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MRS. YANKOVICH — The only thing they tell you in your pediatrician's office, generally, from the consensus that we've seen, to expect these minor things: the fever, the sleeping, irritability, but nothing about the disasterous things that we've seen with our daughter.

MRS. GAUGERT — I don't think he warns people. They are always so busy...they don't have much time for anyone.

ROBBINS — I think if you as a parent and brought your child to a doctor for a DPT shot and the doctor said to you initially, "Well, I have to tell you that some children who get this vaccine get brain damaged," there's no question what your reaction would be. As a responsible parent you'd say, "I wish not to take this vaccine."

But we do things together as a community to protect each other.

MR. GRANT — I often wonder about those people who do these studies and who ultimately are the directors of them, and so forth, what they would say and how they would feel if it did in fact happen to one of theirs. It's an altogether different ballgame then.

THOMPSON — Kelli Holcomb got her shots through the US Army. Her parents were told nothing of the risk of the DPT vaccine.

KELLI HOLCOMB
AGE 8
REACTION: Persistent cry, stiffness
Spastic Quadriplegic and Brain Damage

MR. HOLCOMB — She received the shot in West Germany at a US health clinic. She had a reaction which now is known as excessive screaming reaction. The third shot was then given again at a US Army clinic in Ft. Belvoir, Va. which is right outside of DC. At that time she then experienced what is known as the post pertussis encephalopathy.

THOMPSON Monty Prieser of Charleston, West Virginia is Kelli's attorney. The Holcombs now live in Puerto Rico.

PRIESER She's 8 years old. She is a total quadriplegic. She can only really understand and blink her eyes "yes" or "no."

MRS. HOLCOMB Are you hungry". I didn't see. Are you hungry? Real hungry? I'm gonna lay you down. Kelly, bring it down.

PRIESER She is in a special education school in Puerto Rico When she is shown things and asked things she does blink "yes" or "no". She can do nothing else for herself. Her mother must bathe her, feed her, of course. She has great problems. She will probably like most quadriplegics develop respiratory problems and kidney problems in the future.

The United States was sued for medical malpractice, so to speak, medical negligence, for not warning the child and not saying when the child had the screaming syndrome, in Germany, for not saying to the mother, "Don't have any more." Then we don't believe that the U.S. properly asked the questions before they gave the third shot. The case was settled for $600,000. $390,000 will be paid by the United States, $210,000 will be paid by Richardson-Merrell.

THOMPSON Kelli was injured eight years ago. If she got the shot in a public health clinic today her parents would probably be given a consent form to sign. It gives the official government risks: Brain damage one in every 100,000 shots. High fever, convulsions, abnormal crying or shock...one in every 7,000 children.

Almost all parents sign the form. Kids can't go to school without their shots.

YOUNG — The doctor knows that this is mandated by regulation.

THOMPSON (Interview) — So he has no choice.

YOUNG — So he has no choice, and indeed the parent has no choice.

THOMPSON — Barbara Syska of Silver Spring, Maryland didn't want her child vaccinated. She took it to court...she lost.

MRS. SYSKA — They do not inform parents of the most important aspects of it. At least not all important aspects to make the informed decision and the more important, the consent is coerced.

THOMPSON — Since January 1979 her child has been taught at home.

MENDELSOHN — I recommend that parents consult a lawyer, or that they go to their state legislators and to their elected representatives and make a fuss about it.

THOMPSON — Marge Grant and a group of parents did just that. They lobbied the Wisconsin legislature until they got a law making vaccines voluntary in the state of Wisconsin.

MARGE GRANT — The law now states that if you for any personal belief or personal conviction do not want your child immunized, you certainly do not have to. I insisted that this law must state that any person who immunizes a student under this law must record and identify the manufacturer and lot number used and the type of vaccine being given. And it is now written in the law. And I feel very good about that.

THOMPSON (Interview) Scottie's Law?

MARGE GRANT I guess you could call it that. It's a little late for him but some other child could benefit, certainly.

THOMPSON Wisconsin isn't the only state that has gone against federal guidelines and decided to allow parents a choice about the DPT shot. So have 19 other states. In Maryland, Virginia and the District you must have the shots to go to school.

End of 3nd Segment

THOMPSON So far we have focused on the government and the medical community. But manufacturers, the drug companies, also have a responsibility to make sure that the DPT vaccine is safe and effective.

PREISER If you're going to put something on the market, you have the ultimate responsibility to find out what that product is doing on the market. Is it safe, is it causing problems?

McDOWELL They are the ones who are making the money. They are the ones who can afford to do the necessary studies and yet they haven't done them.

And it's the children out there who are the innocent parties who suffer.

THOMPSON Attorneys Preiser and McDowell accuse the manufacturers of destroying vaccine records before they can be subpoened for a DPT law suit.

We tried to talk to all of the companies that make DPT but none of them would do an on-camera interview. So we asked the FDA about it.

THOMPSON (interview) Do you know if manufacturers systematically destroy records?

ROBBINS You know, I can't answer you. I'm sure they don't keep records...

THOMPSON Do you have any control over that? Do you require them to maintain records?

ROBBINS All records of adverse reactions must be part of their manufacturing file and are inspected each year as each manufacturing establishment is inspected for its manufacturing and control procedures.

THOMPSON (interview) How long do they have to keep them?

ROBBINS I don't know. I'm sorry.

MARGE GRANT Our attorneys went to the FDA and asked for the protocols and the testing of the vaccine, and would you believe just several weeks before they lost...they just couldn't find...in fact, the word they used was, "Those records were here, but they vanished."

I have no question about the fact that there is a cover-up. There has got to be.

ROBBINS There is no reason why we should want to hide those records from anyone. I hope it hasn't occurred. The last thing we want to do is to be negligent in our control of this.

THOMPSON (interview) We've known about the reactions to the shot for 40 years. Why only in 1973 did we start to think about it and worry about it?

ROBBINS I think that there has always been interest in pertussis, but, you know, the vaccine was so effective, the scientific community didn't consider it a problem.

THOMPSON But how effective is the DPT vaccine? The official answer from the Center for Disease Control.

HINMAN The fact that a vaccine is, say, 80% effective means that 4 out of 5 people who receive the vaccine would be protected from Whooping Cough if they are exposed to it but one would not.

BARAFF — It doesn't produce life-long immunity. It doesn't produce immunity in all children who receive it. It's possible that a child could get the full series of shots and still get whooping cough. It's also very likely that they could get the full series of shots and 6 or 7 years later get a modified form of the disease.

THOMPSON — Dr. Stewart says the English statistics show less than two-thirds of those vaccinated are protected.

STEWART — In any outbreak of Whooping Cough or pertussis about thirty percent of the children have been fully vaccinated.

THOMPSON (interview) — How long is the DPT shot effective?

STEWART — For two or three years from the time of receiving it.

THOMPSON — The DPT vaccine has never been clinically tested in the United States. The British did clinical tests on the vaccine back in the late '40's and found it to be effective but reactive.

By Congressional mandate in 1973, the Food and Drug Administration set up panels to review all vaccines on the market. While the report on bacterial vaccines has never been published, we were able to get a draft of it under the Freedom of Information Act.

THOMPSON — It shows that very few manufacturers of the DPT vaccine were able to give the panel any documentation that their vaccine was either effective or safe. It shows that the panel went ahead and continued licenses anyway, pending more information. And it shows one DPT vaccine that was O.K.'d on a three to two vote. Dr. Mortimer was a member of that panel.

MORTIMER — Here we've got a highly reputable manufacturer whose manufacturing techniques insofar as we can tell are impeccable, who insofar as we can tell does everything to monitor what happens with that vaccine as best that manufacturer can, and, moreover, a vaccine upon which the public depends. Therefore, it seems entirely appropriate to us to permit that vaccine to be produced for another period of "X" years.

THOMPSON (Interview) — How can a vaccine, which every child in America might be exposed to, be O.K.'d on a three to two vote?

MORTIMER — Because there was circumstantial evidence that it worked.

THOMPSON (Interview) — But a three to two vote?

MORTIMER — That's a far greater majority than we elect presidents on!

ROBBINS — There was no reason, I think, at that time to question the efficacy of the products because they were so successful. The standards of safety and efficacy that we demand for vaccines probably exceed by a great deal those standards that we have for almost everything else that we offer as medicines.

Every lot that the manufacturer makes is tested both at the mannfacturer and at the Bureau of Biologics.

THOMPSON (Interview) Is that normal?

ROBBINS No, it reflects our concern for this vaccine.

THOMPSON A General Accounting Office audit in 1979 found the test FDA uses to examine those lots is faulty. An FDA panel also questioned the adequacy of current vaccine tests and noted that they are conducted on the premise that children in this country get three shots... in fact most children get four.

Bobby Young who worked at the FDA's Bureau of Biologics..

YOUNG I believe that scientists at FDA would indicate to you that the mouse protection test that they employ for pertussis vaccine is not adequate.

ROBBINS Our analysis of the vaccine effectiveness by the laboratory test is not as good as we would like, but it certainly can't be too bad since the vaccine has been so effective.

YOUNG They have their own vested interest and their own authorities and experts who are being paid salaries to make this appear to be a very protective and safe vaccine. And anything that mitigates against the safety and protectiveness of a vaccine in essence mitigates against their recommendations.

THOMPSON While the government has said for years that the vaccine is effective and safe...it is working hard to try to develop a new vaccine. In fact, with the FDA's help, the Japanese rushed a new, what they call purer vaccine onto the market after Japanese parents lost confidence in the old shot. That vaccine, however, has never been clinically tested so it may be two to four, maybe ten years before it is determined to be safe enough to use here in the US.

THOMPSON (Interview) If the government had said, "Look, there is a real serious problem with this vaccine," a long time ago, maybe we would have had a new vaccine a long time ago.

MORTIMER That's perfectly possible, but the government has to establish priorities.

THOMPSON The fact is, we may have had a safer shot a long time ago. For many years the Eli Lilly Company produced a different type of DPT vaccine which it called TriSolgen.

ROBBINS It was the impression of the physicians that used the vaccine that this was the safest Whooping Cough vaccine on the market. I don't know if that's real. It's only hearsay evidence. It was never really quantitatively compared.

THOMPSON (Interview) Why, if you thought that the Lilly vaccine might be less reactive and still be effective, wouldn't you have taken a close look at it yourself to determine whether it really was a better vaccine?

ROBBINS We are developing a vaccine, but our primary objective is to try to understand in as precise and as modern terms as we can those components of the vaccine that cause side reactions, and that also might cause immunity.

THOMPSON (Interview) But in the case of the Lilly vaccine, is it possible that we could have let a good one get away?

ROBBINS Oh, I think we have no control over that. That was the decision of the Eli Lilly Company to stop its manufacture.

THOMPSON There are some children who absolutely should not get the DTP shot. There are some children who are at serious risk if they do.

We'll examine that in just a moment.

End of 4rd Segment

THOMPSON The FDA is working on a new vaccine which it hopes will be effective but also a lot less reactive than the one that we have now. The problem is, nobody knows when that vaccine will be available. And, in the meantime parents must decide whether they will or will not give their children the DPT vaccine.

We can tell you this...the disease whooping cough... pertussis...is not a pleasant disease. It lasts a long time. But, from everything we have seen, it is no longer a killer...except in infants who are probably too young to receive the vaccine.

We can also tell you this...some children and some families are much more at risk than others. No one knows more about that than Dan and Mary Resciniti of Binghamton, New York.

ANTHONY RESCINITI
AGE: 19
REACTION: Persistent cry, fever, seizures
Severely disabled and retarded

Tony Resciniti...19 years old...he suffers a convulsion about once a day. The drugs to control his convulsions cost $1200 a year...he has spent part of his life in an institution.

Tony convulsed within 24 hours after getting the DPT shot. Regardless, doctors continued the rest of the shots. After Tony's history with the DPT shot, his brother Leo should never have had the vaccine.

LEO RESCINITI
AGE: 17
REACTION: Fever, convulsions
Severely disabled and retarded

Leo Resciniti...17 years old...Only a few hours after his first DPT shot, Leo too, went into convulsions. His temperature soared...regardless, his pediatrician gave him a second shot.

MORTIMER In terms of the severe complication--encephalopathy-- that information was all anecdote until less than a year ago...until the British study appeared.

ROBBINS — Did he say last couple of years? Two years?

THOMPSON (Interview) — That's what he said. Well he said, since the National Childhood Encephalopathy Study in England.

ROBBINS — I can't speak for the whole medical community. I can only speak for myself. I've always known that whooping cough vaccines do produce some side reactions.

THOMPSON — We discovered while researching this story that many doctors and nurses are not aware of the risks or reactions...or the warning signs that mean the DPT shot should not be given the second time.

Case in point: The District of Columbia Medical Society held a recent seminar on immunizations. When a panel of doctors and scientists was asked if a DPT shot should be given to children who have had a febrile convulsions, no definitive answer was given. In fact, Dr. Saul Krugman, a well known professor of pediatrics at New York University's Medical Center said...A history of convulsions is not a reason to avoid the "P" part of the DPT shot. The people attending that meeting were misinformed.

Convulsions are specifically listed by the American Academy of Pediatrics in the Pediatric Redbook as a contraindication to giving another shot. Here is what that doctor's handbook states as reasons not to give another whooping cough part of the DPT shot to your child:

Had a high fever
Had convulsions
Went into shock
Collapsed
Cried Excessively
Lost awareness or
Showed signs of brain damage.

THOMPSON Manufacturers add that you should not give the shot to children with nervous system disorders, those undergoing chemical therapy or who have had an infection or fever. While the American Academy of Pediatrics does not include it in its guidebook, manufacturers say you should not vaccinate a child who has a personal or family history of central nervous system disorders or convulsions, like the Rescinniti family.

But, what about the children who have already been damaged? Who's helping them? Unless they sue, and many families don't have the money or don't want to do that...nobody is helping them pay the enormous costs that a brain damaged child brings upon a family.

MARGE GRANT I just recently read that it is going to go up to $100 a day if you institutionalize a child like Scott. Those are tax dollars. Now, that's $36,000 a year for one individual. I can keep him home where he really belongs, where we want him, for far less. But surely a child like this deserves to stay out of an institution and unless there is compensation, you simply cannot do it.

THOMPSON At least six nations provide compensation for vaccine related injuries. They are Great Britain--which has made tax free awards of $20,000 each to just under 600 DPT victims, Japan, France, Denmark, West Germany and Switzerland. Only one state in this country has a compensation program: California. It's been in effect since 1979. Its first award...a three month old DPT victim.

The only time the U.S. government has compensated victims was for adverse reactions to the swine flu vaccine. It has, however, commissioned two studies to try to determine the cost of an overall vaccine compensation program. It was determined the cost per DPT victim could be as high as $890,000. No legislation has ever been introduced. The official position...

HITMAN — The position of the Department of Health and Human Services has been that there is not as yet evidence that such a system is needed.

THOMPSON — Thousands of children get the "P" part of the DPT shot and apparently suffer few consequences. However, some children have suffered learning disabilities and severe brain damage as a direct result of the shot.

There is no way of knowing how many DPT victims there are in the United States, but there certainly are far more than the medical community or the government would like to admit. The government has known about serious reactions to the DPT shot for 40 years. Its one and only study in 1978 showed a very high rate of reaction to the shot, but that study has virtually been ignored. So has the evidence that other countries have found that Whooping Cough is probably not the dread disease it used to be and the vaccine may not be as effective as previously thought.

We have found in our investigation of the DPT shot that many doctors and nurses are misinformed about just which children are at risk if they are given the vaccine. We have also found most doctors that see reactions to the shot do not report them to the government or the manufacturers or to parents.

We have found vaccines have been allowed on the market with little effectiveness or safety data, and that the tests for determining those things is faulty in itself.

What is perhaps the most disconcerting about all of this is that states and private doctors have blindly followed the lead of the government in making this shot mandatory, while at the same time, we've found some doctors themselves have chosen not to give the "P" part of the vaccine to their own children, choosing instead to give just the "D" and the "T".

Our objective has been to provide information so there can be an informed discussion about Whooping Cough... The dilemma for parents remains.

BARAFF — I would certainly vaccinate my child...yes.

MURPHY — I would probably advise against it...if the rest of the community were getting the Pertussis.

ROBBINS — Much more is to be gained by immunizing the children with our current vaccines with its limitations, than by allowing our children to be exposed to contracting Pertussis.

MENDELSON — I feel that the vaccine should not be used, because the vaccine today represents a much greater threat than the Whooping Cough itself does.

YOUNG — I recommended in writing to my daughter, so she could take this letter to her pediatrician (we don't normally communicate that formally) that my grandsons receive the "D" and the "T" component of DPT but not the pertussis component.

MORTIMER — I believe it should be given to every child in the United States with the exception of very rare children in which there is a specific reason not to.

STEWART — I believe that the risk of damage from the vaccine is now greater than the risk of damage from the disease.

HINMAN — I don't believe we have reached a stage in this country with pertussis where we have approached the stage where vaccination is more hazardous than the risk of disease.

(Child crying, receiving shot
FATHER of Child — See...it's all gone already.

END OF PROGRAM

Before it's too late, vaccinate

Measles epidemics a warning

By ANN CHANDONNET
TIMES WRITER

Before it's too late, vaccinate.

That's the theme of National Immunization Week, Sept. 22-28, a joint campaign of the Children's Action Network and the American Academy of Pediatrics.

The campaign's message is that recent measles epidemics are a warning that many of America's youngsters are vulnerable to diseases once nearly erradicated, said Dr. Rosalyn Singleton. Singleton is a pediatrician at the Alaska Native Medical Center and a fellow of the American Academy of Pediatrics.

"The whole focus of this campaign is a result of the measles epidemic which started suddenly in 1986," Singleton said. "We thought we had eliminated measles from this country, but then we started to see fairly large epidemics."

After an all-time low of 1,000 reported measles cases in 1988, Singleton said, 1990 saw 26,500 cases reported, with more than 60 deaths.

"The main reason this is occuring is that preschoolers are not getting immunized as much as they were."

Nationally, Singleton said, about one-third of pre-schoolers are not fully immunized. In some inner city areas, half of the preschoolers are not immunized. This has triggered major mea-

sles epidemics in Los Angeles, Chicago and New York.

In fact, in 1990, there were more deaths from measles in the United States than have been seen in any single year since 1970. Most of the deaths were among pre-schoolers.

Parents need not fear vaccines, Singleton said. "Vaccines are 95 percent effective. They could have prevented hundreds of deaths nationally."

One toddler in Alaska died in 1990 from the complications of measles.

The cost of a single vaccination is $15 to $25, putting the total cost of immunizing a baby from two months through kindergarten boosters at $250 to $300.

For parents who can't afford vaccinations through a private physician, there are free public sources, like the Indian Health Service and Municipality-sponsored well-baby clinics.

The cost in terms of dollars is insignificant, Singleton said, "if you look at the cost of grief when your child dies."

Infection can have severe ramifications, Singleton added. "Mumps can cause sterility in males. Rubella in a pregnant women can cause congenital rubella in her child — heart defects, deafness, retardation or death. Polio can cause paralysis. Diphtheria and tetanus can cause death. Whooping cough can cause infants to stop breathing, to have seizures from loss of oxygen, or long-term lung damage."

> 'We thought we had eliminated measles from this country, but then we started to see fairly large epidemics.'

Parents may neglect to have their children vaccinated because they fear side effects, Singleton said. But side effects such as fever, fussiness and tenderness at the injection site are short-lived.

"First-time parents today may never have seen a case of polio or a case of measles," Singleton said. "They don't understand that polio can be devastating. They think of measles as 'a regular childhood disease.' But it can cause pneumonia or encephalitis. We need to alert ourselves that these are important diseases to prevent."

Like Singleton, Janine Schoelhorn, immunization program coordinator for the State of Alaska, is concerned that, for many children, vaccination is put off.

"Kids need to get vaccinated on time. As soon as a child is eligible for vaccination, he should be vaccinated. It should not be postponed. When we see vaccine-preventable disease, often we see it in children who are old enough to be vaccinated — but the parents have postponed it. Unfortunately, those are the children most severely affected. Our goal in the state is 90 percent immunization by age two."

By age two, children should have had the following vaccinations:

- 4 DPT (to prevent diphtheria, tetanus and pertussis or whooping cough)
- 3 OPV (oral polio vaccine)
- 1 MMR (measles, mumps, rubella)

Earlier this month, the American Medical Association recommended that a two-dose measles vaccine strategy be implemented in the measles-mumps-rubella vaccine, to make vaccination a simplified procedure.

These immunizations are an absolute requirement for day care entry, Schoelhorn said.

Ironically, children who are cared for at home, whose mothers do not work for their first two years or longer, are among those at high risk for not receiving the proper vaccines by age two. Therefore, when these children *do* venture out into the general population, they are ripe for all sorts of infections.

Schoelhorn cited a state-wide

See Shots, page E2

Shots

Continued from page E1

sample of kindergartens, which found that among kindergarteners last year, fewer than 60 percent had been fully immunized by age two. "So we have quite a few children out there who are at risk."

"Because we have been able to reduce the incidence of disease, people start thinking the vaccine is more dangerous than the disease. And that's just not true," Schoelhorn said.

"Some people think vaccine-preventable diseases are extinct; that there's no chance of them getting them," Schoelhorn said. "Actually, we do have imported disease in Alaska. We have a lot of travel between Alaska and other places, and they are at risk particularly for pertussis, measles and rubella." These diseases can kill.

Measles is so infectious that onlookers sitting in an emergency room or a pediatrician's office can catch it from an infected person's just passing through.

During the national immunization week, Alaska's radio and television stations will be running messages about the importance of immunization, and clinics across the state will state their own local campaigns.

"Alaska has good laws," Singleton said, "so we have some of the best immunization rates for vaccination for school-age children in the nation. But preschoolers are falling through the crack. They usually get the first shots, but don't get the measles at 15 months and the DPT at 18 months. This puts them at risk."

Phone Numbers

The Municipality of Anchorage has a 24-hour recording on immunizations; call 343-4734.

For information about well child clinics, call the Municipal Health Department at 343-4800.

Native American parents whose children are behind in their immunization schedules should call the Alaska Native Medical Center to make appointments. That number is 257-1103.

The national number for free vaccination and health care information through the mail is 800 525-6789.

The latest vaccination

HIB is a special protection for kids

By ANN CHANDONNET
TIMES WRITER

Most parents are familiar with DPT and MMR, but they may never have heard of the latest in vaccinations — HIB.

HIB is short for haemophilus influenzae type B. In Alaska, vaccination with HIB vaccine is not required for day care or kindergarten attendance, said Nina Davidson, a registered nurse who is a nurse specialist with the basic immunizations and HIB program at the Alaska Native Medical Center.

However, it is important for many children to have this special protection, especially Native American children.

"Alaska Natives have about 10 times the rate of influenza as the general population," Davidson said.

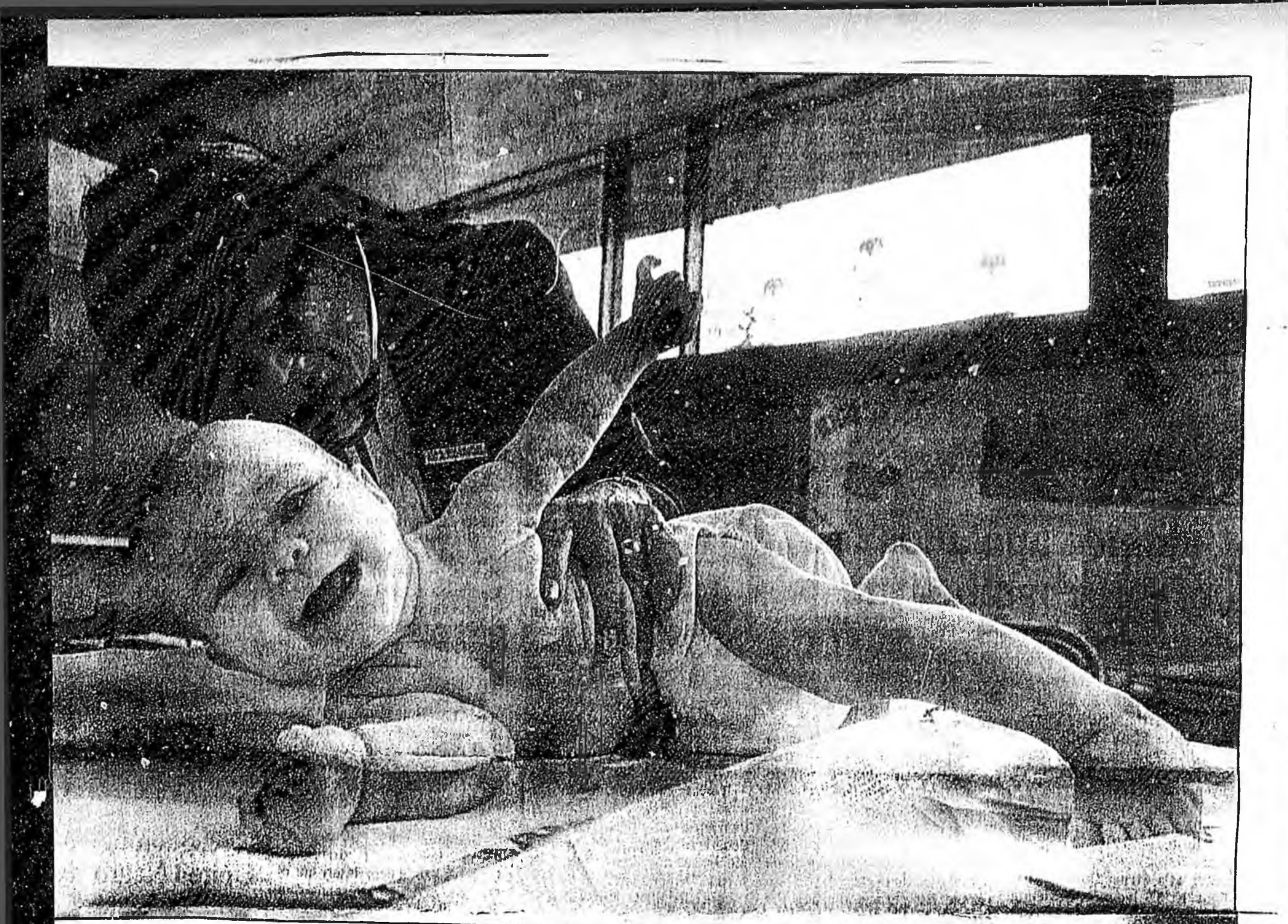
The HIB vaccine has been in distribution only since 1985. The initial vaccine developed was not as effective as the vaccine that has been available in the last year, Davidson said.

HIB needs to be given at the age of two months, Davidson advised.

"Up until the last year, HIB could only be given at 18 months, and most of the disease occurred in kids under that age," Davidson said. "So it's a real leap forward to have a vaccine that can be given to this younger group of children."

The peak incidence of haemophilus influenza is between four and six months.

HIB needs to be prevented because it is the major cause of 80 percent of meningitis cases. Children who are given the HIB vaccine receive two different vaccines, one in a series of three shots and one in a series of four.



Times photo by RUSS KENDALL

nica Bell, 5½ months old, is examined recently by Jean Baker, R.N., just before Veronica is immunized.

Anchorage Daily News Tuesday, May 21, 1991

Parents, doctors express doubts over vaccinations

By SUE CHASTAIN
Knight-Ridder Newspapers

It was more than 10 years ago, but every detail of the day is burned into Barbara Fisher's memory.

She'd taken her 2½-year-old son, Christian, to the pediatrician for some routine shots. A few hours later, she looked in on him.

"He was staring into space, white as a sheet," the suburban Washington mother recalled. "All of a sudden I saw his eyes roll back. His little head went down on his shoulders, and he was out. I carried him to bed, and he didn't wake up for six hours."

Fisher was uneasy, but convinced herself it was just fatigue, or a relapse of a recent flu bout. "If I'd known then what I know now, we would have been in the emergency room."

The boy's problems were only beginning.

"He just deteriorated over the next couple months," said Fisher. "He stopped eating, stopped growing." A lively, precocious toddler who had been speaking in complete sentences, Christian "no longer knew the alphabet or his numbers. He couldn't concentrate — he'd just sit and stare and drool."

Frantic, Fisher took him from doctor to doctor. No one could explain what was wrong, though one suggested maybe it was "just a stage."

It was not until a year and a half later, when she watched a TV show that linked the pertussis (whooping cough) vaccine to cases of brain damage and death, that Fisher began to wonder. Had the "routine" vaccinations — Christian's fourth dose of a shot known as DPT, for diphtheria, pertussis and tetanus — somehow caused his baffling decline?

After reading all the medical literature she could find about reactions to the vaccine, Fisher was no longer just suspicious. "I saw exact descriptions of what I had witnessed that day," she said. "I was furious nobody had warned me. How many children have to be injured, or die, before somebody does something?"

CHILDHOOD VACCINATIONS

To the public health establishment, they're a bulwark against deadly epidemics. To many pediatricians, they're the cornerstone of the practice. So entrenched is the concept of "getting your shots" that the recent measles deaths of nine Philadelphia-area children caused public outrage and a full-force campaign to bring the recalcitrant into compliance.

But a growing number of parents are unconvinced. They believe that some of the required vaccines are far more dangerous, and less effective, than public health authorities say they are. And they are demanding the right to choose — to let their children have some shots, to reject others.

Fisher, with a handful of other parents who believed their children had been hurt or killed by the pertussis vaccine, formed Dissatisfied Parents Together (DPT) in 1982. The Vienna, Va., group, which runs an information clearinghouse and lobbies for safer and more effective vaccines, said it has support and donations from 35,000 people. Requests for information have gone up 50 percent in the last two years, Fisher said.

Knight-Ridder/Tribune News

Barbara Fisher talks to her son, Christian, who she says has "multiple learning disabilities" as a result of a routine childhood vaccination.

These are not people who resist vaccinations for religious reasons — unlike the members of several fundamentalist churches here, whose objections came to light during the measles outbreak.

"Before people write us off as crazies, they should know most of us truly believe, on medical grounds, that some vaccines are dangerous," said Fisher, who co-authored a 1985 book on the pertussis vaccine, "A Shot in the Dark," now in its third printing. "It's not like giving your child an aspirin. We're not against "all" vaccinations — we just want to be able to say no."

Still, vaccinations remain "the closest thing to a religious sacrament we've got in this country," said Richard Moskowitz, a Boston family practitioner who has studied the issue for the last decade and believes that there are so many unanswered questions about the risks of vaccination that giving every child the full complement of shots is "very reckless."

Although he acknowledged that his views are not shared by most doctors, he's seen an increase in "passive support" among colleagues in recent years. "A sizable number share the concerns but are not willing to say so publicly," he noted.

Moskowitz traces the beginnings of vaccination protests to 1976, when the federal government backed an ill-fated mass-immunization drive against swine flu — an epidemic that never materialized. The effort was finally halted when some people contracted Guillain-Barre syndrome, a rare paralyzing disease, after being inoculated.

"That showed people that the so-called medical authorities didn't always know what they were doing," said Moskowitz.

THE MAIN OBJECTION

Although the anti-vaccine contingent is most critical of the pertussis shot — Fisher called it "the oldest and crudest" in use — the primary objection is that any shots should be required for a child to attend school.

Though immunization requirements vary from state to state, they have generally become more comprehensive since the early 1970s, said Walter Orenstein, director of the division of immunization of the Centers for Disease Control (CDC). All states allow medical exemptions; 22, including Pennsylvania, allow philosophical exemptions, and all but two, West Virginia and Mississippi, allow religious exemptions.

"The school laws play a major role in assuring public and community protection," Orenstein stressed. "With a high level of immunization, you break the chain of transmission. If the laws were ever abandoned, we'd see a massive resurgence of disease."

Orenstein said he was aware of the DPT group, which pushed through Congress a 1986 act setting up a national system to compensate parents for vaccine-related injuries or deaths.

It's time for the baby's first DPT shot. Or polio booster. Or MMR vaccination (measles, mumps and rubella). Will the shots really protect your child against the diseases?

According to the conventional wisdom, yes.

Most of the common vaccines "are 95 percent or more effective," said Orenstein. The rate drops to 70 to 90 percent for pertussis, but Orenstein calls that "a pretty good range."

The very fact that no vaccine is 100 percent effective shows why high immunization levels are critical, he said. Children who are unprotected by the vaccine "receive some indirect protection" if every other child they are in contact with "has" been successfully immunized.

A SERIOUS QUESTION

But Moskowitz, who took a year's sabbatical to study the issue in 1982, said effectiveness is "a very serious question."

Studies of numerous disease outbreaks, including the current nationwide measles epidemic, have shown that "at least 50 percent of the victims have been vaccinated — some quite recently," he said. "Many articles in the pediatric literature show that re-vaccination — which public health authorities claim is sometimes necessary to 'restimulate the immunity' — doesn't work."

Nor is there agreement on whether vaccines really wipe out diseases, or whether diseases wax and wane for unrelated reasons. Public health officials credit the pertussis vaccine with nearly eradicating whooping cough, which killed almost 8,000 people at its peak in 1934.

But Moskowitz noted that the

disease "had already begun to decline precipitously long before the vaccine was introduced" in the 1940s. "It's much the same with diphtheria and tetanus," he said.

Even more hotly debated: How safe is it to inject viruses and bacterial toxins into very young children?

Orenstein characterized the common vaccines, including pertussis, as "highly safe — the benefits far outweigh the risks." Claims that the pertussis vaccine can cause brain damage or death have not been proved, he said, adding that recent studies suggest an even weaker link to brain damage than had been thought

"I'm not ready to say it absolutely doesn't cause brain damage, but if it does, it's extremely rare," he said.

Orenstein also said that, because the first pertussis vaccine is given at age 2 months, it is extremely difficult to separate its effects from "coincident events."

"That's about the same time Sudden Infant Death Syndrome (SIDS) peaks, and too early to assess neurological normality," he said. "Because B follows A doesn't mean A caused B."

Fisher argues that the CDC greatly underestimates the problem by classifying many vaccine-caused injuries as unrelated neurological abnormalities, and many deaths as SIDS. From interviews with more than 500 parents and information gleaned from her research, Fisher estimates "a minimum of 12,000 injuries (from vaccines) each year, from learning disabilities to severe and profound retardation, and another 600 to 900 deaths, with most of those written off as SIDS."

BEING INFORMED

Fisher also believes that the public should know about factors that her group maintains put children at risk for a severe reaction to the pertussis vaccine — for instance, a low birth-weight, a recent illness or a family history of allergies. "Doctors don't want to scare people," she said, "but keeping the public ignorant just contributes to the number of injuries and deaths."

Moskowitz contends that vaccination can cause the very disease it is designed to prevent "but in an atypical form, often quite difficult to recognize — a much deeper, more dangerous illness with more complications and new symptoms."

He also has noted that more of his young patients are getting chronic illnesses — ear infections, allergies, eczema, asthma, "the whole gamut." He speculated that the widespread use of both vaccines and antibiotics seems "to be promoting chronic rather than acute responses, infections which don't heal themselves as well as they used to, immune system breakdowns." Vaccines, Moskowitz has concluded, could be creating a generation of the chronically ill.

Rather than trying to eradicate diseases with vaccines, he suggests a return to an old-fashioned notion — exposing children to generally benign childhood diseases such as measles, mumps and rubella when they are young, allowing them to acquire permanent immunity and protecting them from getting more serious forms of the diseases later.

This is less dangerous "than trying to beat nature at her own game," he said.

Orenstein, however, believes that "takes the natural-unnatural argument too far. These are not insignificant diseases — I wouldn't want to put my child through one of them, just to get 'natural' immunity. "Death" is very natural — we used to see a lot of it from these diseases."

To vaccinate or not? The answer is no longer automatic, at a time when few patients accept the notion of medical infallibility.

Fisher's group urges pediatricians to provide parents with information, and to encourage them to ask questions. "Most of the pediatricians don't like to take the time," she said. "But others are very responsible."

Rachel Mueser's first child, Jacob, 8, got every shot in the book. "I didn't really think very hard about immunization then," said the Bala Cynwyd, Pa., mother. "I just did what the pediatrician recommended."

But because her second, Anna, was too sickly to be vaccinated on the usual schedule, Mueser found herself with more time to think over the issue. "The longer I thought about it the more concerned I became," she said.

Mueser has evolved into a classic "pick and choose" parent. She left a pediatrician who tried to scare her into giving shots and sought out one who didn't insist. She did some reading and decided to authorize polio and tetanus vaccinations for both Anna, now 4, and Benjamin, 9 months.

But she decided against the pertussis vaccine ("Anna's practically too old to get it anyway, and I know too many children who've had severe reactions") and diphtheria ("You don't hear about it much anymore").

Anna was due for MMR at 15 months, but Mueser canceled that ("I'd like to give her the opportunity to have the diseases, and get lifelong immunity"). She changed her mind about the measles part of the shot because of the ongoing epidemic, but hasn't yet decided whether Benjamin should get it when he's old enough.

Knowing Anna and Benjamin aren't vaccinated against some diseases bothers her sometimes. "Every time they get sick I'm very scared," she said. "I probably worry more. I'm very vigilant. I give them vitamins every day, and herbal tinctures to support their immune systems. But basically they're strong and healthy, and I like to think it's because they "don't" have all those shots in them."

Making a "truly informed decision" is impossible, she said. "But that doesn't mean you don't have the responsibility to make a decision."

TOUGH DECISIONS

Barbara Fisher's son, Christian, is now 13 and has slowly recovered his physical health. But he is left with "multiple learning disabilities," according to his mother. He's two years behind in reading, has trouble concentrating and gets confused if the teacher puts more than one instruction in the same sentence.

"He knows he's different, and that makes him frustrated and angry," said Fisher. "He asks me, 'Mom, why did you let them give me that shot?' All I can say is, at the time I didn't know."

State of Alaska Epidemiology **Bulletin**

Department of Health and Social Services
Theodore A. Mala, MD, MPH, Commissioner

Division of Public Health
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Bulletin No. 35, November 20, 1991

GUIDE TO CONTRAINDICATIONS (VALID AND INVALID) TO CHILDHOOD VACCINATIONS

Parents are often blamed for poor immunization levels among children under age two; however, evidence suggests that the health care system must assume substantial responsibility for missed opportunities to vaccinate children. Missed opportunities occur when a child brought to a clinic for immunization is not vaccinated because of inappropriate contraindications such as a minor illness. Several conditions or circumstances that are often inappropriately considered contraindications to vaccination are listed in the table above, along with the conditions that constitute valid contraindications for each vaccine. This table incorporates the most recent information on contraindications for DTP vaccine. Four conditions previously considered absolute contraindications are now considered "precautions" by the Immunization Practices Advisory Council (ACIP).

Vaccine	Valid Contraindications		Invalid Contraindications
General For All Vaccines:	An immediate anaphylactic reaction following vaccine		Local reaction (soreness, redness, swelling) following a dose of DTP or MMR vaccine
	Moderate or severe febrile illnesses		Mild acute illness with or without low-grade fever
DTP TOPV IPV MMR HIB HBV			Mild diarrheal illness or gastrointestinal tract disturbance in otherwise well child
			Current antimicrobial therapy
			Convalescent phase of illness
			Prematurity: Same dosage and indications as normal, full-term infants
			Recent exposure to an infectious disease
			A history of penicillin or other nonspecific allergies or relatives with such allergies
DTP	Encephalopathy occurring within 7 days of immunization		Temperature of <40.5 C (105 F) following a previous dose of DTP
	Precautions*	Fever of ≥40.5 C (105F) within 48 hours of vaccination	Family history of convulsions
		Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours	Family history of sudden infant death syndrome
		Seizures within 3 days	
		Persistent, incontrollable crying lasting ≥ 3 hours, occurring within 48 hours of vaccination	Family history of an adverse event following DTP immunization
TOPV	Infection with HIV		Breastfeeding
	Pregnancy		
	Known altered immunodeficiency (hematologic and solid tumors; congenital immunodeficiency, and chronic immunosuppressive therapy)		
	Immunodeficient household contact		
IPV	Anaphylactic reaction to NEOMYCIN or STREPTOMYCIN		
MMR	Anaphylactic reaction following egg ingestion or to NEOMYCIN		Tuberculosis or Positive PPD
	Pregnancy		Pregnancy in mother of recipient
	Known altered immunodeficiency (hematologic and solid tumors; congenital immunodeficiency; and chronic immunosuppressive therapy)		Breastfeeding
			Immunodeficient family member
	Recent (within 3 months) IG administration		Infection with HIV
			Non-anaphylactic reactions to eggs or neomycin

*The events listed as precautions, while not contraindications, should be carefully reviewed. The benefits and risks of administering a specific vaccine to an individual under existing circumstances should be considered. If the risks to the individual are believed to outweigh the benefits, the immunization should be withheld. If the benefits are believed to outweigh the risks (for example, during an outbreak), the immunization should be given.

Melissa

State of Alaska Epidemiology

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Bulletin No. 34, November 19, 1991

90% IMMUNIZATION LEVELS BY AGE 24 MONTHS-- CAN ALASKA ACHIEVE THE "YEAR 2000" GOAL?

Introduction: National Health Objectives for the Year 2000 include increasing basic immunization series levels to **at least 95% for school children and children in licensed childcare facilities** and **to at least 90% for children under age two.** Basic immunization series completion levels of greater than 95% among Alaska school children and children attending licensed childcare facilities have been maintained since 1984 and 1986, respectively. In order to estimate Alaska's progress toward achieving 90% vaccination levels among children under age two, the Alaska Immunization Program conducted a state-wide retrospective study of vaccination histories of Alaskan kindergartners.

Results: 494 of 859 (57.5%) Alaska kindergartners surveyed during the 1990-91 school year had completed the basic immunization series (4 DTP, 3 OPV, and 1 MMR) by their 24-month birthday. Vaccination levels for separate vaccines were highest for MMR (79.3%) and lowest for DTP-4 (61.7%). Of kindergartners surveyed, 640 (74.5%) had received OPV-3 by age 24 months. Regional immunization levels by 24 months of age were highest for the Southwest Region (76.4%) and lowest for the Gulf Coast (38.7%) (Table 1).

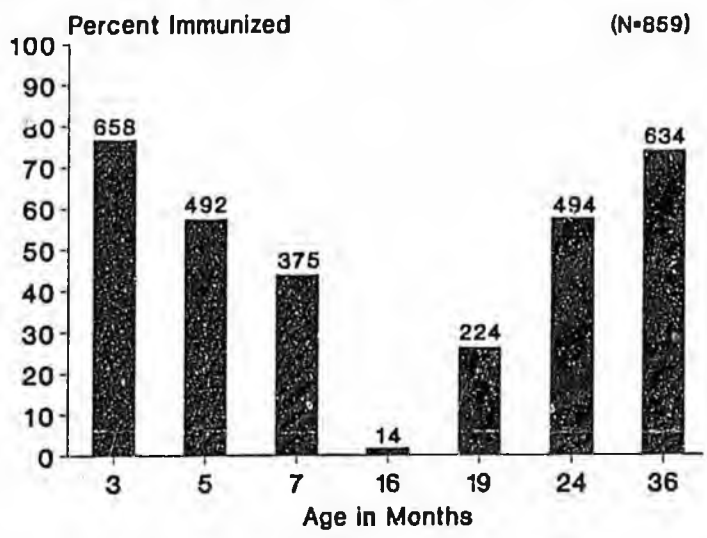
TABLE 1: Percent of Children Completing Primary Series by 24 Months of Age, Alaska Retrospective Survey, 1990-91.

Region	Number Surveyed	4 DTP by Age 2		3 OPV by Age 2		MMR by Age 2		4 DTP 3 OPV 1 MMR by Age 2	
	n	n	%	n	%	n	%	n	%
Anchorage/ Mat-Su	393	236	60.1	289	73.5	299	76.1	214	54.5
Southeast	101	70	69.3	81	80.2	88	87.1	68	67.3
Gulf Coast	75	33	44.0	42	56.0	55	73.3	29	38.7
Southwest	106	82	77.4	94	88.7	97	91.5	81	76.4
Interior	135	78	57.8	95	70.4	101	74.8	74	54.8
Northern	49	31	63.3	39	79.6	41	83.7	28	57.1
All Surveyed Regions	859	530	61.7	640	74.5	681	79.3	494	57.5

Age-appropriate vaccination levels were highest at 3 months of age (76.6%). The level of full, age-appropriate immunization declined gradually after the 3-month vaccination due date, dropped sharply at 16 months (1.6%), increased to 57.5% by 24 months and to 73.8% by 36 months of age (Figure 1).

Two hundred thirty (35%) of 658 kindergartners who were adequately immunized by three months of age were lost to on-time vaccination follow-up by 24 months of age. Eighty-nine (36%) of 246 children who received MMR on or after their 18-month birthday, and were due for DTP-4 at the time of MMR vaccination, missed an opportunity for DTP-4 vaccination at the time MMR was administered.

Figure 1. Age-Appropriate Immunization Levels, Alaska Retrospective Survey, 1990-91.



Summary: Fully one-fifth of Alaskans two years old and younger who are eligible for vaccination, may be unprotected against measles infection. Over 40% may lack one or more vaccinations that could lower their risk of acquiring common childhood diseases.

Recommendations: Alaska health care providers can help to improve the level of protection against vaccine-preventable disease among children under age two.

1) **Implement patient-tracking systems for on-time vaccination of 0-2 year olds and reminder-recall notification of parents.**

2) **Review current data about adverse events associated with vaccination and educate parents about the risks and benefits of vaccination.**

3) **Screen a child's vaccination history carefully at all office or clinic visits, regardless of the reason for the visit. Administer all vaccines for which a child is eligible simultaneously.**

4) **Review conditions inappropriately regarded as routine contradictions for vaccination.**

5) **Eliminate barriers to the receipt of vaccinations--including excessive administration costs, physical examination requirements, and limited clinic hours during which vaccinations are given.**

(Contributed by Janice Schoellhorn, MS, MPH, Section of Epidemiology. Thanks to Gladys Decker, RN, and Deanne Harms, RN, Section of Epidemiology)

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Bulletin No. 18 July 26, 1991

1991 Semi-Annual Infectious Disease Report
Number of Cases by Region

	Southeast		Southcentral		Northern		Total	
	1991	1990	1991	1990	1991	1990	1991	1990
AIDS	1	1	10	11	0	0	11	12
Amoeba	1	1	4	2	0	1	5	4
Anthrax	0	0	0	0	0	0	0	0
Botulism	2	0	2	0	3	0	7	0
Botulism - infant	0	0	0	0	0	0	0	0
Brucellosis	0	0	0	0	0	0	0	0
Campylobacter	12	6	19	18	7	0	38	24
Cholera	0	0	0	0	0	0	0	0
Diphtheria	0	0	0	0	0	0	0	0
Diphyllobothrium latum	0	0	0	1	0	0	0	1
Encephalitis	0	0	0	3	2	1	2	4
Enchinococcus	0	0	0	0	0	0	0	0
Enterotoxigenic E. coli	0	0	0	0	0	0	0	0
Giardia	28	18	37	51	1	3	66	72
Gonorrhea	8	17	300	517	62	69	370	603
Hepatitis A	4	5	78	75	2	10	84	90
Hepatitis B	2	5	16	27	2	5	20	37
Hepatitis non-A non-B	3	1	8	1	1	0	12	2
Hepatitis unspecified	0	0	0	0	1	0	1	0
Legionnaires' disease	0	0	0	0	0	0	0	0
Leprosy	0	0	0	0	0	0	0	0
Leptospirosis	0	0	0	0	0	0	0	0
Malaria	0	1	0	0	0	1	0	2
Meningitis - aseptic	1	3	10	9	5	3	16	15
Meningitis - hemophilus	1	2	7	8	1	4	9	14
Meningitis - meningococcal	0	1	6	5	1	1	7	7
Meningitis - unspecified bacterial	2	3	4	7	0	4	6	14
Mumps	4	0	5	1	1	0	10	1
Paralytic shellfish poisoning	3	1	7	12	0	0	10	13
Pertussis	0	0	8	0	2	0	10	0
Plague	0	0	0	0	0	0	0	0
Polio	0	0	0	0	0	0	0	0
Psittacosis	0	0	0	0	0	0	0	0
Rabies (Animal)	0	0	1	11	2	14	3	25
Reye syndrome	0	0	0	1	0	0	0	1
Rheumatic fever	1	0	0	0	0	0	1	0
Rubella	0	0	0	0	0	0	0	0
Rubeola	0	45	1	20	0	15	1	80
Salmonella	3	4	47	22	3	10	53	36
Shigella	0	3	9	3	0	1	9	7
Smallpox	0	0	0	0	0	0	0	0
Syphilis	3	1	10	8	3	4	16	13
Tetanus	0	0	0	0	0	0	0	0
Trichinosis	0	0	0	0	0	1	0	1
Tuberculosis	1	3	29	13	4	9	34	25
Tularemia	0	0	0	0	0	0	0	0
Typhoid	0	0	0	0	0	0	0	0
Yellow Fever	0	0	0	0	0	0	0	0
Yersinia enterocolitica	1	2	0	7	1	0	2	9

Since only a portion of all reportable illnesses are reported, these figures represent trends rather than actual incidence. More complete reporting of cases to the Division of Public Health will result in more accurate statistics. The above figures represent both military and civilian reporting.

Estimated Total Population 1990:

Southeast	68,989
Southcentral	369,563
Northern	112,491
Total	550,043

CONSTITUTIONAL LAW

By Jennifer Trahan and Susan M. Wolf

Rights of State and Family Clash In Forced-Immunization Cases

THE RECENT measles outbreak in Philadelphia among children of members of the Faith Tabernacle Congregation and the First Century Gospel Church has focused attention on the power of the state to require the hospitalization and immunization of children. Members of these churches oppose immunization and medical treatment on religious grounds.

Six of the congregations' children have died of measles or related infections, and to prevent further deaths, the Philadelphia Health Department obtained an order from Family Court Judge Edward R. Summers requiring the hospitalization of four severely ill children. The city also obtained family court orders requiring the immunization of six other children who had not yet contracted measles.[1]

The state's Superior Court[2] and Supreme Court[3] have refused to stay the family court's immunization orders, and five of the children have since been immunized.[4] These proceedings raise constitutional and state law questions.

Courts have long recognized that the First Amendment's free exercise clause and the 14th Amendment's due process clause protect the rights of parents to freely exercise their religion and to control their children's upbringing without unwarranted state intervention.

In *Wisconsin v. Yoder*,[5] the U.S. Supreme Court held that a criminal conviction of Amish parents who refused to send their children to school beyond the eighth grade on religious grounds violated the parents' First Amendment rights. Similarly, in *Meyer v. Nebraska*, the court — in deciding that a state may not prohibit the teaching of foreign languages to children — determined that the term "liberty" in the 14th Amendment embraces the right of individuals to "establish a home and bring up children."[6] In *Stanley v. Illinois*, the court further recognized that "[t]he rights to conceive and to raise one's children have been deemed 'essential,' [and] 'basic civil rights of man.'"[7]

NONETHELESS, the U.S. Supreme Court has also recognized that there is a limit to the protection afforded by the First and 14th amendments. When the health or welfare of a child is jeopardized, the state can exercise its parens patriae[8] power to protect the child's interests.

For instance, in *Prince v. Massachusetts*,[9] the Supreme Court upheld the conviction of a Jehovah's Witness for allowing her ward to sell religious literature in violation of a state child-labor statute. The court ruled that neither the First Amendment nor the 14th Amendment protected the adult's actions, reasoning that "[p]arents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."[10] The court, in dicta, also declared that "[t]he right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death."[11]

The Supreme Court reached a similar result in *Jehovah's Witnesses v. King County Hospital*.[12] In that case, a district court upheld two state statutes that permitted children of Jehovah's Witnesses to be declared wards of the court in order to authorize blood transfusions over parental objection. Relying on *Prince*, the District Court for the Western District of Washington held the statutes were constitutional despite the limitations they placed on parental First Amendment and 14th Amendment rights.[13] The Supreme Court affirmed the district court's opinion in a one sentence per curiam opinion, in which the court cited *Prince*.[14]

Accordingly, although parents possess both 14th Amendment rights to family autonomy and First Amendment rights to follow religious beliefs in caring for their children, the state's interest in safeguarding the health of children can outweigh these rights in some circumstances. The crucial question then becomes: When does a threat to the health of a child justify state intervention?

IN THE RECENT situation in Philadelphia, the family court ordered the hospitalization of four measles-stricken children. Because the children were clearly ill and several other children had already died because of their parents' refusal of treatment, the court's order seems consistent with constitutional precedent and state law.

Both *Prince* and *Jehovah's Witnesses* indicate that a state has the power to protect a child from a life-threatening situation, despite parents' constitutional claims. In addition, state courts have consistently held such intervention justified.[15] As one court said: "[T]o deny one's child medical care necessary to save his life because of one's own religious views, falls within the kind of conduct which is not protected by the guaranty of religious freedom."[16]

> The state's interest in safeguarding the health of children may outweigh parents' First and 14th amendment rights. The question is: When does a threat to a child's health justify state intervention?

Even if a child's life is not immediately endangered, courts have generally ordered treatment when the child's condition is nonetheless serious.[17] For instance, in a recent Pennsylvania decision, *In re Cabrera*,[18] the Superior Court ordered blood transfusions for a child with sickle-cell anemia over parental religious objection, even though the child was not in "imminent danger of death." The court ruled that "a patient [need not] be at death's door before medical intervention [is] allowed to alleviate (or even minimize) the likelihood of a patient sustaining a debilitating or even fatal injury." Thus, the family court's order in the measles cases, requiring the hospitalization of children who were seriously ill and possibly in imminent danger, seems clearly supported by case law.

The family court's hospitalization order is also arguably correct under Pennsylvania statutory law. A Pennsylvania law provides that a child will not be deemed an abused child if his or her parent fails to provide medical treatment in the practice of religious beliefs.[19] Another Pennsylvania statute, however, provides that the state may protect a child who lacks "proper parental care...necessary for his [or her] physical...health."[20] The city of Philadelphia argued that, although the children were not "abused" children, intervention was proper.

Other states have enacted clearer child-protection laws by combining into one statute what Pennsylvania has placed in two separate statutes. For example, Florida's child-protection law provides:

> [A] parent...legitimately practicing his religious beliefs, who by reason thereof does not provide specified medical treatment ...may not be considered abusive or neglectful for that reason alone, but such an exception does not ...[p]reclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician.[21]

This statute, while recognizing parents' First Amendment rights, nonetheless clearly permits state intervention when the health of a child requires it. Courts in Pennsylvania might be given better guidance if the state Legislature were to amend state law and adopt such a provision.

THE FAMILY court orders that require the immunization of the six children are more debatable. Because these children were not yet ill, the health risk to them was more attenuated than the risk to the children whom the court ordered hospitalized. Accordingly, it is less clear that the state's interest was sufficiently compelling to outweigh the parents' constitutionally protected rights.

The U.S. Supreme Court recognized that states have the power to require vaccination in *Jacobson v. Massachusetts*.[22] In this case the court upheld the constitutionality of a state compulsory-vaccination law against challenges that it interfered with personal liberty. All states, including Pennsylvania, have since enacted legislation requiring proof of immunization before a child enters school.[23] Nonetheless, Pennsylvania is among the states that grant a religious exemption. A Pennsylvania statute provides that "[the requirement that school age children be immunized] shall not apply in the case of any child whose parent or guardian objects in writing to such immunization on religious grounds."[24]

In the current situation, the city argued that the local measles crisis was so severe — with more than 900 cases and six deaths reported — that the parents' First Amendment rights were outweighed. The city also claimed that immunization was the least intrusive method to protect the children's health, since the alternative was continual monitoring of the children.

The city further argued that Pennsylvania's statutory exemption of school-age children from immunization was inapplicable because the children involved were preschool-age. Finally, the city maintained that it was empowered to act under another statute that says, "All departments of health...shall have full power, and shall make...such rules and regulations, which in their judgment may be proper and necessary, for the protection of public health."[25]

THE CITY'S argument that the threat to the children was serious enough to justify intervention in the absence of actual illness led the family court into uncharted territory. Although there are dicta in *Prince* suggesting that a state has power to protect the community and children from "communicable diseases" despite parental religious claims,[26] at least one court, under different circumstances, has explicitly refused to allow state intervention over parental religious objections when the children were not actually ill.

In *In re Appeal in Cochise County/Juvenile Action No. 5666-J*,[27] a child had died of an intestinal rupture that the mother allowed to remain untreated because of her religious views. The state sought to declare the mother's other children "dependent" on the grounds that the mother said that she would not provide medical care for them either if they were to become ill.[28] The Arizona Supreme Court, however, refused to declare the other children "dependent" because they were still in good health. The court found the state's interest in the health of the children insufficient to outweigh the mother's constitutional rights to raise a family and to exercise her religious beliefs.[29] The court noted that if any of the other children were to become ill, the state would then have sufficient justification to intervene.[30]

Although the *Cochise* court showed a reluctance to authorize state intervention in the absence of the actual illness of the children, the facts of that case seem distinguishable from the Philadelphia situation. In Philadelphia, the measles epidemic posed a specific and current threat to the children. Moreover, if any of the non-immunized children contracted measles, their lives could have been seriously jeopardized before the city realized that intervention was required. Finally, immunization is arguably less intrusive than the relief sought in *Cochise*.

The family court's immunization order also appears to be justifiable under Pennsylvania statutory law, although other states have more clearly empowered intervention in such situations. For instance, a provision in Maryland law indicates that when the state's secretary of health declares an emergency or epidemic, children may be immunized over parental religious objections.[31] The Pennsylvania Legislature could provide clearer guidance by specifying that in an emergency or epidemic, both school-age and preschool-age children may be immunized notwithstanding any religious exception.

Accordingly, the family court's immunization order plausibly construes Pennsylvania law and appears to be a constitutionally defensible exercise of the state's parens patriae authority, given the gravity of the measles epidemic in Philadelphia.

When constitutionally protected parental rights endanger the lives of children, courts consistently intervene. The rationale is most clearly stated in *Prince*: Parents are not free to deprive their children of the chance to reach majority and to decide then whether to embrace the parents' religion. The family court acted well within that tradition in ordering the hospitalization of ill children. The immunization orders were an extension of that doctrine, arguably mandated by the nature of the disease, the imminence of the threat of infection and the lack of adequate alternatives.

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(1) In re W.E., 304813-01 (March 4, 1991); In re K.E., 304813-02 (March 4, 1991); In re R.E., 304813-03 (March 4, 1991); In re E.S.H., 304813-01 (March

Continued on following page

Before a firm institutes a work force reduction, it should consider whether cost-cutting measures may be instituted in other areas. Reducing the size of a summer associate program, for example, could limit the firm's rate of growth without the risk of liability inherent in terminating current employees. Similarly, cost-cutting needs may be met by retraining an associate in another practice area rather than releasing the associate. In addition, the firm may make lateral hires based only on immediate need rather than on a perceived future benefit.

If the firm has decided that it must reduce its work force immediately, it should plan the involuntary reduction program paying close attention to adrealizes, for example, that most of the employees to be let go are minorities, it risks a discrimination claim.

One objective selection criterion often used in work force reductions is lack of seniority. A virtue of using length of service with the firm as a selection criterion is that the U.S. Supreme Court has held that seniority-based layoff is an absolute defense to claims of discrimination.[1] Even if a work force reduction based on employees' junior status affects a "disproportionate" number of protected employees, criteria promulgated by the Equal Employment Opportunity Commission provide that the negative impact will not constitute illegal discrimination.[2]

Generally, all a business has to do to implement a layoff based on seniority is to compare hire dates. A law firm may, instead, wish to compute seniority based on number of years of practice — an especially appropriate criterion in a firm with a large number

evaluations are based on a standard, graded form, a firm would be able to justify laying off those associates with the lowest grades.

If less standardized criteria are used, the firm should carefully review all personnel, performance and training records to make certain that it can clearly show why one associate was selected over another. Associate evaluations serve a dual purpose. Not only do they form the basis for determining advancement or compensation, but they also act as evidence in the event of an employment discrimination suit.

A firm may develop whatever selection criteria meet its needs. But if the selection process disparately affects a protected class, the firm's criteria must be demonstrated to be a business necessity.[3] In other words, the criteria must be demonstrably job-related.

Law firm economics, including partner-to-associate ratios, may heavily influence which attorneys are to be released. Partners are not immune from termination — and a firm may consider formally evaluating its partners just as it evaluates its associates. If partners are to be terminated, a firm should be prepared to justify its actions based on objective, quantifiable criteria — such as length of service, productivity, ability to train associates or ability to attract business.

Contractual Relationship

Although most attorneys are "at-will" employees — not employed pursuant to an employment contract — handbooks, manuals, policies, rules or other materials that have been distributed may form the basis for a claim that a contractual relationship has been formed. These documents should be reviewed to ensure that they contain no contractual commitments. For example, if an employee handbook disavows any contractual intent but states "In the event of layoffs, all terminations will be based on seniority" — and then the firm implements performance-based terminations — fired employees may base a breach of contract claim on the statement.

Other actions by firms may give rise to reliance-based contractual claims. For example, if an attorney resigns a position after being promised long-standing employment at another firm, employment relationship is not terminable at will. Although the existence of an oral contract may be difficult to prove, the firm should avoid making statements that could be interpreted as enforceable promises.

Severance Benefits

A firm may consider providing benefits to assist the terminated attorneys. If severance benefits are provided, the firm should give written notice of precisely what the attorney will receive. Firms should be careful not to otherwise encourage a lawsuit by treating similarly situated attorneys differently with respect to severance benefits. For example, if a third-year male associate is offered a certain amount in the form of severance pay, a terminated female associate in the same class should be offered the same amount.

If the firm intends to provide a terminated attorney severance pay or benefits, it should consider obtaining a waiver and release. A waiver and release bars the attorney from recovering damages. In order to make the waiver and release enforceable, some pay or benefits not ordinarily provided by the firm must be provided.

The critical event that comes between termination and a potential employment-related lawsuit is the dismissal interview. A tactful and positive exit interview may reduce the risk of litigation. Law firm consultants recommend that those conducting the dismissal be honest, give the attorney the full details of the situation, discuss support packages and references, specify time restraints and describe outplacement services if available.

News of terminations may damage the firm's reputation among potential recruits and rival firms. Nevertheless, if a work force reduction is necessary, the firm must consider whether its proposed termination policy would adversely affect members of any protected class and whether it can document non-discriminatory and neutral reasons for its actions. Without adequately guarding against possible liability, the firm ironically may be forced to defend itself against the same associates it trained to litigate.

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(1) 28 U.S.C. 2,000 et seq.

(2) Brotherhood of Teamsters v. U.S., 431 U.S. 324 (1977).

(3) 29 CFR Sec. 1607.4D.

Mr. Peyton is chairman of the labor department at Baltimore's Weinberg and Green. Mary E. Ryan, an associate at the firm, assisted in the preparation of this article.

Opposition to Medical Treatment Raises Constitutional Questions

Continued from preceding page

4, 1991); In re K.J.M., 308817-01 (March 4, 1991); In re J.R.R., 308819-01 (March 4, 1991).

(2) In re K.E., 232 Misc. 16 (March 8, 1991); In re R.E., 233 Misc. 16 (March 8, 1991); In re K.J.M., 234 Misc. 16 (March 8, 1991); In re W.E., 235 Misc. 16 (March 8, 1991); In re E.S.H., 236 Misc. 16 (March 8, 1991).

(3) In re R.E., 45 ED Misc. 1991 (March 8, 1991); In re K.J.M., 46 ED Misc. 1991 (March 8, 1991); In re E.S.H., 47 ED Misc. (March 8, 1991); In re W.E., 48 ED Misc. 1991 (March 8, 1991); In re K.E., 49 ED Misc. 1991 (March 8, 1991).

(4) The sixth child contracted measles and was therefore not immunized.

(5) 406 U.S. 205 (1972).

(6) 262 U.S. 390, 399 (1923).

(7) 405 U.S. 645, 651 (1972) (citations omitted).

(8) "Parens patriae" literally translates as "parent of the country" and refers to the role of the state as sovereign and guardian of persons under legal disability. Black's Law Dictionary 1008 (5th ed. 1979).

(9) 321 U.S. 158 (1944).

(10) Id. at 170.

(11) Id. at 166-67.

(12) 390 U.S. 598 (1968) (per curiam), aff'g 278 F. Supp. 488 (W.D. Wash. 1967).

(13) 278 F. Supp. at 504-05.

(14) Jehovah's Witnesses v. King County Hospital, 390 U.S. 598 (1968).

(15) See, e.g., J.V. v. State, 516 So. 2d 1133 (Fla. Dist. Ct. App. 1987) (blood transfusions to child held proper despite parental religious objections. N.E.2d 769 (Ill.) (same), cert. denied, 344 U.S. 824 (1952).

(16) Levitsky v. Levitsky, 190 A.2d 621 (Md. 1963).

(17) See, e.g., In re Eric B., 189 Cal. App. 3d 996, 235 Cal. Rptr. 22 (1987) (court ordered monitoring of child after chemotherapy completed); In re Sampson, 37 A.D.2d 668, 323 N.Y.S.2d 253 (1971), aff'd, 278 N.E.2d 918 (1972) (rejecting argument that state intervention is permitted only when the life of the child is in danger). But see In re Green, 292 A.2d 387, 392 (Pa. 1972) ("as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is *not immediately imperiled* by his physical condition").

(18) 552 A.2d 1114, 1120 (Pa. Super. Ct. 1989).

(19) 11 Pa. Stat. Ann. Sec. 2203 (Cum. Supp. 1990).

(20) 42 Pa. Cons. Stat. Sec. 6302 (1989).

(21) Fla. Stat. Ann. Sec. 415.503(8)(*f*) (West Supp. 1989).

(22) 197 U.S. 11 (1905). See also Zucht v. King, 260 U.S. 174 (1922) (municipality can require a child's vaccination as a condition for attending school).

(23) Comment, "The National Childhood Vaccine Injury Act of 1986: A Solution to the Vaccine Liability Crisis?" 63 Wash. L. Rev. 149, 150 (1988).

(24) 24 Pa. Stat. Ann. Sec. 13-1303a(d) (1989).

(25) 53 Pa. Stat. Ann. Sec. 14-401 (1989).

(26) Prince, 321 U.S. at 166-67.

(27) 650 P.2d 459 (Ariz. 1982).

(28) Id. at 460.

(29) Id. at 463, 465.

SB

288

No. 1

FISCAL NOTE

Bill Version: SB 288

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL (S) Publish Date: 5/13/91

Revision Date:
Dept. Affected: Health and Social Services
Title: Audits and Inspections of Certain Health Facilities/Results used for payment & Ratesetting
BRU:
Component:
Sponsor: Rules Committee
Requestor: Governor
COMPONENT SERIAL NO.

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY92	FY93	FY94	FY95	FY96	FY97
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	940.0	1,128.0	1,354.0	1,624.0	1,949.0	2,339.0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

Revenue is calculated assuming that one percent of facility medicaid expenditure is recouped through audits. Fifty percent of these collections will be returned to the federal government.

See attached for further analysis.

Prepared by: Jay A. Livey, Deputy Commissioner
Phone: 465-3030
Division: Office of the Commissioner
Date: 4/26/91

Approved by Commissioner: Theodore A. Mala, MD, MPH
Date: 4/30/91
Agency: Department of Health and Social Services

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

(Rev 10/90)

ANALYSIS (cont.):

If this legislation passes, there is no expenditure impact because the Department will continue its current auditing activities. However, there is a positive revenue impact to the State because the legislation will allow the Department to be able to continue to audit into the future. Based on departmental experience and Medicare audit results, the Department estimates that, annually, one percent of future expenditures can be recouped as a result of audits.

If this bill were to not pass, the legal confusion resulting from the Cordova decision would make it difficult for the Department to be able to recoup any funds through audits from health providers for overpayments made by the Department during past years nor would the Department be able to recoup future overpayments. The Department has estimated that potential recoveries from audits for fiscal years 1985 through 1991 will range from between $7,000,000 and $10,000,000. Additionally, without this legislation it is possible that the revenue identified in the fiscal note would not be collected. It should be noted that because Medicaid is a federal participation program, fifty percent (50%) of audit collections would be returned to the federal government.

If the State were not allowed to recoup funds based on audit findings, the Federal government would still expect their share of overpayments to facilities for medicaid patients to be returned to them for both past and future years. Even though the State would not be aggressively auditing facilities, the Federal government would be auditing the State rate setting process and refusing to participate in payment rates which are questioned through an audit. We anticipate that these audits would result in a state liability for past years that is less than the audit finding projected above but one that could still be significant. The Department has projected that without the statutory ability to audit, recoup, and incorporate the findings into future rates, Federal audits of the State rate setting process could result in a State liability of approximately $850,000 per year for fiscal years 1989, 1990 and 1991. State liability in future years will depend upon the degree of aggressiveness with which the Federal government audits.

WALTER J. HICKEL
GOVERNOR

281

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

May 13, 1991

The Honorable Richard I. Eliason
President of the Senate
P.O. Box V
Juneau, AK 99811

Dear President Eliason:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to audits and inspections of health facilities receiving payment for medical assistance for needy persons and to the use of audit and inspection results in recapturing overpayments and reimbursing underpayments to such health facilities.

The bill has three major components: the findings of the legislature concerning its intent on the role of audits and inspections in state medical assistance programs; expressly stating in statute the legislature's intent that the results of Department of Health and Social Services' audits and inspections be used in setting prospective rates to facilities; and expressly stating in statute the legislature's intent that the department collect for overpayments made to facilities, and issue additional payment to facilities if the audit or inspection shows an amount due.

The bill is needed to clarify that, from the time it established a prospective rate system for the medical assistance program in 1983, the legislature intended that the department use audit and inspection results in setting prospective rates, adjusting payments to facilities, collecting for overpayments, and reimbursing for underpayments to facilities. The bill is necessary because the Alaska Supreme Court ruled in City of Cordova v. Medicaid Rate Commission, 789 P.2d 346 (Alaska 1990), that the rate-setting statute for facilities in the medical assistance programs (AS 47.07.070) was silent on the subject of prospective recoupment from a facility based on audit results and, therefore, precluded recoupment by the department. Given the substantial commitment of public money to medical assistance

programs, it is important for the legislature to more clearly affirm its position that the department use audits and inspections to monitor the spending of that money to appropriately adjust rates, to seek reimbursement for overpayments, and to pay the facilities additional money in the case of underpayments.

Failure to adopt this bill will likely result in additional litigation regarding the use of these audits, with a substantial amount of money at issue. I urge your prompt and favorable action on this legislation.

Sincerely,

Walter J. Hickel

Walter J. Hickel
Governor

PROPOSED CHANGES TO
SB 288

From the Department of Health & Social Services

Page 3, Line 11:

Insert after "shall" **for the facility's fiscal year beginning after June 30, 1992**

Page 3, Line 13

Insert after "facility" **based upon prospective rates set after July 1, 1992.**

Page 3, Line 17:

delete Sec. 4., renumber following sections.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

March 31, 1992

Senator Arliss Sturgulewski
Room 427
State Capitol
Juneau, Alaska 99811

Dear Senator Sturgulewski:

Yesterday you expressed interest in the status of SB 288. This bill was introduced after the Alaska Supreme Court ruled that the Department of Health and Social Services does not have the authority to recapture funds from health care facilities when audits disclose differences of opinion over accounting methods.

The court said the department could recapture funds under other circumstances including cases of fraud or misrepresentation.

The bill as it was introduced would give the department the authority to conduct audits in any manner and at any time they choose and then recapture funds from the facilities.

The audit staff in the department has a backlog of work that goes back as far as 1986.

The Alaska State Hospital and Nursing Home Association (ASHNHA) believes that it is unreasonable for the department to be allowed to recapture funds that are the subject of disagreements over accounting methods when the audit raising the issue is six years late.

The department audit staff works without formal regulations, without standard audit programs or procedures and the ASHNHA membership believes that structure should be developed.

With that in mind, we have worked with department audit personnel and the Commissioner's Office over the past eight months to try to convince them to take a more comprehensive approach to SB 288.

ASHNHA members worked with me to develop the attached bill draft which we believe will produce an auditing program that will work for the state, for ASHNHA members and keep our prospective rate setting system intact.

Senator Fischer chaired a meeting of the interested parties and ASHNHA and the department each agreed to consider several compromise language changes.

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When we next met (without Senator Fischer) the department said they can not accept ASHNHA's approach to the legislation and asked if we would be willing to let the bill die and work on the structural problems during the coming interim.

The ASHNHA negotiators agreed to continue working with the department on this problem through the interim because we believe a bitter fight over the original version of SB 288 would be detrimental to the working relationship between the department and the facilities.

Senator Fischer has tried to help find a way for the department and facilities to agree on an audit process. The department however, still resists the development of a formal written process.

As you know, the Division of Legislative Audit adheres strictly to policies and procedures governing the conduct of their audits. They follow standard procedures for discussing audit findings with the auditees and reporting those findings and conclusions to the Legislature. By doing so, they maximize efficiency and both the auditors and auditees are clear on how the process works.

We believe that the Department of Health and Social Services should conduct their audits under a process that is at least as well defined and documented as that followed by the Division of Legislative Audit.

We request that you allow ASHNHA and the department to work together on this issue and let us drop SB 288 for this year. Passage of that bill will only lead to an acrimonious relationship between the state's health care facilities and the department.

Please let me know if you would like to discuss this issue in more detail.

Sincerely,

Garrey M. Peska, C.P.A.
Vice President - Finance

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

DRAFT OF PROPOSED COMMITTEE SUBSTITUTE FOR SB 288

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to audits of health facilities receiving payment for medical assistance for needy persons and to the use of audit results in setting prospective rates, recapturing overpayments and reimbursing underpayments to such health facilities; and providing for an effective date."

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

*Section 1. PURPOSE. The amendments of AS 47.07.070 in this Act are adopted to

(A) provide a sound basis for the state to set prospective rates of payment to health facilities;

(B) clarify the process by which audit adjustments may be used to set prospective rates;

(C) clarify the process by which audit adjustments may be retroactively recaptured or reimbursed.

Section 2. AS 47.07.070 (a) is amended to read:

(a) The department shall set the prospective rate of payment to a health facility under this chapter and AS 47.25.120 -- 47.25.300 based on a fair rate for reasonable costs incurred by the facility. <u>In setting a rate the department may utilize the results of department audits as specified in 47.07.070 (g).</u> The department may not set a rate until after a public hearing before the Medicaid Rate Advisory Commission except that this hearing requirement is not applicable if a new rate is immediately necessary to afford adjustmental relief to a facility as determined under regulations

adopted by the department. The department shall by regulation list the factors it considers in making its rate determinations under this section. A rate set under this section does not take effect until it is approved in writing by the commissioner of health and social services or the agency assigned by the commissioner to perform this function. The written determination of the basis of the findings and conclusions, a citation to the regulations supporting the findings and conclusions, and a statement of the decision.

*Section 3. AS 47.07.070 is amended by adding a new subsection to read:

(g) The department may conduct audits of a health facility's records to assure compliance with regulations promulgated under this chapter. Using the results of departmental audits, the department shall ;

(1) set prospective rates based on audit adjustments which have been prepared within six months of the later of the date the cost report is due or submitted and which have been agreed to by the facility and the department. Adjustments which are not agreed upon are addressed in (2) of this section;

(2) recapture overpayments or reimburse underpayments which are due to fraud, intentional misrepresentations or final resolution of disputed audit adjustments. The disputed audit adjustments must have been identified in (1) of this section. The recapture or refund may be by assessment, adjustment to the facility's prospective rate or withholding from payments due to the facility or the department.

(3) promulgate regulations governing the conduct of Medicaid audits of health facilities. The regulations adopted shall include definitions of:

(A) field audits and desk audits

(B) scope and purpose of audits for Medicaid purposes

(C) timing of audits

(D) timing of and procedures for disclosure of audit findings to facilities

(E) procedure for calculation of fiscal impact of proposed audit adjustments

(F) process for facilities to appeal audit findings

(G) process for auditing Medicaid Rate Advisory Commission staff reports used to set rates

*Section 4. This Act takes effect immediately under AS 01.10.070 (c).

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

January 21, 1992

Senator Arliss Sturgulewski, Chair
Senate Health, Education & Social Services Committee
Room 427, Capitol Building
P.O. Box V
Juneau, Alaska 99811

Dear Senator Sturgulewski:

Senate Bill 288 is:

> "An Act relating to audits and inspections of health facilities receiving payment for medical assistance for needy persons and to the use of audit and inspection results in recapturing overpayments and reimbursing underpayments to such health facilities; and providing for an effective date"

This bill is currently in the Senate Health, Education & Social Services Committee.

The Alaska State Hospital and Nursing Home Association (ASHNHA) is opposed to SB 288.

The current Medicaid reimbursement system is a prospective rate setting system. Each facility's reimbursement rates are negotiated and set before the beginning of the fiscal year. If the facility is efficient and costs are lower than the pre determined Medicaid reimbursement rate, the facility shares a profit with the state. If they are inefficient and costs exceed the reimbursement rate, the facility takes a loss.

SB 288 would change the Medicaid reimbursement system to allow for recoupments based on audits completed long after the end of the facility's rate year.

The attached June 27, 1991 letter from Gary Grandy, Administrator of Petersburg General Hospital details the objections facilities have to this attempt to create a retrospective reimbursement system through audit findings.

The attached July 1, 1991 letter from Stephen Rose of Inslee, Best, Doezie & Ryder, P.S. details the legislative history of the statutes which established the prospective Medicaid reimbursement system in Alaska.

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According to research done by Mr. Rose, the Federal Government has recognized this problem. The Health Care Financing Administration (HCFA) asked for comments on the subject in 1981 and offered the following statement:

> ". . . we are concerned that the retroactive adjustments in payments that could be required as a result of audit findings might, in some cases, conflict with the requirements of State payment systems. This potential for conflict could arise because some payment systems, especially those that use prospectively determined class rates, do not allow adjustments to be made after a payment rate is determined." (Emphasis mine)
>
> (HCFA Request for Comments, 46 Fed.Reg. 47,967 - 1981)

After reviewing comments on the issue, HCFA decided not to require retroactive adjustments in conflict with prospective payment systems.

ASHNHA membership believes that the state must have the authority to conduct timely audits of the facilities.

ASHNHA membership further believes that the state currently has sufficient authority to conduct timely audits and use audit adjustments in setting facility reimbursement rates.

The primary ASHNHA objection comes when the state conducts audits years after the end of the fiscal year under audit then tries to recoup costs based on those audits.

Audits of 1985 facility operations are still not completed. ASHNHA membership believes that backlog is unacceptable. Facility costs incurred in 1985 were used to set reimbursement rates for 1987. It does not seem reasonable at this late date for the state to attempt to recoup costs that were set five years ago under a prospective reimbursement system.

Please let me know if I can answer questions or provide your committee with additional information.

Sincerely,

Garrey M. Peska, C.P.A.
Vice President for Financial Affairs

Enclosures

PETERSBURG GENERAL HOSPITAL
and Long Term Care Facility
Phone: (907) 772-4291
P.O. Box 589
Petersburg, Alaska 99833

June 27, 1991

Theodore A. Mala, M.D., M.P.H.
Commissioner
Department of Health & Social Services
P.O. Box H
Juneau, Alaska 99811-0601

Dear Commissioner Mala:

Re: 1985 Audit Issue & Senate Bill No. 288

On June 18th, 1991, Karl Garber, Financial Officer for our Lady of Compassion Care Center, and I met with Jay Livey by teleconference regarding the status of the 1985 Appeals and the Senate Bill No. 288. As a follow-up to that meeting, I am writing you to ascertain that you understand some of the issues that remain unresolved and to solicit your assistance in reaching a satisfactory decision for all concerned.

I re-emphasize what I stated when Mr. Garber and I met with you on April 9th, 1991, that my bottom line concern is to put an end to the continuing legal fees that are costly for both the facilities and the State of Alaska.

Therefore, it is imperative that you understand our position. First, we believe that the State's position that there are millions of dollars that need to be recovered from the facilities is a wrong premise for the following reasons:

1. The Supreme Court Decision in the City of Cordova, et el vs. Medicaid Rate Commission, closed the door on recoupments. The only issue arguably left open is whether a Common Law right to recoupment exists based on "false information to the Commission" or whether it was disagreements on "varying interpretations of a 'reasonable allocation method'". I maintain that the latter situation occurred and the Supreme Court does not indicate that this is justification for a Common Law right of recoupment (Opinion, Supreme Court No. 5-3030, 3AN-89--267 Civil, page 11).

   I further maintain that the Affidavit of Michael R. Sanders, Audit Manager, Department of Health and Social Services, stating the "false information" submitted by the facilities is not false information; instead, they are disagreements based on varying interpretations of allocation methods. Please also understand that we do support recoupments where fraud and abuse can be proven.

2. An understanding of a "Prospective" system versus a "Retrospective" payment system is also imperative. A storekeeper who beforehand (prospectively) places a price on a loaf of bread in order to sell that loaf and the buyer of that loaf of bread, who in good faith purchases the loaf, does so with an understanding that six years later the storekeeper is not going to knock on his door and demand additional money for all the loaves bought because the storekeeper has now found that there were disagreements over how accountants determined certain aspects of the original price of the original loaf. Instead, the storekeeper and the buyers settle the accounting disagreements; the storekeeper sets a new price for the future loaves (prospectively) and life moves on.

I remind you that in the case of Petersburg this has already happened. As an example, we disagreed originally over the visiting physician space; we conceded and every Medicare-Medicaid report since then has carved out the costs of the visiting physician space, thus setting the most accurate rates possible for all years since then--because we are on a prospective system.

Does the Department desire to return to a retroactive system of recoupment? Senate Bill 288 certainly does this. In the present form, ASHNHA will vigorously oppose this legislation for the following reasons:

1. It attempts to rewrite history for the past eight years. Has the legislature ever passed a law that retroactively took money from facilities--say schools, for example?

2. It would seem that for the legislature to pass the bill, it would invalidate the State plans that have been filed with HCFA for the fiscal years involved. Those State plans are based on a prospective system and rules and regulations that the Supreme Court has upheld as having no valid recoupment possibility. Why would the legislature muddy the waters by invalidating State plans?

3. Senate Bill 288 is unconstitutional and would be at odds with the legality of "rights acquired by judgement are property rights which cannot be taken without due process of law". And that due process, taken clear to the Alaska Supreme Court, upheld the facilities' rights of no recoupments.

4. I have personally read much of the history of the present Medicaid Statutes and it is replete with indications of a "prospective" system and a "payment rate prior to the fiscal year as a result of discussions between each facility and the State." In other words, a prior agreed upon contract, which had no mention of recoupments--which is a retrospective system. The retrospective system was being abandoned for a new prospective system.

For the sake of brevity, I will not present additional comments at this time. I will conclude by recommending a solution that might meet the needs of the Department and the facilities. We respectively request the Department to withdraw their motion for continuance of the Appeals on Medicaid Audits and allow for their speedy resolution. At least some of the Department's paranoid fears that the Federal Government is going to come "down" on you are not merited. You have complied with your "State Plans", which were based on a prospective system, with no recoupments mentioned.

Next, if the Department desires to have a system that provides for audit recoupment in the future, then I recommend that the Department and the facilities work together and carefully review all of the present regulations, such as year-end conformance and audit procedures, and/or look at a new system route to reach a consensus that can jointly be placed in the bill to affect its passage for future years, but let us not try to rewrite history. That would only set off another round of lawsuits and be very expensive for all concerned.

Believe me, to ignore these recommendations is going to continue the age-old gap between the Department and the facilities. Commissioner Mala, I do not believe that you want that anymore than I do. It is an expensive, ridiculous position for both of us.

To this end, please lend your support to a meeting with Jay Livey, when Mr. Livey returns from his vacation, and some of the facility representatives, to see if we can resolve our differences in a cooperative, open manner. Lastly, and to impress upon you the frustration of this situation which I have seen for nearly five years, the stack of papers on this matter on my desk now measures 12 inches deep. That is a lot of dialogue and represents a lot of legal fees that have been paid.

Please feel free to call or write on this matter. If I do not hear from you, I will trust that you will request those in your Department, who are involved, to work with us in a manner of cooperation to expedite an early and final solution to these problems.

Sincerely,

Gary W. Grandy
Administrator

cc: Jay Livey
Harlon Knutson--ASHNHA
Karl Garber

INSLEE, BEST, DOEZIE & RYDER, P.S.

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July 1, 1991

Please respond to

869-3428

VIA FACSIMILE

Mr. Harlan Knudson
Alaska State Hospital and
Nursing Home Association
319 Seward Street #11
Juneau, AK 99801-1173

Re: SB 288

Dear Mr. Knudson:

Brian Gilbert of Cordova Community Hospital has asked me to share with you an analysis I prepared regarding the Legislative History of the statutes which established the Medicaid prospective payment system in Alaska. As is demonstrated below, it was never the Legislature's intent to establish a recoupment program based on audit results.

SB 288 distorts reality. Namely, SB 288 is an attempt to rewrite the Medicaid statutes to allow for retroactive recoupments based upon audit results.

When you read SB 288 you will note that the Department claims that this Bill "clarifies" the Legislature's intent and that the Legislature always intended to use audits to adjust rates. Nothing could be further from the truth. It is misleading to call this Bill a "clarification". It is nothing less than an attempt to completely alter the Medicaid payment system. In fact, when the prospective payment system was first passed in Alaska, it was the Department who testified before the Legislature that each facility would have to operate and provide care at the rate determined prior to each fiscal year.

Below are excepts from the testimony presented to the Legislature supporting the prospective payment legislation.

Prior to 1983 the Medicaid program in Alaska reimbursed health care facilities based upon the "reasonable costs" incurred by the facility for patient care. (AS 47.07.070, Repealed § 3, ch. 95 SLA 1983). The methodology in 1983 was retrospective cost-based. The Commissioner for the Department of Health and Social Services in his Position Paper regarding H.B. 19 in May of 1983 described this methodology as follows:

> Hospital and Nursing home [sic] rates in Alaska have traditionally been established retrospectively, that is, costs are estimated at the beginning of a fiscal year and an "interim payment" determined. At the end of the fiscal year, the total interim payments made is [sic] compared to the allowable costs of the facility. The difference is either collected from or paid to the facility. This process is referred to as "cost settlement." (Emphasis added).

The Medicaid methodology was called retrospective because the final reimbursement calculation was made after the patient's treatment. The system was "cost-based" because the measure of reimbursement was based on expenditures actually made by the health care facility.

Major deficiencies in the cost-based reimbursement system began to be realized. Since health care providers were reimbursed for their expenditures actually made, the provider earned additional income for each service rendered. It became apparent that a cost-based retrospective methodology simply lacked incentives for health care providers to hold down costs. (See, 50 Fed. Reg. 24, 459 (1985)).

In 1983 the State of Alaska made the decision to abandon its retrospective cost-based system and to adopt a prospective budget based system. (AS 47.07.070, Repealed, § 3, ch. 95 SLA 1983). The Legislature made the following finding in 1983:

> The legislature finds that, because Medicaid is a joint state and federal program and because federal Medicaid funds have been and are likely to continue to be reduced dramatically, a retrospective payment system no longer serves as an appropriate method of compensation . . . A prospective payment system is

> necessary to prudently address payments to health facilities under Medicaid and general relief medical assistance programs. (Emphasis added).

In 1983 the State of Alaska began implementation of a budget based prospective payment system and established the Medicaid Rate Commission (See, Ch. 95, SLA 1983 recorded at AS 47.07.070 and AS 47.07.180; 7 AAC 43.670 (Reg. 92, Jan. 1985)).

The Alaska State Legislature in 1983 directed the Department of Health and Social Services to establish a Prospective Payment System to be administered by the newly created government body called the Medicaid Rate Commission. (AS 47.07.070 and AS 47.07.180, Ch. 95, SLA 1983).

In 1983, AS 47.07.070 was amended to read in pertinent part:

> The [medicaid rate] commission shall determine prospectively the rate of payment to a health facility under this chapter . . . (Emphasis added).

AS 47.07.070(a), § 1, Ch. 182, SLA 1972; am § 3, Ch. 95, SLA 1983.

The implementing regulations stated in pertinent part:

> PROSPECTIVE PAYMENT RATES DEFINED. (a) Prospective payment rates are prospectively determined payment rates to be paid by the department to health facilities providing health care services to recipients of the Medicaid and General Relief Medical Programs.
>
> (d) Prospective payment rates will have an effective date. All services provided before the effective date will be paid by the department at the preceding rate. All services provided on or after the effective date will be paid by the department at the new prospective payment rate. (Emphasis added).

Many attempts were made to pass prospective payment system legislation prior to the actual passage in 1983. Certain topics recur throughout the proposed legislation as cornerstones of the prospective payment system. First, the prospective payment system required the up-front negotiation of

rates which would then be fixed for the fiscal period to which they applied. Second, the year-end recoupment and cost settlement practices were to be eliminated. Third, the reimbursement system was to be based on current budgeted costs as opposed to actual costs incurred.

On January 27, 1983, SB 85 was introduced in the Senate. Testimony before the Senate HESS Committee addressed the need for the establishment of a prospective payment system. SB 85 was later replaced by a Committee Substitute draft of SB 85 (CS SB 85 (HESS)).

On April 4, 1983, the Department of Health and Social Services again issued its Position Paper on CS SB 85.

The Position Paper on CS SB 85 begins with an overview of the Medicaid reimbursement in Alaska and notes:

> Prospective payment, on the other hand, provides for the establishment of the payment rate prior to the fiscal year as a result of discussions between each facility and the State, each facility must then operate and provide care at this predetermined rate for the fiscal period. (Emphasis added).

On February 23, 1983, Frank W. Seuffert, a researcher for the State Advisory Council, prepared a Memorandum for Senator Kerttula, regarding SB 85. In pertinent part, researcher Seuffert's Memorandum states:

> Prospective reimbursement would be desirable for Medicaid and GRM for the following reasons: (1) It encourages cost containment by giving hospitals a set target over which they make a profit, under which they accept a loss . . .

In keeping with its previous Position Paper which noted that there would be no retroactive cost settlement with a prospective payment system, Position Paper CS SB 85 notes that one of the "major provisions of SB 85" is the repeal of the definition of "cost settlement" as was contained in AS 47.07.080(a).

On April 18, 1983, Mr. Betit, Director of the Department's Division of Public Assistance, testified before the House Finance Committee regarding the House counterpart to CS SB 85.

Mr. Betit explained that the prospective payment system as detailed in CS SS HB 19 provided for up-front negotiations before the fiscal year started in order to "set" the prices which the Department would pay. Mr. Betit stated that this approach would "give us greater certainty about what it is we are spending . . . and hold the hospitals and nursing homes to these prices for the duration of the year". (Emphasis added). (House Finance Committee Hearing on CS SS HB 19 (Fin.), April 18, 1983, recorded on tape HFC 83-45.

Mr. Betit concluded his testimony by commenting on year-end and audit procedures stating:

> There would be no cost settling or getting . . . basically . . . either paying up or recouping from the hospital at the end of each fiscal year as presently goes on. (Emphasis added).

The prospective payment system legislation was formerly adopted by the Legislature and became law. (AS 47.07.070, Ch. 95, SLA 1983). After the prospective payment system was adopted, the Medicaid Rate Commission listed its objectives for this new system. One objective was to "provide predictability" for state program expenditures to health facilities. (7 AAC 43.674(2)).

In order to comply with the new prospective payment system legislation, organizational changes had to be made within the Department of Health and Social Services. The first change was the creation of the Medicaid Rate Commission. (AS 47.07.070, Ch. 95 SLA 1983). The second major change was the elimination of the "audit function".

This complete elimination of the audit function is described in the Legislative Audit of the Department of Health and Social Services for Fiscal Year 1985 (hereafter "1985 Legislative Audit") as follows:

> Prior to [the establishment of the Medicaid Rate Commission] health facility providers submitted cost settlement reports at year-end which were then reviewed and/or audited by DHSS auditors. This procedure was in effect under the retrospective payment system of cost settling with Medicaid health facility providers. Subsequently, statute changes required that Medicaid health facility providers be

> paid under a prospective payment system. Under the prospective payment system, patient day rates are established based on estimated reimbursable costs submitted by the provider and approved by the MRC [Medicaid Rate Commission]. The audit positions that previously performed the audits were transferred to the MRC. However, these positions were reclassified to budget analysts. No audit positions have been established at the MRC. (Emphasis added).

The Executive Director of the Medicaid Rate Commission, Dr. Charles L. Eveland, prepared an Organizational Chart of the Medicaid Rate Commission which showed the replacement of the auditor positions by Program Budget Analysts.

With the implementation of the prospective payment system in Alaska, all audit functions of the Medicaid program ceased. Since the prospective payment system was budget based, it is not surprising that the executive director established three program budget analyst positions to replace the no longer needed auditor positions. Also, since the legislature repealed the definition of "cost-settlement", the legislature made clear its intent to end the year-end audit and cost-settlement process.

Having reviewed the Legislative History behind Alaska's prospective payment system, there is no doubt in my mind that it never contemplated recoupments being taken based on audits. SB 288 euphemistically calls itself a "clarification" of Legislative Intent. It is not. SB 288 represents a radical departure from the prospective payment system.

Very truly yours,

INSLEE, BEST, DOEZIE & RYDER, P.S.

Stephen D. Rose

SDR:ab
3141s

Kodiak Island Hospital
& Care Center

1915 E. Rezanof Drive
Kodiak, AK 99615
(907) 486-3281 FAX (907) 486-2336

February 4, 1992

Senator Arliss Sturgulewski
Room 427, Capitol
P.O. Box V
Juneau, AK 99811

Dear Senator Sturgulewski:

I am writing to encourage your vigorous opposition to SB 288 which would allow the State to make recoupments based upon audits completed long after the end of the facility's rate year. This bill would restore facilities to a retrospective system for recoupments, while the facility is based on a prospective rate system. This means that the State sets the rates for facilities based upon base year costs and the rates are then set prospectively for the year. To permit audits going back several years, or retrospective audits, undermines the prospective payment system. This sets up situations where the State may go back after a three, four or five year period and determine that certain costs that were allowed should not have been allowed and to make recoupments.

The problem with this system is adequately outlined in letters from the Alaska State Hospital and Nursing Home Association to Senator Arliss Sturgulewski and to Commissioner Mala.

I encourage you to vote no on this bill.

Sincerely,

Edmon W. Myers
Administrator

EWM/dpr

EXAMPLE OF PROSPECTIVE 1993 RATES BASED ON AUDITED INFORMATION
FOR FACILITIES WITH A 12/31/91 FISCAL YEAR END

	Desk Review	Field Audit
3/31/92	Cost Reports to Department	
4/30/92	Department's Request for Desk Review Items	
5/31/92	Facilities Response to Request.	
6/30/92	Department's Preliminary Desk Review Report (PDRR).	Department's Decision to do a Field Audit.
7/31/92	Facilities Response to PDRR.	
8/31/92	Department's Final DRR (FDRR).	Department's Field Audit Completed.
9/30/92	Facilities Appeal Deadline on the FDRR.	Department's Preliminary Audit Report (PAR).
10/30/92	Facilities submit Year-end Submittal to the Department.	Facilities Response to PAR.
11/25/92	Department proposes the rate to the Facilities based on unappealed FDRR items.	Department proposes the rate to the Facilities based on agreed-to PAR items.
	Appealed items would be settled at the time the appeal is finally resolved.	Disagreed PAR items would be settled at the time the Audit and any related appeals are finally resolved.
12/15/92	MRAC recommends rate.	
12/31/92	Department sets rate.	

rates:fin

SB 288
Navy Peck
2/7/92

The ASHNHA members are not opposed to the department having the authority to conduct Medicaid audits.

The members believe rates should be set based on timely audit information.

They are opposed to this bill because it reverses the basic concept of prospective rate setting in Alaska's Medicaid reimbursement system.

We have a prospective rate setting system now.

That means each facility's reimbursement rates are negotiated and set before the beginning of the fiscal year.

If the facility is efficient and costs are lower than the pre determined Medicaid reimbursement rate, the facility shares a profit with the state.

If they're inefficient and costs exceed the reimbursement rate, the facility takes a loss.

SB 288 would change the Medicaid reimbursement system to allow for recoupment based on audits completed long after the end of the facility's rate year.

The department has an audit backlog that spans several years now.

The facilities don't think it's reasonable to do an audit 4 or 5 years late and then ask them to pay money back to Medicaid because the audit discloses misinterpretations or disagreements over the meanings of regulations.

If fraud is indicated, ASHNHA believes the state does have and should have the authority to recover the funds.

In the Supreme Court decision that caused the state to introduce this bill, the Court said:

> "We would have no hesitation in ordering a refund of money which had been awarded based on false representations. Likewise, if the grant had been expended for an illegal purpose, a refund would be appropriate. However, those situations do not exist here."

ASHNHA finance officers have offered a number of suggestions for how the department might be able to clear up the audit backlog and stay current.

For example: ASHNHA members believe the department should make more use of desk audits instead of full field audits especially for the facilities that receive the least amount of Medicaid funds.

SB 288
2/7/92

We believe the department auditors should focus their audit procedures on those financial areas that affect the prospective rate setting process.

We see audit adjustments that reclassify assets or revenue accounts when those adjustments have no affect on Medicaid reimbursement rates. We also see audit adjustments for $5 or $10.

The current year Medicaid appropriation for facilities is $109 million. $5 and $10 adjustments are not worth the auditors' time.

Generally, auditors will establish a materiality threshold and they won't even bother with audit adjustments below the threshold dollar amounts.

ASHNHA members believe that the department's Medicaid audits could be done on a timely basis if the audit scope and purposes were better defined.

If this bill is to pass, ASHNHA members believe it should include a requirement that the Medicaid audits be timely completed.

ASHNHA members believe timely completed means within six months of the date the facility has to submit the final Medicaid cost reports for the year.

ASHNHA members also suggest that the bill should require the department to promulgate regulations governing the conduct of Medicaid audits of hospital and nursing home facilities.

That should include definitions of:

(A) Field audits and desk audits
(B) Scope and purposes of audits for Medicaid purposes
(C) Timing of audits
(D) Timing of and procedures for reflecting audit findings in rate setting
(E) Process for facilities to appeal audit findings

The ASHNHA Health Care Financing Committee met this week and reviewed the language the department said they were going to propose as a Committee Substitute for the bill.

The ASHNHA Finance Committee has problems with big chunks of the committee substitute and we're drafting alternative language to submit.

Now that we have the official CS, we can identify the specific page and line numbers for amendments.

I would be happy to answer questions about the work we've been doing with the department on this issue.

There are finance officers from facilities in Anchorage waiting to testify this morning also and they might fill in any holes I've left.

THE SUPREME COURT OF THE STATE OF ALASKA

CITY OF CORDOVA, ALASKA, a Municipal Corporation, and PETERSBURG GENERAL HOSPITAL, Appellants, v. MEDICAID RATE COMMISSION, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, STATE OF ALASKA, Appellee.	Supreme Court No. S-3030 3AN-88-267 CIVIL O P I N I O N [No. 3578 - March 30, 1990]

Appeal from the Superior Court of the State of Alaska, Third Judicial District, Anchorage, Karen L. Hunt, Judge.

Appearances: Stephen D. Rose, Inslee, Best, Doezie & Ryder, P.S., Bellevue, Washington, Scott A. Sterling, Jensen, Harris, & Roth, Anchorage, for Appellants. Lawrence C. Delay, Assistant Attorney General, Anchorage, Douglas B. Baily, Attorney General, Juneau, for Appellee.

Before: Matthews, Chief Justice, Rabinowitz, Burke, Compton, and Moore, Justices.

RABINOWITZ, Justice.

I. INTRODUCTION.

This appeal involves attempts by the Medicaid Rate Commission ("the Commission") to recover $167,361.00 paid by the State to the City of Cordova, owner and operator of the Cordova Community Hospital ("Cordova"), and $26,036.56 paid to the Petersburg General Hospital ("Petersburg") for Medicaid services provided by the two hospitals during 1984-85.

II. FACTS AND PROCEEDINGS.

In 1983, the legislature adopted a prospective payment system for Medicaid.[1] Under the old, retrospective system, health care facilities were reimbursed by Medicaid based on the "reasonable costs" incurred by the facility for patient care. Under the new, prospective system, facilities are reimbursed by Medicaid at rates determined by the Commission in advance of the provision of services by the facilities. See AS 47.07.070(a). The prospective system provides an incentive for facilities to minimize their costs because a facility providing a service at a cost less than the pre-determined rate is permitted to keep the difference ("earns a profit"), while a facility providing the service at a cost greater than the pre-determined amount suffers a loss in the amount of the difference.

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1. Ch. 95, SLA 1983.

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The hospitals submitted budgets and requests for prospective payment rates for their fiscal year (FY) 1985, ending June 30, 1985. These budget requests were reviewed by one of the Commission's program budget analysts. A staff analysis for each of the two hospitals was performed and the budget analyst recommended prospective payment rates for each. The Commission thereafter adopted prospective payment rates for the two hospitals, and paid them for Medicaid services based on these rates.

In the summer of 1986, the Commission began to audit the budget forms and rate requests submitted by health care facilities, including those submitted by Cordova and Petersburg for FY85. Cordova's field audit was conducted in January of 1987. The final audit report was completed in November of 1987. At its December 11, 1987, meeting, the Commission (whose members at this meeting included Mr. Randy Super, designated as a member of the Commission by the Department of Health and Social Services (DHSS) Commissioner Myra Munson) voted to accept the audit, which revealed that Cordova had been overpaid $167,361.[2]

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2. Although representatives of Cordova were present at the hearing, they were apparently not permitted to present evidence or argument. On December 16, DHSS notified Cordova that it could pay the $167,361 in one lump sum within 30 days, or alternatively DHSS would recoup the overpayment from current claims payments to Cordova.

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Petersburg's FY85 audit began in October of 1986. This audit determined that Petersburg had been overpaid $26,036.56. At an informal hearing held on September 18, 1987, the Commission accepted the audit report and sought to recover the overpayment from Petersburg. Under protest, Petersburg paid the alleged $26,036.56 overpayment and filed a request for an administrative hearing.

Cordova filed suit in Anchorage superior court, and the superior court granted Cordova a temporary restraining order preventing the DHSS from recouping the overpayment from current claims payments. Petersburg then filed a motion to intervene as a party plaintiff. The motion was granted. The hospitals thereafter filed a motion for summary judgment and for a permanent injunction. The State filed an opposition to the motion. Among the State's attachments to its opposition were affidavits signed by Millie Duxbury, Mary Bensen, and Sister Barbara Haase. The hospitals subsequently filed a motion to strike these affidavits on the ground that they failed to comply with the requirements of Civil Rule 56(e).

After hearing the parties' arguments on the hospitals' motion for summary judgment, the superior court rendered an oral decision. The court first held that retroactive recoupment of overpayments was not available to the Commission because the relevant statute, AS 47.07.070(a), permits only prospective action. Second, although the Commission presently has authority

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recoupment of past overpayments prior to S .693 being adopted. Therefore, it is this court's conclusion that plaintiffs are not public interest litigants.

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under 7 AAC 43.693(d) (eff. 8/9/86, Reg. 99) to recoup overpayments, it did not have that authority under the applicable audit regulation, 7 AAC 43.700. Third, in a decision going to the heart of the present appeal, the superior court held:

> Until 7 AAC 43.693(d) was promulgated, the Commission did not have any authority to act retrospectively, so if the Commission cannot go back into 1985 and reset the rates, what is its remedy? If the audit reveals error in the budget analysis or misrepresentation, these errors should be corrected by adjusting rates for the ensuing year or years. If the hospital has made a profit on Medicaid payments, then payments exceeded the reasonable costs incurred. If this profit were the result of some miscalculation or misrepresentation, it can be taken into account in subsequent years when the budget analys[t]s are calculating reasonable costs for the upcoming fiscal year. In adjusting the rates for the new year to account for errors made on Medicaid payments from previous years, the Commission is able to recover costs which were paid out in error without acting outside the scope of its authority. Therefore if there were miscalculations or misrepresentations the Commission's remedy is to make prospective adjustments to account for such errors.

The superior court also held that the DHSS Commissioner's designation of Randy Super did not constitute an impropriety that would void the December 11, 1987, hearing; the court concluded that this delegation of the Commissioner's responsibilities to Mr. Super was authorized by AS 44.17.010.

The hospitals then filed a motion requesting that the superior court clarify its oral ruling. The hospitals also filed a motion for actual attorney's fees and costs which was countered

by the State's motion for Rule 82 attorney's fees and a motion to remand the case to the Commission.

The superior court denied the hospitals' motion for clarification and entered an order denying attorney's fees and costs to either party.[3] This appeal followed.

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3. This order stated:

> Both parties have filed a motion seeking to be declared the prevailing party. In addition, the plaintiffs seek to be declared public interest litigants. All motions are denied. The plaintiffs prevailed [o]n the issue of whether the state could retroactively recoup overpayments prior to the adoption of 7 AAC 43.693. The defendants prevailed on the issues of whether the state could audit the plaintiff's FY 1985 year prior to adoption of .693; whether the designee of the commissioner could attend the meetings and vote. Therefore, it is the conclusion of this court that neither party is the "prevailing party" for the purposes of awarding attorney fees.
>
> Further, plaintiffs contend that they are public interest litigants. The plaintiffs fail to meet the test of being litigants which would lack sufficient economic incentive to bring the lawsuit if it did not involve issues of general importance. These plaintiffs do have the economic incentive to file the lawsuit as they readily did. Further, the issues raised are of importance not to the general hospital population in Alaska, but only to these hospitals experiencing a claim for recoupment of past overpayments prior to § .693 being adopted. Therefore, it is this court's conclusion that plaintiffs are not public interest litigants.

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III. DISCUSSION.

The superior court's decision to grant the State relief prospectively turns on its interpretation of AS 47.07.070.[4] That statute provides:

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4. The superior court first determined that the right to retroactive recoupment is not inherent in the right to audit embodied in 7 AAC 43.700. During FY85, the following two versions of 7 AAC 43.700 were in effect:

> 7 AAC 43.700. AUDIT AND INSTITUTIONAL REVIEW. (a) As a condition of participation in the medicaid program, providers under secs. 675 - 700 of this chapter must provide reasonable access to fiscal and patient care records for all medicaid beneficiaries.
>
> (b) Providers must allow inspection of records by authorized officials of both state and federal agencies connected with the medicaid program.
>
> (c) Providers with facilities in Alaska must make available for inspection their fiscal and patient records either at their facility within the state of Alaska or at a business office located within the state of Alaska. (eff. 8/18/79, Reg. 71)
>
> 7 AAC 43.700. HEALTH FACILITY AUDITS. (a) The commission will, in its discretion, inspect the financial records of a health facility receiving payments from the department. The commission will inspect financial records during normal business hours and will notify a facility of a proposed inspection of its records at least 10 working days before the inspection.
>
> (b) If the commission directs, a health facility receiving payments from the department for aligible state program recipients must produce its financial records for inspection by the commission at a location within the State of Alaska or at

(footnote continued)

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(a) The commission shall determine pro-

(footnote continued)

another place agreed upon by the commission and the health facility.

(c) At the request of the commission, a health facility must send copies of financial records to the commission offices within 10 working days after the request. (eff. 10/21/84, Reg. 92, repealed 8/9/86)

In 1986, the Commission adopted a new audit regulation:

7 AAC 43.693. FACILITY AUDITS. (a) The commission will inspect the financial records of a facility receiving payments from the division of medical assistance. The commission will inspect financial records during normal business hours and will notify a facility of a proposed inspection of its records at least 10 working days before the inspection.

(b) If the commission directs, a facility receiving payments from the division of medical assistance for eligible state program recipients shall produce its financial records for inspection by the commission at a location within the state or at another place agreed upon by the commission and the facility.

(c) At the request of the commission, a facility shall send copies of financial records to the commission office within 10 working days after the request is received.

(d) The commission will review the findings of facility audits. Audit findings that determine that the division of medical assistance has overpaid or underpaid will be acted upon in the following manner:

(1) If the audit findings relate to a facility's fiscal year already ended, the division of medical assistance will be notified of amounts due from or to the facility.

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(footnote continued)

spectively the rate of payment to a health facility under this chapter and AS 47.25.120 - 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

(2) education, research, and appropriate capital development.

(footnote continued)

(2) If the audit findings relate to a facility's fiscal year in progress, the approved rate will be adjusted to reflect a correct payment rate. The level of adjustment will be prorated to ensure that the division of medical assistance will recoup all money by the end of the facility's fiscal year or that the facility will receive all money due it, as appropriate. (eff. 8/9/86, Reg. 99)

We agree with the superior court that under AS 44.62.240 ("Silence or failure to follow any course of conduct is considered earlier inconsistent conduct"), the recoupment provision of 7 AAC 43.693(d) is inconsistent with 7 AAC 43.700 because 7 AAC 43.700 is silent as to recoupment. We also agree that "the agency's failure to conduct any audit in the time between the passage of the prospective payment system and the promulgation of 7 AAC 43.693(d)" is an indication of inconsistency, and that the promulgation of 7 AAC 43.693(d) vitiates the State's argument that the authority to recoup is implied in the authority to audit found in 7 AAC 43.700. In brief, we affirm the superior court's holding that ".700 did not provide for recoupment."

We reject the superior court's interpretation of AS 47.07.070. Although AS 47.07.070 authorizes the Commission prospectively to determine the rate of payment to be made to a health care facility, the statute is silent on the subject of prospective recoupment from a health care facility based on audit results. AS 47.07.070 cannot fairly be read as implicitly authorizing the Commission to consider audit results in its determination of prospective payment rates for the current fiscal year. Cf. Bowen v. Georgetown University Hospital, ___ U.S. ___ 109 S. Ct. 468, 102 L. Ed. 2d 493 (1988) (interpreting Medicare Act provision expressly providing for retroactive corrective adjustments, and holding that retroactive cost-limit rules were not authorized by the provision, which permitted retroactive case-by-case adjudication, not retrospective rule-making).

7 AAC 43.693(d) is the only regulation which authorizes the Commission to undertake corrective action based upon an audit.[5] As noted previously, however, that section [illegible]

inapplicable to the issues in this appeal since it became effective after the fiscal year in question.[6]

We also reject appellees' argument that AS 47.07.074 provides authority for recoupment.[7] It is clear that the text of the statute does not state or imply that the amount of the payment will be affected by any audit.

In concluding that the superior court erred, we observe, as we did in Lake Otis Clinic v. State, 650 P.2d 398, 394 (Alaska 1982):

---

6. Appellees do not contest the inapplicability of 7 AAC 43.693(d) to Cordova and Petersburg for fiscal year 1985.

Appellees argue that the superior court's ruling can be sustained on the alternative theory that they are entitled to assert a common law right of recoupment. See Mount Sinai Hosp. of Greater Miami, Inc. v. Weinberger, 517 F.2d 329 (5th Cir. 1975). Assuming that we would recognize a common law right of recoupment, the record is devoid of any indication that the facilities presented false information to the Commission. Although this aspect of the case is the subject of ongoing administrative proceedings, it appears from the record that discrepancies between the 1985 fiscal year calculations and calculations made in 1987 turn on varying interpretations of "reasonable allocation method."

7. Alaska Statute 47.07.074 provides:

> Audits and inspections. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow
>
> (1) the department and the commission reasonable access to the financial records of medical assistance beneficiaries; and
>
> (2) inspection of financial records by state

(footnote continued)

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> We would have no hesitation in ordering a refund of money which had been awarded based on false representations. Likewise, if the grant had been expended for an illegal purpose, a refund would be appropriate. However, those situations do not exist here.

We also noted that in the grant context:

> The source of both liability and remedy must emanate explicitly or implicitly from the grant statutes, regulations duly enacted and consistent with the statute, or provisions in the grant agreement. . . . If the grantor, however, has failed to establish such a right of recapture through provisions in the grant agreement or duly promulgated regulations, it may well have forfeited its ability to impose the sanction in the absence of explicit statutory authority. Because of such failure, no legal basis would exist for the sanction; it would also be unfair to grantees to subject them to unannounced and improvised detriments.

Id. at 388 (quoting R. Capalli, Rights and Remedies Under Federal Grants, at 98-99 (1979)).

IV. WAS RANDY SUPER A "DESIGNATED APPOINTEE"?

The superior court held that the Commissioner's designation of Randy Super did not constitute an impropriety sufficient to void the December 11, 1987 hearing, concluding instead that this delegation of authority by the commissioner to Mr. Super was authorized by AS 44.17.010. The State argues that

---

(footnote continued)

> and federal agencies to the extent required by federal law.

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this issue is moot because the Commission decided not to act on its December 11, 1987, decision and reheard Cordova's audit review on December 10, 1988, with a panel of members appointed by the governor.

As a general rule, we "refrain from deciding questions 'where the facts have rendered the legal issues moot.'" Hayes v. Charney, 693 P.2d 831, 834 (Alaska 1985) (quoting Doe v. State, 487 P.2d 47, 53 (Alaska 1971)). However, mootness doctrine is a product of judicial policy, not constitutional mandate,[8] and we have recognized on numerous occasions that certain technically moot questions merit review under the "public interest" exception to the mootness doctrine.[9] We recently articulated the criteria to be considered in determining whether to review a moot question:

> The public interest exception involves the consideration of three main factors: 1) whether the disputed issues are capable of repetition, 2) whether the mootness doctrine, if applied, may repeatedly circumvent review of the issue and, 3) whether the issues presented are so important to the public interest as to justify overriding the mootness doctrine.

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8. See, e.g., Etheredge v. Bradley, 502 P.2d 146, 153 (Alaska 1972).

9. See, e.g., Falke v. State, 717 P.2d 369, 371 (Alaska 1986) (addressing merits of a claim that candidate's name should have been on ballot although election had already been held; Kentopp v. Anchorage, 652 P.2d 453, 457-58 (Alaska 1982) (addressing merits of malapportionment claim even though

(footnote continued)

Hayes v. Charney, 693 P.2d 836, 834 (Alaska 1985) (citations omitted).

We agree with the hospitals that the public interest exception to the mootness doctrine applies and have decided to address this issue. The issue is likely to arise again, may well evade review, and is of considerable public importance.

The hospitals allege that Randy Super's participation as a member of the Commission at the December 11, 1987, hearing was unlawful because he was not appointed by the governor as required by AS 47.07.120-.130. The State contends that his participation was proper, that is, that AS 47.02.120 only required Mr. Super's appointment by the DHSS Commissioner as her designee.

The superior court did not resolve the issue by interpreting AS 47.07.120-.130. Instead, the court relied on AS 44.17.010, which provides:

> Delegation of functions. The principal executive officer or each state department may assign the functions vested in the department to subordinate officers and employees.

The State buttresses the superior court's decision by reference to AS 44.17.040, which includes the word "appointments":

> Department staffs. The principal executive officer of each department may establish

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(footnote continued)

reapportionment plan had already been implemented) and cases cited therein at 457 n.3.

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> necessary subordinate positions, make appointments to these positions, and remove persons appointed within the limitations of appropriations and subject to state personnel laws. Each person appointed to a subordinate position established by the principal executive officer is under the supervision, direction, and control of the officer.

It is a maxim of construction that specific statutes should be given precedence over more general ones. See, e.g., National Bank of Alaska v. State, Dep't of Revenue, 642 P.2d 811, 817 & n.10 (Alaska 1982) (citing numerous authorities). Guided by this maxim, we reject the superior court's reliance on AS 44.17.010 and the State's concomitant reliance on AS 44.17.040). Alaska Statutes 47.07.110, .120, and .130 are more specific, and we hold that they control. Those statutes provide:

> AS 47.07.110. Medicaid Rate Commission established. The Medicaid Rate Commission is established in the Department of Health and Social Services. (S 6 ch. 95 SLA 1983)
>
> AS 47.07.120. Composition of commission. The commission consists of five members as follows:
>
> (1) the chief executive officer of a health facility that is licensed by the state but not owned or operated by the state or federal government and that is subject to the budget review process under this chapter;
>
> (2) the commissioner of administration, the commissioner of health and social services, or the appointed designee of either commissioner;
>
> (3) a physician licensed to practice medicine in the state who is actively engaged in the practice of medicine and who is not employed by the state;

> (4) a certified public accountant with relevant experience;
>
> (5) a person representing consumers of health services who does not have a direct or indirect interest in any entity that provides health care services. (§ 6 ch. 95 SLA 1983)
>
> AS 47.07.130. Appointment of members. Members of the commission are appointed by the governor and serve at the pleasure of the governor. (§ 6 ch. 95 SLA 1983)

Furthermore, we agree with the hospitals' argument that the superior court's decision also violates other principles of statutory construction. First, construing "appointed designee" to have the same meaning as "designee" violates the presumption that every word of a statute has a purpose and is not superfluous.[10]

Second, "statutes relating to the same subject matter should be read together as a whole in order that [the] total scheme . . . avoids ignoring one or the other." National Bank of Alaska v. State, Dep't of Revenue, 642 P.2d 811, 818 (Alaska 1982) (quoting Hafling v. Inlandboatmen's Union of the Pacific, 585 P.2d 870, 678 (Alaska 1978)). That is, AS 47.17.030's

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10. See, e.g., Alaska Transp. Comm'n v. Airpac, Inc., 685 P.2d 1248, 1253 (Alaska 1984) (quoting 82 C.J.S. Statutes § 316, at 551-52 (1953)); Alascom, Inc. v. North Slope Borough, 659 P.2d 1175, 1178 & n.5 (Alaska 1983) (quoting 2A C. Sands, Statutes and Statutory Construction § 46.06 (4th ed. 1973)); City of Homer v. Ganal, 650 P.2d 396, 399 (Alaska 1982); City and Borough of Juneau v. Thibodeau, 595 P.2d 626, 634 (Alaska 1979) (citing State v. Lundquist, 374 P.2d 246 (Wash. 1962)).

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requirements that all members be appointed by the governor cannot be ignored. Thus, we reject the State's implicit argument that AS 47.17.020(2) trumps the "general rule" stated in AS 47.17.030.[11]

The judgment of the superior court is REVERSED.

ORDER

Pursuant to Appellate Rules 508(e) and (f) (1), attorney fees of $ 4,000.00 are awarded to Appellant and the Appellant shall serve and file with this court an itemized and verified cost bill by April 9, 1998. Entered by direction of Justice Rabinowitz.

Dated: 3-30-98 Deputy: Shirley Beck

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11. Our resolution of the recoupment issue makes unnecessary any discussion of the superior court's decision not to strike affidavits which allegedly were out of compliance with Civil Rule 56(e), as well the need to address the attorney's fees issue. Upon remand the superior court should determine the appropriate amount of attorney's fees available to Cordova and Petersburg under Civil Rule 82.

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The End kpv

313

SB

FISCAL NOTE

BILL NO. SB 313

STATE OF ALASKA
1992 LEGISLATIVE SESSION

Revision Date:

Title: An Act relating to insurance coverage for the treatment of phenylketonuria.

Department Affected: All State
BRU: All State

Component:

Sponsor: Sturgulewski
Requestor: Senate HESS Committee

COMPONENT SERIAL NO.

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0	0	0	0	0	0
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	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE	0	0	0	0	0	0
TOTAL	0	0	0	0	0	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.)
Despite the expansion of coverage under this bill, the occurrence of phenylketonuria (PKU) in newborns is so small, the application of an insurance rate increase would be impossible to quantify.

Prepared By: Gary Bader Gary M. Bader
Division: Retirement and Benefits

Phone: 465-4470
Date: January 30, 1992

Approved by Commissioner: Nancy Bear Usera
Agency: Department of Administration

Date: 1/30/92

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

Rev 10/90

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB 313

Revision Date:
Title: "An Act relating to insurance coverage for the treatment of phenylketonuria.
Sponsor: Senator Sturgulewski
Requestor:

Dept: University
BRU: All
Component: All

Component Serial No. 730

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE						
FUNDING: (Thousands of Dollars)						
GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0
POSITIONS:						
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)
Incidence rate is so low as to preclude estimation of budget impact. Prescription drug treatment is estimated to be $575/month/person per Jean Freeman of Human Resources 2/28/92

Prepared by: Marsha Hubbard, Director — Phone: 474-7593
Division: Statewide Budget Office — Date: 3/5/92

Approved by: Brian Rogers, Vice President for Finance
Agency: University of Alaska — Date: 3/5/92

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

Rev1/92

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. Senate Bill No. 313

Revision Date:
Title: Insurance coverage for the treatment of phenylketonuria
Sponsor: Sturgulewski
Requestor: HES

Dept. Affected Health & Social Services
BRU: State Health Services
Component: Maternal, Child & Family Health

COMPONENT SERIAL NO. 0-60-40602-290

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

Estimate of current year impact: none

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 1/23/92

Approved by Commissioner: Theodore Mala, MD, MPH
Agency: Department of Health and Social Services
Date: 1/24/92

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

(Rev 12/91)

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB 313

Revision Date: 2/4/92 **Department Affected:** Commerce & Econ. Dev.

Title: An Act relating to insurance cover-age for treatment of phenylketonuria **BRU:** Insurance

Component: Operations

Sponsor: Senator Sturgulewski

Requestor:

COMPONENT SERIAL NO. 0 3 5 4

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER FUND SOURCE:						
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.)

Prepared By: Don Koch, Chief of Market Surveillance **Phone:** 465-2577

Division: Insurance **Date:** 2/4/92

Approved by Commissioner: Glenn A. Olds

Agency: Department of Commerce & Economic Development **Date:** 2.3.92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR Gov. Legis. Ofc., & Impacted Agency(ies).

Rev 10/7/91

(1) Because PKU effects so few individuals, Aetna + Blue Cross do not oppose SB 313

Why Introduced

(2) Arliss knew a family in Dunnington that had 3 children w/ PKU that suffered mental retardation

(3) Constituent in Anchorage with PKU baby unable to get insurance coverage

(4) There has been no testimony in opposition to the bill

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI

Senate

311 C STREET, SUITE 550
ANCHORAGE, ALASKA 99501
(907) 561-7615

While in Juneau
STATE CAPITOL
JUNEAU, ALASKA 99801-1182
(907) 465-3818

MEMORANDUM April 21, 1992

TO: Representative Johnny Ellis, Chairman
House Rules Committee

FROM Senator Arliss Sturgulewski
Senate District F

RE: Calendaring request for SB 313 "An Act relating to insurance coverage for the treatment of phenylketonuria."

I respectfully request an early calendaring of SB 313 which is in the House Rules Committee.

I have enclosed a sponsor statement and packet of information on SB 313. If you have any question regarding this legislation, please contact me or Betty Hargrave on my staff.

Thank you for your consideration of this request.

Enclosures

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI
3/11/92

911 C STREET, SUITE 550
ANCHORAGE, ALASKA 99503
(907) 561-7615

While in Juneau
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

Sponsor Statement on:

SB 313 "An Act relating to insurance coverage for the treatment of phenylketonuria."

Senate Bill 313 would amend state law by adding a new section to AS 21.42 requiring insurers and hospital or medical service corporations that offer individual or group disability insurance to provide coverage for treatment of phenylketonuria(PKU).

PKU is a rare inherited metabolic disorder. Babies born with PKU are unable to process proteins, such as milk, and so in order to remain healthy, they must maintain a strict diet and are placed on a mineral and vitamin enriched formula. If this is not done, then the build up of proteins causes severe brain damage and mental retardation. This bill would require insurance companies to cover the cost of PKU formula.

Enclosed is a position paper from Commissioner Mala in support of this bill. Commissioner Mala points out that the cost of the formula is far less than the cost of treatment for the permanent and long term damage caused by the lack of treatment. The Department of Health and Social Services, Division of Public Health has submitted a zero Fiscal Note.

Michael Ford, Legislative Counsel, Division of Legal Service prepared a sectional analysis of SB 313 which I have enclosed.

Also enclosed are zero Fiscal Notes from the Department of Administration, Division of Retirement and Benefits; the Department of Commerce and Economic Development, Division of Insurance; and the University of Alaska, Statewide Budget Office.

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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240 Main Street, Suite 500
Juneau, Alaska 99801-2101

MEMORANDUM December 10, 1991

SUBJECT: Sectional analysis (SB 313)

TO: Senator Arliss Sturgulewski

FROM: Michael F. Ford
Legislative Counsel

The following is a section by section analysis of SB 313:

Section 1 - Requires insurers and hospital or medical service corporations that offer individual or group disability insurance, to provide coverage for treatment of phenylketonuria. Provides that certain insurance policies are excluded from this required coverage. Allows the insurer or service corporation to impose reasonable contract limitations on the required coverage, not including a preexisting condition exclusion or higher deductible or copayment than for other conditions.

Section 2 - Technical amendment that imposes the required coverage in section 1 upon hospital or medical service corporations.

Section 3 - Applicability section that requires that coverage mandated under section 1 only applies to insurance policies and contracts entered into or renewed on or after the effective date of the Act.

MFF:LMB
91-304.lmb

SENATE BILL NO. 313

For an Act entitled: "An Act relating to insurance coverage for the treatment of phenylketonuria."

Summary

This bill amends AS 21.42, The Insurance Contract, by adding a new section, AS 21.42.375, Coverage for Treatment of Phenylketonuria.

AS 21.42.375 requires an insurer, authorized under AS 21.09 or AS 21.87, to provide coverage for the formulas necessary for the treatment of phenylketonuria (PKU). This section does not apply to

1. a Medicare supplemental insurance policy;
2. long-term care insurance;
3. an insurance policy regulated under 5 USC 89 or 42 USC 135mm;
4. an insurance policy that provides services or reimbursement exclusively for optometric or vision care, dental or orthodontic care, podiatric, ambulance, mental health or chiropractic care; and
5. an insurance policy that the director has, in writing, determined should be excluded from this section.

Discussion

PKU is a rare inherited genetic disorder occurring in approximately 1 in 11,000 live births. Testing for PKU is required during the first week of life (between 48 hours and 7 days of age) and is done with a simple heel prick. Children with PKU are unable to metabolize an essential amino acid (phenylalanine), which is found in the proteins of most foods. To remain healthy, children with PKU must maintain a strict diet and ingest a mineral and vitamin enriched formula. If the protein intake is not severely restricted, the build up of proteins causes severe brain damage and mental retardation. The use of special formulas and a controlled diet can prevent the excess of protein in the individual's body and the brain

damage can be prevented, allowing the individual an opportunity to develop normally. There is an average of one new PKU infant diagnosed yearly in the State of Alaska.

The Department's Section of Maternal, Child, and Family Health sponsors PKU genetic counseling and follow-up services (clinics) in Anchorage (one in the spring and one in the fall). Each clinic is staffed by a physician, nutritionist, social worker, and a genetics counselor. Currently, there are 12 individuals with PKU utilizing the services provided by the State's PKU clinics. Beyond the clinics, the PKU individuals are given a monthly blood test. The results of the blood tests are forwarded to the Anchorage Genetics counselor, then distributed to the PKU individual's pediatrician.

In addition to the blood tests, the diets of PKU individuals are monitored on a monthly basis. Special formula, for PKU individuals, serves the same health and life sustaining purpose that medications do for many other diseases. The cost for formula and special foods vary depending on the child's age. One case of formula costs about $180. Depending on the child's age, they may use two to three cases of formula per month.

Without the special diet, the cost to the PKU individual is a lifetime as a severely mentally retarded citizen. The financial cost to the State for institutionalization could exceed a million dollars per person over a lifetime. The cost of the formula is far less than the cost of treatment for the permanent, long-term damage caused due to the lack of the special diet.

Many states require, by statute, that insurance companies cover PKU formula, one of which is the State of Washington. Many insurance companies that serve Alaska residents will not cover PKU formula without the statutory requirement. Due to the cost of the special diet to the family of a PKU individual, especially low-income families, there is the risk that the necessary precautions are not taken, thereby subjecting the PKU individual to the risk of permanent, long-term damage.

Recommendation

The Department supports SB 313, which will require insurance coverage of formula necessary for the treatment of phenylketonuria.

Peter M. Nakamura, MD, MPH, Director
Division of Public Health

Date: 1/27/92

Theodore A. Mala, MD, MPH
Commissioner
Department of Health and Social Services

Date: 24 Jan 1992