alaska State Legislature appropriate \$4 million to the Alaska Children's Trust Fund? There are three reasons:

- 1) Experts agree that child abuse is at the core of many other social problems.
- 2) We know that if child abuse is to be prevented it must be assumed as a community responsibility.
- 3) The Children's Trust Fund model shifts responsibility for child abuse prevention to the community.

The trust fund model has four elements which assist in the accomplishment of this mission.

- The composition of the Advisory Board establishes a public-private partnership. Individuals from state agencies and individuals working in the private sector make up the composition of the governing board of the trust fund. This governing body has been instrumental in building communication and funding linkages between the two sectors. In approximately 15 states, a comprehensive child abuse prevention plan has been adopted through the efforts of its Board. The state plans have proven to be tremendously useful in providing direction for funding, as well as providing direction for communities with what needs to be done locally to prevent child abuse.

- The model funds primary and secondary prevention programs. Even with the few states that mention treatment in the statute, the policy has been to fund only primary and secondary prevention efforts. Programs funded by the nation's trust funds serve as a

laboratory for prevention research and evaluation efforts. They help us document the value of prevention, and teach us which programs are effective with specific populations.

- It emphasizes community-based child abuse prevention efforts with a strong emphasize on volunteerism. In FY 1990, 1600 community-based programs were funded nationally. The grant size ranged from a low of \$1700 in North Dakota to a high of \$75,000 in Florida.

- It institutionalizes prevention at a community level. Oftentimes, structurally this is accomplished through a matching formula. As this model seeks to place parent support programs in churches, life-skills education in schools and youth organizations, and parenting education and support services in hospitals, prevention becomes institutionalized in our communities as a needed service for the health and well-being of its residents. Over the years, the average grant size has been relatively low, between \$20 and \$25,000, thus enabling many communities the ability to pick up the funding. Two states have tracked the programming after the money from the trust fund had ceased for several years, and they found that 80 percent of the programs previously funded were still in existence.

In addition, the model leverages dollars from the Federal Prevention Challenge Grant Program which statutorily calls for a \$1 match for every \$4 spent by the state trust fund. This match has been very useful also in leveraging private dollars for the trust fund.

Child abuse prevention efforts are still relatively new, and we do not have long-term studies that indicate how much money we are saving by investing in prevention. However, early intervention efforts that have been studied such as Head Start indicate that substantial savings do occur when we reach families with support and services prior to problems escalating into a damaging situation.

When each and every community accepts responsibility for institutionalizing prevention in its churches, schools, hospitals, youth organizations, the workplace, and other settings, we will see a significant difference in the incidence of child abuse in our country. The Children's Trust Fund model and the child abuse prevention movement have proven to be extremely effective in assisting communities reach that end. We encourage you to support the \$4 million appropriation to the Alaska Children's Trust Fund.



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

ALASKA COMMISSION ON CHILDREN AND YOUTH

POSITION PAPER

House Bill 50: Making an Appropriation to the
Alaska Children's Trust Fund

The Alaska Children's Trust Fund was established by statute in 1988. Alaska is one of 49 states to have established such fund since 1980.

Trust funds were created to accomplish two goals: to focus on the increasingly high numbers of reported cases of child abuse, and to fund prevention programs at the community level.

The Alaska Children's Trust Fund is designed to provide funds to community-based child abuse prevention programs only. Funds are awarded through a competitive grant process, using the net income of the Fund. The statute requires that the principal remain in the Fund in perpetuity and that only the net income from investments be used as a funding source.

There can be no doubt that child abuse is a serious problem in our state. In FY90 alone, the Division of Family and Youth Services investigated 8,000 reports of child abuse - and there is general agreement that this is only a fraction of the total number of children who suffer violent physical, sexual, and mental abuse each and every day in our state.

The legacy of child abuse should be apparent to anyone who listens to the news or reads the paper: our jails, treatment programs, runaway shelters, and counseling programs are filled with people who were abused as children. The only way to stop the cycle of violence - and to begin to chip away at the enormous cost of treatment - is through prevention.

Prevention is a good, sound investment. The U.S. House Select Committee on Children, Youth, and Families estimates that for every dollar spent on prevention, three to ten dollars are saved in treatment, incarceration, and societal costs. It is far more cost effective to fund a

community-based prevention program than it is to build another jail.

In FY88, a total of \$21 million was allocated through 43 state trust funds to support more than 1,200 programs - an increase of 20% over FY87. The types of programs most frequently funded include support programs for new parents, pre-parenting programs for teens, programs for high risk parents, public information and education on child abuse, and specialized programs for substance abusing and incarcerated parents.

The National Alliance of Children's Trust Funds, which tracks and monitors the status of all 49 states' funds, reports that direct appropriations are the most stable sources of funding for children's trust funds, accounting for 39% of revenue. House Bill 50 is the first attempt to capitalize the Alaska Children's Trust Fund. The bill is a top priority of the Alaska Commission on Children and Youth, the entity designated to serve as the Board of Directors of the Trust Fund.

We look forward to an opportunity to work with the Department of Revenue in making a sound investment of this allocation and awarding grants to child abuse prevention programs in your community.

We urge your strong support of this bill.

Contact: Carla Timpone, Executive Director

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AN ACT

Establishing the Alaska Commission on Children and Youth; abolishing the Office of Child Advocacy; relating to the Alaska children's trust fund; and providing for an effective date.

Section 1. AS 37.14.220 is repealed and reenacted to read:

Sec. 37.14.220. ADMINISTRATION OF THE FUND. The fund shall be administered by the Alaska Commission on Children and Youth.

Sec. 2. AS 37.14.220 is repealed and reenacted to read:

Sec. 37.14.220. ALASKA CHILDREN'S TRUST FUND BOARD ESTABLISHED.

(a) The Alaska Children's Trust Fund Board is established in the Office of the Governor. The board is composed of four executive-branch members and seven public members, who are appointed by, and serve in that capacity at the pleasure of, the governor.

(b) The board shall elect a member to chair the board.

(c) The Office of the Governor shall provide staff for the board.

Sec. 3. AS 37.14.230 is amended to read:

Sec. 37.14.230. POWERS AND DUTIES OF THE COMMISSION [BOARD].

When acting as administrator of the fund, the commission [THE BOARD] shall

(1) hold [REGULAR MEETINGS AND] special meetings it considers necessary; the commission [BOARD] may hold meetings by teleconference;

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(2) award grants from the net income of the fund to community-based programs and projects that the commission [BOARD] finds will aid in the prevention of child abuse and neglect;

(3) monitor approved programs and projects for compliance with AS 37.14.200 - 37.14.270;

(4) before providing assistance to a program or project, approve written findings on the program or project that include a consideration of the means of measuring the effectiveness of the program or project;

(5) apply for, and use net income from the fund to obtain, private and federal grants for the prevention of child abuse and neglect;

(6) solicit contributions, gifts, and bequests to the fund;

(7) keep audio tape recordings of each meeting of the commission [BOARD] to be made available on request; and

(8) submit to the governor and the legislature by February 1 each year a report describing

(A) the child abuse and neglect prevention services that were provided by the programs and projects to which the commission [BOARD] awarded grants; and

(B) the annual level of contributions, income, and expenses of the fund.

* Sec. 4. AS 37.14.230 is amended to read:

Sec. 37.14.230. POWERS AND DUTIES OF THE BOARD [COMMISSION].

The board [WHEN ACTING AS ADMINISTRATOR OF THE FUND, THE COMMISSION] shall

(1) hold regular meetings and special meetings it considers necessary; the board [COMMISSION] may hold meetings by teleconference;

(2) award grants from the net income of the fund to

37.14.230

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community-based programs and projects that the board [COMMISSION] finds will aid in the prevention of child abuse and neglect;

(3) monitor approved programs and projects for compliance with AS 37.14.200 - 37.14.270;

(4) before providing assistance to a program or project, approve written findings on the program or project that include a consideration of the means of measuring the effectiveness of the program or project;

(5) apply for, and use net income from the fund to obtain, private and federal grants for the prevention of child abuse and neglect;

(6) solicit contributions, gifts, and bequests to the fund;

(7) keep audio tape recordings of each meeting of the board [COMMISSION] to be made available on request; and

(8) submit to the governor and the legislature by February 1 each year a report describing

(A) the child abuse and neglect prevention services that were provided by the programs and projects to which the board [COMMISSION] awarded grants; and

(B) the annual level of contributions, income, and expenses of the fund.

* Sec. 5. AS 37.14.240(d) is amended to read:

(a) Except as provided in (d) of this section, the [THE] principal of the fund and any capital gains or losses realized on the principal shall be retained perpetually in the fund for investment as specified in AS 37.14.210, and may not be used for the awarding of grants.

* Sec. 6. AS 37.14.240 is amended by adding a new subsection to read:

(d) Up to \$150,000 per year may be appropriated from the principal of the fund for the administrative expenses of the board [COMMISSION].

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pal of the fund for the administrative expenses of the commission.

* Sec. 7. AS 37.14.240(d) is amended to read:

(d) Up to \$150,000 per year may be appropriated from the principal of the fund for the administrative expenses of the board [COMMISSION].

37.14.240(d)

* Sec. 8. AS 37.14.270 is amended by adding a new paragraph to read:

(5) "commission" means the Alaska Commission on Children and Youth established under AS 44.19.521.

37.14.270(5)

* Sec. 9. AS 37.14.270 is amended by adding a new paragraph to read:

(6) "board" means the Alaska Children's Trust Fund Board.

37.14.270(6)

* Sec. 10. AS 39.05.100(a) is amended to read:

(a) A person appointed to a board or commission of the state government shall be and have been before the last general election, (1) a registered voter in the state, if the appointment is made at large or (2) a registered voter from the judicial district, if the appointment is made from a specific judicial district. The student member of the Board of Regents of the University of Alaska appointed under AS 14.40.150(b), AND the student member of the Alaska Commission on Postsecondary Education appointed under AS 14.42.015(e), and a member of the Alaska Commission on Children and Youth appointed under AS 44.19.521, are exempt from the requirement of this subsection if the member was not old enough to be a registered voter in the last general election.

39.05.100(a)

* Sec. 11. AS 39.05.100(a) is amended to read:

(a) A person appointed to a board or commission of the state government shall be and have been before the last general election, (1) a registered voter in the state, if the appointment is made at large or (2) a registered voter from the judicial district, if the appointment is made from a specific judicial district. The student

39.05.100(a)

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member of the Board of Regents of the University of Alaska appointed under AS 14.40.150(b) and [,] the student member of the Alaska Commission on Postsecondary Education appointed under AS 14.42.015(e) [, AND A MEMBER OF THE ALASKA COMMISSION ON CHILDREN AND YOUTH APPOINTED UNDER AS 44.19.521,] are exempt from the requirement of this subsection if the member was not old enough to be a registered voter in the last general election.

Sec. 12. AS 39.50.200(b) is amended by adding a new paragraph to read:

(50) Alaska Commission on Children and Youth (AS 44.19.521).

Sec. 13. AS 44.19 is amended by adding new sections to read:

ARTICLE 17. ALASKA COMMISSION ON CHILDREN AND YOUTH.

Sec. 44.19.521. CREATION OF COMMISSION. (a) There is created in the Office of the Governor the Alaska Commission on Children and Youth.

(b) The commission consists of four executive-branch members and seven public members, who are appointed by, and serve in that capacity at the pleasure of, the governor. At least one of the public members must be under the age of 21 at the time of appointment. The commission shall elect one of its members as chair. The chair may appoint other officers as necessary.

Sec. 44.19.523. TERMS OF OFFICE; COMPENSATION. (a) The term of office of a member of the commission is three years.

(b) A vacancy shall be filled in the same manner as the original appointment. A person appointed to a vacancy serves for the unexpired portion of the term.

(c) Public members of the commission serve without compensation for their services but are entitled to per diem and travel allowances authorized under AS 39.70.180.

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Sec. 44.19.525. POWERS OF THE COMMISSION. The commission may

(1) use legal, technical, secretarial, and administrative services as may be provided by the governor;

(2) use voluntary and uncompensated services of private persons and organizations as may be made available to the commission;

(3) receive, and use for operating purposes, money from the federal government or other sources;

(4) hold public hearings;

(5) establish and maintain an office in Anchorage, or at a location determined to be the most appropriate location by a majority vote of the commission, and hire an executive director and technical and clerical staff that are necessary to perform the duties of the commission; and

(6) take other actions reasonably necessary to carry out the duties of the commission.

Sec. 44.19.527. DUTIES OF THE COMMISSION. (a) The commission shall develop a comprehensive statewide plan that identifies the needs of children and youth, individually and as they relate to their families, and makes recommendations to enhance their quality of life. In meeting this charge, the commission may

(1) recommend the services and programs that should be available for children and families in the areas of child care, health, social services, education, special education, child protection, parent and staff training, nutrition, poverty, mental health, safety, and employment of youth;

(2) identify the service needs of children and where gaps and overlaps in services exist;

(3) monitor the emerging needs of and problems facing children, and develop effective, comprehensive, and coordinated strategies.

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leges to address those needs and problems;

(4) develop and recommend adoption of a process for monitoring and evaluating children's programs;

(5) provide opportunities for the public to participate in the planning and development of children's programs and policies;

(6) receive and act upon requests for recommendations from parents, state officials, members of state advisory committees, legislators, representatives of the state court system, and providers of children's services on matters related to children and youth;

(7) meet with and make recommendations to state officials and members of advisory committees who are responsible for the expenditure of state and federal money and provide recommendations to the legislature and the department on structural and procedural changes, contracting of services, establishment of standards, and the consolidation of efforts designed to deliver services in a more cost-effective manner;

(8) serve as a statewide clearinghouse for government and nongovernment programs and resources relating to children, youth, and families;

(9) serve as an advocate for the interests of children by informing the public, including leaders of the business community, educators, local and state officials, the legal system, and the communications media of the nature and scope of problems faced by children;

(10) coordinate efforts and consult and cooperate with persons, departments, organizations, and groups, including other boards and commissions, interested in the problems and concerns of children and youth; and

(11) make recommendations to the governor, legislature, and state officials with respect to legislation, regulations, and appro-

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provisions for programs or services that benefit children and youth.

(b) In formulating the strategy to address the needs of and problems facing children, the commission shall actively solicit advice and information from children and youth of all ages and socioeconomic backgrounds. The commission shall also seek advice and information from parents and children's services providers, including those with expertise in the areas of mental health, health care, prenatal care, adolescent drug and alcohol treatment, education, special education, early childhood education, early childhood special education, non-profit funding sources, child abuse and neglect, domestic violence, child care, dependence, delinquency and the justice system, minority issues, and family support systems.

(c) The commission shall prepare and publish an annual report on the status of children in the state and its recommendations and proposals for change. The commission shall provide the governor and the legislature with copies of the report by the 15th day of each regular legislative session.

Sec. 44.19.529. TECHNICAL ASSISTANCE AND STAFF SUPPORT. The executive branch departments shall cooperate with the commission and provide technical assistance to the commission upon the request of the commission.

* Sec. 14. TEMPORARY USE OF PRINCIPAL. Notwithstanding AS 37.14.230 and 37.14.240, as amended by secs. 3, 5, and 6 of this Act, until July 1, 1992, the Alaska Commission on Children and Youth may use not more than \$50,000 from the principal of the Alaska children's trust fund for the purposes specified in AS 37.14.240(b)(2) and (3).

* Sec. 15. REVISOR'S INSTRUCTION. To be consistent with the changes made by secs. 1, 3, 6, and 8 of this Act, wherever in AS 37.14.200 - 37.14.270 and in the regulations adopted under those statutes "Alaska Chil-

Chapter 16

dren's Trust Fund Board" or "board" is used, they shall be read as referring to the Alaska Commission on Children and Youth and the commission, respectively. Under AS 01.05.031, the revisor of statutes shall implement this section in the statutes and under AS 44.62.125(b)(6), the regulations attorney shall implement this section in the administrative regulations.

* Sec. 16. REVISOR'S INSTRUCTION. To be consistent with the changes made by secs. 2, 4, 7, and 9 of this Act, wherever in AS 37.14.200 - 37.14.270 and in the regulations adopted under those statutes "Alaska Commission on Children and Youth" or "commission" is used, they shall be read as referring to the Alaska Children's Trust Fund Board and the board, respectively. Under AS 01.05.031, the revisor of statutes shall implement this section in the statutes and under AS 44.62.125(b)(6), the regulations attorney shall implement this section in the administrative regulations.

* Sec. 17. AS 37.14.270(5), AS 47.50.100(b)(50), AS 44.19.521, 44.19.523, 44.19.525, 44.19.527, and 44.19.529 are repealed June 30, 1993.

* Sec. 18. AS 37.14.270(1), AS 47.50.010, 47.50.026, 47.50.030, 47.50.040, and 47.50.050 are repealed.

* Sec. 19. TERMS OF INITIAL APPOINTEES. Notwithstanding AS 44.19.523, enacted by sec. 13 of this Act, the governor shall set the terms of the members initially appointed to the Alaska Commission on Children and Youth so that four members serve three-year terms, four members serve two-year terms, and three members serve one-year terms.

* Sec. 20. REVIEW OF LAWS RELATING TO CHILDREN. The Alaska Commission on Children and Youth, established under sec. 13 of this Act, may review the laws of the state with regard to matters involving children. If a review is done, the commission shall prepare and publish a report of its findings and recommendations and provide the governor and the legislature with copies by January 1, 1992.

Chapter 16

* Sec. 21. Sections 2, 4, 7, 9, 11, and 16 of this Act take effect June 30, 1993.

* Sec. 22. Except as provided in sec. 21 of this Act, this Act takes effect July 1, 1990.

Eff. §§ 2,
4, 7, 9, 11
and 16 take
effect
6/30/93;
remainder
of Act
takes
effect
7/1/90

for
HB50.

2-2-2-2

No. 91-41

Feb. 25, 1991

New Appointees to the Alaska Commission on Children and Youth

Mark Evans, Fairbanks
Valerie Davidson, Juneau (re-appointed)
Steven Struebe, Big Lake
Patricia Walsh, Nome
Revoe Hill, Chugiak
Melinda Gruening, Juneau
Sandra Hobbs, Anchorage
Cheri Jacobus, Anchorage*
Jeannie Alexander, Juneau*
Bob Cole, Juneau*
Steve Hole, Juneau*

* Executive Administration Appointments

####

Kathleen Rhea
Parent Aid Family Support Center
Testimony 3-7-91 re: HB 50

1. Introduction

name, position, representing PAFSC and children/families affected by abuse
work with children, families, educators, and their programs for almost 25 years
M&S Degree child development, family life
Alaska 14 1/2 years, 6 1/2 years, PAFSC 4 1/2 years

I believe after 25 years of both personal and professional experience, that child abuse, neglect, and violence in the home are at the root of just about every human and social problem we have today... from crime, violence in the streets, alcohol/drug abuse to the destruction of human life on a global level.

I believe that the only way we can effectively impact these problems is through prevention, the only way to prevent child abuse, neglect, and family violence is through intervention at the parenting level.

PAFSC cost effective, 67% acts

2. Child Abuse/Neglect

types of ca/n

physical - obvious, visible, physically treatable

others - may be less immediate effects, not visible, obvious, aware of them but less recognition

affects on the child

immediate - physical

long-term, life long - low self esteem, problems with violence/anger, behavior problems, school problems, psych, social, emotional problems, substance abuse developmental problems, dysfunctional, safety/trust issues

affects on family

harm to family system, dysfunction in the family...family becomes dysfunctional, affects other family members, future generation
everyone is hurt, child violent in school may have witnessed violence in home
importance of childhood experiences, family life, in later life

affects on community/society

damage goes far beyond child and family

I believe and I have seen that the child abuse today becomes the abuser of tomorrow, the sex-offender, the criminal, alcoholic/drug abuser, runaway, pregnant teen, suicide victim, drop-out
each of these is not directly or always caused by ca/n, however family dysfunction has a major impact

3. PAFSC

PAFSC - program which reaches parents at risk for ca/n through prevention and intervention services.

cost effective both in terms of our current funding level and bare bones operation and in terms of savings to the state for treatment of long term effects and behaviors

history

funding

services

clients

staff

67% cuts to PAFSC proposed

HOUSE COMMITTEE REPORT

(7)

Date Referred: January 22, 1991

FURTHER REFERRALS: Finance

Date of Committee Action: 3/7/91

The HESS Committee considered:

HB 50

HOUSE BILL NO. 50

APPROP: ALASKA CHILDREN'S TRUST FUND

"An Act making an appropriation to the Alaska children's trust fund; and providing for an effective date."

RECOMMENDATIONS:

be replaced with _____ the same title

a new title

have attached amendments(s)

do pass

do not pass

no recommendations

individual recommendations

additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) _____

APPROVES PREVIOUS: (Dept/Date) _____

fiscal impact _____

fiscal note(s) _____

zero fiscal note _____

zero fiscal note(s) _____

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

	Check appropriate column:	Do Not Pass	No Rec	Amend
	<i>[Signature]</i>	(LINCOLN)		<input checked="" type="checkbox"/>
Betty Davis	<i>[Signature]</i> (GONZALES)			<input checked="" type="checkbox"/>
	<i>[Signature]</i> (HANLEY)		X	
Mary Miller				
Chris Davis				
<i>[Signature]</i> (CARNEY)	<i>funding should come from the mental health trust.</i>			

[Signature]
CO-Chairman's Signature

* DELIVER TO: LHSCHES *
 * * * * *
 * ORIGINAL *
 * SENT: 03/07/91 TIME: 10:50 *
 * FROM: LTCCMAT *
 * SUBJECT: 012 FS HHESS FAM 3/7/91 *
 * PRINT DATE: 03/07/91 TIME: 10:50 *
 * * * * *

SUBJECT LINE TO READ: TC NO,; FL/FS;SHORT SUBJECT;DATE

T/C NO: 91-03-012
 DATE: 3/7/91
 SPONSOR: H HESS
 SUBJECT: HOUSE BILLS 50, 93, AND 136-FAMILY
 MODERATOR: MARY
 SITE: MAT-SU LIO

FINAL STATS

TESTIFIED:
 NAME/REPRESENTING ADDRESS PHONE BILL NO.

1 EMIL PORTSCHELLER JR NATIONAL-CENTER-FOR-FAMILIES-AND-CHILDREN
 POB 1645 PALMER 99645 746-3011
 2 JIM COLVER POB 427 PALMER 99645 745-8474
 3

OBSERVED
 NAME/REPRESENTING ADDRESS PHONE BILL NO.

1
 2

TESTIFIED: 2
 UNABLE:
 OBSERVED:
 TOTAL: 2

START TIME: 8:30 AM END TIME: 10

*
* DELIVER TO: LHSCHES *
* *
* *
* ORIGINAL *
* SENT: 03/07/91 TIME: 10:08 *
* FROM: LTCCSOL *
* SUBJECT: 91-03-012:FS-HB50,93,136;3-7 *
* PRINT DATE: 03/07/91 TIME: 10:08 *
* *

SUBJECT LINE TO READ: TC NO.,SHORT SUBJECT,DATE

T/C NO: 91-03-012
DATE: 3-7-91
SPONSOR: HOUSE HEALTH EDUCATION AND SOCIAL SERVICES
SUBJECT: HB50,93,136
MODERATOR: ALYSON
SITE: SOLDOTNA

FINAL STATS

WE HAD NO PARTICIPANTS AND DID NOT DIAL INTO THE TELECONFERENCE

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*****
*
* DELIVER TO: LHSCHE$
*
* ORIGINAL
* SENT: 03/07/91 TIME: 10:26
* FROM: LIOCMIL
* SUBJECT: 91-03-012;FS;CHILD;3/7
* PRINT DATE: 03/07/91 TIME: 10:26
*
*****

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SUBJECT LINE TO READ: TC NO.; PL FS;SHORT SUBJECT;DATE

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T/C NO: 91-03-012
DATE: 3/7
SPONSOR: H HESS
SUBJECT: CHILDREN'S TRUST
MODERATOR: JUDY
SITE: ANCHORAGE

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FINAL STATISTICS

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*****
TO TESTIFY
NAMES/REPRESENTING ADDRESS PHONE BILL NO.
1. PAT WILLIAMS/CHILD ADVOCACY NETWORK HB 50
2. RICHARD HERMOSILLO HB 93/136
*****

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TO OBSERVE:
NAME/ REPRESENTING ADDRESS PHONE BILL NO.
1. SUE MILES FOB 772196 ER 696-0404 50,93,136
*****

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TESTIFIED: 2
UNABLE: 0
OBSERVED: 1
TOTAL: 3

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START TIME: 8:30 END TIME: 10:00

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

DATE 3/7/91

JOINT _____

TAPE # 18

JOINT _____

TIME CALLED TO ORDER 8:35 (am/pm)

TIME ADJOURNED 10:05 A.M.

ROLL CALL:	PRES	ABST	TIME ARRVD	JOINT MEMBERS PRESENT:
Rep. Patrick Carney	✓	_____	_____	_____
Rep. Georgiana Lincoln	✓	_____	_____	_____
Rep. Bettye Davis	✓	_____	_____	_____
Rep. Cheri Davis	✓	_____	_____	_____
Rep. John Gonzales	✓	_____	_____	_____
Rep. Mark Hanley	✓	_____	_____	<u>late @ 8:38 AM</u>
Rep. Mary Miller	✓	_____	_____	<u>late @ 8:37 AM</u>

AGENDA:

BILL NO.	SHORT TITLE	ACTION TAKEN
*HB 50①	Approp.: Children's Trust Fund	<u>Passed w/ ind. recommendations</u>
*HB 93③	Child Custody Investigators	<u>Need to be heard Fri Mar 8th</u>
*HB 136②	Misc. Divorce and Custody Laws	<u>Passed w/ ind. Recommendations</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER:

Rep. Frank Ulmer?

SPECIAL ANNOUNCEMENTS: Teleconference bet. Juneau, Anch, Soldotna + Chicago



Alaska State Legislature
House of Representatives
 COMMITTEE ON HEALTH, EDUCATION
 AND SOCIAL SERVICES

DATE: March 7, 1991

PLACE: Capitol Room 106

SUBJECT OF MEETING:
 *HB 50 APPROP.: CHILDREN'S TRUST FUND

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
✓ Lynn Squires	TCC	522 Seward	99801	785-9105	586-3585	<input checked="" type="radio"/>	N	HB 50
✓ Jenny Burkerton	TCC	323 Seward	99801	465-544	586-3585	<input checked="" type="radio"/>	N	HB 50
✓ Virginia John-Daniels	Self	Douglas	99824	364-2235	586-3785	<input checked="" type="radio"/>	N	HB 50
✓ SARALYN TABACHNICK	AWAKE	Box 20809	99802		586-6623	<input checked="" type="radio"/>	N	HR 50
✓ Sherrie Gow	ALASKA WOMEN'S LOBBY / KIDPAC	714 22156	99802		463-6744	<input checked="" type="radio"/>	N	HB 50
Carla Timpane	AK Comm. on children & youth	Box A Juneau	99811		465-3155	Y	<input checked="" type="radio"/>	HB 50: position paper submitted
✓ Kathleen Shea	Parent and Family Support Center	427 W. 12th Juneau	99801		586-3785	<input checked="" type="radio"/>	N	HB 50
						Y	N	
						Y	N	
						Y	N	
						Y	N	

HB

52

HB 52 An Act relating to child support for children who are not minors and representation of their interests during certain proceedings; and relating to postsecondary educational support of certain children.

Fiscal Note (blue)

NEW MATERIALS

SSBH 52 (7LS04338\G)

1. Sponsor Memo Request for Hearing
2. Sponsor Memo of 2/3/92 re SSHB 52 with sectional analysis
3. Steve Strube letter of support

Alaska State Legislature

HOUSE OF REPRESENTATIVES

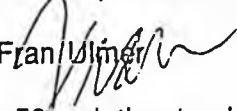


REPRESENTATIVE FRAN ULMER

MEMORANDUM

January 14, 1992

TO: Rep. Georgianna Lincoln, Co-chair
Rep. Pat Carney, Co-Chair
House Health, Education and Social Services Committee

FROM: Rep. Fran Ulmer 

RE: SSHB 52 relating to child support for children who are not minors

I would like to request a hearing for Sponsor Substitute for HB 52 which provides child support up to the age of 19 years for dependent children who are still attending high school. The revised bill eliminates all other prior language in the bill authorizing the court to order child support for children over the age of 18 who are attending college or vocational school. In SSHB 52, child support is authorized only until the child completes high school or reaches the age of 19, whichever comes first. This provision will eliminate the need for those 18 year old children who are still in school to draw upon public assistance as they do now.

The revised version of HB 52 should satisfy all those criticism of the bill which were expressed at the previous hearing on the bill in the HESS committee.

Thank you for your consideration of this request.

Alaska State Legislature

HOUSE OF REPRESENTATIVES

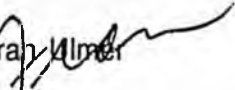


REPRESENTATIVE FRAN ULMER

MEMORANDUM

February 3, 1992

TO: Rep. Pat Carney, Co-chair
Rep. Georgianna Lincoln, Co-chair
House Health, Education and Social Services Committee

FROM: Rep. Fran Ulmer 

RE: Sponsor Substitute for HB 52, relating to child support for non-minors

The purpose of SSHB 52 is to provide child support for unmarried, 18 year old children who are living as dependents and actively pursuing a high school diploma. This support is authorized until the child finishes high school or reaches 19 years of age, whichever comes earlier.

Currently, courts are authorized to order child support only for minor children. The result is that many Alaska children must complete their final year of high school without the benefit of financial support from the non-custodial parent. Some families in this situation have applied for Aid to Families with Dependent Children which provides for public assistance payments until the child completes high school or reaches age 19. SSHB 52 would eliminate the need for those families to apply to the state for assistance.

For those children with developmental disabilities who may require additional years to complete secondary school, current law already provides the authority to award continuing support payments for a handicapped adult child. *Streb v. Streb*, 774 P.2d 798 (Alaska 1989).

The sponsor substitute is a substantial redrafting of the original HB 52. All references to support for non-minor children over the age of 19 have been dropped from the bill. The current version of this legislation uses AFDC guidelines in regard to non-minor assistance payments to establish upper limits for the duration of child support. It affirms the importance of completing secondary education and the need for the support of children to be borne equitably by both parents.



Sponsor Substitute for HB 52
Sectional Analysis

Section 1. A court appointed representative for a child under the age of 19 whose interests may be affected by a divorce may attend divorce mediation conferences.

Section 2. While divorce litigation is pending, the court is authorized to order reasonable support for unmarried children under the age of 19 who are actively pursuing a high school diploma and who are living as dependents with a parent or guardian.

Section 3. Provides that a judgment may be modified regarding child support for unmarried children under the age of 19 who are actively pursuing a high school diploma.

Section 4. Requires post-majority support to be included, among other items, as issues covered by dissolution agreements.

Section 5. Among other items, a dissolution petition must state the marital and educational status of each child under the age of 19 born to or adopted by the petitioners.

Section 6. A petition for dissolution may be dismissed, or an action continued, if a representative of an unmarried child under the age of 19 objects to a term providing, or failing to provide, support.

Section 7. In an action involving the custody, support or visitation of a child, the court may appoint someone to represent a child under the age of 19 who is actively pursuing a high school diploma or its equivalent and living as a dependent.

Section 8. Replaces the word "minor" with the word "child" regarding the appointment of a person to provide guardian ad litem services in divorce proceedings

Section 9. Deletes the word "minor" from "minor child" in regard to the court's authority to order parents to assign to the custodian of the child the portion of salary or wages sufficient to pay the ordered child support.

Section 10. Deletes the word "minor" from "minor child" in regard to subrogated child support orders.

JAN 10, 1992

REP. FRAN ULMER

PO BOX V

JUNEAU, AK 99811-3100

RE: HB 52 (SPONSOR SUBSTITUTE)

DEAR FRAN,

THANK YOU FOR CLARIFYING MY CONCERNS ABOUT THE POST-MAJORITY CHILD SUPPORT BILL.

I SUPPORT THE SPONSOR SUBSTITUTE AS WRITTEN AND HOPE YOU WILL SUBMIT IT TO THE LEGISLATURE.

IT IS ALSO MY HOPE THAT THIS BILL WILL NOT BE ALTERED, AS IT PASSES THROUGH COMMITTEES, TO ADD UNFAIR BURDENS ON NON-CUSTODIAL FAMILIES AND CHILDREN THAT THE STATE WOULD NOT ALSO EQUALLY IMPOSE UPON CUSTODIAL FAMILIES AND THEIR CHILDREN. AS YOU KNOW, ALL PERSONS INCLUDING CHILDREN ARE GAURENTEED EQUAL TREATMENT, OPPORTUNITIES, AND PROTECTION UNDER THE LAW.

ON JAN 8, 1992 THE LEGISLATIVE COMMITTEE OF THE GOVERNOR'S COMMISSION ON CHILDREN AND YOUTH DISCUSSED THIS BILL, AND WE PLAN TO CONTINUE THE DISCUSSION AT OUR NEXT MEETING IN LATE JANUARY.

I BELIEVE THIS BILL IS GOOD PUBLIC POLICY AND I WILL ADVOCATE FOR IT AT EVERY OPPORTUNITY.
SINCERELY,

THE PRECEDING PAGES WERE TREATED AS
A UNIT IN THE ORIGINAL FILE.

Alaska State Legislature

HOUSE OF REPRESENTATIVES



REPRESENTATIVE FRAN ULMER

MEMORANDUM

May 2, 1991

TO: Rep. Georgianna Lincoln, Co-chair
Rep. Pat Carney, Co-chair
House Health, Education and Social Services Committee

FROM: Rep. Fran Ulmer

RE: HB 52, relating to child support for non-minors

Throughout American history, the duty of parents to support their children terminated upon emancipation. Emancipation was defined as either living independently from the family, marrying, or reaching a state-determined age of adulthood, invariably age 21. About 20 years ago, however, arguments were made that someone old enough to be drafted should be allowed to vote. As a result, the 26th Amendment to the U.S. Constitution was enacted which lowered the voting age in federal elections to 18. Soon thereafter, many states followed federal precedent and set 18 as the age for voting in state elections and as the age of majority.

When the age of majority was 21, child support generally lasted until children were able to become successfully independent. Children had completed high school by 21 and most children in college were almost finished. Those out of school were supporting themselves by 21. But, when the age of majority was reduced to age 18 in the early 1970's, child support terminated well before independence was a realistic possibility. Children between ages 18-21 were either attending high school, college or vocational school, looking for work, or making wages that were too low to sustain self-sufficiency. Since housing and rental costs have outpaced inflation since the 70's, many 18-21 year olds cannot afford to live independently of their parents today, even many of those with jobs. In order to accommodate these realities, many states have altered their child support laws to extend support until children are more realistically in a position to be independent.

The purpose of HB 52 is to provide child support for non-minor children for educational purposes. HB 52 allows the court to order child support for non-minor children in two instances:

(a) for unmarried children who are under the age of 22, living as dependents with a parent or guardian, and who have not completed high school; support may be ordered until secondary education is terminated; this extended period allows for handicapped and developmentally disabled students who may take longer to finish their secondary education; and

District 4B — Juneau

P.O. Box 5 • Juneau, Alaska 99811-3100 • (907) 465-4947



Recycled Paper.

(b) for unmarried children under the age of 26 who are at least half-time students in good standing in a post-secondary education program that qualifies for the use of scholarship loans from the Alaska Post-Secondary Education Commission. This extended period would allow a child who chooses to enlist in the military to complete military service before pursuing post-secondary education. In this instance, a child is eligible for child support while enrolled in a post-secondary program, but not during military service.

HB 52 authorizes the court to order "reasonable" support for post-secondary education. When determining what is reasonable, this legislation directs the court to consider:

- (a) the earnings, income and resources of the parents;
- (b) the financial needs and resources of the child, his or her physical and emotional condition, as well as the educational needs of the child;
- (c) the standard of living, including the likely educational attainment, the child would have enjoyed if the divorce had not occurred.

It is unfortunately true that in almost every divorce, children are the losers. Family incomes decline and children who might otherwise have received financial assistance for college expenses see their opportunities evaporate in the cross-fire of divorce. HB 52 seeks to ensure that children's interests are adequately protected when a divorce or dissolution occurs.

HB 52
Sectional Analysis

Section 1. A court appointed representative for a child under the age of 26 whose interests may be affected by a divorce may attend divorce mediation conferences.

Section 2. While divorce litigation is pending, the court is authorized to order reasonable support for unmarried children under the age of 22 who are actively pursuing a high school diploma and are living as dependents, and reasonable post-secondary educational support for children as outlined in Section 10 of the bill (see below).

Section 3. Provides that a judgment may be modified regarding child support for unmarried children under the age of 22 who are actively pursuing a high school diploma, and reasonable postsecondary educational support for other children as outlined in Section 10 of the bill.

Section 4. Requires post-majority support and postsecondary educational support to be included, among other items, as issues covered by dissolution agreements.

Section 5. Among other items, a dissolution petition must state the educational status of each child under the age of 26 born to or adopted by the petitioners.

Section 6. For dissolutions which will receive heightened scrutiny, the written agreements must include post-majority support and postsecondary educational support that is at least as great as would be ordered by a court under Section 10 of the bill.

Section 7. A petition for dissolution may be dismissed or an action continued if a representative of a child who is not a minor objects to a term providing or failing to provide post-majority support or postsecondary educational support.

Section 8. In an action involving the custody, support or visitation of a child, the court may appoint someone to represent the child who is not a minor with regard to postsecondary educational support or other post-majority support.

Section 9. Replaces the word "minor" with the word "child" regarding the appointment of a person to provide guardian ad litem services in divorce proceedings

Section 10. (a) Authorizes the court to order 4 years of reasonable postsecondary educational support for children while they are:

- 1) unmarried;
- 2) under the age of 26;
- 3) at least half-time students in good standing in a career education program, college or university that qualifies for loans from the Alaska Post-Secondary Education Commission;

(b) Directs the court to consider the following issues when determining what reasonable support may be:

- 1) the earnings, income and resources of the parents, including real and

- personal property;
- 2) the financial needs and resources, physical and emotional condition, and educational needs of the child; and
 - 3) the standard of living, including the likely educational attainment, the child would have enjoyed had the marriage stayed intact.

Section 11. Deletes the word "minor" from "minor child" in regard to the court's authority to order parents to assign to the custodian of the child the portion of salary or wages sufficient to pay the ordered child support.

Section 12. Deletes the word "minor" from "minor child" in regard to subrogated child support orders.

Section 13. The changes made by this Act constitute a material change in circumstances for purposes of a motion to modify a child support determination under AS 25.20.110.

THE ASSOCIATION FOR CHILDREN FOR
ENFORCEMENT OF SUPPORT (ACES)

ALASKA CHAPTER
P. O. Box 92910
Anchorage, Alaska 99509
(907) 274-2010

May 3, 1991

Representative Georgianna Lincoln
House HESS Co-Chair
P. O. Box V
Juneau, AK. 99811

Dear Rep. Lincoln:

The Alaska Chapter of ACES encourages all HESS members to vote DO PASS on HB52.

There are many children in the school system who turn 18 (the age of majority) during their senior year in school. My own son turns 18 only three weeks after starting his senior year. Custodial parents do not relinquish their financial responsibilities while their child is a senior in high school, despite the fact that they may turn 18 years old. It doesn't seem fair that non-custodial parents, however, no longer have a responsibility at that point.

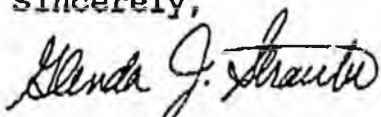
To say the least, the senior year in high school is the most expensive year in a child's life. It is already sad to watch so many of them go without the basic needs, much less the humiliation of not being able to afford to engage in any senior social activities - for lack of funds.

And this problem is only going to get worse since new laws have made it clear that kids will be starting school later, so it is a given that eventually all kids will turn at least 18 years old while they're in high school.

The provision for financial help with a college education will also help Alaskan kids. Since it is not mandatory, and merely allows that issue to be considered before the courts, we encourage you to support that option also.

Alaskan children and custodial parents thank you for your consideration of this bill. Please vote YES.

Sincerely,



Glenda J. Straube
Volunteer Coordinator

UPDATE

Altering the Boundaries of Child Support

by Jeff Ball

Introduction

If one thinks of child support as a cube, one can visualize how recent changes in legislation, case law and philosophy have transmogrified the once-static cube into an expanding elastic shape. If the length of the cube represents the longevity of one's duty to support a child, the width the spectrum of persons having a potential duty of support, and the depth the amount of the duty, including the degree to which non-monetary benefits may be considered as part of the obligation, one can see how all three dimensions are being stretched beyond past borders.

Three separate occurrences have played dominant roles in the degree of fluctuation the cube has recently undergone. The first event was the nationwide reduction in the age of majority from 21 to 18, and the resultant reduction in the length of the support duty in most states. While a few states such as Mississippi and Colorado still use 21 as the age of majority,¹ most states lowered the legal threshold of adulthood to 18 soon after the U.S. Constitution was amended to lower the voting age to 18 in federal elections.² Consequently, many states adjusted the termination of the obligor's responsibility to support the child to the lower age, though some states such as New York did not.³ This created a gray area in which a child may still be dependent on parents for support without any entitlement to it. For instance, if a child is attending high school at age 18 and living at home, he or she would not be entitled to support in states that equate emancipation with age of majority. Most states have adjusted their termination date to take into account post-minority children who are still dependents.⁴ In several states this date has gone beyond a child's completion of secondary education to college or vocational training.⁵ Additionally, parents of adult children who are dependent due to a physical or mental disability may be liable for support in most states.⁶

This ties into the second driving influence in the reshaping of child support — a movement to ensure that someone is responsible for a dependent child,



preferably someone close to the child and not the state. A combination of the conservative philosophy of weaning dependents from state dependence and liberal interest in ensuring that persons who inadequately care for themselves receive support has resulted in safeguards when the primary obligor or obligors cannot provide sufficient support for their children. Step-parents in many states are being held liable for the support of their non-adopted step-children when there is an enduring implicit or explicit parent/child relationship formed and the natural absent parent is not fully supporting the child.⁷ In some states step-parent liability exists as long as the natural parent of the child remains married to the step-parent.⁸ In some cases grandparents are facing liability to support grandchildren who are born to teenaged parents.⁹ The use of the doctrine of *in loco parentis* has led to findings of financial liability of persons who are not next of kin although they fill that role.¹⁰ Clearly the movement is in the direction of holding responsible for support those who have had a substantial, long-term influence on the child.

Another cause for expansion of the cube is the increasing awareness that support awards have, historically, inadequately represented the costs of raising a child, especially the skyrocketing costs of providing children with medical and dental needs.¹¹ As a response, many states are re-examining their methods for computing the support award amount, resulting in significant increases in many instances over what would have been awarded in the past. It appears that the federal government's mandate that all states have support guidelines has accelerated this review.¹²

This article will examine the first two dimensions of the support cube, the length of the support duty and the breadth of responsibility of that duty.

The Length of the Support Duty

From the days of Blackstone and Kent, the law has recognized the duty of parents to support their children.¹³ This common law duty terminated upon emancipation, which either meant living independently from the family,¹⁴ marrying,¹⁵ or reaching a state-determined age at which the rights and responsibilities of adulthood were conferred, invariably age 21.¹⁶

Several states have long recognized the power of parties to contract for support duty that exceeded the statutory duty, and to have that agreement incorporated into a judicially-enforceable court order.¹⁷ Additionally, some states, such as Tennessee and Wyoming, have had judicially-created doctrines entitling adult children who are incapacitated to support from their parents.¹⁸

About 20 years ago, when the youth movement in America was powerful, arguments were made that someone old enough to be drafted should be allowed to vote. Congress passed and two-thirds of the states ratified the 26th Amendment to the U.S. Constitution, which lowered the voting age in federal elections to 18.¹⁹ An avalanche of state legislative activity followed in which states not only lowered the age entitling one to vote in a state election to 18, but also reduced the age of majority to 18.²⁰ The reduction created confusion and litigation regarding then-current orders in which the duty of support lasted until the child reached the age of majority. Did this mean 21 or 18? Case law is divided whether the reduction affected existing orders and agreements in which no age was specified. A child's attaining the age of 18 became the end of the obligor's support duty in many states.²¹

Education Beyond Majority Age

When the age of majority was 21, few cases outside those involving disabled adult children resulted in litigation of the extension of the support duty. Children had finished high school by 21; most children in college were almost finished. Those out of school were supporting themselves by 21. When the age of majority was reduced generally to 18 in the early and mid-seventies, a group of quasi-dependent, healthy children emerged that did not fit under either a blanket dependency or independence niche. These children were either attending high school, college, or vocational school, looking for work or making wages that were too low to sustain self-sufficiency. As housing and rental costs have outpaced inflation since the mid-seventies,

many 18 through 20-years olds cannot afford to live independently of their parents, even many of those with jobs.

Many states have altered their support duty laws to encompass those cases in which it is fair to presume dependency, such as an unmarried child finishing high school and living at home.²² Of course many children do not complete high school by their 18th birthday, and many states have opted not to place high school students in the position of choosing education or work. Some states require that support continue until a child is 19 or finishes high school or its equivalent, whichever occurs first.²³ Other states leave post-minority support decisions to the discretion of the court.²⁴

When it comes to forcing an adult child to choose between post-secondary education and work, or a combination of the two, states vary in their responses. Some states view education of one's child as a paramount parental duty, even if the child would be too old to receive support if not in school.²⁵

Other states review the circumstances of each case and leave it to the discretion of the court to determine whether a support duty exists.²⁶ These states take into account promises made or reasonable expectations the child had of parent-supported, post-secondary education, as well as the financial means of the parents and the child's immediate capacity for full or partial self-support. An interesting situation arises where a duty exists to pay college expenses for a child of divorced parents while one does not exist for a child in similar circumstances of nonseparated parents.²⁷

Another value judgment made in many of these cases has to do with determining the likelihood that, if the family had remained unified, the child would have gone to college and had his or her education bankrolled by the family. Many courts look at family background to see if one can auger a duty.²⁸ A situation may arise where a child of well-educated parents who has little academic potential may be entitled to continued support while a more gifted child from a modest family background may not.

Still some other states do not allow the courts to assert jurisdiction over post-minority children unless the parents had signed a separation agreement incorporated in a court order that provides for adult child support, particularly college expenses.²⁹ The theory is that parties are free to extend a support duty, while the court ensures that there is a minimal duty of support owed while the child is a minor.

Disability

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CORRECTION

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HAS BEEN REPHOTOGRAPHED
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Disability

Physical or mental disabilities in an adult child are common exceptions to the termination of sup-

port duty upon the child reaching adulthood.³⁶ Where states diverge is the degree to which the adult child must be mentally or physically disabled, functionally dependent on others, and destitute in order to qualify or continue to qualify for support.³¹

Some states look at the disability factor alone, determining that an adult child found to be at least marginally handicapped is entitled ultimately to parental support.³² A few states include emotionally-dysfunctioning adult children in their definitions of disabled children for the purpose of finding a parental duty of support.³³

States also disagree about the necessity of the disability occurring during the child's minority in order to justify a post-minority support obligation. Some states contend that there cannot be a springing duty of support after an interim of no duty, so that an adult child who becomes disabled would not have recourse to make a support claim against one or both parents.³⁴ Others reason that the need of the child is the determining factor, not the age at which the disability began.³⁵

Dependency

Some states find a support duty if the child is or remains dependent on the obligor. This broad catch-all category may include disabled adult children as well as adult children attending school.³⁶ It may also include children who are indigent, receiving public assistance or unemployed.³⁷ Often a state that has a law requiring a parent to support an indigent child regardless of the child's age to the best of the parent's ability has a reciprocal duty emanating from the child to the parent if the parent is indigent.³⁸

Premature Termination of the Support Duty

So far this article has reviewed ways to elongate a support duty past the age of majority. At the same time, myriad precedents exist for terminating a support duty before a child reaches the age of majority. With duty often based on the premise that support is tied to dependency, both emotionally and financially, parents of children who manifest independence may find themselves without a child support duty. When a child marries, enters the armed services, lives independently of his or her parents, earns enough to be self-sufficient, or is emancipated officially by a court, the parental support duty may be severed.³⁹ Generally, duty termination requires actions by the minor child that indicate independence; a parent may not unilaterally or even through agreement with the other parent absolve himself or

herself of the support duty for a minor child. Courts, ever the third party to a domestic relations matter, have long been hesitant to sanction a parent's attempt to possibly jeopardize a child's welfare by permitting a premature termination of a support duty without strong signs that a minor child will be self-sufficient.⁴⁰

Armed Services

To paraphrase an old adage, the army will make a man (or woman) out of you. Enlisting in the armed services is considered in many states as an act of independence sufficient to support a termination of the parental support duty.⁴¹ Other states require more proof of self-sufficiency than merely the act of enlisting.⁴² Also, since most states have lowered their age of majority to 18, and one cannot enlist in the armed services before 18, the issue of emancipation is mainly academic. In states such as New York where a support duty extends until the child is 21, the issue is still important. Although there is no military draft at this time, and its abolition coincided roughly with the time the age of emancipation and support duty length were lowered in most states to the 18th birthday of the child, it is interesting to speculate whether an involuntary act by a child such as reporting lawfully to the armed services branch that drafted him (or her) would also be grounds for termination of the parent's support duty.

Marriage

In most states, to be pronounced husband and wife is to be pronounced independent of the couple's parents, regardless of the couple's capability to fend for themselves.⁴³ Although considered a prime indicium of self-sufficiency, the marriage ceremony of course does not by itself instill in minor children the ability to function without financial and often emotional support from either set of parents. As a result, some states do not find marriage itself an "emancipating" act, without further proof of the couple's independence.⁴⁴ Indeed, when minor newlyweds expecting a child move in with parents, the financial responsibilities may measurably increase for the parents.

Independent Living

When a minor child voluntarily moves out of his or her parents' home, establishes an independent means of financial support, and acts in a responsible manner that leads one to conclude the child can function adequately in an adult world, the justification for a parent's continued support duty often

ends, and courts will sometimes terminate the legal duty.⁴⁵ Some courts, constrained by statute and precedent, will not find a minor capable of self support regardless of the evidence.⁴⁶ Also, some states require an affirmative court action brought by the responsible parent to terminate the support duty and will not retroactively reduce the arrearages accrued since the date of independence.⁴⁷ Indeed, federal law requires states, as a condition of continuing to receive federal welfare money, to prohibit retroactive modification of accrued arrearages, as each support installment past due is to be considered vested.⁴⁸ Thus a child may earn more than a parent responsible for his or her support and yet the support duty continues until the parent takes steps to terminate it.

Determining whether a child is independent for support purposes generally hinges on the facts of each case. A minor child may live in his or her parents' home and yet the court may still find that the child is independent and the parent's support duty terminated. A minor child may live away from home in a college dormitory or with some friends and the court may still find a parental duty of support. It boils down to a court determining whether it will allow a parent to abrogate a duty prematurely, and if so, under what conditions and presumptions.

Death of a Parent

When an obligor parent dies, does his or her support duty automatically end? States are split on this point, some finding that death terminates all responsibility⁴⁹ and others finding that the obligor's estate may be liable.⁵⁰

In many states with a history of county responsibility for "public charges," the county is statutorily authorized to proceed against the estate of the deceased obligor to collect reimbursement for any county aid provided to the decedent's child.⁵¹ Other states allow the surviving parent to collect from the decedent's estate for past, current and future support, the latter usually as a lump sum.⁵²

The Breadth of the Support Duty — Who is Liable?

Parents

Traditionally, the father was responsible for the support of his minor child.⁵³ Over the last several decades the responsibility has broadened to include

both mother and father, either as the custodial parent or non-custodial parent.⁵⁴ The law has moved away from placing the father only in the center of the family circle, from whom all duties emanate and to whom all responsibilities are owed. Although several states still have possibly unconstitutional language stressing gender distinction, the trend has been to classify duty neutrally by referring to the parent-child relationship itself and the capability of either or both parents to support the child adequately. Also, the distinction between the support duty of fathers of children born out of wedlock and that of fathers at one time or another married to the child's mother has for the most part disappeared, as the children born out of wedlock have received favorable treatment from the U.S. Supreme Court over the past two decades in equal protection cases.⁵⁵

Another interesting consideration is the existence of a parental duty of support when neither parent has legal custody of the child, such as when a custody order ends at 18 or when parents are living together. Is there a support duty to these parents' adult children if they are attending college? Does it matter whether or not the adult child selected a path that was with parental blessings? States vary as to whether a duty exists in such circumstances.⁵⁶

Step-parents

As divorce has become a common phenomenon in America, many children live with spouses of their custodial parents who are not the children's natural parents. Step-parent liability is now a major issue affecting millions of children. Some states impose step-parent liability by statute,⁵⁷ while others have used estoppel and *in loco parentis* principles to create a common law duty.⁵⁸ Estoppel theory comes into play when a step-parent has held him or herself out to be the natural father of the child or has totally assumed a parental role for a long period of time. The latter concept is the basis for the *in loco parentis* theory of liability. It is clear that children adopted by step-parents have the same rights of support from the adoptive step-parent as if the step-parent were a natural parent.

Some states look to the natural parent who is absent from the household as the primary obligor, with the step-parent secondarily liable.⁵⁹ Other states place the liability on both step-parent and natural parent, which is sometimes implicitly done by taking into account the contribution of the step-parent to the payment of the child's expenses and the step-parent's income when determining the natural parent's liability.⁶⁰

Most states tend to terminate the step-parent duty when the relationship between step-parent and