ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

7820 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

HB
478

HOUSE COMMITTEE REPORT

(9)

Date Referred: February 14, 1994 FURTHER REFERRALS: Judiciary

Date of Committee Action: 3/7/94

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 478

HOUSE BILL NO. 478 EMT'S AUTHORITY TO PRONOUNCE DEATH

"An Act relating to the authority of mobile intensive care paramedics and emergency medical technicians to pronounce death under certain circumstances."

RECOMMENDATIONS: [X] the same title
be replaced with CS HB 478(HESS) [ ] a new title

[ ] have attached amendments(s)
[X] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the ______ Committee

ADOPTS: House HESS Comm letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal impact ______ [ ] fiscal note(s) ______

[X] zero fiscal note H+SS (2) [ ] zero fiscal note(s) ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
[signature]	X				
[signature]	X				
[signature]	X				
[signature]	✓				
[signature]	✓				
[signature]	/				
[signature]	✓				
Tom Brice	✓				
Harley Olberg	✓				

[signature]
CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB 478

Revision Date:
Title: An Act relating to paramedics and EMT's to pronounce death under certain circumstances.
Sponsor: Therriault
Requestor: House HES

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: EMS Training & Licensing
COMPONENT SERIAL NO. #297

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0	0	0	0	0	0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY95	FY96	FY97	FY98	FY99	FY00
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:	FY95	FY96	FY97	FY98	FY99	FY00
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY94) cost $ NONE

ANALYSIS: (Attach a separate page if necessary)

There is no fiscal impact.

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 02/23/94

Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S.
Agency: Department of Health & Social Services
Date:

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(Rev 10/93)94fisno.xls/OBR

H&SS-EMS TRAINING & LICENSING - ZERO FISCAL NOTE

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB 478

Revision Date:
Title: An Act relating to paramedics and EMT's to pronounce death under certain circumstances.
Sponsor: Therriault
Requestor: House HES

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: Post Mortem Examinations
COMPONENT SERIAL NO. #293

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0	0	0	0	0	0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY95	FY96	FY97	FY98	FY99	FY00
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:	FY95	FY96	FY97	FY98	FY99	FY00
FULL-TIME						
PART-TIME						
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There is no fiscal impact.

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Division: Public Health
Phone: (907) 465-3090
Date: 02/23/94

Approved by Commissioner: Margaret R. Lowe, M.Ed., E.T.S.
Agency: Department of Health & Social Services
Date.

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H&SS - POST MORTEM EXAMINATIONS -- ZERO FISCAL NOTE

MAR 2 1994

LASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street • Anchorage, Alaska 99508-5334 • (907) 562-2662

February 24, 1994

Representative Gene Therriault
Alaska State Legislature
P. O. Box V (MS 3100)
Juneau, AK 99811

Dear Representative Therriault:

Our Legislative Affairs Committee recently discussed your House Bill #478 that would allow paramedics and emergency medical technicians to pronounce death under certain circumstances. While generally supportive of your bill, we would like to suggest some language changes. As your bill is currently written on page two beginning on line eighteen: "Paramedics or EMTs would sign death certificates." As a medical association, we oppose this. There currently exists a medical examiner system which is responsible for signing death certificates for out-of-hospital deaths. We would encourage this system be preserved and lines 19 through 22 on page two be deleted. I would also suggest on page three, line two, the word "or" be changed to "and." This change would make findings of death a bit less subjective for personnel in the field.

If I can be of any other help to you regarding language changes on this bill, please do not hesitate to contact me.

Sincerely yours,

Donald R. Lehmann, M.D., A.B.F.P.
President, Alaska State Medical Association
Chairman, Legislative Affairs Committee

DRL:bj

HB 478
House Health, Education & Social
Services Committee Letter of Intent

1. HB 478 REQUIRES ADDITIONAL TRAINING FOR EMTs

The House Health, Education and Social Services committee notes that the range of responsibilities held by emergency medical technicians in Alaska would be expanded by House Bill 478. This expanded responsibility will require that emergency medical technicians be well-trained in recognizing signs of death. It is therefore the intent of the House Health, Education and Social Services committee that the training of emergency medical technicians include specific instruction on the recognition of rigor mortis and of post mortem lividity. This instruction should be part of both the initial training for emergency medical technicians and the continuing education required to maintain currency of an emergency medical technician certificate. It is also the intent of the House Health, Education and Social Services committee that the department, under the authority of AS 18.08.080, amend 7 AAC 26 to include this requirement.

2. HB 478 REQUIRES EXTENSIVE NOTIFICATION

The House Health, Education and Social Services committee notes that the provisions of HB 478 may affect all emergency medical technicians and mobile intensive care paramedics in the state of Alaska. It is therefore imperative that full notification take place as soon as possible after the bill becomes law. It is evident that emergency medical technicians and mobile intensive care paramedics must be notified of this new responsibility, but it is also important that all emergency physicians be notified of this change in a timely manner. It is the intent of the House Health, Education and Social Services committee that, at the earliest practical opportunity after HB 478 becomes law, the department dispatch notifications to each emergency physician in the state as well as to each emergency medical technician and mobile intensive care paramedic in the state.

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

STATE CAPITOL, JUNEAU 99801
(907) 465-3759

HB 478
House Health, Education & Social
Services Committee Letter of Intent

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COPIES

[illegible] LEGISLATIVE TELECONFERENCE NETWORK PAGE [illegible]

[illegible] DATE & TIME: 03/09/94 [illegible] STATUS: [illegible]

*** [illegible] SUMMARY ***

[illegible] HOUSE HES [illegible] EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY
[illegible] FOR PUBLIC HEARING LEGISLATIVE BUNDE
[illegible] [illegible] SMITH TEL#: (907)465-[illegible]
[illegible] JUNEAU CAPITOL CAP106

[illegible] TESTIMONY [illegible] ALLOWED 3 MINUTE LIMIT
[illegible] WILL BE TAKEN WITH A [illegible] MINUTE LIMIT
[illegible] ON 03/07/94 AND HAS [illegible] UPDATES

*** AGENDA ***
1 HB 478 [illegible] AUTHORITY TO PRONOUNCE DEATH

*** PARTICIPATING LIOS ***

ANC ANCHORAGE	[illegible] #200		LOCATION STAFF
BAR BARROW	COURTHOUSE BLDG		LOCATION STAFF
BET BETHEL	301 WILLOW ST.		LOCATION STAFF
COR CORDOVA	705 2ND STREET		LOCATION STAFF
[illegible] [illegible] JCT.	JARVIS CTR. [illegible]		LOCATION STAFF
[illegible] FAIRBANKS	[illegible] CUSHMAN ST		LOCATION STAFF
[illegible] GLENNALLEN	COMMUNITY CTR.		LOCATION STAFF
JUN JUNEAU	CAPITOL	CAP106	LOCATION STAFF
[illegible] KET [illegible]LAN	[illegible] FRONT STREET		LOCATION STAFF
[illegible]	[illegible]		LOCATION STAFF

*** [illegible] OFFNET LIST ***

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[illegible] OFFNET 2	FT. YUKON	GIG GILMORE	(907)662-[illegible]
[illegible] OFFNET 3	GALENA	[illegible] NORTH	(907)656-[illegible]

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1 JOHN SULLIVAN [illegible] REGION [illegible] TSFY. HB 478
6150 TUTTLE PLACE ANCHORAGE AK 99507 (907)562-6[illegible]

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1 MR. DAVID OUTASHPUCK NORTHSLOPEFIRE D TSFY. HB 478
PO BOX 69 BARROW AK 99723 (907)852-0307

PARTICIPANTS IN:BETHEL BET
1 GEORGE YOUNG CITY OF BETHEL OBSV. HB 478

PARTICIPANTS IN:DELTA JCT. DJT

1 MS.	ELLEN	HOFFORD	DELTA RESCUE 200	OBSV. HB 478	
	PO BOX 1257		DELTA JUNCTION	AK 99737	(907)895-4746
2 MR.	JOEY	PETTON	DELTA RESCUE 200	TSFY. HB 478	
	PO BOX 885		DELTA JUNCTION	AK 99737	(907)895-4975
3 MR.	DONALD	FRANK	DELTA RESCUE	OBSV. HB 478	
	HC 60 BOX 4439		DELTA JUNCTION	AK 99737	(907)895-5109

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2 MR.	CRAIG	LEWIS		TSFY. HB 478	

CN: 40443 DATE & TIME: 03/07/94 15:00 TO 16:00 STATUS:T STATS. TR

PARTICIPANTS IN:FAIRBANKS FBX

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4 MR.	THOMAS	MASON	AK	TSFY. HB 478	
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1 MS.	ELIZABETH	MUIR DELANEY	C.R.E.M.S.	OBSV. HB 478	
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2 REP	CUNDE	BUNDE		TSFY. HB 478
			AK	(907)000-0000
3 REP	AL	VEZEY		TSFY. HB 478
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4 REP	GARY	DAVIS		TSFY. HB 478
			AK	(907)000-0000
5 REP	HARLEY	OLBERG		TSFY. HB 478
			AK	(907)000-0000
6 REP	TOM	BRICE		TSFY. HB 478
			AK	(907)000-0000
7 REP	BETTYE	DAVIS		TSFY. HB 478
			AK	(907)000-0000
8 REP	IRENE	NICHOLIA		TSFY. HB 478
			AK	(907)000-0000
9 REP	GENE	THERRIAULT		TSFY. HB 478
			AK	(907)000-0000
10	TO	OBSERVE		OBSV. ALL ITEMS
11	TO	OBSERVE		OBSV. ALL ITEMS
12	TO	OBSERVE		OBSV. ALL ITEMS
13	TO	OBSERVE		OBSV. ALL ITEMS
14	TO	OBSERVE		OBSV. ALL ITEMS
15	TO	OBSERVE		OBSV. ALL ITEMS
16	TO	OBSERVE		OBSV. ALL ITEMS
17	TO	OBSERVE		OBSV. ALL ITEMS
18	TO	OBSERVE		OBSV. ALL ITEMS
19	TO	OBSERVE		OBSV. ALL ITEMS
20	TO	OBSERVE		OBSV. ALL ITEMS
21	TO	OBSERVE		OBSV. ALL ITEMS

[illegible] TO OBSERVE OBSV. ALL ITEMS
[illegible] TO OBSERVE OBSV. ALL ITEMS
[illegible] [illegible] [illegible] TSFY. HB 478
AK (907)000-0000

PARTICIPANTS IN:KETCHIKAN KTN
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[illegible] MR. EL GENE MERRILL SOL HIGH SCHOOL OBSV. HB 478
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375 KATMAI SOLDOTNA AK 99669 (907)262-5941
7 MS. LISA PARKER SOL HIGH SCHOOL OBSV. HB 478
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8 MS. SARAH COOPER SOL HIGH SCHOOL OBSV. HB 478
[illegible] [illegible] AVE SOLDOTNA AK 99669 (907)262-[illegible]

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1 MR. BRENT URSEL TSFY. HB 478
MCGRATH AK (907)524-3299

PARTICIPANTS IN:OFFNET 2 ZZZ OF2
[illegible] MR. SIG GILMORE TSFY. HB 478
FT. YUKON AK (907)662-2462

PARTICIPANTS IN:OFFNET 3 ZZZ OF3
1 MS. JANET DURKIN TSFY. HB 478
GALENA AK (907)656-1381
[illegible] TO TESTIFY TSFY. ALL ITEMS

ATTACHMENT #1

Comments on HB506
Prepared by
Department of Administration - Division of Finance
March 7, 1994

Three sections of the bill affect the Division of Finance; Section 6 which relates to assignment of wages and Sections 9 and 10 which relate to withholding of disbursements made by the Department of Administration.

Section 6:
We would want to point out the potential for problems associated with student loan repayment taking priority over garnishments already in effect for an individual. Employers typically have a priority scheme for processing multiple garnishments and levies with child support taking top priority in all cases. While we cannot speak for all employers, the state's practice is to process garnishments and levies in the order in which received. Subsection (c) would alter that process by requiring the state to cease withholding for garnishments already in place and instead begin withholding for student loan repayment. Garnishments in place are normally banking institutions or other third parties with a judgement against an employee.

Sections 9 & 10:
We believe there are three possible approaches to implementing the intent of these sections, each with a different impact.

1. As written, the bill charges the Department of Administration with responsibility for performing the computer file matches and subsequent research to make absolutely certain payments are withheld from the right person.

2. Language could be included in Title 14 that has the same effect as the current language but place responsibility for research and identification of the right person on Post Secondary Education. They would then notify the Department of Administration of specific individuals for whom payments are to be withheld.

3. Under language already in Title 9, Post Secondary Education could get a court order to direct withholding of payments to a vendor.

Option 2 or 3 are the preferred option from the Department of Administration perspective. They do not create new work for which a fiscal note would be required. Option 1 creates new work in the department and would require a fiscal note.

H/HESS ROLL CALL FORM

BILL HB 478 DATE 3/7/94

TAPE 94-38B NUMBER 283

SUBJECT OF VOTE TO PASS HB ~~[illegible]~~ 478 AS AMENDED OUT OF COMMITTEE WITH ACCOMPANYING FISCAL NOTE

MEMBER	YEA	NAY	ABS
Rep. Cynthia Toohey	✓		
Rep. Con Bunde	✓		
Rep. Gary Davis	✓		
Rep. Al Vezey	✓		
Rep. Pete Kott	✓		
Rep. Harley Olberg			
Rep. Bettye Davis	✓		
Rep. Irene Nicholia	✓		
Rep. Tom Brice	✓		
TOTAL	8	0	

++

BILL HB 506 DATE 3/7/94

TAPE 94-38B NUMBER 549

SUBJECT OF VOTE AMENDMENT #1, TO ADOPT

MEMBER	YEA	NAY	ABS
Rep. Con Bunde		✓	
Rep. Gary Davis		✓	
Rep. Al Vezey		✓	
Rep. Pete Kott		✓	
Rep. Harley Olberg			
Rep. Bettye Davis	✓		
Rep. Irene Nicholia	✓		
Rep. Tom Brice	✓		
Rep. Cynthia Toohey		✓	
TOTAL	3	5	

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

DATE: 3/17/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
* HB478: EMTs Authority to Pronounce Death
* HB364: POSTPONED
HB506: STUDENT LOAN PROGRAM
* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
✓ MARK JOHNSON	DHSS, EMS	P.O. BOX 110616 Juneau	99811-0616	463-5807	465-3027	(Y)	N	HB 478
✓ PAIGE ADAMS	Coalition of Student Leaders	6-B Lifesaver Drive Sitka	99835	966-2244	747-7734	(Y)	N	HB 506
✓ DON WANIE	Dept of Admin Div. of Finance	Box 110204 Juneau, AK	99811	586-3663	465-3435	(Y)	N	HB 506
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Page ___ of ___

REPRESENTATIVE
GENE THERRIAULT
P O Box 55326
North Pole, Alaska 99705
(907) 488-0862

House District 33

Alaska State Legislature

House Of Representatives

While in Juneau
State Capitol
Juneau, Alaska
99801-1182
(907) 465-4797

HB 478 The authority of mobile intensive care paramedics and emergency medical technicians to pronounce death under certain circumstances.

SPONSOR: Rep. Gene Therriault

SPONSOR STATEMENT:

House Bill 478 proposes to allow mobile intensive care paramedics and Emergency Medical Technicians (EMT) to determine and pronounce death under certain circumstances. Registered paramedics or certified EMTs who are active members of a certified emergency medical service, may make a determination and pronouncement of death if a physician is not immediately available upon determining that the person has suffered irreversible cessation of circulatory and respiratory functions.

Currently, when a member of an emergency medical service begins CPR they are required to continue resuscitation until the person recovers, the EMT or paramedic is relieved by either a medical facility or physician the responding parties become physically exhausted and no longer able to continue, their physical safety is seriously threatened, or a physician pronounces the person dead.

Many times physicians and medical facilities are not immediately available, and emergency medical response members are required to continue unproductive resuscitation for several hours.

HB 478 would allow an EMT or paramedic to declare death in situations where a physician is not available. This will help emergency response teams who respond to the emergency medical needs of Alaska.

REPRESENTATIVE
GENE THERRIAULT
P O. Box 55326
North Pole, Alaska 99705
(907) 488-0862

House District 33

Alaska State Legislature

While in Juneau
State Capitol
Juneau, Alaska
99801-1182
(907) 465-4797

House Of Representatives

Sectional Analysis

HB 478

SECTION 1:

This section makes a technical amendment to AS 09.65.120 DEFINITION OF DEATH, to add mobile intensive care paramedics and emergency medical technicians to the list of individuals who may pronounce death.

SECTION 2:

Section 2 of HB 478 proposes new language, AS 18.08.089 AUTHORITY TO PRONOUNCE DEATH, which introduces detailed circumstances in which a registered mobile intensive care paramedic or a certified emergency medical technician may determine and pronounce the death of a person.

The paramedic or EMT may pronounce a person dead when a physician is not immediately available for consultation by radio or telephone and the paramedic or EMT has determined that the person has suffered irreversible cessation of circulatory and respiratory functions. The EMT or paramedic who determines and pronounces death must be an active member of a certified emergency medical service.

The paramedic or EMT who determines the death shall document the clinical criteria for the determination and pronouncement of death on the person's emergency medical service report form and notify the appropriate medical director as soon as communications can be established. The original bill proposed that the paramedic or EMT complete and sign the death certificate, but currently a medical examiner system is responsible for signing death certificates for out-of-hospital deaths. Therefore I have proposed an amendment which deletes a small section of line 19 of page 2 which refers to the signing of a death certificate by a paramedic or EMT and replaces it by having the EMTs and paramedics present the appropriate authorities with the same information that would be included in the death certificate.

Proposed AS 18.08.089(d)(1) gives the definition of "acceptable medical standards" as injuries incompatible with life, the presence of rigor mortis, the presence of post mortem lividity (i.e. the body has lost all color and has turned gray), or a

failure to show signs of spontaneous pulse or respiratory functions in response to "properly administered resuscitation efforts." Injuries incompatible with life are defined in this section as cardiac arrest accompanied by incineration, decapitation, open head injury with loss of brain matter, or detruncation.

Proposed AS 18.08.089(d)(3) defines "properly administered resuscitation efforts" as at least 30 minutes of CPR on a non-hypothermic patient when a person authorized to perform advanced cardiac life support techniques is not available. When a patient is hypothermic at least 60 minutes of CPR in conjunction with rewarming techniques is required as described in the current State of Alaska Hypothermia and Cold Water Near-Drowning Guidelines published by the Division of Public Health. A minimum of 30 minutes of CPR combined with properly performed advanced life support techniques would be required when a person authorized to provide such services is present.

8-LS1678\A.1
Lauterbach
3/2/94

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE THERRIAULT

TO: HB 478

Page 2, line 19:

Delete "sign"

Insert "provide to the person who signs"

Delete ", which must include"

HB 478
House Health, Education & Social
Services Committee Letter of Intent

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HB
488

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

DATE: 3-18-94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
*HB 291: CONSUMER PROTECTION INTERN PROGRAM
-- BILLS HELD OVER --
HB 488: RESTRICT STUDENT LOANS TO ALASKA SCHOOLS
HB 422: CHILD CUSTODY: VISITATION RIGHTS
* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Sherrie Goll	Alaska Women's Lobby	P.O. Box 22156 Juneau	99802		463-6744	(Y)	N	HB 422
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/17/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
*HB 490: School Construction: AK Bidder Preference
*HB 488: Restrict Student Loans to Alaska Schools
*HB 341: Physician's Assistants Services

*INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Diane Barrans	ACPE	3030 Vintage Blvd				Y	(N)	Available for questions HB 488
Bob Ward	AGC	10003 Frank Maier Dr Juneau AK 99801		789-3713	586-1648	(Y)	N	ASG Tier
Joe McCormick	ACPE	3030 Vintage Blvd				Y	(N)	will answer questions
Kim Busch	DMA					Y	(N)	will answer Questions
Dave W. Williams	DMA					(Y)	N	
John Riley	Alaska Academy of Physician Assistants	1217 E 10th Ave Anchorage AK	99501	257-4600		(Y)	N	HB 341
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

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

DATE: 3/17/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Duane Guiley	DOE	801 West 10th St. Ste 201 Juneau, AK. 99801			465-8679	Y	N	Available to answer questions
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB488

Revision Date: 2/14/94
Title: An Act relating to the scholarship loan program; and providing for an effective date.
Sponsor: Representative Vezey
Requestor: Representative Vezey

Dept Affected: Alaska Commission on Postsecondary Education
BRU: Postsecondary Education
Component: Student Loan Program
COMPONENT SERIAL NO. 0218

Expenditures/Revenues — Thousands of Dollars

OPERATING EXPENDITURES	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	18.5	18.5	18.5	18.5	18.5	18.5
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	18.5	18.5	18.5	18.5	18.5	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES (1022)	0.0	0.0	-189.8	-764.8	1,733.7	-3,105.4

FUND SOURCE

	FY95	FY96	FY97	FY98	FY99	FY00
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other	18.5	18.5	18.5	18.5	18.5	18.5
TOTAL	18.5	18.5	18.5	18.5	18.5	18.5

Estimate of any current year (FY94) costs ($): 0.0

POSITIONS

	FY95	FY96	FY97	FY98	FY99	FY00
FULL-TIME	.5	.5	.5	.5	.5	.5
PART-TIME						
TEMPORARY						

ANALYSIS (Attache a separate page if necessary): Elimination or significant reduction in the number of student attending out-of-state institutions will have a marked impact on the student loan program. It is estimated that the program will require a full time position for 4 to 6 months of the year (during awarding periods). This full time position will review applications that involve out-of-state requests, review in-state alternatives, and, handle any and all appeals resulting from denied applications. Currently the Commission process more than 13,000 applications each year, of which approximately 60 percent are in-state applicants and 40 percent are out-of-state. It is expected that most, if not all, first year out-of-state applicants will be denied based on available in-state alternatives. However, for those degree programs that are not supported in Alaska, i.e. medical education, the impact or reduction in the approved applicants would be less dramatic. Based on FY93 applications the Commission estimates that a total of 1,793 students will attend out-of-state institutions without benefit of Alaska Student Loan funding as a result of this bill.

Prepared by: *Douglas S. Hanon* — Phone Number: *(907) 465-6757*
Division: *Alaska Commission on Postsecondary Education* — Date: 3/3/94

Approved by Commissioner: *Joe L. McCormick, Executive Director* Joe L. McCormick — Date: 3/3/94
Agency: *Alaska Commission on Postsecondary Education*

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(Rev 10/93) 94fisno.xls/DBR

Analysis (continued): The following estimates the reduced attendence under the Alaska Student Loan Program and shows the basis (assumptions) for these estimates:

ASSUMPTIONS:

1) 13,500 applicants in FY95 and a 1.5 percent growth rate per year.
2) 40 percent of the applicant apply for out-of-state institutions.
3) 24 percent of all applicants are first year, 18 percent are second year, 16 percent are third year, 19 percent are fourth year, eight percent are graduate, and 15 percent are proprietary.
4) average award is $4,900.
5) 95 percent of first year out-of-state applicants will attend in-state alternatives under the Alaska Student Loan Program.
6) 85 percent of second year out-of-state applicants will attend in-state alternatives under the Alaska Student Loan Program.
7) 40 percent of third year out of-state applicants will attend in-state alternatives under the Alaska Student Loan Program.
8) 0 percent of fourth year and advanced degree applicants will attend in-state alternatives under the Alaska Student Loan Program.

	State Fiscal Year (and academic year)						
	1995	1996	1997	1998	1999	2000	TOTAL
Number of Applicants	13,500	13,703	13,908	14,117	14,328	14,543	84,099
Number of Out-of-State (OS) Applicants	5,400	5,481	5,563	5,647	5,731	5,817	33,640
Number of OS 1st year Applicants	1,296	1,315	1,335	1,355	1,376	1,396	8,073
Number of OS 2nd year Applicants	972	987	1,001	1,016	1,032	1,047	6,055
Number of OS 3rd year Applicants	207	210	214	217	220	223	1,292
Number of OS 4th year Applicants	1,026	1,041	1,057	1,073	1,089	1,105	6,392
Number of OS 5-8th year Applicants	432	438	445	452	459	465	2,691
Number of OS Other Applicants	810	822	834	847	860	873	5,046
Number of OS Applicants not using ASL	1,793	1,820	1,847	1,875	1,903	1,932	11,170
Estimate of Reduced Loan Volume	8,785,778	8,917,565	9,051,329	9,187,098	9,324,905	9,464,779	54,731,454
Estimate of Reduced Principal Payment	0	0	175,716	708,134	1,605,280	2,875,342	5,364,471
Estimate of Reduced Interest Payments	0	0	14,057	56,651	128,422	230,027	429,158
Estimate of Total Reduced Income	0	0	189,773	764,784	1,733,703	3,105,369	5,793,629

* OS = Out-of-state

MAR 8 1994

Alaska State Legislature

While in Session:
State Capitol Building
Juneau, Alaska 99801-1182
907-465-3719

Interim:
119 N. Cushman
Suite 211
Fairbanks, Alaska 99701
907-456-5081

Representative Al Vezey

March 7, 1994

SPONSOR STATEMENT HB 488

"An Act relating to the scholarship loan program; and providing for an effective date."

Alaska is the only state in the union that finances students who are attending out of state schools. As a result we are encouraging the export of one of our greatest assets. We lose in several ways.

Obviously the subsidized loans that we provide students who attend educational institutions outside of the state represents money that does not circulate in our state economy. Less obvious is the fact that some of our best students are encouraged to attend out of state schools. This results in lower academic standards for our own institutions. It also results in some of our best talent establishing ties and eventually jobs in other states (or countries). At the same time the demand for teaching in our state institutions is diminished. This results in a lower overall quality of educational services in our state institutions.

We can no longer afford this degree of largess with our state resources. Currently our student loan fund is diminishing. It is going to be difficult to find general fund monies to appropriate to the student loan fund in order to recapitalize it. If these monies are circulating within the state, it will easier for the legislature to find funds with which to recapitalize the student loan fund.

If we fail to recognize this drain on our resources we will find our student loan program depleted. It will be difficult to find the will to appropriate money that will go to out of state institutions.

Increasing Access to Postsecondary Education and Training

Over the past 22 years, ASL has

- awarded over 195,000 loans
- to 100,000 Alaskans
- totaling $780 million

Of the borrowers

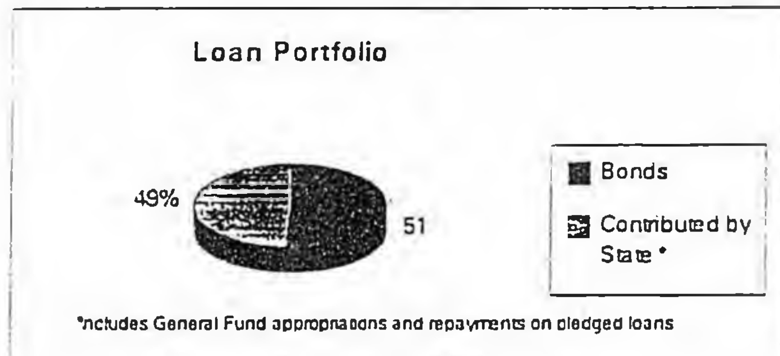
- about half attended in-state schools
- more than 90% enrolled in undergraduate or vocational programs
- about 10% pursued advanced or professional degrees

A recent match of 40,000 student loan borrowers with Alaska Department of Labor wage and salary files found that in 1992

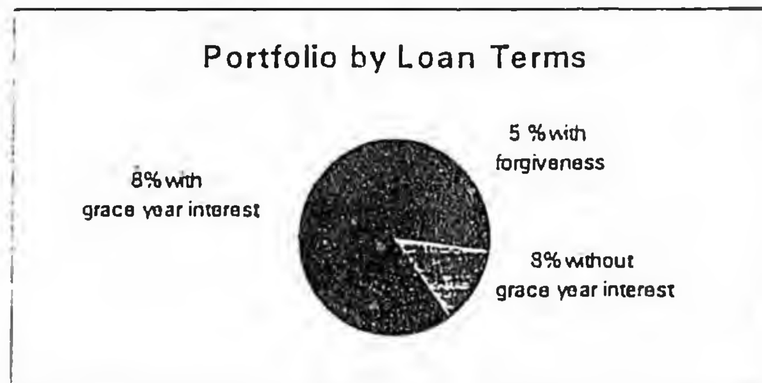
- ASL borrowers contributed $478 million in skills and knowledge to the state's economy as measured in wages
- Close to 65%[1] of the most recent borrowers worked in Alaska one or more quarters
- About 70% claimed Alaskan residency

The Alaska Student Loan Revolving Fund

At present, the loan portfolio totals $498.2 million

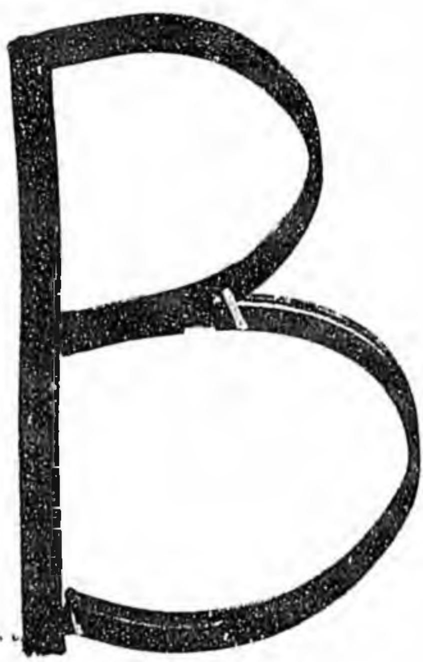


Outstanding loans carry varying interest rates and repayment terms



The effective interest rate interest over the life of a loan is less than the stated interest both because of forgiveness on older loans and the interest subsidy on all loans while a student is in school. For example, the effective interest rate on 8% grace year interest loan for a student who remains in school for a four year period is 5.75%. For a one-year vocational student, the rate is 6.89%. At effective rates, the Fund has lent out monies at less than its cost of capital for many years.

[1] Borrowed for the 1989-90 or the 1990-91 school year


HB

490

HOUSE COMMITTEE REPORT

(9)

Date Referred: February 14, 1994 FURTHER REFERRALS: Finance

Date of Committee Action: 3/17/94

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 490

HOUSE BILL NO. 490 SCHOOL CONST: ALASKA BIDDER PREFERENCE

"An Act allowing a local bidder preference in certain contracts for school construction."

RECOMMENDATIONS: [ ] the same title
be replaced with ______________________ [ ] a new title

[ ] have attached amendments(s)
[X] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the ______________ Committee

ADOPTS: ______________ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[x] fiscal impact Education [ ] fiscal note(s) ______________

[ ] zero fiscal note ______________ [ ] zero fiscal note(s) ______________

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Pete Kott	✓				
Al Vezey	✓				
Gary L. Davis	✓				
[illegible]	✓				
Harley Olberg	✓				
Bettye Davis	✓				
Tom Brice	✓				

[signature]

CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA

1994 LEGISLATIVE SESSION

BILL NO. HB490

Revision Date: March 10, 1994

Title: "An Act allowing a local bidder preference in certain contracts for school construction."

Sponsor: Representative Vezey

Requester: Representative Vezey

Department Affected: Education

BRU: School Finance

Component: Educational Facilities Support

COMPONENT SERIAL NO. 1957

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS (Range)	$0.0	$1,250.0 to $1,500.0	$1,250.0 to $1,500.0	$1,250.0 to $1,500.0	$1,250.0 to $1,500.0	$1,250.0 to $1,500.0
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE FUND SOURCE:						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY94) impact: $ -0-

ANALYSIS: (Attach a separate page if necessary.) The estimated impact for FY95 is $0, because it is too late for districts to modify budget requests. The estimate for FY96 through FY00 is in the range of $1,250,000 to $1,500.000.

Please see attached continuation page for detail

Prepared by: Duane Guiley

Phone: 465-8679

Division: School Finance

Date: March 10, 1994

Approved by Commissioner: [signature] Jerry Covey

Agency: Education

Date: March 10, 1994

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DOE FISCAL NOTE

FISCAL NOTE (continued): DEPARTMENT OF EDUCATION

Division School Finance Bill Number HB 490

Bill Title An Act allowing a local bidder preference in certain contracts for school construction

Sponsor Representative Al Vezey

This legislation requires provision for a 5% Alaska bidder preference on all competitively bid school construction contracts. There is no fiscal impact on the agency directly. The fiscal impact will be due to increased school construction grant estimates submitted by districts and subsequent grant awards and construction contracts, which may or may not, include an Alaska's bidder preference. Because the legislation requires the provision for a 5% Alaska bidder preference, districts will likely increase the project budgets accordingly. Once a grant award is made, districts spend the total amount provided. Rarely are excess funds refunded.

Had this legislation been in place prior to the passage of SB 60, the potential fiscal year 1994 increased cost would have been $8,608,465. At the present time, the fiscal year capital budget is unknown and districts have no opportunity to adjust project budget requests to allow for the 5% Alaska bidder preference. As such, the FY95 impact is $0.

Based on annual average funding levels for school construction, the projected impact on future years will range from $1,250,000 to $1,500,000.

APPROVED:

Director Duane Guiley Division School Finance

Signature Date March 10, 1994

Commissioner/Deputy

Signature Date 3/11/94

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

DATE: 3/17/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
*HB 490: School Construction: AK Bidder Preference
*HB 488: Restrict Student Loans to Alaska Schools
*HB 341: Physician's Assistants Services
* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Diane Barrans	ACPE	3030 Vintage Blvd				Y	(N)	Available for questions HB 488
Bob Ward	AGC	1600 3 Frank Maier Dr Juneau AK 99801		789-3713	586-1648	(Y)	N	ASG Test
Joe McCormick	ACPE	3030 Vintage Blvd				Y	(N)	will answer questions
Kim Busch	DMA					Y	(N)	will answer Questions
Dave W. Williams	DMA					(Y)	N	
John Riley	Alaska Academy of Physician Assistants	1217 E 10th Ave Anchorage AK	99501	257-4600		(Y)	N	HB 341
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

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

DATE: 3/17/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Duane Guiley	DOE	801 West 10th St. Ste 201 Juneau, AK 99801			465-8679	Y	N	Available to answer questions
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

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Interim:
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Suite 211
Fairbanks, Alaska 99701
907-456-5081

Representative Al Vezey

March 3, 1994

SPONSOR STATEMENT HB 490

"An Act allowing a local bidder preference in certain contracts for school construction."

Currently 4 AAC 31.080 prohibits political subdivisions of the state from granting a local bidder preference on project funded under AS 14.11.011 - 14.11.020 and AS 14.11.100.

This bill does not mandate that a local bidder preference be granted but it will require that the DOE permit a local bidder preference if the political subdivision sees fit to do so.

Sec. 14.11.017. Grant conditions. (a) The department shall require in the grant agreement that a municipality that is a school district or a regional educational attendance area

(1) agree to construction of a facility of appropriate size and use that meets criteria adopted by the department if the grant is for school construction;

(2) provide reasonable assurance by a means acceptable to the department, that the cost of the project will be uniform with the costs of the most current construction or major maintenance projects, as appropriate, in the area;

(3) agree to limit equipment purchases to that required for the approved project plan submitted under (5) of this subsection and account for all equipment purchased for the project under a fixed asset inventory system approved by the department;

(4) submit project budgets for department approval and agree that the grant amount may, at the discretion of the department, be reduced or increased by amounts equal to the amounts by which contracts vary from the budget amounts approved by the department; and

(5) submit to the department for approval, before award of the contract, a plan for the project that includes educational specifications, final drawings, and contract documents.

(b) The cost of any school construction or major maintenance activity encompassed by the definition of "costs of school construction" under AS 14.11.135 is payable under a grant awarded from the appropriate fund under AS 14.11.015 without regard to whether the costs were incurred before the

(1) award of the grant;

(2) approval of the grant application by the board; or

(3) effective date of an appropriation to the appropriate grant fund for the year in which the grant is funded.

(c) The department, by regulation, may establish the time period in which activities described in (b) of this section must have occurred in order to be paid under a grant. (§ 6 ch 5 SLA 1990; am §§ 11, 12 ch 78 SLA 1993)

Effect of amendments. — The 1993 amendment, effective June 26, 1993, added "if the grant is for school construction" in paragraph (a)(1); inserted "or major maintenance" and references to "appropriate" in paragraph (a)(2) and subsection (b); substituted "project" or "appropriate" for "school construction" throughout; inserted "submitted under (5) of this subsection" in paragraph (a)(3); deleted "construction" preceding the first "contract" and "drawings" in paragraph (a)(5); added subsection (c); and made stylistic changes.

Editor's notes. — Section 23(a), ch. 78, SLA 1993 provides that the amendment of (a) and (b) by § 11, ch. 78, SLA 1993 does not apply to grants awarded under AS 14.11.005 — 14.11.019 after June 30, 1993.

Section 23(b), ch. 78, SLA 1993 provides that the addition of (c) by § 12, ch. 78, SLA 1993 does not apply to capital improvement grants included in appropriations for fiscal year 1994.

Sec. 36.30.170. Contract award after bids. (a) Except as provided in (b) — (h) of this section, the procurement officer shall award a contract based on the solicited bids with reasonable promptness by written notice to the lowest responsible and responsive bidder whose bid conforms in all material respects to the requirements and criteria set out in the invitation to bid.

(b) The procurement officer shall award a contract based on solicited bids to the lowest responsive and responsible bidder after an Alaska bidder preference of five percent, an Alaska products preference as described in AS 36.30.322 — 36.30.338, and a recycled products preference under AS 36.30.339 have been applied. In this subsection, "Alaska bidder" means a person who

(1) holds a current Alaska business license;

(2) submits a bid for goods, services, or construction under the name as appearing on the person's current Alaska business license;

(3) has maintained a place of business within the state staffed by the bidder or an employee of the bidder for a period of six months immediately preceding the date of the bid;

(4) is incorporated or qualified to do business under the laws of the state, is a sole proprietorship and the proprietor is a resident of the state, or is a partnership and all partners are residents of the state; and

(5) if a joint venture, is composed entirely of ventures that qualify under (1) — (4) of this subsection.

(c) Except as otherwise provided under (e) or (f) of this section, if a bidder qualifies under (b) of this section as an Alaska bidder, is offering services through an employment program, and is the lowest responsible and responsive bidder with a bid that is not more than 15 percent higher than the lowest bid, the procurement officer shall award the contract to that bidder. This subsection does not give a bidder who would otherwise qualify for a preference under this subsection a preference over another bidder who would otherwise qualify for a preference under this subsection.

(d) The procurement officer shall award an insurance-related contract based on solicited bids to the lowest responsive and responsible bidder after an Alaska bidder preference of five percent. In this subsection, "Alaska bidder" means a person who meets the criteria set out in (b)(1) — (5) of this section and who is an Alaska domestic insurer.

(e) If a bidder qualifies under (b) of this section as an Alaska bidder, is a sole proprietorship owned by an individual who is a person with a disability, and is the lowest responsible and responsive bidder with a bid that is not more than 10 percent higher than the lowest bid, the procurement officer shall award the contract to that bidder. This subsection does not give a bidder who would otherwise qualify for a preference under this subsection a preference over another bidder who

would otherwise qualify for a preference under this subsection or (f) of this section.

(f) If a bidder qualifies under (b) of this section as an Alaska bidder, if 50 percent or more of the bidder's employees at the time the bid is submitted are persons with a disability, and if the bidder is the lowest responsible and responsive bidder with a bid that is not more than 10 percent higher than the lowest bid, the procurement officer shall award the contract to that bidder. The contract must contain a promise by the bidder that the percentage of the bidder's employees who are persons with a disability will remain at 50 percent or more during the contract term. This subsection does not give a bidder who would otherwise qualify for a preference under this subsection a preference over another bidder who would otherwise qualify for a preference under this subsection or (e) of this section.

(g) The division of vocational rehabilitation in the Department of Education shall add to its current list of qualified employment programs a list of individuals who qualify as persons with a disability under (e) of this section and of persons who qualify under (f) of this section as employers with 50 percent or more of their employees being persons with disabilities. A person must be on this list at the time the bid is opened in order to qualify for a preference under (e) or (f) of this section.

(h) A preference under (c), (e), or (f) of this section is in addition to any other preference for which the bidder qualifies, including the preference under (b) of this section; however, a bidder may not receive a preference under both (e) and (f) of this subsection for the same contract.

(i) This section applies to all insurance contracts involving state money. In this subsection, "state money" includes state grants and reimbursement to municipalities, school districts, and other entities.

(j) In this section, "person with a disability" means an individual

(1) who has a severe physical or mental disability that seriously limits one or more functional capacities in terms of employability; in this paragraph, "functional capacities" means mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills;

(2) whose physical or mental disability

(A) results from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological disorders, paraplegia, quadriplegia, other spinal cord conditions, sickle cell anemia, specific learning disability, or end stage renal disease; in this subparagraph, "neurological disorders" include stroke and epilepsy; or

(B) is a disability or combination of disabilities that are not identified in (A) of this paragraph and that are determined on the basis of an evaluation of rehabilitation potential to cause substantial functional limitation comparable to a disability identified in (A) of this paragraph; and

(3) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time. (§ 2 ch 106 SLA 1986; am §§ 7 — 9 ch 65 SLA 1987; am §§ 6, 18 ch 102 SLA 1989; am § 3 ch 175 SLA 1990; am §§ 1 — 3 ch 114 SLA 1992)

Revisor's notes. — Subsection (i) was formerly AS 36.30.850(e). Renumbered in 1992. Subsection (j) enacted as (i). Relettered in 1992.

Effect of amendments. — The 1989 amendment, effective September 10, 1989, deleted "as defined under AS 36.30.100(c)" following "employment program" in subsection (c); and divided subsection (i) (formerly AS 36.30.850(e)) into two sentences, substituting "In this subsection, 'state money' includes" for "Including" at the beginning of the present second sentence.

The 1990 amendment, in subsection (b), inserted "and a recycled products preference under AS 36.30.339" in the first sentence in the introductory paragraph and made a series of minor stylistic changes throughout the subsection.

The 1992 amendment, effective June 23, 1992, made a subsection reference substitution in subsection (a); rewrote subsection (c); and added subsections (e)-(i).

Editor's notes. — Section 6, ch. 114, SLA 1992 provides that the 1992 amendments to this section apply "to procurements that begin on or after June 23, 1992."

Opinions of attorney general. — An agent will be considered the bidder only if the agent is in fact a principal with the power to convey a leasehold interest in its own right. Otherwise, he is not entitled to the bidder preference. July 1, 1989 Op. Att'y Gen.

NOTES TO DECISIONS

Quoted in State v. Johnson, 779 P.2d 778 (Alaska 1989).

Collateral references. — Validity, construction, and effect of requirement under state statute or local ordinance giving local or locally qualified contractors a percentage preference in determining lowest bid. 89 ALR4th 587.

Sec. 36.30.180. Purpose. The legislature finds that there exists in the state continuing high unemployment, underutilization of resident construction and supply firms, and high costs unfavorable to the welfare of Alaskans and to the economic health of the state. The purpose of bidder preference for resident firms when the state acts as a market participant is to encourage local industry, strengthen and stabilize the economy, decrease unemployment, and strengthen the tax and revenue base of the state. (§ 1 ch 70 SLA 1985)

HB
492

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB 492

Revision Date:
Title: Civil Liability: Medical Malpractice
Sponsor: House HESS Committee
Requestor:

Department Affected: Commerce and Economic Development
BRU: Insurance
Component: Operations

COMPONENT SERIAL NO. 354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
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 EXPENDITURES	0	0	0	0	0	0

CHANGE IN REVENUES ( )	0	0	0	0	0	0

FUND SOURCE						
1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

Estimate of current year (FY 94) cost: $ 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

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: 3/4/94

Approved by Commissioner: Paul Fuhs [signature]
Agency: Commerce and Economic Development
Date: 3-7-94

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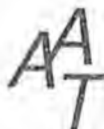
COMMERCE & ECONOMIC DEVELOPMENT - INSURANCE- ZERO FISCAL NOTE



Alaska Action Trust
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March 9, 1994

Representative Toohey, Co-Chair, House HESS
Representative Bunde, Co-Chair, House HESS
Representative Davis, Vice-Chair, House HESS
Representatives Vezey, Kott, Olberg, Davis, Nicholia and Brice

Dear Members of House Health, Education and Social Services Committee,

The Alaska trial lawyers thank you for the opportunity to provide testimony and materials on HB 492 and HB 493, health care liability compensation reform. Dan Hensley will provide testimony before your committee March 10th. In advance of his appearance before your committee, I have put together some materials for your review.

HB 429 and HB 493 are being proposed by the Alaska trial lawyers as an alternative health care liability proposal. This plan would require major changes in the health care liability compensation system and addresses the real or perceived inequities that exist.

Clearly, from the standpoint of the medical professional, there is a continuing anxiety that their assets and livelihoods are continually placed in danger by the "threat" of medical negligence litigation. This real or perceived threat causes them to provide medical care and services which may not be warranted or needed and has also resulted in a number of health care professionals not being insured and relying upon other devices in order to attempt to protect their interests. Further, there is an asserted concern about the filing of non-meritorious claims.

From the standpoint of the trial lawyers and their constituents, there is the anxiety that the rights of injured people will continue to be eroded and those who have sustained injury will no longer have a fair and just forum in which to resolve their disputes. There is a perception that those health care professionals who negligently cause injuries are not willing to accept the social responsibility to pay for the costs in obtaining adequate insurance. It is also felt that a civil jury must have freedom to resolve disputes between members of our society,

unfettered by artificially imposed limitations with regard to the type and amount of damages that they can find to fairly compensate an injured person. There is also the perception that the system is unbalanced, unduly favors the medical profession, causes excessive delay and costs, and that only the most seriously injured can receive just compensation.

It is our belief that HB 492 and HB 493 address these major issues.

Mandatory Insurance: This plan requires mandatory insurance for all health care providers which would be issued through a State Authority. This would guarantee to individuals who are injured as a result of medical negligence that there would be sufficient assets to compensate them for the injuries they sustain. The plan establishes a mechanism providing insurance coverage to those health care providers in rural areas or in certain high risk specialties where the physicians' income is not sufficient to afford insurance. The Authority would be in a position to accurately determine premium income, insurance administrative costs, the frequency and severity of claims asserted, and their resolution.

Limitation of Liability: While trial lawyers are adamantly opposed to any "caps" with regard to damages that may be asserted, they realistically understand that cost containment in some form must be an integral part of any proposal that is to be adopted. No recovery for either compensatory or punitive damages may exceed the amount of the liability coverage required by the Authority. Thus, while no "caps" on types of damages are imposed, leaving the jury free to make these fundamental and important decisions, there is still a limitation placed on the amount of overall assets that are available for the compensation of the injured. This limitation would certainly provide full coverage for most claims asserted and would give a degree of predictability that the insurance companies claim is necessary in order to underwrite claims.

Furthermore, all medical negligence litigation is depersonalized by removing the health care provider as a named defendant. All health care providers would be covered under a single insurance policy. All claims in a case would be defended by a single attorney thereby materially expediting litigation and substantially reducing costs. There would be universal medical coverage for all health care providers and the problems that Jackson v. Powers appears to have created on behalf of the hospitals would no longer exist. Also the plan would preclude the award of compensatory or punitive damages in excess of the amount of the insurance provided by the Authority and the perceived need to practice "defensive medicine" would no longer exist.

Resolution of Non-Catastrophic Damage Claims: The present court system is not well designed to handle the non-catastrophic damage claims. Therefore, under this plan all medical negligence claims

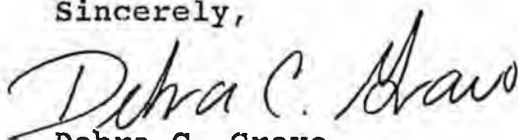
of less than $200,000 would be resolved by arbitration, with costs shared by the parties. The costs of the arbitration procedure would also be reduced by limiting the number of experts and the length of the proceedings. The plan also provides a disincentive for the losing party to appeal, but still preserves the ultimate right to jury trial.

<u>Non-Meritorious Claims</u>: There presently exists the medical malpractice screening panel, which does not work. The panel is biased by its form, is time consuming for those who participate, substantially delays litigation, and does not generally result in the resolution of claims. This plan eliminates the panel. In its place the plaintiff would be required to file a certificate of merit by a Board certified or Board eligible medical care provider asserting to the validity of the claim. The attorney would be required to file the certificate with the court, asserting that in his or her good faith belief, the value of the claim which he or she is filing is worth more than $200,000. The attorney would be liable for monetary sanctions under Civil Rule 11 for asserting a frivolous claim or for not asserting in good faith reasonable case value.

The materials offered the committee come from a variety of sources. They are consistent in their message though -- there is little correlation between medical malpractice "reforms" and health care costs. Medical liability is not a factor in rising health care costs and tort "reforms" will have an insignificant effect on health care costs. The proposal offered by the Alaskan trial lawyers would however, address the real or perceived concerns of the medical community.

Thank you again for the opportunity to participate in this very important debate. If I can provide additional materials or information, please call me here in Juneau at 586-1033.

Sincerely,



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M E M O R A N D U M

To: Presidents, Presidents-Elect and Executive Directors -- State and Major Local Bar Associations

From: J. Michael McWilliams *Mike*

Subj: Health Care Costs and Tort "Reform"

Date: June 18, 1993

During the past year, I have, like you, seen on numerous occasions assertions -- such as those contained in the enclosed articles -- that caps on noneconomic damages in medical malpractice cases result in lower health care costs for everyone. The American Bar Association's Special Committee on Medical Professional Liability recently completed research on the matter. The Special Committee found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted.

I believe you will be interested in the enclosed chart that was developed by the Special Committee. If you would like more information about this document, please contact Lillian Gaskin of the ABA Governmental Affairs Office at 202/331-2604.

Enclosure

cc: R. William Ide III
Members, ABA Board of Governors
Members, NABE Governmental Relations Section
Members, NABE Public Relations Section

Justice for all for Justice

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office. May 1993.
Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).

Percentage of Increase from 1982 to 1990 in Personal Health Care Costs Per Capita, State by State

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
1	Massachusetts	$1,508	$3,031	101
2	California	1,451	2,894	99
3	New York	1,417	2,818	99
4	Nevada	1,380	2,757	100
5	Rhode Island	1,351	2,707	100
6	Connecticut	1,348	2,699	100
7	North Dakota	1,325	2,661	101
8	Illinois	1,308	2,619	100
9	Missouri	1,285	2,568	100
10	Michigan	1,281	2,569	101
11	Pennsylvania	1,273	2,536	99
12	Kansas	1,271	2,548	100
13	Ohio	1,247	2,493	100
14	Maryland	1,232	2,436	98
15	Minnesota	1,229	2,480	102
16	Hawaii	1,228	2,469	101
17	Florida	1,228	2,427	98

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
18	Wisconsin	1,219	2,449	101
19	Nebraska	1,216	2,452	102
20	Colorado	1,209	2,415	100
21	Alaska	1,187	2,367	99
22	Iowa	1,176	2,351	100
23	Washington	1,165	2,311	98
24	Oregon	1,165	2,312	98
25	South Dakota	1,154	2,322	101
26	Delaware	1,153	2,268	97
27	Tennessee	1,144	2,262	98
28	New Jersey	1,115	2,224	99
29	Arizona	1,112	2,211	99
30	Texas	1,110	2,192	97
31	Louisiana	1,106	2,185	98
32	Indiana	1,101	2,201	100
33	Maine	1,091	2,175	99
34	Oklahoma	1,086	2,139	97
35	West Virginia	1,057	2,088	98

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
36	Virginia	1,054	2,076	97
37	Georgia	1,048	2,072	98
38	Montana	1,036	2,059	99
39	Alabama	1,033	2,286	121
40	Arkansas	994	1,944	96
41	New Hampshire	986	1,981	101
42	Vermont	978	1,956	100
43	Kentucky	957	1,875	96
44	North Carolina	931	1,833	97
45	New Mexico	904	1,792	98
46	Mississippi	897	1,751	95
47	Utah	896	1,784	99
48	Wyoming	873	1,756	101
49	Idaho	868	1,726	99
50	South Carolina	857	1,689	97
	U.S. Average	1,220	2,425	99

* *This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported [illegible]t it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged $2,255.*

** *Rounded off to the nearest whole number.*

The Wrong Diagnosis:

The Impact of Medical Malpractice Costs on the Rising Cost of Health Care

A Report of the
Coalition for Consumer Rights,
a center for public interest research and education

By Ken Padgett and Nancy Cowles

March 1991

The Wrong Diagnosis:
The Impact of Medical Malpractice Costs on the Rising Cost of Health Care

Health care costs skyrocket

Health care costs have more than doubled since 1980 and the cost of health insurance continues to soar at a rate two times above the rate of inflation[1].

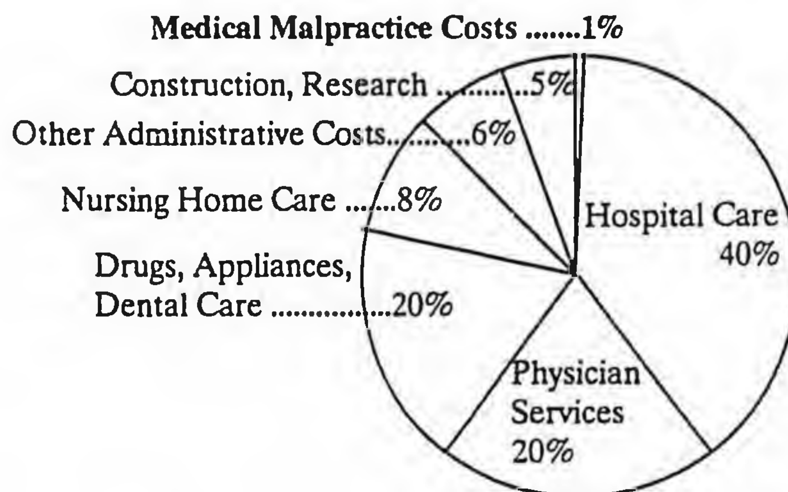
Americans now spend over $600 billion each year for health care -- more than $2,100 per person and over 11% of our Gross National Product (GNP). This total includes all expenses for personal health care (e.g. health insurance and out of pocket expenses) as well as hospital and physician expenses[2].

Rising health care costs are widely recognized as one of the biggest problems facing Illinois and the nation. Solutions to the problem of rapidly rising health care costs are not easily found. Unfortunately in this crisis atmosphere, some politicians and organized medicine are peddling old prescriptions which will not work.

Specifically, the medical society and Governor Edgar would have people believe that the legal system and the present method of malpractice compensation are causing skyrocketing health care costs. Their prescription is to limit the amount of compensation injured patients can receive.

This report examines the relationship between medical malpractice costs and overall health care costs. It also examines the results of compensation limits which have been tried in other states.

Medical malpractice costs are not a major contributor to rising health care costs



Of the $539.9 billion total spent in the United States on health care in 1988, only 1% was medical liability cost[3]. Medical liability costs include doctors' premiums, hospitals' premiums, and insurance companies' legal fees and claims defense.

For all physicians in 1987, medical liability insurance was 4% of gross revenue and 6.5%

of expenses. Table 1 lists selected specialties. Table 2 is a comparison of physician fees to medical malpractice insurance costs. Of the average $31.82 fee for a doctor visit, $1.88 from each doctor visit goes to pay medical malpractice insurance premiums, $12.49 goes to expenses such as rent, mortgage, utilities, non-physician payroll, medical supplies, outside lab work, and depreciation, rent, or lease of equipment, and $16.45 goes to the doctor's net income.

Clearly, medical malpractice costs comprise a negligible portion of the overall health bill.

Table 1: Breakdown of physician income and expenses by specialty

Specialty	Gross Income *	Net Income*	Exp-enses*	Med Mal Premium*	% of Income	% of Expenses
All Physicians	$256.0	$132.3	$123.7	$15.0	5.9 %	12.0%
General/Family	212.7	91.5	121.2	8.9	4.2%	7.3%
Internal Medicine	239.6	121.8	117.8	8.4	3.5%	7.1%
Surgery	352.6	187.9	164.7	24.5	6.9 %	15.0%
Pediatrics	185.5	85.3	100.2	7.1	3.8%	7.0%
Ob/Gyn	336.4	163.2	173.2	35.3	10.5%	20.4%

*In thousands of dollars

Source: Socioeconomic Characteristics of Medical Practice 1988, AMA Center for Health Policy Research

Table 2: Breakdown of physician fees by specialty

Specialty	Fee for Doctor Visit	Med Mal Premium	Net Profit
All Physicians	$31.82	$1.88	$16.45(51.7%)
General/Family	$24.52	$1.03	$10.54(43.0%)
Internal Medicine	$34.11	$1.19	$17.11(50.8%)
Surgery	$32.51	$2.24	$17.32(53.3%)
Pediatrics	$31.57	$1.20	$14.51(46.0%)
Ob/Gyn	$36.65	$3.85	$17.78(48.5%)

Source: Socioeconomic Characteristics of Medical Practice 1988, AMA Center for Health Policy Research

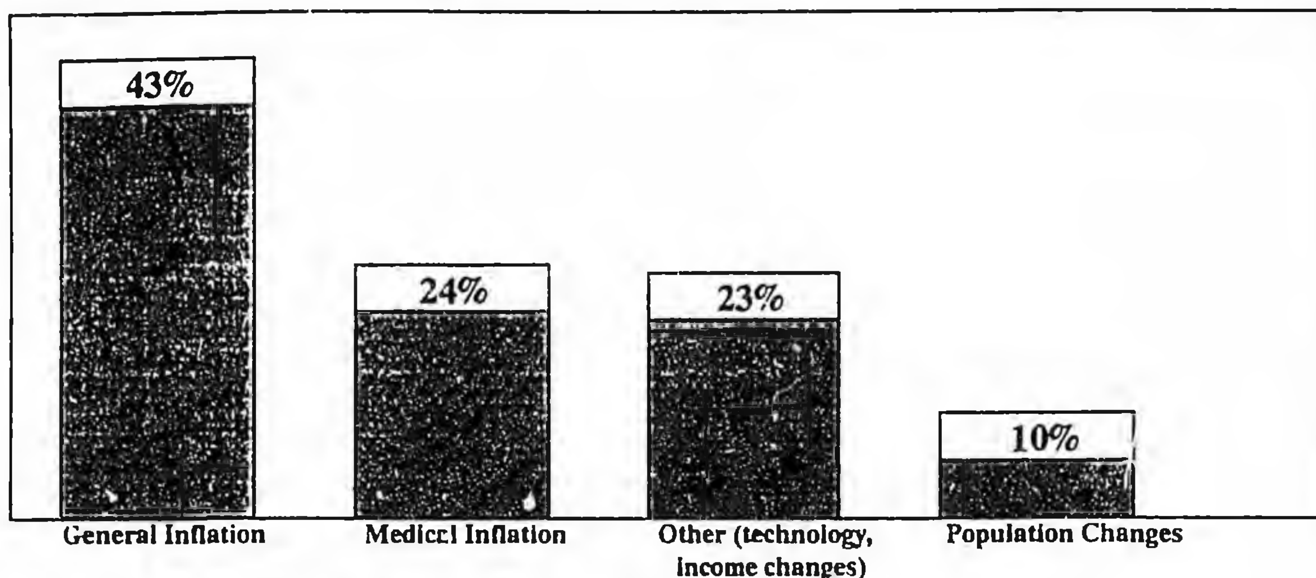
Many factors cause health care costs to increase

A report from the United States Commerce Department[4] projects that the total for health care costs in 1990 will reach $675.7 billion and for 1991, $756.3 billion. Unless some action is taken, health care costs are expected to rise from between 12 and 15% per year for the next five years.

The Commerce Department attributes the rising costs of health care to factors such as sophisticated, but expensive technology; innovative, but costly treatments for AIDS, heart disease, and cancer; the increasing number of seniors, and health care related to chemical dependency.

1990 was the sixth consecutive year that health care spending grew faster than the economy. A close examination of cost increases over time identifies some of the specific causes of health care inflation. For example, health care costs rose 10% from 1987 to 1988.

Table 3: Breakdown of 1989 increase in health care costs



According to the Department of Health and Human Services, the following factors explain the increase[5]. General inflation accounted for 43% of the growth in costs, medical inflation accounted for 24%, population changes 10%, and all other changes accounted for 23%[6]. General inflation and medical inflation are usually not separated from one another. Separating the two shows more clearly the various sources of cost increases. Population changes are increases in the size of the population and the effect that more consumers have on price. All other factors are factors which are difficult to separate such as technology, changes in sex or age distribution in the population, or changes in real income.

Over the last 28 years, the physician services component of the Consumer Price Index (CPI) has increased at an annual rate of 6.9%. This rate of growth consistently has been greater than that of inflation.

Rising health care costs inherent in U.S. health system

The Commerce Department outlines other important factors increasing health care costs such as waste, fraud, and limited competition.

Hospitals drive up the costs of health care through unnecessary procedures. One of the areas in which this problem occurs most frequently is in Caesarian sections. A California study of 316 non-military hospitals showed that the hospitals that stood to gain the most financially had the highest repeat C-section rates -- as high as 95.1% in private, for profit hospitals[7]. Hospitals which were not-for-profit had noticeably lower rates of repeat C-sections. C-sections cost significantly more than natural births, thus the hospitals reap financial benefits.

At a panel meeting of the National Conference of State Legislatures' State Alliance for Access to Health Care, Dr. David Himmelstein noted that the insurance industry in the United States pushes up the costs of health care, as well.

"Overall, we pay $519 per person per year in this country for cost of billing and administration.[8]"

This is nearly one quarter of total per capita health care spending.

Economist Rashi Fein, Professor of Social Medicine and Health Policy at Harvard attributes part of the increase in costs to: "the growth of the complexity of insurance ..... which adds to the cost of administration and doesn't buy health care[9]."

Malpractice costs do not drive up the cost of health care

Organized medicine and their insurers claim that increasing medical malpractice lawsuits and skyrocketing awards, especially those for non-economic damages have raised the cost of health care through rising medical malpractice premiums and defensive medicine. They present this argument despite the fact that annual claims per 100 physicians dropped from 10.2 in 1985 to 6.7 in 1987[10]. In addition, Best's reported that, in 1989 underwriting losses in medical malpractice dropped to a decade low[11]. Even using the figures provided by insurers and organized medicine, the total cost of liability insurance is small[12].

The Illinois State Medical Inter-Insurance Exchange (ISMIIE), a doctor-owned liability insurer, and St. Paul Fire and Marine Insurance Company, the nation's largest medical liability insurer, have reduced the premiums they have been charging doctors. ISMIIE did not raise its premiums from 1985 to 1990[13], and ISMIIE paid a 5.4% dividend to its physician members in 1990[14]. St. Paul reduced its premiums from 6% to 25% in 22 states in 1990[15].

The story is very similar for hospitals. During the period July-September 1989, median monthly insurance expenditures as a percentage of total expenditures varied by size of the hospital, but ranged from a low of 1.47% in hospitals of 150-199 beds to a high of 2.05% in hospitals of 50-74 beds.[16]

Defensive medicine is beneficial to health care quality

Organized medicine often points to defensive medicine as a negative result of the threat of liability suits. However, unnecessary practices should not be confused with defensive medicine or reasonable standards of care. In the event of a medical malpractice suit, tort law requires that doctors show they met a "reasonable standard of care" in the treatment they follow. That requires them to do as much or as little as the average physician would have done when presented with a similar situation. To the extent that tort law forces doctors to exercise a reasonable standard of care, costly injuries and adverse events are actually limited. Reducing the actual amount of doctor negligence should be the cost-containment strategy for policy makers concerned about medical malpractice.

A recent study by the Harvard Medical Practice Group found that 4% of hosptializations in New York resulted in injury or illness to patients . 28% of those 'adverse events' were caused by negligence. Often, the methods that doctors use to insure that they meet that standard of care are beneficial to patients. These practices consist of additional record-keeping, tests, therapy, time with patients, and follow-up visits.[17] Defensive medicine is a way to prevent these injuries, while unnecessary procedures only lead to more.

The Harvard study also found that only about one in eight patients injured through neglience ever file a medical malpractice suit and only one in 16 receive any compensation.

According to William Ira Bennett, the editor of the Harvard Medical School Health Letter,

"A common complaint is that the costs of 'defensive medicine' are also raised by the current fear of malpractice. This is hard to prove. ...In reality, though, failure to order a questionable test is the basis for only a small minority of malpractice judgements; most(other than slips and falls in the hospital), involve clearly wrong procedures or diagnoses."[18]

Revisions in tort law will not lower health care costs or medical malpractice premiums

Restrictions on medical malpractice suits as a means to contain costs is ineffective. The costs of medical malpractice have been shown to be a very small percentage of total health care spending. To focus on controlling this minor portion of health care cost increase is to miss the bigger picture. The necessary solution to the problem of high health care costs is large-scale cost containment. In addition, capping the amount of non-economic damage awards and other tort revisions have not reduced premiums for doctors.

A 1986 General Accounting Office report, "Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms", studied six states which had enacted many different revisions in tort laws, including caps.

> "Officials of the interest groups GAO surveyed in California and Indiana said that the changes to the tort laws of their states had helped to moderate upward trends in the cost of insurance and the average amount paid per claim. Representatives from the groups surveyed in Arkansas, Florida, New York, and North Carolina generally believed the tort law changes in their states **had little effect. GAO identified no studies undertaken in the six states to determine the impact of any specific reforms."**[19] (emphasis added)

Premiums do not fall in states which enact caps.

In Idaho, the year after implementing a cap for non-economic damages, medical malpractice premiums rose 49%. Minnesota and Missouri saw rate increases of 22% and 39% respectively after enacting caps.[20]

Doctors and insurance companies don't claim that rates will drop either. Bob Trunzo of St. Paul, quoted in Medical Economics Magazine says,

> "St. Paul has made it abundantly clear that we aren't going to reduce our rates up front just because some type of tort reform gets passed. ...[N]owhere has it been proved that tort reform will affect our loss costs. Experience tells us that these reforms don't always have the intended effect."[21]

Table 4: St. Paul's 1987 Rate Increase for Medical Malpractice Insurance in States with Caps on Damages

STATE	NON-ECONOMIC CAP ENACTED Year Enacted-Amount of Cap	1987 RATE HIKE
Alabama	1987- $400,000	30%
California	1975- $250,000	25%
Colorado	1986- $250,000	50.8%
Idaho	1987- $400,000	49.4%
Louisiana	1975- $500,000 (total award)	25%
Minnesota	1986- $400,000	22%
Missouri	1986- $350,000	38.6%
Utah	1986- $250,000	15.3%
Virginia	1981- $1 million (total award)	15%

Extensive Minnesota study shows no relation between premiums and claims

A study in 1988 by the Commissioner of the Minnesota Department of Commerce found that recent malpractice premium increases are not the result of high jury awards, or in fact the result of any insurer costs. Department examiners sought to review every claim filed in these states since 1981- a total of 4,747 medical malpractice files from Minnesota, North Dakota and South Dakota. The study concluded that between 1982-1987, while malpractice premiums tripled, there was no increase in claim frequency or severity or the percentage of jury awards for malpractice cases.[22]

Indiana costs as high as Illinois

In 1975, Indiana passed a revamped tort system touted as the way to control the costs of health care[23] .The net effects of the changes have been large profits for insurers and limits on the amount of compensation that claimants can receive. These laws did not result in cost containment.

As of 1982, the last year data were available, health care cost per capita in Indiana was $1101. In Illinois, the cost per capita was $1308 -- a difference of only $200. Hospital costs per capita show the same relationship: Indiana $512, Illinois $700.

Reform of the current tort system is not the answer to containing health care costs. Many of the differences between the cost of health care per capita in Indiana and Illinois can be attributed to the more urban, more populous nature of Illinois. Some differences in the cost of living are to be expected. What has been demonstrated here is that changing the tort system is not an effective means of controlling costs.

ENDNOTES

1. U.S. Industrial Outlook U.S. Commerce Department. 1991.

2. Ibid.

3. "Costs of Medical Malpractice Drop After An 11-Year Climb." The New York Times. Milt Freudenheim. 1989.

4. Op. Cit. in 1

5. "National Health Expenditures, 1988." Health Care Financing Review Health Care Financing Administration. 1990.

6. Ibid.

7. "Some Hospitals Are Found To Cash-In on C-Sections." National Underwriter. Christopher Dauer. Feb. 1991.

8. "Private Health Sector is Blasted." National Underwriter. Neil McGhee. Feb. 1991.

9. Ibid.

10. "Medical Professional Liability Claims and Premiums, 1985-1987." Socioeconomic Characteristics of Medical Practice. Eric J. Slora and Martin L. Gonzalez. 1988.

11. Medical Liability Monitor. Vol. 15 No. 9 Sep. 1990.

12. "Will Defensive Medicine Really Protect You?" Medical Economics. Arthur Owens. 1988.

13. "Medical Malpractice Insurance Cap Urged." Southern Illinoisian. Cindy Humphrys. April 25, 1990.

14. "Exchange to Give Dividends." Illinois Medicine. April 1990.

15. "Insurers Reducing Malpractice Fees For Doctors In U.S." The New York Times. Robert Pear. September 9, 1990.

16. "Datawatch." Hospitals. Feb, 1990.

17. Op. Cit. in 12.

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False Claims:

The Relationship Between Medical Malpractice "Reforms" and Health Care Costs

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BACKGROUND

A public policy debate over medical malpractice costs has been alive for nearly two decades. The first time the debate reached the public was during the so-called "medical malpractice crisis" of the 1970s and 1980s when doctors found that their medical malpractice insurance premiums were skyrocketing and in some cases, that their policies were being cancelled.

At that time, the insurance industry blamed rising medical malpractice premiums on lawsuits. Therefore, the American Medical Association joined with insurance groups to lobby state legislatures across the country to institute tort "reforms." Many states did change their tort laws to make it more difficult for victims of medical malpractice to file lawsuits, and to place limits on the amount a plaintiff could be awarded by a jury.

THE CURRENT DEBATE

Today, medical malpractice costs are debated in a different context: rising medical costs and public concern over access to health care. Policy makers at the state and federal levels are feeling greater pressure from voters to contain medical costs and provide universal access to health care.

For example, health care costs and health insurance drew consistent attention during the recent presidential campaign. Medical costs are forcing increasing numbers of Americans into bankruptcy.[1] National opinion polls consistently show that health care is one of the key issues that voters want the new president to address. For example 67% of those polled say either that significant changes are needed in the health care system, or that it is beyond repair.[2]

As the context of the medical malpractice debate has changed, so have the number of problems blamed on lawsuits. During the presidential election campaign, George Bush and Dan Quayle blamed lawyers and lawsuits for health care inflation, eroding access to health care, as well as medical malpractice premium hikes. Bush charged, during the October 15 debate, that "these malpractice lawsuits [are] breaking the system."[3]

Meanwhile, the American Medical Association and the insurance industry continue to push tort "reforms" regulating medical malpractice lawsuits as the solution to containing and controlling the rising price of health care. In a somewhat new twist, doctors now claim that it is not simply medical malpractice premiums, since they are going down, but rather the fear of lawsuits which forces them to practice expensive "defensive medicine." They argue that limiting lawsuits and awards will eliminate the need for "defensive medicine" and presumably reduce costs.

ANALYSIS

This report examines the relationship between medical malpractice tort "reform" and health care costs.

Over the past 18 years, every state in the country has enacted at least one "reform" measure. By tightening access to the courts or limiting the amount a victim can recover in damages, these "reforms" were originally proposed to control health care costs by lowering malpractice premiums and presumably reducing the costs of "defensive medicine."

In order to test the effectiveness of tort "reforms," we decided to compare the states' tort "reform" initiatives and per capita health care costs.

We reviewed documents that compiled information on tort "reforms" and per capita health care costs. The AMA Tort Reform Compendium describes the tort "reforms" enacted in each of the 50 states up until 1989. Caps on damage recovery, limits on attorney fees, changing or eliminating joint and several liability, and periodic payment of damages are just a few of the ten tort "reforms" recommended by the American Medical Association.

The best estimates of per capita health care costs in 1990 are found in a February 1992 report by the U.S. General Accounting Office entitled Health Care Spending: Nonpolicy factors account for most state differences.

After reviewing the data, we have found that there is no indication that enacting major tort "reforms" is positively correlated with lower health care costs.

In fact, the states with the lowest per capita health care spending are less likely than average to have enacted the caps on damages, limits on attorney fees, periodic payment of damages or modified the collateral source rule. The states with the lowest per capita expenditures are more likely to have enacted fewer tort "reforms" overall than the average. (See chart A on the following page.)

Chart A: A Review of Tort Restrictions in the States Spending the Most and LeastPer Capita on Health Care

Ten Most Expensive States	**Attorney Fee Regulations Enacted in**	**Collateral Source Rule Modified in**	**Limits on Recovery Enacted in**	**Periodic Payment of Damages Enacted in**
Massachusetts	1986	1986	1986	
California	1975	1975	1975	1975
New York	1976, 85	(1975-81) 1981		1985
Nevada				
Rhode Island		(1976-86) 1986		1986
Connecticut	1986	1985, 87		(1986-87) 1987
North Dakota		(1977-83) 1987	(1977-83)	(1977-83) 1987
Illinois	1985	1976, 85	(1975-79)	1985
Michigan	1981	1986	1986	1975, 86
Missouri			1986	1986
Ten Least Expensive States				
South Carolina				1976
Idaho	(1975-81)	(1975-81)	(1977-81) 1987	1987
Mississippi				
Wyoming	1977			
Utah	1985	1985	1986	1986
New Mexico			1976	1976
North Carolina				
Kentucky		1988		
Arkansas				1979
Vermont				

Please note: Years in parentheses indicate that a state had previously enacted a statute which was allowed to expire or was declared unconstitutional. A date followed by a comma and another date indicates that the statute was amended.

Caps on Damages

Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30% of the ten states spending the least in health care have enacted limits on recovery of damages; 55% of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is no correlation between the least expensive states and limits on damages. (See Chart 3 on the following page.)

Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.[4]

Periodic Payment of Damages

Sixty-two percent of all states have a rule permitting periodic payment of damages. Only 50% of the ten states with the lowest per capita health expenditures allow periodic payments. A periodic payment plan doesn't help a victim who may need the bulk of his award immediately to help defray medical costs or pay the mortgage. But, the AMA notes that periodic payments do help the insurance company hedge its bets in the event the victim "dies prematurely," by preventing a "windfall" to the victim's heirs.[5] In the meantime, the doctor's insurance company is free to reinvest and earn interest on the unpaid damages.

Attorney Fee Regulation

Only 20% of the states with the lowest per capita health spending have attempted to limit attorney's fees; 57.5% of the remaining 40 states have laws which limit attorney's fees. In its 1980 review of the constitutionality of New Hampshire's medical liability statute, the New Hampshire Supreme Court noted that there was "no direct evidence that juries consider attorney fees in coming to a verdict" and concluded that limiting attorney fees would do little to reduce medical liability insurance rates or control health care costs.[6]

Eliminating the Joint and Several Liability Rule

Changing or eliminating the joint and several liability rule is another popular "reform." While 60% of the states with low per capita spending have enacted such laws, 56% of all states also do.

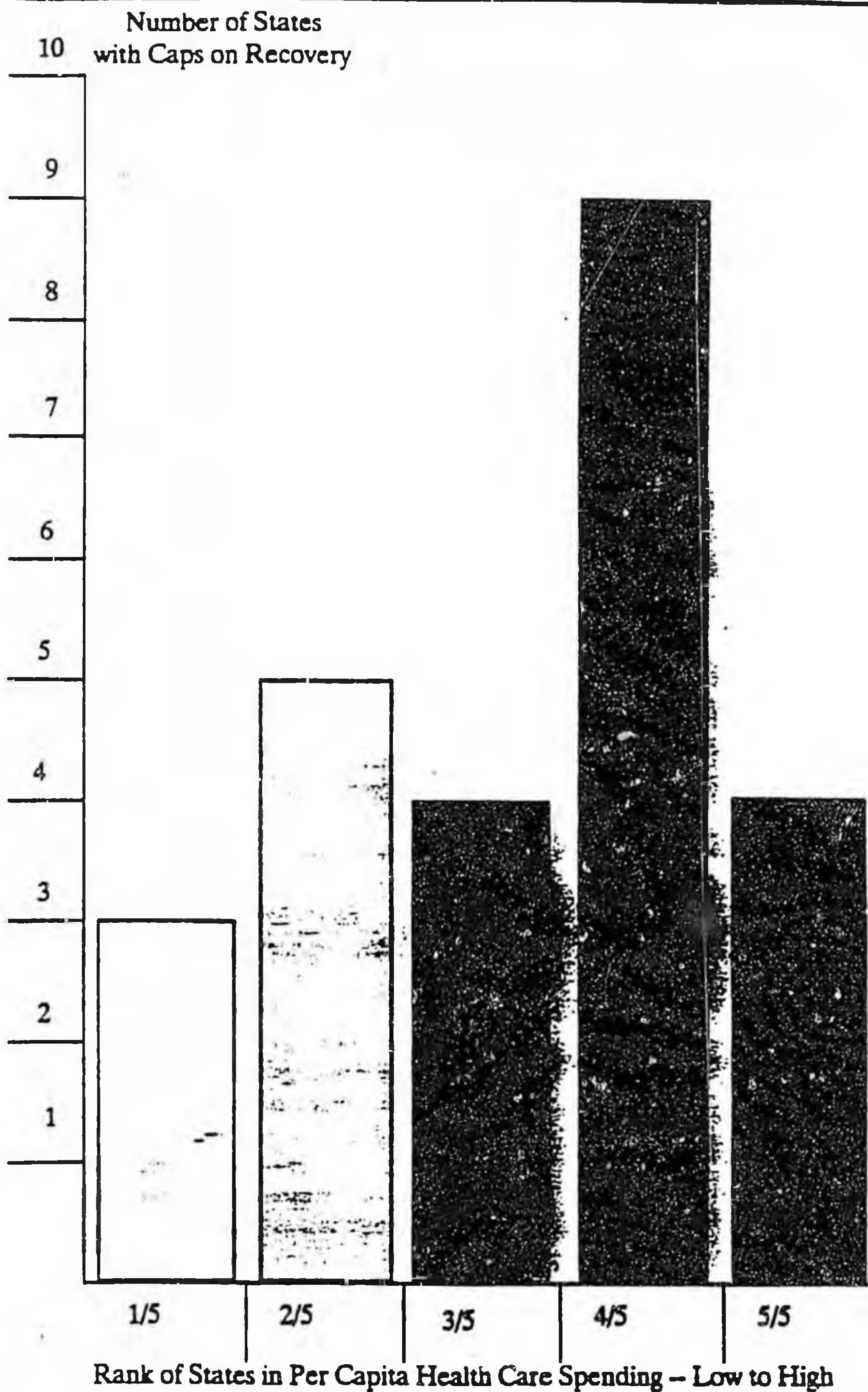

Chart B: Limits on Recovery v. Health Care Spending

Modifying the Collateral Source Rule

Only two of the ten states with the lowest health spending have enacted a law modifying the collateral source rule; 54% of the remaining 40 states have done so.

Controlling for Time

We were also concerned that different "reforms" were enacted at different points in time, making it difficult to gauge whether enough time had elapsed for a law to demonstrate its intended effect. Nearly half of the of the four statutes examined in Chart A were enacted at least ten years ago. Only one statute was enacted after 1987. The per capita spending data we examined was estimated for 1990.

Malpractice Premiums and Defensive Medicine

According to a study done by the Congressional Budget Office in 1992, the cost of doctors' medical malpractice premiums amount to less than 1% of the total health care tab in the United States. But the medical industry believes that the cost of medical malpractice premiums do not tell the whole story: doctors claim that the fear of medical malpractice lawsuits has led them to practice "defensive medicine" by conducting unnecessary tests as a protection against lawsuits.

A study released in February 1993 by proponents of tort "reform," the National Medical Liability Reform Coalition, concluded that "defensive medicine" could cost about $7 billion per year. The study's author, Lewin-VHI, Inc., admits that defensive medicines costs are difficult to quantify because "physicians have a variety of possible motivations besides defensive medicine to perform excess procedures, including financial incentives in some cases."[7] Even accepting the proponents' conclusions, defensive medicine accounts for less than one per cent of total health care costs.

Other studies dispute the whole premise that defensive medicine is inherently wasteful, contending that practices associated with "defensive medicine" are also associated with sound diagnostic procedures and reduced risk of wrong or incomplete diagnoses.--In its October 1992 study, the Congressional Budget Office states that "it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform." The report concludes: "Restructuring malpractice liability alone would not generate large savings in U.S. health care costs."[8]

The primary medical malpractice insurer in the country, St.Paul Fire and Marine Insurance Company, has even admitted in an addendum to the Florida State Supreme Court that it expects little to no savings from tort reform initiatives.[9]

Demographic Factors Help Explain Health Care Costs

States with a higher per capita income had a strong correlation to higher per capita health care spending, according to a report released in February 1992 by the General Accounting Office. That same study noted that "state policies play a limited role in reducing spending differences" between states. [10]

Illinois' Experience

In Illinois, the medical lobby pushed through the legislature a "reform" package in the mid-1970s which included caps on awards, provision for arbitration, and establishment of a pretrial screening panel. Both the limits on recovery and the pretrial screening panel were declared unconstitutional by the Illinois State Supreme Court. The Court said that limits on recovery, in particular, were "arbitrary and constituted a special violation of the state constitution." However, that didn't stop the Illinois State Medical Society from pursuing caps and other restrictions on Americans' constitutional rights as a "solution" to the health care crisis.

In 1985, the ISMS convinced the General Assembly to enact further restrictions on medical malpractice suits in the name of lower insurance premiums These new restrictions included the elimination of punitive damages against negligent health care providers, certification of the merit of the case by another doctor, periodic payments of damages exceeding $250,000, reduction of awards by the amount received from collateral sources such as the victim's own health insurance, and strict limitations on attorneys' fees. In 1987, the General Assembly approved a bill which reduced the statute of limitations on medical malpractice suits for minors. All these limitations put together make pursuing a medical malpractice lawsuit in Illinois even more difficult than before.

What effect did these changes have on overall health costs? Our research reveals that Illinois was estimated to be the 8th most expensive state in terms of per capita health care spending in 1990. In 1982, the last year the Health Care Financing Administration reported such data, Illinois was also ranked 8th.

CONCLUSION

Doctors and insurance companies argue that introducing tort "reforms" at the state and federal level will reduce the exorbitant costs of health care in the United States. However, despite the fact that every state in the nation has enacted some kind of tort "reform," we found no evidence that tort "reform" is an effective method of controlling health care costs.

APPENDIX A

Brief summaries of the major tort "reform" efforts across the United States.

1. Changes or elimination of the ad damnum clause. An ad damnum clause states the amount of monetary damages the plaintiff is claiming. Changes to or elimination of the clause is designed to prevent widespread publicity over potentially inflated claims.

2. Arbitration. Some states have set up a system in which the patient and the health care provider enter into a voluntary written agreement to submit any injury claim to binding arbitration. Agreeing to submit to arbitration is not a condition of receiving treatment. Arbitration is viewed as an alternative to and in lieu of a trial and subsequent judicial review of the claim will be limited. Many states statutes make specific reference to a consumer's waiver of a right to a trial and many also regulate whether there is a grace period in which the written agreement may be revoked.

3. Plaintiff Attorney Fee Regulation. Statutes regulate the fees plainti attorneys may collect in a variety of ways -- by establishing a sliding scale for fees, by establishing a maximum percentage attorneys may collect and by providing for court review of the reasonableness of attorney fees. In addition, attorneys are prohibited from charging any fees if the plaintiff loses in court.

4. Collateral Source Rule. The collateral source rule prohibits the introduction into evidence at trial any indication that a patient has been compensated or reimbursed for his injury from any source other than the defendant. Under this rule, a plaintiff may receive double compensation for his injury. Some states have sought to limit double compensation by modifying the collateral source rule to introduce evidence of compensation received.

5. Frivolous Lawsuit Penalties. These statutes generally require that a party making a frivolous claim or defense may be held liable for payment of the other party's reasonable attorney fees and court costs.

6. Joint and Several Liability Rule. The joint and several liability rule provides that a person who causes an injury concurrently with another person can be held liable for payment of the entire judgment. Where joint liability is eliminated, each defendant is liable only for that portion of damages attributed to his percentage of fault. Several states have restricted or eliminated the doctrine of joint liability or have restricted the situations in which it can be applied.

7. Caps or Limits on Recovery. Some states have sought to limit the amount of money a plaintiff may be awarded either by limiting specific types of damages, such as non-economic damages, or by placing an absolute limit on the amount of money that may be recovered. Some statutes provide for exceptions to the caps.

8. Patient Compensation Funds. A few states have set up patient compensation funds which give the participating health care providers additional insurance coverage for high payments. Participating health care providers must demonstrate that they have medical liability insurance or financial responsibility to pay the amount below which the fund will not pay.

9. Periodic payment of damages. Statutes legislating the periodic payment of damages over the lifetime of the plaintiff or the actual period of disability have been enacted in most states.

10. Pretrial Screening Panels. Pretrial screening panels are designed to provide a review of the merits of medical malpractice claims. The decision of the panel is not binding on a judge or jury and does not prevent a plaintiff from pursuing a trial.

NOTES

1. Jacobson, Sherry, "Medical Bankruptcies Rising," Chicago Sun-Times, August 9, 1992.

2. Hasson, Judi, "Democrats skeptical of chances for reform" USA Today, June 29, 1992.

3. Neus, Elizabeth. "Lawsuits Disputed as Health Care Woe." Gannett News Service in the Chicago Sun-Times. October 19, 1992.

4. "The Myth of Medical Malpractice Savings: The Nothing for Nothing Trade-off in Indiana's Health Care System." The Coalition for Consumer Rights. Chicago, Illinois. February 1992.

5. AMA Tort Reform Compendium, 1989, American Medical Association, Chicago.

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7. Brostoff, Steven. "Stopping 'Defensive Medicine' Can Save Billions, Study Says." National Underwriter, February 8, 1993.

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9.Addendum to Florida Supreme Court

10. Health Care Spending: Nonpolicy factors account for most state differences, General Accounting Office, February 1992.

MEDICAL AND HOSPITAL PROFESSIONAL LIABILITY

A REPORT PREPARED FOR THE TEXAS HEALTH POLICY TASK FORCE

BY

TONN AND ASSOCIATES

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I.. EXECUTIVE SUMMARY

There are concerns in Texas, as well as in other states, about the economic impact that medical and hospital professional liability has on the overall health care delivery system. There is also concern about how it affects patient access to health care. This report examines the complex issues and initiatives that make up the framework of medical and hospital professional liability.

Physicians, hospital executives, consumers, insurers and plaintiff attorneys have different perspectives on many aspects of this process. To the credit of the Texas Medical Association, the Texas Trial Lawyers Association, and the Texas Hospital Association, they have all demonstrated cooperation and support through their assistance with this study. In addition, insurers and self-insured hospitals have assisted by providing extensive data.

The issues presented are complex and involve financial, medical, legal, and insurance issues. The findings indicate that changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas. Medical professional liability costs for premiums and indemnity payments are estimated to be less than one percent of health care expenditures, both in Texas and the U.S. as a whole.

The debate and concern about the economic impact of "defensive medicine" is ongoing, but findings indicate that

reducing defensive practices and over-utilization of health care services is more complex than "tort reform" and will require more consensus on practice standards and peer review initiatives. A recent Harvard study concluded, "Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as a result of a specific suit. Thus, it was unclear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors."[1] In hospitals, many "defensive practices" have become institutionalized.

While the overall economic impact to the health care delivery system is minimal, the impact is very significant to a patient who has been injured and believes they have received negligent treatment. The potential impact is also significant to a health care provider who feels falsely accused of malpractice.

In Texas, the legal processes appear to be in the mainstream of how most states address tort law. The findings indicate that further study may be warranted for many areas presented in this report. Assertions that there are frivolous claims may be caused in part by confusion about what constitutes a "claim" for data compilation

purposes as well as by statutes of limitation. Under current law, parties who are potentially, but not primarily, liable are sued to avoid the limitations bar and then dismissed before trial without any indemnity being paid. Even so, over one half of all claims filed are closed with no indemnity payment and further review of the effectiveness of Rule 13 may be warranted.

The study found that very few claimants have received multi-million dollar payments, overall caps would tend to shift costs versus reducing overall costs, few cases are resolved by jury judgments and non-economic damages do not appear to be a major factor in settlements paid to claimants.

The high costs associated with the medical expense component of claims involving newborns indicate a need to address the underlying problems that contribute to risk, treatment, and injury to newborns.

Numerous studies concur that Medicaid patients do not file disproportionate numbers of malpractice claims.

The process of reporting medical malpractice claim information to the State Board of Medical Examiners is cumbersome. Additionally, there is a need to more closely examine whether there is a correlation between multiple liability claims against a provider and the provider's professional competence.

Physicians in Texas, as well as other states, carry a large share of the medical professional liability financial

burden. However, malpractice premiums for Texas physicians compare favorably with other states. The availability of insurance has been increasing and there is competition among the companies. Analyzing the availability of hospital professional liability is difficult because of differences between limits of liability, self-insuring mechanisms, and the use of non-admitted or licensed carriers.

Comparing the actual indemnity payments on behalf of physicians in 1980 constant dollars indicates that the average payments have leveled off in Texas since the middle 1980's. For hospitals, both claims frequency and average payments have continued to increase.

A number of state statutes that affect this subject are scheduled to expire during 1993 and will need to be addressed by the next legislative session.

CALIFORNIA'S MICRA: PROFILE OF A FAILED EXPERIMENT IN TORT LAW RESTRICTIONS

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EXECUTIVE SUMMARY

As the Clinton Administration prepares to present its health care proposal to the nation, doctors, insurance companies, hospitals, HMOs, and other participants in the health care industry are aggressively campaigning for restrictions on the legal rights of medical malpractice victims. The model for this campaign is a 1975 California statute, the Medical Injury Compensation Reform Act, or MICRA. Its provisions:

- Place a $250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries.

- Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.

- Permit those found liable for malpractice to pay the compensation they owe victims on an installment plan basis.

- Enable health care providers to require patients to waive their right to a jury trial in the event of malpractice.

- Impose a short "statute of limitations" on malpractice victims.

- Establish a sliding scale for attorneys fees which discourages lawyers from accepting serious or complicated malpractice cases.

Supporters of a similar federal law have promised the White House that it would reduce overall national health care costs. The purpose of this analysis is to determine what impact, if any, MICRA has had on the cost of health care in California. Because MICRA has been in effect for seventeen years, it is possible to test the validity of the assertions that a federal law based on MICRA would lower the nation's health care costs.

HEALTH CARE EXPENDITURES. Health care costs have grown by 533%, faster than the inflation rate in California, since the passage of MICRA in 1975. Since 1985, the California Medical CPI has grown nearly twice as fast as the rate of general inflation.

Health care costs in the state are as high, and by some measures higher, than the national average. California's CPI for medical care has grown faster than national health care costs since 1975, and the rate of growth in California is accelerating compared to the U.S.. In short, California is experiencing the same, if not a more destabilizing, health care crisis than the nation now faces.

malpractice insurance both in California and nationally, and have been the major beneficiaries of the MICRA restrictions on victims.

Moreover, to the extent that the data show that reductions in payouts have been passed on to medical care providers through reduced premiums, particularly in California, the physicians and hospitals have not passed the savings through to consumers in the form of overall lower health care costs. The providers themselves have profited from the restrictions on victims' rights.

Restrictions on compensation of malpractice victims should reduce premiums. But MICRA has not done so in California. Contrary to the assertions of the medical lobby, MICRA has not reduced health care costs in California. Imposition of such a law on a federal basis would not significantly reduce health care costs.

DEFENSIVE MEDICINE. The data do not support the assertion that MICRA-like restrictions on victims' rights will lower health care costs by reducing the practice of "defensive medicine," which is increasingly viewed as a misnomer. According to a review of Cesarean sections -- a procedure which is routinely said to be performed because of physicians' fears of malpractice suits -- tort restrictions in California and other states do not reduce the use or misuse of c-sections compared to other states.

Imposition of MICRA on a federal basis would not reduce health care costs arising from unnecessary medical procedures.

Introduction

As the Clinton Administration prepares to present its health care reform plan to the nation, increasing attention is being paid to proposals to restrict the legal rights of victims of medical malpractice.

In calling for such restrictions, the medical lobby – principally the 294,000 member American Medical Association, health insurance companies, and hospital trade associations – argues that the cost of malpractice suits is a major driving force behind the nation's health care crisis. Restrictions on malpractice suits, it is claimed, would significantly lower the cost of health care.[1]

Advocates of restrictions on malpractice suits have urged the President and members of Congress to utilize a California statute, the Medical Injury Compensation Reform Act, or MICRA, as the model for national legislation to be incorporated in the Clinton health care plan.

MICRA was enacted by the California Legislature in 1975 in response to rapidly-increasing medical malpractice insurance premiums. The powerful insurance and physicians' lobbies told state legislators that medical malpractice lawsuits and jury awards were responsible for the higher premiums.

Insurance companies threatened that the costs associated with malpractice insurance were rising at such a rate that their only option was to raise health care professionals' liability premiums or to withdraw from the market altogether.[2] Physicians and hospitals emerged as high visibility advocates for the legislation: many opted to "go bare" (practice without malpractice insurance), some discontinued providing certain high-risk procedures, while others threatened to quit.[3]

It is ironic that MICRA is being portrayed as a solution to the nation's health care crisis, for the law has become increasingly controversial in California. In recent years, MICRA has come under severe criticism from victims' support organizations, consumer groups, legislators and others. They have questioned whether MICRA has achieved any benefits for California's consumers, and have noted its profound impact upon the victims of medical malpractice. Many have demanded amendment or repeal of MICRA.

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1 ""Medical Liability: Key Facts" and "Medical Liability: Principles for Reform," published by the National Medical Liability Reform Coalition, February, 1993. See also, "The Continuing Need for Leglislative Reform of the Medical Liability System," American Medical Association (AMA), National Medical Specialty Society, February, 1987. "Keeping Californians Healthy," Californians Allied for Patient Protection (CAPP), The Coalition to Preserve MICRA, 1992.

2 Medical Malpractice: Case Study on California, General Accounting Office (GAO), December 1986, p. 8.

3 Id.