ALASKA LEGISLATURE COMMITTEE FILES 1995-1996 8672

8701 HOUSE LABOR & COMMERCE

192

LINCOLN LIFE

1300 South Clinton
Fort Wayne, IN 46802

March 27, 1996

Representative Norman Rokeberg
House Labor and Commerce Committee
State Capital
Juneau, Alaska 99801-1182

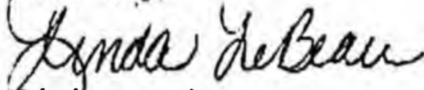
SENT VIA FACSIMILE (907) 465-2819

RE: CS 197 - **DOMESTIC VIOLENCE**

Dear Representative Rokeberg:

We have reviewed a copy of CS 197 and an amendment which has been suggested by State Farm. We very much support the State Farm amendment and appreciate the opportunity to pass on our comments.

Sincerely,



Linda S. LeBeau
Government Relations Consultant
Telephone: (219) 455-3747
Facsimile: (219) 455-6777

The Company You Keep®

New York Life Insurance Company
51 Madison Avenue, New York, NY 10010
212 576-7807 Fax: 212 576-4473

Eileen L. Gallagher
Assistant Vice President

March 27, 1996

VIA FACSIMILE
The Honorable Norman Rokeberg
House Labor and Commerce Committee
Alaska State Capitol
Juneau, AK 99801-1182
Fax# (907) 465-2819

Re: State Farm's Amendment to SB 197

Dear Representative Rokeberg:

I am writing on behalf of New York Life Insurance Company to strongly support State Farm's amendment to Senate Bill 197 regarding insurance for domestic violence victims. New York Life's underwriting policy does not deny coverage to proposed insureds solely because they have been victims of domestic violence.

The amendatory language (see attached) would prohibit insurers from discriminating against victims of domestic abuse based on an individual's status as a victim of domestic abuse. Additionally, while prohibiting this discrimination, a preferential class of applicants is not created. Therefore, this language would facilitate the important social goal of preventing discrimination against victims of domestic abuse.

In closing, I would like to strongly urge the inclusion of State Farm's amendment to this bill.

Sincerely,

Eileen L. Gallagher

Eileen L. Gallagher

ALLSTATE LIFE INSURANCE COMPANY
LAW AND REGULATION DEPARTMENT
3100 Sanders Road, J5B
Northbrook, Illinois 60062

Direct Dial Number (847) 402-2627
Facsimile (847) 402-3781

JOHN MATHEWS
Counsel

March 27, 1996

House Labor & Commerce Committee
c/o Representative Norman Rokeberg

Re: Senate Bill 197 - Domestic Violence Legislation

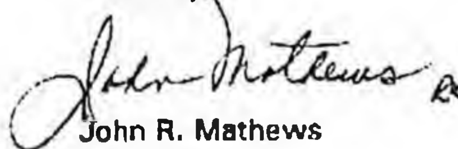
Dear Representative Rokeberg:

On behalf of Allstate Life Insurance Company, Northbrook Life Insurance Company, Glenbrook Life Insurance Company, Lincoln Benefit Life Insurance Company and Surety Life Insurance Company, I am writing regarding the amendment to Senate Bill 197, Domestic Violence legislation.

We support the addition of this amendment because, while we agree that it is inappropriate to use an individual's status as a victim of domestic abuse, it is necessary for an insurer to be able to underwrite based on the physical and mental condition of the individual. The proposed amendment would permit an insurance company to underwrite based on the applicant's medical condition. The State Farm amendment very simply addresses our concerns with regard to CS197 Domestic Violence Legislation.

We appreciate your consideration of our comments and hope that you favorably consider the amendment.

Sincerely,



John R. Mathews
Counsel

JRM:rk

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690
Tel 212 578-2190   Fax 212 578-8869

Sharon B. Cockey
Government Relations Counsel

House Labor and Commerce Committee
c/o Representative Norman Rokeberg

RE CS197

Dear Representative Rokeberg:

MetLife strongly supports the State Farm amendment to CS197, which relates to insurance for domestic violence victims and which requires certain disclosures by insurers. We feel that the amendment succinctly and adequately addresses our concerns and opposition to CS197.

We strongly urge your Committee to adopt this amendment, which is fair to both insureds and the insurance industry.

In the event that you need additional information, please feel free to contact me.

Very truly yours,

Sharon B. Cockey

Sharon B. Cockey
Government Relations Counsel

March 27, 1996

** TOTAL PAGE.002 **

ALLMERICA
FINANCIAL

SENT BY TELEFAX: (907) 465-2819

March 26, 1996

State of Alaska
House Labor and Commerce Committee
c/o Rep. Norman Rokeberg

RE: Domestic Violence Bill: CS 197

Dear Committee Members:

We strongly urge that you support the State Farm amendment to the domestic violence bill under consideration before the Committee. We agree that it is inappropriate to use an individual's status as a victim of domestic abuse in the underwriting process for insurance. On the other hand, insurers should be permitted to underwrite and rate for medical conditions in the same manner that they would for a proposed insured who is not a victim of domestic violence.

We believe that it would be unfairly discriminatory to single out victims of domestic violence for special treatment. Absent this amendment (or similar language), insurers would be required to treat these individuals more favorably than those suffering from the same medical conditions through different events.

We appreciate any efforts which would encourage the adoption of this important amendment.

Very truly yours,

Katherine L. Colman

Katherine L. Colman, FLMI, HIA
Assistant Vice President
Law Staff Administration & Compliance

KLC:Mi\ak-cs197

440 Lincoln Street, Worcester, Massachusetts 01653, Phone 508-855-1000, Fax 508-853-6332

March 20, 1996

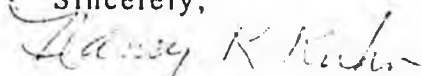
Dear Labor and Commerce Committee,

Alaska has one of the highest domestic violence rates in the nation. What a sad commentary that innocent victims of domestic violence would need worry about health insurance as a result of the harm inflicted upon them. Increases in health insurance premiums, or denial of benefits to the victim is punishment. We should protect and secure the rights of victims, and seek censure of the perpetrators. Domestic violence victims are not currently protected from insurance discrimination in Alaska. SB 197 offers an opportunity to be proactive instead of reactive, and there is no fiscal impact to the State budget.

SB 197, sponsored by Senator Dave Donley, prohibits insurers from increasing premiums, or canceling or denying insurance solely on the basis of domestic violence.

I urge you to vote favorably in support of SB 197 and to pass it quickly out of committee.

Sincerely,



Nancy K Kuhn
President
Interior Alaska Women's Political Caucus
2060 Amy Dyan Rd
Fairbanks, AK 99712

AMENDMENT

OFFERED IN THE HOUSE
TO: CSSB 197(L&C)

#1

Proposed committee substitute:

Section AS 21.36 is amended by adding new sections to read:

Sec. 21.36.430 INSURANCE FOR DOMESTIC VIOLENCE VICTIMS; (a) An insurer offering life, disability or health insurance in Alaska may not discriminate against a victim of domestic abuse based on an individual's status as a victim of domestic abuse. This prohibition shall not prevent an insurer from underwriting or rating for a medical condition in the same manner as they would for an insured or applicant who is not a victim of domestic abuse.

(b) This section applies only to an insured or applicant for insurance.

(c). An insurer is granted immunity for criminal or civil liability resulting from compliance with this statute.

9-LS1218\M
Ford
3/26/96

HOUSE CS FOR CS FOR SENATE BILL NO. 197( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DONLEY, Ellis, Salo, Duncan, Pearce, Zharoff, Lincoln

REPRESENTATIVE Davies

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to insurance covering an insured who is a victim of domestic
2 violence and requiring certain disclosures by the insurer."

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

4 * Section 1. AS 21.36 is amended by adding new sections to read:
5 Sec. 21.36.430. INSURANCE FOR DOMESTIC VIOLENCE VICTIMS;
6 RECORDS. (a) An insurer may not (1) refuse to issue or renew insurance coverage;
7 (2) cancel an existing policy of insurance; (3) deny a covered claim; or (4) increase
8 the premium on an insurance policy if the refusal, cancellation, denial, or increase
9 results only from the fact that the applicant or insured was a victim of domestic
10 violence.
11 (b) Records maintained by an insurer that reflect the fact that the insured was
12 a victim of domestic violence are confidential and may not be disclosed by an insurer,
13 except with the permission of the applicant or the insured as required by a court of
14 competent jurisdiction or as required by the division of insurance.

1 Sec. 21.36.440. REQUIRED DISCLOSURE FOR FAILURE TO PROVIDE
2 COVERAGE TO AN APPLICANT. An insurer who refuses to provide insurance
3 coverage to an applicant initially applying for insurance shall
4 (1) inform the applicant that the applicant has a right to know the
5 reason for the refusal; and
6 (2) upon receipt of a written request from the applicant, provide a
7 written explanation of the refusal to the applicant.
8 Sec. 21.36.450. DEFINITION. In AS 21.36.430 - 21.36.440, "insurer"
9 includes
10 (1) an insurer, as defined in AS 21.90.900;
11 (2) a group health plan, as defined in 29 U.S.C. 1167(1) (Employee
12 Retirement Income Security Act of 1974);
13 (3) a health maintenance organization, as defined in AS 21.86.900;
14 (4) a hospital service corporation or medical service corporation, as
15 defined in AS 21.87.330;
16 (5) a writing carrier, as defined in AS 21.55.500; and
17 (6) an entity offering a service benefit plan, as referred to in 42 U.S.C.
18 1396g-1.
19 * Sec. 2. This Act applies to a policy of insurance that is entered into or renewed on or
20 after the effective date of this Act.

9-LS1218\K
Ford
3/14/96

HOUSE CS FOR CS FOR SENATE BILL NO. 197( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DONLEY, Ellis, Salo, Duncan, Pearce, Zharoff, Lincoln

A BILL

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7 (2) cancel an existing policy of .surance; (3) deny a covered claim; or (4) increase
8 the premium on an insurance policy if the refusal, cancellation, denial, or increase
9 results only from the fact that the applicant or insured was a victim of domestic
10 violence.
11 (b) Records maintained by an insurer that reflect the fact that the insured was
12 a victim of domestic violence are confidential and may not be disclosed by an insurer,
13 except with the permission of the applicant or the insured as required by a court of
14 competent jurisdiction or as required by the division of insurance.

1 Sec. 21.36.440. REQUIRED DISCLOSURE. An insurer who refuses to
2 provide insurance coverage to an applicant or insured, or who cancels existing
3 coverage shall provide a written explanation of the refusal or cancellation to the
4 applicant or insured.
5 Sec. 21.36.450. DEFINITION. In AS 21.36.430 - 21.36.440, "insurer"
6 includes
7 (1) an insurer, as defined in AS 21.90.900;
8 (2) a group health plan, as defined in 29 U.S.C. 1167(1) (Employee
9 Retirement Income Security Act of 1974);
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12 defined in AS 21.87.330;
13 (5) a writing carrier, as defined in AS 21.55.500; and
14 (6) an entity offering a service benefit plan, as referred to in 42 U.S.C.
15 1396g-1.
16 * Sec. 2. This Act applies to a policy of insurance that is entered into or renewed on or
17 after the effective date of this Act.

Kenai-Soldotna Women's Resource & Crisis Center

March 20, 1996

Members of the House Labor & Commerce Committee:

Rep. Kott, Chair
Rep. Rokeberg, V. Chair
Rep. Porter
Rep. Sanders
Rep. Masek
Rep. Elton
Rep. Kubina

Dear Committee Members:

We support SB197. It is a proactive step in ensuring the insurance needs of Alaskan victims of domestic violence continue to be met.

Insurance discrimination against victims of abuse occurs on a widespread basis in the lower 48 and must not be allowed in Alaska.

Insurance discrimination puts victims at risk both by denying them the benefits that insurance provides and by discouraging them from seeking help that may cause them to lose their insurance.

No one asks to be beaten or abused. Domestic violence is a crime which permeates all races, religions, and economic classes. A person's "likelihood" of being a victim of a crime should not be used as a basis for underwriting insurance -- this mentality clearly places responsibility for criminal behavior on the victim, not the perpetrator. *To deny insurance to a victim of crime is unconscionable!*

<u>Please support SB197 as written, with no amendments!</u>

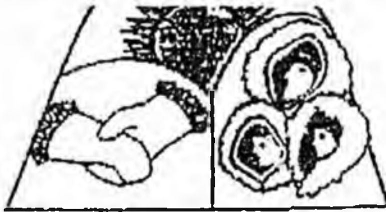
Thank you!

Sincerely,

Brenda G. Wieffering
Executive Director

325 South Spruce Street
Kenai, Alaska 99611

Business Line . . . 283-9479
Crisis Line . . . 283-7257



Bering Sea Women's Group
A Safe Shelter for Women and Children
P.O. Box 1596 / Nome, Alaska 99762 / (907) 443-5444 or 1-800-570-5444 / (907) 443-5491

TRANSMITTAL COVER SHEET

Date: 3-20-96

To: Rep. Kott **Fax #:** 465 2819

From: Beverly Bowers **Fax #: 907-443-3748**

Total page including the cover: 1

Comments:

I support SB 197. Please move it out of the Committee in its current form.

Signature: Beverly Bowers

facsimile
TRANSMITTAL

to: Rep. Kott, Chair for (H)L&C
fax #: (907)465-2819
re: SB197
date: March 20, 1996
pages: 1 page(s) total, including this cover sheet

Please support SB197, as written, with no amendments. I am so pleased to see legislators writing proactive legislation!!! Protecting victims from insurance discrimination should definately be a priority to lawmakers and I'm happy to see you working towards that goal.

As I'm sure you are aware, insurance discrimation against victims of abuse occurs on a widespread basis in the lower 48 and must not be allowed in Alaska. SB197 would afford Alaska the opportunity to stop insurance discrimination before it starts.

Please share this message with the other members of your committee. I'll be looking forward to seeing this bill move forward for the protection of victims.

From the desk of...

Michelle A. Callaham
Executive Director
USAFV
P.O. Box 36
Unalaska, AK 99685

tel: 907-581-1500
fax: 907-581-4568

Alaska Women's Resource Center
111 W. 9th Avenue • Anchorage, Alaska 99501 • (907) 276 0528 • Fax: (907) 278-0944

George: Do we have this letter in the packets - 3-21 P

March 20, 1996 VIA FAX

House Labor & Commerce Committee
Alaska State Capitol

Dear Representatives Kott, Rokeberg, Elton, Kubina, Masek, Porter, & Sanders:

I am writing to request your support for SB 197. The current bill protects the citizens of Alaska from insurance discrimination.

Discrimination in any arena is unacceptable; in the insurance industry, it is directly impacting upon the life and death of individuals. Insurance discrimination puts victims at risk both by denying them the benefits that insurance provides and by discouraging them from seeking medical assistance that may cause them to lose their insurance. Insurance carriers are currently able to assess the health of an individual and determine the appropriate premium with regard to any pre-existing medical condition. If this assessment is also granted in response to personal circumstances, it is an encroachment on our freedom as Americans.

Your support of SB 197 will protect the individual rights of Alaskans and let America know that we value the rights of our citizens.

Sincerely,

Diane J. Heard

Diane J. Heard
Executive Director

PS - Diane knows you already support this - but just wants you to have a copy of what's going to the committee.

LESSMEIER & WINTERS

ATTORNEYS AT LAW

ONE SEALASKA PLAZA
SUITE 303
JUNEAU, ALASKA 99801-1249

MICHAEL L. LESSMEIER
GREGORY W. LESSMEIER
SHELDON E. WINTERS
MARGARET A. DOWLING*

*WASHINGTON STATE BAR

TELEPHONE: (907) 586-5912
FACSIMILE: (907) 463-3030

March 20, 1996

Representative Pete Kott
Alaska State Legislature
State Capitol (MS 3100)
Juneau, Alaska 99801-1182

Re: CSSB 197

Dear Representative Kott:

On behalf of State Farm, I wanted to briefly respond to a couple of issues that came up during the hearing this past Monday. We continue to have strong objections to the confidentiality provisions in Subsection (b). The confidentiality provisions are unnecessary and burdensome. Consider for a moment that insurers, particularly health insurers, routinely have in their possession material of the most sensitive nature. For example, medical records may disclose whether a person is HIV positive, problems with substance abuse, marital difficulties or virtually any other mental or physical problem imaginable. The disclosure of such information may be just as damaging to the person involved as would be the disclosure of an incident of domestic violence. Yet there has been no need to legislate confidentiality for any of these other conditions.

This is because the confidentiality of this material is already carefully safeguarded. Indeed, the common law has long recognized a physician patient privilege which protects the confidentiality of medical records, except in certain circumstances where confidentiality is deemed waived. One example of such an exception occurs when a person places their medical condition at issue by making a personal injury claim. Another example of such an exception would occur if the material is relevant to establish a fraudulent claim.

Any insurer who did not respect the confidentiality of such material would be doing so at great peril. That is probably why no instances of an insurer violating confidentiality in our state have

been identified. It simply makes no sense to us to now legislate confidentiality for this one condition. We continue to believe the confidentiality provisions in the present bill are not necessary, are ambiguous and not justified by any existing problem

We also continue to strongly object to the required disclosure provision. If there is a discrimination complaint, the underwriting or claim file will contain the information necessary to resolve the complaint one way or the other. The required disclosure provision will in no way effect this.

We believe the proposal we have submitted contains a clear, specific, powerful prohibition which prevents discrimination against victims of domestic abuse in the area of concern. We urge you to adopt this language and not get side tracked on provisions which are unnecessary, unclear and controversial.

Sincerely,

LESSMEIER & WINTERS

By: Michael L. Lessmeier

MLL

cc Norman Rokeberg
Beverly Masek
Brian Porter
Jerry Sanders
Kim Elton
Gene Kubina

Women In Safe Homes
P.O. Box 6552
Ketchikan, Alaska 99901
ADMINISTRATION: 907-225-0202
CRISIS LINE: 907-225-9474
FAX LINE: 907-225-2472

TELEFAX TRANSMITTAL SHEET

DATE: 3/20/96

FROM: Gigi Pilcher, Executive Director

TO: members of the House Labor and Commerce Committee

FAX NUMBER:

TOTAL # OF PAGES (including cover): 1

MESSAGE: I urge your support of SB197 with no amendments.

HARD COPY TO FOLLOW: YES or NO

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1057 W. Fireweed Ln, Suite 230
Anchorage, Alaska 99503

Business 907/276-7279
24 HourCrisis 907/276-7273
Toll Free 1-800-478-8999
Fax 907/278-9983
TTDY 907/278-9988

March 18, 1996

Representative Pete Kott, Chair
House Labor and Commerce
State Capitol
Juneau, AK 99801

Dear Representative Kott:

STAR strongly supports SB 197. By denying medical coverage to victims of Domestic Violence, the insurance companies are further "punishing" the victim.

To hold a woman accountable for her abuser's behavior by denying medical coverage will serve to push domestic violence back in the closet. Women will become more reluctant to seek medical help. If they must seek help, they will be forced to lie and cover up the "real" reason for their visit to the hospital or personal doctor.

Forcing women to "keep the silence" around abuse **will further endanger both the victim and the children involved.** A cost that I suggest is too high to pay in exchange for the big business of insurance.

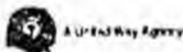
I urge you to take the much needed step in protecting women and children in Alaska by passing **SB 197**.

Thank you for your consideration.

Trisha Gentle

Trisha Gentle
Executive Director

cc: All members of House Labor and Commerce Committee
Representative Dave Donley



FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. CS SB 197 (L&C)

Revision Date: February 20, 1996
Title: Prohibit Increase in Ins. for Domestic Violence
Sponsor: Senators Donley, Ellis, Salo
Requestor: Senate L&C Committee

Department: Commerce and Economic Development
BRU: Insurance
Component: Operations
COMPONENT SERIAL NO. #354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
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						

CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 96) cost: $ 0.0

POSITIONS

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

ANALYSIS: (Attach a separate page if necessary)
No fiscal Impact.

Prepared by: Joan Brown, Administrative Officer — Phone: 465-2597
Division: Insurance — Date: 2/20/96

Approved by Commissioner: William L. Hensley — Date: 2-20-96
Agency: Commerce and Economic Development

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
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SENATOR DAVE DONLEY

ALASKA STATE LEGISLATURE

Sponsor Statement

CSSB 197(L&C)
Prohibiting Insurance Companies from Discriminating Against Victims of Domestic Violence
2/22/96

CSSB 197(L&C) amends SB 197 to increase the proposed protections to victims of domestic violence against insurance company discrimination. SB 197 protected domestic violence victims from insurance premium increases. The Committee Substitute additionally protects victims from having insurance cancelled or from having claims denied. Additionally, it prohibits insurers from using or disclosing records which reflect the insured as a victim of domestic violence. It also requires insurers to disclose the reason insurance coverage or an application was denied.

CSSB 197(L&C) was drafted with the advise and support of the Division of Insurance.

CSSB 197(L&C) prohibits insurance companies from refusing to provide coverage, from canceling a policy, and from increasing premiums only on the basis that the insured is a victim of domestic violence.

These precautions are necessary to protect victims of domestic violence. An informal survey by the Sub-Committee on Crime and Criminal Justice of the United States Judiciary Committee shows that eight out of sixteen of the largest insurance companies use domestic violence as a factor while rating insurance.

In 1995, seven states passed legislation similar to CSSB 197(L&C) including Florida, Connecticut, Iowa, Delaware, California, New Jersey, and Massachusetts. Legislation similar to CSSB 197(L&C) passed California's legislature with only one opposing vote. There is legislation similar to CSSB 197(L&C) pending in four states and in Congress.

Currently, there is no protection in Alaska for victims of domestic violence against insurance premium increases, cancellation, or denial. CSSB 197(L&C) protects innocent victims of domestic violence from being unfairly discriminated against by insurance companies. Insurers discriminating against domestic violence victims has been a serious problem in the lower 48 and CSSB 197(L&C) will prevent similar occurrences in Alaska.

If you have any question regarding CSSB 197(L&C), please contact myself or Amber Ala of my staff at 465-3892.

DD/aa

January-May: STATE CAPITOL • JUNEAU, AK • 99801-1182 • (907) 465-3892 • FAX: (907) 465-6595
June-December: 716 W. 4TH AVE. • STE. 430 • ANCHORAGE, AK • 99501 • (907) 258-8181 • FAX: (907) 258-1648

MEMBER: Senate Finance Committee • Senate State Affairs Committee

Insurance Discrimination Against Victims of Domestic Violence

Prepared by the Women's Law Project and
the Pennsylvania Coalition Against Domestic Violence
September, 1995

health and other insurance, victims may feel they have no alternative but to stay in an abusive situation.

Victims will stop seeking appropriate and necessary medical treatment, counseling, legal intervention and other forms of assistance, as they learn that insurers use information in client records documenting their help-seeking activities to deny them insurance. Victims will also refrain from identifying the cause of their injury and filing insurance claims. Furthermore, doctors, health care workers and other service providers who have started identifying and documenting abuse may stop if continuing to do so will put their patients at risk of losing their insurance. The enormous efforts made over the past twenty years to create new sources of assistance and avenues of relief for victims of domestic violence will be for naught.

? Does insurance discrimination against victims of domestic violence occur frequently?

Yes. An informal survey by the staff of the Subcommittee on Crime and Criminal Justice of the United States House Judiciary Committee in 1994 revealed that eight of the sixteen largest insurers in the country were using domestic violence as a factor when deciding whether to issue and how much to charge for insurance. In March of 1995, the Pennsylvania Insurance Commissioner surveyed company practices in Pennsylvania and found that a substantial number of health, life and accident insurers - 28% of the respondents - utilized domestic violence as an underwriting criterion.

? How many people are affected by these practices?

We know that many insurance companies discriminate against victims of domestic violence and that many people are victimized. (A July, 1994 study by The Commonwealth Fund reported that almost four million American women were physically abused by boyfriends and husbands in 1993.)

It is difficult to say just how many people are affected by these practices. Insurers are not required to tell applicants the reasons for rejections or other adverse actions and victims may not know that domestic violence was a consideration. Those who know that domestic violence is the reason for action taken against them by an insurance company, have very good reasons for not reporting discriminatory insurance practices — fear of further violence to themselves and their children from the batterer, as well as social stigma and

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Rev. 6/98

Central Microfilm Services
Departement of Education
State of Alaska

Insurance Discrimination Against Victims of Domestic Violence

Prepared by the Women's Law Project and
the Pennsylvania Coalition Against Domestic Violence
September, 1995

Insurance Discrimination and Victims of Domestic Violence

? How are insurance companies discriminating against victims of domestic violence?

Many insurance companies are denying victims of domestic violence access to all kinds of insurance by using domestic violence as an underwriting criterion, i.e., a basis for determining who to cover, how much to cover and how much to charge.

? How do insurers learn that someone is a victim of domestic violence?

When applying for insurance, individuals often sign a release to permit the insurer to obtain medical records. Usually, it is those medical records which reveal the information. This is becoming more common because physicians have been encouraged to follow protocols to identify and document abuse for the purpose of providing trained help and referrals.

There are also companies, such as the Medical Information Bureau (MIB) and Equifax, that maintain databases on risk factors, including violence. Insurance companies who become members of these databases are required to report client risk factors and are entitled to request risk-related information on an applicant or insured.

Insurers can also get information from other records, such as public court documents and credit reports, which are becoming popular underwriting tools and often contain information about court orders, including protection from abuse orders.

? How does insurance discrimination hurt victims of domestic violence?

Insurance discrimination puts victims at risk both by denying the benefits that insurance provides and by discouraging them from seeking help that may result in loss of insurance.

Without insurance, victims are unable to obtain health care for themselves and their families or provide for their families in case of death or disability. If unable to obtain

health and other insurance, victims may feel they have no alternative but to stay in an abusive situation.

Victims will stop seeking appropriate and necessary medical treatment, counseling, legal intervention and other forms of assistance, as they learn that insurers use information in client records documenting their help-seeking activities to deny them insurance. Victims will also refrain from identifying the cause of their injury and filing insurance claims. Furthermore, doctors, health care workers and other service providers who have started identifying and documenting abuse may stop if continuing to do so will put their patients at risk of losing their insurance. The enormous efforts made over the past twenty years to create new sources of assistance and avenues of relief for victims of domestic violence will be for naught.

? Does insurance discrimination against victims of domestic violence occur frequently?

Yes. An informal survey by the staff of the Subcommittee on Crime and Criminal Justice of the United States House Judiciary Committee in 1994 revealed that eight of the sixteen largest insurers in the country were using domestic violence as a factor when deciding whether to issue and how much to charge for insurance. In March of 1995, the Pennsylvania Insurance Commissioner surveyed company practices in Pennsylvania and found that a substantial number of health, life and accident insurers - 28% of the respondents - utilized domestic violence as an underwriting criterion.

? How many people are affected by these practices?

We know that many insurance companies discriminate against victims of domestic violence and that many people are victimized. (A July, 1994 study by The Commonwealth Fund reported that almost four million American women were physically abused by boyfriends and husbands in 1993.)

It is difficult to say just how many people are affected by these practices. Insurers are not required to tell applicants the reasons for rejections or other adverse actions and victims may not know that domestic violence was a consideration. Those who know that domestic violence is the reason for action taken against them by an insurance company, have very good reasons for not reporting discriminatory insurance practices — fear of further violence to themselves and their children from the batterer, as well as social stigma and

embarrassment. Finally, insurers are not required to file the criteria they use in deciding who to insure with state insurance departments or disclose that information to the public.

? What are some examples of insurance company discrimination against victims of domestic violence?

California

A Santa Cruz woman was repeatedly turned down for health insurance following review of medical records which detailed beatings by her husband.

A California hospital reports denial of payment by HMOs for repeated treatment for injuries caused by domestic violence.

Delaware

In August, 1994, Nationwide Insurance Company denied an application for life insurance based on medical records "indicating an unstable family environment" because they included documentation of three assaults by the husband against the wife and counseling.

Iowa

Prudential Insurance Company denied a woman a life insurance policy in November, 1993, because the woman had a history of multiple assaults from her ex-boyfriend.

A woman was sexually abused as a child and received some counseling. Despite a clear record and good health since then, when she applied for disability insurance, she was turned down on the basis of the earlier treatment.

Minnesota

Three insurance companies denied health insurance to a women's shelter because "as a battered women's program we were high risk."

A women's shelter in Rochester was told that it was considered uninsurable because its employees are almost all battered women.

A woman who sought the services of Women House in St. Cloud because the abuse during her 12-year marriage had escalated to such an extent that she was hospitalized for a broken jaw and spent 2 weeks in a mental health unit of a hospital, was denied health insurance by two companies, one saying it would not cover any medical or psychiatric problems that could be related to the past abuse.

A woman from rural Minnesota was beaten severely by her ex-husband. After she remarried, she applied for health insurance and was told that she would not be covered for treatment relating to the pre-existing conditions of depression and neck injury which were caused by the prior abuse.

Oregon

In 1994, Allstate Insurance Company canceled the homeowners' insurance of a woman whose former spouse set fire to the home twice. The woman had been abused by the former spouse throughout the marriage and left the marriage in 1992. Following cancellation, the woman was referred to the Oregon Fair Plan and was quoted a price for insurance that was eight times what she had previously been paying. After the former spouse was convicted and imprisoned for arson, the woman applied for insurance with Hartford, but was rejected for a poor credit record which was a result of the her former husband's failure to pay family debts for which he was responsible.

Pennsylvania

In October, 1993, a resident of Cumberland County, Pennsylvania was denied life, health and mortgage disability insurance by State Farm Insurance Company and life insurance by First Colony Life Insurance Company because of information in medical records revealing an incident of domestic violence. State Farm has since changed its policy and no longer considers domestic violence in the issuance of any line of insurance.

A York County woman whose employer provides health insurance through a self-insured plan has been unable to obtain reimbursement for health care expenses resulting from abuse because of an exclusion for expenses arising from or related to a domestic dispute.

A Lancaster County woman has been unable to obtain reimbursement for emergency room treatment for injuries resulting from domestic violence under her employer's self insured health plan. She has been billed for over $5000.

Washington

A woman's homeowner's policy was canceled by Safeco Insurance Companies in May, 1993 by letter reciting 5 claims filed over the 12 year life of the policy and noting concern that the most recent three occurred within a span of four months, but "more importantly", the most recent one "involved a domestic violence situation of individuals that are living with" the insured. The angry ex-wife of her boyfriend's brother damaged her door

A landlord's policy was canceled because the insurer learned that the landlord intended to rent a home to a woman's shelter.

A child was twice denied health insurance because he had been abused in a day care facility.

A woman was twice denied insurance due to treatment received for physical, emotional and sexual abuse inflicted on her by her family during her childhood and by her spouse during marriage. In the late 1980's her employer's disability insurance carrier denied her disability coverage because of a nervous condition related to abuse. In 1993, Cigna denied her application for an increase in life insurance coverage provided through her employer based on a diagnosis of dissociative disorder related to counseling received for abuse. Although she also suffers from obesity, Type II diabetes and a seizure disorder, the abuse related counseling is the only reason given by the insurers as grounds for

denial. She has divorced her abuser, has no further contact with her family of origin and is not on any medications.

A man who was physically attacked by his wife was denied nearly $2000 worth of health coverage for injuries he sustained. He was told that his wife, who owned the company that purchased the group coverage, instructed the insurer not to cooperate with him. Following divorce, he obtained an individual policy with exclusions for pre-existing conditions relating to domestic violence.

? What reasons do insurers give for using domestic violence as an underwriting criterion, and why are they invalid?

1. *Some insurers say that a victim of domestic violence makes a voluntary lifestyle or career choice, like skydiving, riding a motorcycle or washing skyscraper windows, for which an insurance company should not be responsible.*

   Domestic violence is a crime - not a career, a lifestyle or a choice. No one chooses to be battered and no one chooses to remain in a violent situation. Leaving a violent domestic situation is a difficult process, complicated by concerns for safety and economics.

   Victims realistically fear that their batterer will pursue and harm them and/or their children if they leave. Studies show that violence does not stop and may increase after leaving.

   Without money, it is impossible to get away and establish a new home and feed your children. Housing is a problem: shelters offer only temporary housing, often for 30 days or less, a very difficult time frame in which to create a new life.

2. *Others argue that domestic violence is a risk factor that needs to be considered by insurers and that limiting their ability to take domestic violence into account will impair their ability to offer affordable insurance products.*

   Domestic violence is a crime and a person's likelihood of being a victim of a crime should not be used as a basis for underwriting insurance.

   Furthermore, insurers have produced no actuarial studies showing that domestic violence is a particular risk that changes the overall cost of insurance. We know that there are many insurers who do not use domestic violence as an underwriting criterion and they are able to stay in business and provide affordable products. Even those companies with policies requiring denial of coverage to victims of domestic violence in fact cover victims and resulting injuries, when as is often the case, the abuse remains unidentified. Domestic violence is therefore already factored into the pricing of insurance products without impairing the market.

In addition, insurers do not, in a scientific and consistent manner, take into account all so-called risk factors when underwriting and rating insurance. To the contrary, although there are numerous risk factors which insurers can choose to use, they do not use all of them and their selection is not based solely on risk. Some classifications are not chosen because it is more cost effective to pay the claims than to identify and segregate the information needed to use them as underwriting criteria. Others may not be used because their use would negatively impact on marketing. Even where risk is the driving force behind the selection of criteria, the determination of risk is often based on assumptions and stereotypes, rather than any scientific assessment of risk.

Nor are insurers completely free from regulation. They are subject to extensive state regulation and are restricted by law from using particular classifications for underwriting and rating, including race, age, ethnic origin, residence, sex, and some physical or mental disabilities. Despite potential or actual statistical correlation to various health claims and morbidity, these classifications have been legally decreed to be unacceptable criteria for discriminating among insurance risks.

Many laws prohibit redlining - the practice of refusing to insure or raising the cost of homeowners' insurance in high crime areas - even though one could expect more crime or damage to homes in those areas. Yet, with respect to domestic violence, insurers are essentially redlining particular homes.

By virtue of government and private initiatives, we as a society have made a decision that domestic violence cannot be tolerated and that protection must be offered to its victims. Allowing insurers to deny insurance based on records created when someone takes steps to obtain assistance will deter victims from seeking help and undo all our efforts.

3. *Life insurers argue that insuring the life of a victim gives the batterer an incentive to kill and collect on the policy, and, if the insured is killed, the insurer could be sued for issuing a policy with knowledge of a history of domestic violence.*

Insurers have failed to provide any evidence that insurance acts as an incentive to further domestic violence or that denying insurance deters domestic violence. Domestic violence experts find that batterers abuse for power and control, not profit. Any hypothetical danger posed by providing coverage is outweighed by the known cost of denying insurance to victims of domestic violence: the inability of the victim to care for herself and her family, the perpetuation of violence and the increased health care costs imposed on society.

In addition, insurers are already fully protected from suit by contract and law. Insurance policy provisions typically prohibit beneficiaries from recovering when the death or injury is a result of intentional misconduct. Furthermore, state laws regulate and limit the

rights of a slayer from inheriting real and personal property and receiving benefits from insurance policies arising out of or as a result of the death of the person slain. Insurers should be fully protected from suit as long they issue policies only with the consent of the insured and follow all applicable laws and procedures. Insurers have not identified any situation in which they have paid on a policy or been successfully sued for a homicide which resulted from the issuance of a policy with knowledge of a domestic violence situation.

? Isn't insurance discrimination against victims of domestic violence already illegal? If not, is something being done to make it illegal?

Until very recently, there have been no laws making such discrimination illegal. In 1994, state legislatures started considering legislation to stop insurance discrimination against victims of domestic violence. So far, laws have been enacted in five states: Connecticut, Delaware, Florida, Iowa and Massachusetts. Legislation is pending in six additional states: California, Louisiana, New Jersey, New York, Pennsylvania and Wisconsin. Several bills are being considered in Congress (introduced by Senator Wellstone (MN) and Representatives Schumer (NY), Wyden (OR), and Molinari (NY)). In addition, the National Association of Insurance Commissioners (NAIC), an association of all state insurance regulators is developing model law to address discrimination against victims of domestic violence.

? What do the new laws and legislative proposals do?

Most prohibit insurers from using domestic violence as a basis for underwriting or rating insurance, meaning that they prohibit an insurer from refusing to insure someone or charging them a higher premium because they are, have been or might become a victim of domestic violence. They may also prohibit insurers from writing policies that exclude coverage for injuries resulting from domestic violence.

? How are insurance companies reacting to legislative proposals to prohibit discrimination against victims of domestic violence?

Very few insurers have changed their practices voluntarily. Only one - State Farm - has changed its underwriting and rating policies and no longer considers domestic violence as a reason to rate or deny insurance. Most of the Pennsylvania insurers who use domestic

ALASKA WOMEN'S LOBBY

416 Harris Street, Suite 208, Juneau, Alaska 99801
(907) 463-6744 phone / (907) 586-2680 fax

14 February 1996

The Alaska Women's Lobby supports the passage of CSSB197 which relates to insurance coverage for a victim of domestic violence; and requires insurers who refuse coverage to an applicant or insured to provide a written explanation for that coverage.

The number of domestic violence victims who have been refused insurance coverage is a growing national problem.

We urge the passage of this bill which will remove one more traumatic barrier for victims of domestic violence.

Sincerely,

Leah L. Burton
for the Alaska Women's Lobby

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

TONY KNOWLES, GOVERNOR

P.O. BOX 110805
JUNEAU, ALASKA 99811-0805
PHONE: (907) 465-2515
FAX: (907) 465-3422
TDD: (907) 465-5437

February 16, 1996

The Honorable Tim Kelly
Chairman
Senate Labor & Commerce Committee
State Capitol, Room 101
Juneau, AK 99801-1182

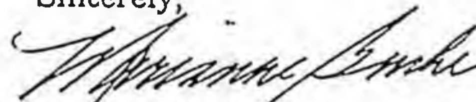
Dear Senator Kelly:

Re: CS for SB 197 (9-LS1218\C Ford 2/15/96)

Thank you for the opportunity to testify last Thursday on SB 197, relating to insurance coverage for victims of domestic violence. I am aware of the kinds of responses that are occurring in other states to this issue. Typically, these responses tend to create a special class of persons as a means of addressing egregious action by a few insurers. The proposed committee substitute bill submitted by Senator Donley avoids this mistake while directly addressing the issue in a reasonable and workable manner.

This legislation makes the use of the fact that a person is a victim of domestic abuse, an unfair trade practice, while preserving the right to insurers to underwrite based on existing medical conditions. It avoids a mandate of coverage yet deals with the use of inappropriate information. The Division of Insurance supports this bill.

Sincerely,



Marianne K. Burke
Director

MKB/cw2378.ins
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cc: Senator Donley

TESTIMONY OF TERRY FROMSON - Attorney, Women's Law Project (Philadelphia)

My name is Terry Fromson. I'm an attorney with the Women's Law Project in Philadelphia, a non-profit law office dedicated to improving the legal and economic status of women. I am here today as a NAIC consumer representative, and I'm grateful for the opportunity to have input on this important issue during this year.

I represent a woman in Pennsylvania who was denied insurance from two different insurance companies because of a 'so-called' history of domestic violence. She was denied life insurance, health insurance and mortgage disability insurance. She's not available today to tell you her story in her own words. Since she was denied insurance almost 2 years ago, she has lent herself to this effort, on behalf of herself and all battered individuals, to stop this practice. To tell you the truth, she's worn out from it. She simply cannot tell her story in public again, unfortunately, and I hope you will accept my words in her place.

She's a 25-year old woman who holds down two jobs and has a 5-year old daughter. Approximately two years ago following the family's departure from the family home, the death of the husband's father, the husband began drinking heavily. Arguments followed, and a physical incident occurred. Her husband pushed her--pushed her into a piece of furniture with a pointed object. She ended up having a gash that went through her clothing, through her hip, bruises on her body. She did what advocates for battered women advise you to do. She went to her doctor and she sought treatment. She asked her doctor very specifically to please record this information, both the nature of her injuries and the cause of her injuries; so that should she need help in the future, either for herself or for her daughter, she would have evidence to bring forward.

Unfortunately, she then proceeded to try and get a better deal on her life insurance. She felt she was being charged too much. She went to an insurance agent, and applications were filed for life insurance as well as health and mortgage disability. She received letters from both of those companies informing her that, based on medical records, which revealed a history of domestic violence, she was unable to be insured. To say the least, this shocked her, and only contributed to the upset she had been experiencing over her own personal situation.

She came to the Pennsylvania Coalition Against Domestic Violence, and the Coalition came to the Women's Law Project. We have been working together in an effort to overcome this problem. On her behalf, and on behalf of the class of similarly situated people, we filed a complaint with our state insurance department. In conjunction with the state insurance department, we have been working on legislation in our state. A bill was recently introduced, that we hope will pass, to amend the Unfair Insurance Practices Act--to specifically rule out this kind of behavior from insurance companies. Recently, I was pleased to receive a letter from the Insurance Department. They are undertaking a survey of insurance companies in our state to find out what their practices are.

I would, also, like to read from the Congressional Record of the Senate on March 9, 1995 when Senator Wellstone introduced a bill entitled, *Victims of Abuse Access to Health Insurance Act* because Mr. Wellstone describes three additional instances of discrimination that occurred in the state of Minnesota. So, if I could just read briefly from his statement. Senator Wellstone says: In Minnesota, three insurance companies denied health insurance to an entire women's shelter because as a battered women's program, we were high risk." The women's shelter in Rochester was told that it was considered uninsureable because its employees are almost all battered women. A woman sought the services of Women House in St. Cloud because the abuse during her 12-year marriage had escalated to such an extent that she was hospitalized for a broken jaw and spent 2 weeks in a mental health unit of a hospital. She was, subsequently, denied coverage by two insurance companies. One said they would not cover any medical or psychiatric problems that could be related to past abuse.

I think these stories that you have heard this morning, both in my recounting and on the telephone, respond to the charge of the committee to assess the extent to which this problem exists. Unfortunately, we can't provide numbers to you; and there are good reasons for that. Domestic violence is a problem that has been shrouded in secrecy, not only because of the shame and emotional problems associated with it, but because of the fear of retaliation of coming forward. And, secondly, we simply have no access to the underwriting standards used by the insurance companies. But, we do have some information to go on.

In addition to the stories you have heard this morning, we know that there are a lot of victims of domestic violence. There are all kinds of statistics out there that have been collected since domestic violence became a public issue. In a recent 1994 survey, the Commonwealth Fund reported 4 million

battered women in 1993. We know as a result of Congressman Shumer's efforts to survey the problem after my client came forward, the calls to 16 major companies in the United States revealed that 8 considered domestic violence an underwriting standard in both issuance and reading of policies. Now, while some of those insurance companies have modified their policy after Congressman Shumer's efforts, they still consider domestic violence a factor to be considered in what they are describing as the most serious and life threatening circumstances. Since I have no idea how they are determining which cases come under that category, and since it still leaves women at risk, I still think this is a problem. In addition, recently, I received a copy of a report from the Texas Office of Public Insurance Counsel, which, through state legislation, received the authority to request underwriting practices and survey them in their state. And they report that 12% of the companies surveyed decline coverage to low-income women because they understood that that group of women would have a higher risk of filing health claims.

What this shows is that companies are behaving on misperceptions about what domestic violence is. The companies that responded to Congressman Shumer that they were considering domestic violence a factor did so on two grounds. One, that this was a voluntary risk-taking activity on the part of women. This simply is not true, and it's something that domestic violence advocates have been trying to work on for a long time. Women are confined in these circumstances for all sorts of reasons, including economics, housing, children, and fear of retaliation. We know that the violence doesn't leave when you leave the household. We also know that domestic violence covers all kinds of people as an earlier witness testified. This is not a problem that is confined to any socio-economic class or race.

I am satisfied that this is a problem that needs to be addressed; and I hope that this committee can come forward and address it because I believe if it is allowed to persist, it will have an incredibly adverse effect both on the victims and the advocacy that we have been pursuing for the last 20 years.

Twenty years ago, this was not an issue anyone knew anything about. It is no longer shrouded in silence. States, the federal government, and non-profit organizations have worked hard to end domestic violence. They have created new legal protections, counseling services, treatment services--all kinds of help for victims of domestic violence. Advocates have worked with victims to come forward and take advantage of those services. If a victim now has to come forward to get help at the risk of losing insurance, which is devastating to someone who is in danger of physical injury--whose children are in danger of physical injury or in danger of losing their housing--they won't come forward; and we will be set back 20 years.

My client reported her injury just as she was supposed to; and it came back and hit her in the face. I don't know what she will do the next time she has to think about pursuing anything with her insurance company.

Domestic violence advocates have worked hard to educate people to the fact that domestic violence is a crime. Law enforcement personnel have treated it as a private matter. It is a crime; and, under the law it should be treated that way. With respect to insurance companies, we would like them to understand that it is crime, also. It is not a medical condition. It is a crime, and it should not be used as a basis for denying or treating victims differently.

I would like to ask this committee to take a position opposing these practices--to encourage states to take action voluntarily, if they are able to under their existing legal framework, or to pursue a change in

their law so that this practice is not allowed in their state. I would like to see you move forward wi the model legislation that was drafted. I've reviewed that legislation, and commented on it. It nee some fine tuning, in my opinion; but, I think it's a wonderful thing for the NAIC to do. I would like see you support the federal legislation. There are know two bills pending. Senator Wellstone ar Representative Wyden have raised this issue recently in Congress. I ask you to do everything that within your authority to do.

Thank you for the opportunity to testify today.

SB 197: "An Act prohibiting increases in health insurance premiums if the insured is a victim of domestic violence."

Some insurers have made a practice of increasing health insurance premiums based solely on the fact that the person was the victim of domestic violence directed against a spouse. This discriminatory practice has been widespread. A number of states have taken legislative action to prohibit such actions. The intent of this legislation is to prevent an insurer from increasing health insurance premiums solely because a person is a victim of spousal domestic abuse. The bill adds a section to AS 21.36 in the unfair trade practices statutes prohibiting this activity.

The department supports this legislation.

William L. Hensley, Commissioner

Date: 1/24/96

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violence as an underwriting criterion are continuing to do so two years after the practice became public and the subject of legislation.

Some insurers voice support for legislation protecting domestic violence victims, but with limitations, urging a number of amendments and provisos to pending legislation. These include language that would allow insurers to underwrite and rate on the basis of mental and physical history regardless of the underlying cause, language that would protect an insurer from liability for any injury resulting from compliance with the legislation, and language that would allow insurers to deny insurance to abusers.

Others simply oppose any limitation on their ability to consider abuse in underwriting and rating, stating that insurers should have leeway in considering this type of material information.

? Why don't we need language to protect victims of domestic violence from abusers who kill to collect on insurance?

Insurers have failed to provide any evidence that insurance acts as an incentive to further domestic violence or that denying insurance deters domestic violence.

Moreover, the language they seek to add to protect against such an occurrence is over-broad, reaching beyond the stated narrow concern about beneficiaries of life insurance policies.

? What is wrong with allowing insurers to underwrite on the basis of the applicant's medical condition, regardless of the cause of the condition?

The purpose of the protective legislation will be undermined if it allows insurers to underwrite on the basis of medical conditions caused by abuse. Such an exception would allow an insurer to deny insurance to a victim of domestic violence based on medical records documenting bruises or broken bones resulting from the violence and have the same effect as allowing an insurer to deny insurance based on the domestic violence itself. Consideration of the medical records in any way will deter victims from seeking help and leaving. The only way to end the cycle of violence is to make sure that battered individuals are able to freely seek assistance for abuse.

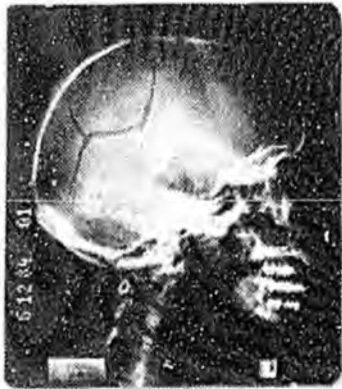
Permitting underwriting on the basis of abuse-related medical conditions will also enable insurers to discriminate indirectly against victims of domestic violence. Insurers will be able to deny an applicant and refuse to renew an insured based on a medical condition that is frequently associated with abuse. They will also be able to apply particular medical criteria selectively to victims of abuse, for example, determining only victims of abuse ineligible for insurance because of treatment for bruises and black eyes. Because insurers are subject to little regulation in their selection and use of medical underwriting criteria, no one will know or stop them from selecting and applying medical underwriting criteria with the express intent of weeding out abuse victims.

Furthermore, allowing insurers to consider the health status of victims of domestic violence is inconsistent with the trend toward limiting the insurers consideration of health status in both issuance and rating of insurance through "community rating" and "guaranteed issuance".

? If legislation prohibits insurers from considering medical conditions caused by abuse, doesn't it create a special class of individuals who get special treatment?

No. Prohibiting discrimination of the basis of domestic violence will insure that victims of domestic violence are treated like all other applicants. It is insurers who have created the special class, singling out domestic violence as a special classification of uninsurability.

Nor does protection for victims of domestic violence make inequitable an otherwise equitable system of underwriting. Insurance industry practices are not premised on either fundamental fairness or uniformity. Insurance companies already treat people differently regardless of how compelling their circumstances may be. For example, timing and preexisting condition clauses may result in one pregnant woman being covered while another is not. A violent neighborhood will not be taken into account, but a violent household will be in determining whether to issue insurance. Some companies cover some conditions, while others do not. In this context, it is disingenuous to argue unfairness with respect to legislation that is necessary to end domestic violence.


Some men break more than their girlfriend's hearts.
A bad relationship can hurt more than your feelings.

This year, in emergency rooms, clinics and physicians offices

One in five women

will seek medical care because of injuries or presenting problems caused by domestic violence.

You can help.

You Can Help . . .

by understanding the scope of domestic violence.

DOMESTIC VIOLENCE IS A MAJOR HEALTH ISSUE. It is the single largest cause of injury to women in the United States. Abused and battered women account for:

- 22% to 35% of women seeking emergency services for any complaint
- 14% of women seen in ambulatory-care internal medicine clinics
- 25% of all women who attempt suicide
- 25% of women seeking psychiatric emergency services
- 23% of pregnant women seeking prenatal care
- 45% to 59% of mothers of abused children
- 58% of women over 30 years old who have been raped
- 50% of all female homicide victims

—National Statistics courtesy of the American Medical Association

"In Alaska, more than 9,000 women and their children sought emergency safe shelter in Alaska's statewide shelter program during FY 93."

—Alaska Council on Domestic Violence and Sexual Assault

HEALTH CARE PROFESSIONALS are among the first persons a woman will turn to for help. You have a unique opportunity to offer-effective, timely identification and referral that can end the cycle of violence.

You Can Help . . .

by understanding the problem of domestic violence.

DOMESTIC VIOLENCE is characterized as a pattern of coercive behaviors that may include:

- Repeated battering
- Psychological abuse
- Sexual assault
- Progressive social isolation from friends and family
- Deprivation (food, money, shelter, transportation)
- Intimidation
- Threats of violence
- Destruction of home or personal property

These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim.

Although men can find themselves in this situation, 95% of reported cases involve women. For this reason this booklet is written assuming the patient is a woman. For the most part, the same advice applies regardless of the sex of the patient.

Domestic violence occurs in all ethnic groups, all economic classes, all religions and all age groups. Abuse often begins when a woman becomes pregnant. 17.5% of all low birth weight babies are born to battered women. Children who live in homes where domestic violence occurs are 13 times more likely to be physically abused than children living in non-violent homes. Children who witness the battering of their mothers can demonstrate significant behavioral and/or emotional problems.

Domestic violence does not just happen once or twice:

- Battering increases in frequency and severity over time
- Women may live with violence for a long time before seeking help
- Many women fear greater harm from partners if they leave or report abuse
- The danger of abuse actually does increase for women during separation or divorce
- Some women in abusive relationships do not have the financial resources to live without their partner

Your response to domestic violence can contribute to a woman's understanding of the seriousness of abuse and her ability to end the violence. The failure to identify abuse may result in withholding important resources at exactly the point when a woman is most able to initiate change.

You Can Help . . .

by identifying domestic violence.

How and What to Ask

Domestic violence should be considered a potential health problem for all women, especially pregnant women and women receiving emergency medical treatment. Due to the prevalence of domestic violence, the American Medical Association advises routine screening of all women (guidelines are available from the AMA; see page 12). If you are treating a child for suspected or confirmed neglect and/or abuse, also check for abuse toward the mother.

Routine assessment with new patients and periodic reassessment with all patients during regularly scheduled visits provides a structure to identify patients in violent, threatening or highly controlling relationships. Screening questions fit logically into a patient's social and family history. It is appropriate to include questions about interpersonal violence in any evaluation.

Establish a physically and emotionally safe setting to interview patients. Ensure the woman's partner, children and family members are not present. A battered woman will not discuss an abusive situation if her abuser is present; she may be reluctant to cause further stress for her children by discussing her situation while they are present.

Simple, direct questions delivered with concern in a safe and confidential encounter are the most effective way to identify domestic violence. For example: "What happens when there are fights and disagreements at your home?" "Someone hurt you tonight . . . . can you tell me about it?" "I'm concerned that someone hurt you like this . . . tell me how it happened?"

Build trust and confidence with your patient. Avoid any reaction that would cause the woman to feel humiliated or at fault. Remember the patient may be the victim in a very violent situation; she is not responsible for the abuse. Ask for enough detail to be able to form an accurate assessment of the level of violence in the relationship. Keep in mind she wants to end the abuse, not the relationship.

WHAT TO LOOK FOR
Common Diagnoses/Clinical Indicators

Signs of Physical Abuse

Injuries most commonly involve the head, neck, chest and abdomen. Trauma to the genital area is also commonly observed. During pregnancy, the breasts and abdomen are particularly common injury sites.

Nature and Circumstances of Injuries Suspect of Abuse

- Injury inconsistent with history
- Numerous injuries at multiple sites in absence of catastrophic event (motor vehicle crash etc.)
- Injuries in multiple stages of healing; old and often untreated injuries often evident
- Repeated or chronic injuries
- Patterned injuries such as belt buckles, fist marks, heel/shoe mark from kicking or stepping on the victim's back or abdomen
- Bilateral injuries (ex. bilateral extremity injuries)
- Delay in seeking medical care for injury
- Partner unwilling to leave woman alone in treatment, anxious to answer all questions directed to patient

Head and Spinal Injuries

- Serious head injuries are common
- Mild traumatic head injury from cumulative trauma such as repeatedly being shoved/slammed against a wall; slurred speech and hearing deficits are commonly observed
- Back/spinal injuries as a result of being pushed, shoved or thrown, often repeatedly; these injuries often resemble what is seen with fall-related injuries but the nature and circumstances of the injury reveal that the injury was inflicted (ex. patient has other injuries not likely to be caused by a fall)
- Ruptured ear drums as a result of blows to the head/ears

Sprains and Fractures

- Fractures associated with falls due to being pushed and/or shoved
- Fractures of the forearm are commonly seen as woman attempts to shield herself with her arms
- Facial and orbital fractures from direct blows to the the area of the eyes

Contusions, Bruises and Lacerations

- Proximal or central bruising on the body, often in hidden areas covered by clothing is highly suspicious for abuse (ex. bruises on inner thighs)
- Black eye (s)
- Facial lacerations: frequently a U-shaped cut is observed with bruising due to a ring that the abuser had on when he hit/punched the victim
- Cuts and slashes: often observed on a victim's hand/wrist area as she attempts to defend herself from a knife
- Neck burns and strangle marks around the throat/neck
- Finger marks: often observed on inner soft tissue of the legs and/or arms from the abuser holding the victim down (during sexual assault, beating, etc.)

Burns and Bites

- Burns: often from a cigarette, iron, radiator commonly involving the hands, feet
- Friction burns from being restrained, dragged (ex. rope burns)
- Human bite marks

Self-Inflicted Injuries

- Abused women are at very high risk for suicide and suicide attempts
- Self-induced or attempted abortions

Signs of Sexual Abuse

- Frequent vaginal and urinary tracts infections; difficulty/painful urination (dyspareunia)

- Chronic pelvic pain
- Pelvic inflammatory disease (PID) with negative lab findings
- Recurrent sexually transmitted diseases (STD's): the batterer may force his partner to have unsafe sex
- Irregular vaginal bleeding
- Pain and fear upon examination; vaginismus (very tense vaginal muscles when exam attempted)
- Poor contraceptive compliance and/or multiple therapeutic abortions: the batterer may forbid use of contraceptives and family planning
- Sexual dysfunction

Medical Signs During Pregnancy

- Any injury during pregnancy, particularly injuries to the breasts, abdomen and genital area
- Pre-term abortions, bleeding, miscarriages and premature labor: abused women are at significantly higher risk of having intrauterine growth retardation and low-birth weight infants
- Hyperemesis (excessive vomiting)
- Substance abuse, poor nutrition or depression
- Late or sporadic prenatal care: the abuser restrains the woman from obtaining prenatal care

Related Medical Findings

- Chronic pain syndrome due to diffuse, repetitive trauma (no evidence of visible injury may be present at time of examination)
- Recurrent sinus infections and/or dental problems secondary to facial trauma
- Physical symptoms related to stress, chronic post-traumatic stress disorder, other anxiety disorders or depression. Examples are:
  - panic attacks
  - eating disorders; malnutrition
  - chronic headaches
  - abdominal and gastrointestinal complaints

- numbness and tingling (parestesia)
- atypical chest pain
- frequent visits with vague complaints or symptoms without evidence of physiologic abnormality

- Frequent use of prescribed tranquilizers or pain medications

Mental Health/Psychiatric Symptoms

- Depression
- Substance abuse
- Post-traumatic stress reactions/disorder
- Suicide attempts or gestures

Patients' and Partners' Behavioral Signs

- Patient's anxiety or distress is out of proportion to the severity of injuries or complaints
- Patient is reluctant to speak in front of her partner
- The partner accompanies patient, stays close and answers questions directed to her
- Denial or minimization of violence by partner or patient
- Intense jealousy or possessiveness demonstrated by partner or reported by patient
- Self-blame by patient for abuser's violence

Issues for Treatment

An abuser's pattern of controlling and intimidating his partner creates the following obstacles to treatment:

- Limited access to routine and/or emergency medical care; missed appointments
- Noncompliance with treatment: not allowed to obtain or take medication

You Can Help . . .

by providing treatment and effective intervention.

Treat the Illness or Injury

Assess the chief complaint or probiem against the shared recognition of the violence. A review of symptoms with particular attention to sites of previous injury and chronic pain may help both the health care professional and the patient identify how the violence affects her general health. If the patient is pregnant, review both injury and stress related health risks to her fetus. If she has children in the home, review the possible risks to her children resulting from domestic violence. Inform the patient that her situation is potentially lethal, that domestic violence is a crime and that she is protected by the law. *Use caution in administering or prescribing tranquilizers, painkillers, and sleeping pills which alter the patient's ability to escape or avoid assault.*

Assess Safety

Escalating injuries, sexual assault, threats of homicide or suicide, threats against other family members, gun possession, either party's use of drugs and alcohol, and separation and divorce proceedings are all associated with a higher risk of serious injury or death. The absence of these factors does not however guarantee safety.

If your patient does not feel safe, then it is imperative for her to begin working with crises intervention advocates at once. Help her to call the local domestic violence services in your area from the safety and privacy of your office. Help her identify other "safe" places or people she can turn to for help such as relatives, friends or community members.

If the patient indicates she "feels safe for now" then give her information on services that are available to her and a list of shelters or other safe programs. Encourage her to participate in a women's support group, consider legal protection or contact an advocate or counselor who works with victims of domestic violence. Couples counseling or family intervention services are not recommended due to the increased risk of harm. A complete listing of domestic violence programs and shelters in Alaska is provided on page 11.

Document Findings

When bruises and other injuries heal, the medical record you have written may be the only evidence that remains of assault. Take the time to fully document your findings. Use simple, but descriptive, language and quote the patient's own words as much as possible (ex. " My husband hit me with his fist" versus "Patient was abused" or "hit by fist."). Use a sketch of the body to indicate the sites of current—and past—injuries. Record all details of the event including: name, address and phone # of the abuser, if disclosed; if police are called, the name, badge and phone number of the officer; name of anyone who accompanies the victim. If possible, photograph the injuries. Let the patient know that her medical record is confidential but available to her should she decide to use it for court proceedings.

As a health care professional in Alaska, you are required by law to formally report confirmed and suspected child abuse and neglect immediately to the nearest office of the state's Department of Health and Social Services, Division of Family and Youth Services.

All facilities providing emergency treatment are required to have emergency room protocols covering the treatment of cases involving domestic violence. Model protocols can be obtained through the Family Violence Prevention Fund (see page 12).

Follow-up

Address domestic violence at each subsequent visit. Reassess the patient's safety, her children's safety and the effectiveness of strategies she has used to diminish the violence.

Know That You Can Make a Difference.

"As health professionals, we must make every effort to end domestic violence. Women must be able to live their lives free from violence, both inside and outside the home. Our awareness, our intolerance of violence, and our active interventions greatly diminish the license for domestic violence. As professionals, we can make a remarkable difference."

—former Surgeon General Antonia C. Novello, MD, MPH

Resource List of Shelter and Domestic Violence Prevention Programs in Alaska

Immediate Area Resources ______________________________

Local Shelter Crisis Line # ______________________________

Local Law Enforcement # ______________________________

State Division of Family and Youth
Services Statewide Referral # 1-800-478-4444

State Division of Family & Youth Services Local # ______________________________

City	Program	Phone
Anchorage	Abused Women's Aid in Crisis	crisis 272 0100 office 279-9581
Anchorage	Alaska Women Resource Center	office 276-0582
Anchorage	Standing Together Against Rape	crisis 563-7273 office 563-9981
Barrow	Arctic Women in Crisis	crisis 852-0267 office 852-0261 toll-free statewide 1-800-478-0267
Bethel	Tundra Women's Coalition	crisis 543-3456 office 543-3444
Dillingham	Safe & Fear-Free Envrionment	crisis 842-2316 office 842-2320
Emmonak	Emmonak Women's Shelter	office 949-1434
Fairbanks	Women in Crisis Counseling and Assistance	crisis 452-RAPE office 452-2293
Fairbanks	Tanana Chiefs Conference, Family Services Program	office 452-8251
Homer	South Peninsula Women's Services	crisis 235-8101 office 235-7712
Juneau	Aiding Women in Abuse and Rape Emergencies	crisis 586-1090 office 586-6623
Juneau	Parent Aid and Family Support Center	office 586-3785
Juneau	Tongass Community Counseling Center	office 586-3585
Kenai	Leeshore Women's Resource & Crisis Center	crisis 283-7257 office 283-9479
Ketchikan	Women in Safe Homes	crisis 225-9474 office 225-0202
Kodiak	Kodiak Women's Resource & Crisis Center	crisis 486-3625 office 486-6171
Kotzebue	Maniilaq's Regional Women's Crisis Program	crisis 442-3969 office 442-3311
Nome	Bering Sea Women's Group	crisis 443-5444 office 443-5491
Palmer	Valley Women's Resource Center	crisis 746-4080 office 746-4080
Seward	Seward Life Action Council	office 224-5257
Sitka	Sitkans Against Family Violence	office 747-3370
Unalaska	Unalaskans Against Sexual Assault and Family Violence	office 581-1500
Valdez	Advocates for Victims of Violence	crisis 835-2999 office 835-2980

Resources for further information

Network on Domestic Violence and Sexual Assault
130 Seward Street, Suite 501
Juneau, AK 99801
586-3650

Council on Domestic Violence and Sexual Assault
P .O. Box 111200
Juneau, AK 99811-1200
465-4356

Project SAFE
Domestic Violence Training Project
614 Orange Street
New Haven, CT 06511

National Coalition of Physicians Against Family Violence
c/o American Medical Association
Department of Mental Health
515 North State Street
Chicago, IL 60610

Family Violence Prevention Fund
Building One, Suite 200
1001 Potrero Avenue
San Francisco, CA 94110
(415) 821-4553

American Medical Association
Diagnostic and Treatment Guidelines on Domestic Violence
c/o AMA
Department of Mental Health
515 North State Street
Chicago, IL 60610

Alaska Domestic Violence Training Project
Section of Maternal, Child and Family Health
Division of Public Health
1231 Gambell St.
Anchorage, AK 99501
274-7626

This booklet is published by the Alaska Network on Domestic Violence and Sexual Assault with funds from the Federal Family Violence Prevention and Services Act, Administration for Children and Families

Front cover graphic developed by the Family Violence Prevention Fund ©1987

Alaska Network on Domestic Violence
and Sexual Assault

130 Seward Street, Suite 501
Juneau, AK 99801

SB

201

No. 3

FISCAL NOTE

Bill Version: CSSB 201 (FIN)

STATE OF ALASKA

1996 LEGISLATIVE SESSION

(S) Publish Date: 4/26/96

Revision Date:	Original	Dept Affected	Natural Resources
Title:	An Act relating to the employment of emergency fire-fighting personnel by the commissioner of...	BRU:	Resource Development
		Component:	EFF Non-Emergency
Sponsor:	Senator Lincoln		
Requestor:	Senate Finance	Component Serial No.	TO BE ESTABLISHED

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES	250.0	250.0				
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	250.0	250.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

	FY97	FY98	FY99	FY00	FY01	FY02
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
1061 CIP Receipts **	250.0	250.0				
TOTAL	250.0	250.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $ none

POSITIONS

	FY97	FY98	FY99	FY00	FY01	FY02
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)

This bill provides hiring authority to DNR to utilize EFF for fire suppression, hazard reduction, fire prevention, habitat restoration or improvement and other related activities in emergency and nonemergency circumstances under AS 41.15.030. The Bureau of Land Management, National Park Service, U.S. Fish and Wildlife Service, and the U.S. Forest Service have identified prescribed burning projects which require approximately 300 days of work for trained fire fighting crews. This work cannot be effectively or efficiently conducted without a trained workforce. Funding will be provided by the agency(s) requesting fire management work other than wildland fire suppression. In FY95 the Division received approval through the capital budget to receive and expend up to $500.0 in federal receipts to supply Emergency Fire Fighting crews to federal agencies on a reimbursable basis.
**(Reference: SLA94, CH4, Sec 10, Pg 10, Ln 23).
A separate component will be set up to account for these contractual activities apart from emergency fire suppression funded through state general funds.

Prepared by: Tom Boutin, Director — Phone: 465-3379
Division: Forestry — Date: 26-Apr-96
Approved by Commissioner: — Date: 26-Apr-96
Agency: Natural Resources

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FISCAL NOTE

No. 2

Bill Version: SB 201

BILL (S) Publish Date: 3-25-96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date: March 18, 1996
Title: An Act Relating to the employment of fire-fighting personnel
Sponsor: Senator Lincoln
Requestor: S. RES

Dept. Affected: Public Safety
BRU: Fire Prevention
Component: Fire Prevention Operations
COMPONENT SERIAL NO. 0494

EXPENDITURES/REVENUES: (Thousands of Dollars) (inflation not included)

OPERATING	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
CHANGE IN REVENUES ( ) Revenue Code	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program						
1006 GF/MHTIA						
Other						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

Estimate of current year (FY 96) impact: $ -0-

POSITIONS:

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
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.)

Passage of this bill will allow the commissioner of the Department of Natural Resources to more fully utilize personnel under departmental control. The public good will be more fully served by passage of this proposal in that a body of trained personnel will be made immediately available for use in non-fire emergencies.

Prepared By: Kenneth H. Lea, Deputy Fire Marshal
Phone 465-5522
Division: Fire Prevention
Date: March 18, 1996

Approved by Commissioner: [signature]
Date: 3/18/96
Agency: Ronald L. Otte, Department of Public Safety

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ALASKA STATE LEGISLATURE

Senator Georgianna Lincoln

State Capitol
Juneau, Alaska 99801-1182
(907) 465-3732
Fax (907) 465-2652

Committees:
Resources
Transportation
Legislative Council

Minority Caucus Chair

Budget Subcommittees:
Natural Resources
Corrections

DISTRICT R

April 30, 1996

MEMORANDUM

TO: Representative Pete Kott
Chair, House Labor and Commerce

FROM: Senator Georgianna Lincoln GL.

SUBJECT: **Bill Scheduling Request**

I am requesting the scheduling of Senate Bill 201, "an Act relating to the employment of emergency fire-fighting personnel by the commissioner of natural resources," before the House Labor and Commerce Committee.

This legislation provides the Department of Natural Resources with the authority to utilize already-trained emergency fire fighting employees for fire management, fire suppression and fire prevention activities by adding a new subsection to AS 41.15.030.

This legislation will have no fiscal impact on the state's budget in FY 97.

Attached is a packet containing the sponsor statement, sectional analysis and fiscal note from the Department and letters of support for the legislation.

Thank you for your consideration of this request.

GL:pt

ALASKA STATE LEGISLATURE

Senator Georgianna Lincoln

State Capitol
Juneau, Alaska 99801-1182
(907) 465-3732
Fax (907) 465-2652

Committees:
Resources
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DISTRICT R

SPONSOR STATEMENT
Senate Bill 201

An Act relating to the employment of emergency fire-fighting personnel by the Commissioner of Natural Resources.

Senate Bill 201 has been introduced to provide the Department of Natural Resources with the authority to utilize emergency fire fighting employees for fire management, fire suppression and fire prevention activities by adding a new subsection to AS 41.15.030.

Existing law (AS 41.15.030) authorizes the commissioner to hire emergency fire fighting personnel but does not expressly authorize their use for fire prevention, fire suppression, hazard reduction or other related activities. Senate Bill 201 would clarify that emergency fire fighting personnel could be employed by the Department of Natural Resources in emergency and non-emergency circumstances to construct and maintain fire breaks and trails, remove brush and timber deadfall, conduct prescribed burns, improve wildlife habitat (e.g. moose browse).

Enactment of the bill into law also will ensure that the Department of Natural Resources may take advantage of existing federal money for non-emergency fire prevention projects.

In FY 95, the Division of Forestry received approval to receive and expend up to $500,000 in federal receipts to supply emergency fire fighting crews to federal agencies on a reimbursable basis. Presently, of the available federal money, the Department of Natural Resources has identified projects totaling $250,000. The Bureau of Land Management, the National Park Service, the U. S. Fish and Wildlife Service and the U. S. Forest Service are ready to begin fire prevention projects which will require approximately 300 days of work for these emergency fire fighting crews.

Senate Bill 201 would enable these federal dollars to be utilized by already trained emergency fire fighting crews for these projects.

Many of these emergency fire fighting crews live in rural/bush Alaska. Job opportunities are limited in these communities. This legislation allows for increased flexibility for using the trained emergency fire fighter crews in rural/bush Alaska to fulfill the manpower-intensive prevention projects.

Basic fire prevention projects, such as clearing brush around villages. could be performed prior to an emergency situation. During years when fire fighting jobs are not available, enactment of this legislation would help to stabilize Alaska's economy in various regions by providing off-season employment.

In conclusion. Senate Bill 201 will result in a considerable savings to the state while providing a substantial economic benefit to smaller Alaska communities.

ALASKA STATE LEGISLATURE

Senator Georgianna Lincoln

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Committees:
Resources
Transportation
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Natural Resources
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DISTRICT R

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Minto
Nenana
Nikolai
Northway
Nulato
Paxson
Pilot Station
Rampart
Red Devil
Ruby
Russian Mission
Shageluk
Slana
Sleetmute
Stevens Village
Stony River
Takotna
Tanacross
Tanana
Tatitlek
Tazlina
Telida
Tetlin
Tok
Tuluksak
Tyonek
Upper Kalskag
Valdez
Venetie
Whittier
Wiseman

SECTIONAL ANALYSIS
CS Senate Bill 201(Finance)

An Act relating to the employment of emergency fire fighting personnel by the commissioner of natural resources.

Section 1 provides an amendment to clarify that fire fighters employed by the Department of Natural Resources for fire prevention and related acticvities are within the exempt state service.

Section 2 confirms authority in the Commissioner of the Department of Natural Resources to employ emergency fire fighting personnel for a variety of fire management, fire suppression, and fire prevention activities by adding a new subsection to AS 41.15.030. Existing law authorizes the commissioner to hire emergency fire fighting personnel but does not expressly authorize their use for fire prevention, hazard reduction, habitat restoration or other related activities.

Language included in Senate Finance prohibits the Department of Natural Resources from using state general funds for **emergency fire fighting personnel for non-emergency purposes.**

Section 3. References the Fire Suppression Fund to mirror the above language in AS 41.15.030.

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. SB201

Revision Date:	22-Mar-96	Dept Affected	Natural Resources
Title:	An Act relating to the employment of emergency fire-fighting personnel by the commissioner of...	BRU:	TO BE DETERMINED
		Component	New - TO BE ESTABLISHED
Sponsor:	Senator Lincoln		
Requestor:	Senate Resources	Component Serial No.	TO BE ESTABLISHED

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES	250.0	250.0				
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	250.0	250.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1008 GF/MHTIA						
1061 CIP Receipts **	250.0	250.0				
TOTAL	250.0	250.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $ none

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)

This bill provides hiring authority to DNR to utilize EFF for fire suppression, hazard reduction, fire prevention, habitat restoration or improvement and other related activities in emergency and nonemergency circumstances under AS 41.15.030. The Bureau of Land Management, National Park Service, U.S. Fish and Wildlife Service, and the U.S. Forest Service have identified prescribed burning projects which require approximately 300 days of work for trained fire fighting crews. This work cannot be effectively or efficiently conducted without a trained workforce. Funding will be provided by the agency(s) requesting fire management work other than wildland fire suppression. In FY95 the Division received approval through the capital budget to receive and expend up to $500.0 in federal receipts to supply Emergency Fire Fighting crews to federal agencies on a reimbursable basis.

**(Reference: SLA94, CH4, Sec 10, Pg 10, Ln 23).

DNR proposes a separate component be set up to account for these contractual activities apart from emergency fire suppression funded through state general funds.

Prepared by:	Tom Boutin, Director	Phone :	465-3379
Division:	Forestry	Date :	22-Mar-96
Approved by Commissioner:		Date:	22-Mar-96
Agency:	Natural Resources		

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FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO: SB 201

Revision Date: March 18, 1996
Title: An Act Relating to the employment of fire-fighting personnel
Sponsor: Senator Lincoln
Requestor: S. RES

Dept. Affected: Public Safety
BRU: Fire Prevention
Component: Fire Prevention Operations
COMPONENT SERIAL NO. 0494

EXPENDITURES/REVENUES: (Thousands of Dollars) (inflation not included)

OPERATING	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
CHANGE IN REVENUES ( ) Revenue Code	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program						
1006 GF/MHTIA						
Other						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

Estimate of current year (FY 96) impact: $ -0-

POSITIONS:

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
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.)

Passage of this bill will allow the commissioner of the Department of Natural Resources to more fully utilize personnel under departmental control. The public good will be more fully served by passage of this proposal in that a body of trained personnel will be made immediately available for use in non-fire emergencies.

Prepared By: Kenneth H. Lea, Deputy Fire Marshal
Phone 465-5522
Division: Fire Prevention
Date: March 18, 1996

Approved by Commissioner: [signature]
Date: 3/18/96
Agency: Ronald L. Otte, Department of Public Safety

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STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF NATURAL RESOURCES

SUPPORT SERVICES DIVISION

400 WILLOUGHBY AVENUE
JUNEAU, ALASKA 99801-1796
PHONE: (907) 465-2406
FAX: (907) 465-2492

March 19, 1996

The Honorable Loren Leman
Chairman, Senate Resources Committee
Alaska State Legislature
Room 113, Capitol
Juneau, Alaska

Dear Senator Leman:

I would like to provide the Senate Resource Committee with some additional details on some of the points of discussion that came up during the Senate Resources Committee hearing on SB201 yesterday.

We discussed why fire suppression money cannot be used for programs other than the actual fighting of wildland fire. AS 41.15.010 requires the Department of Natural Resources to protect State, Private and Municipal land from wildland fire commensurate to the value of the resources at risk. Annual suppression expenses can vary dramatically depending on the severity of a fire season. Actual expenditures have been analyzed over a ten year period (excluding the high and low years) and show that $9.5 million is the annual state funds expenditure. The legislature funds the fire program at substantially under that amount. The FY96 appropriation for fire suppression was $3.5 million, which is distinct from the forest management appropriation. By the way of clarification, this is an appropriation out of the General Fund, not the Fire Suppression Fund. Fire suppression funding is used for the fixed costs and actual firefighting on the ground. Use of suppression funding for other programs, such as prescribed burns, would be misappropriation of funds by the agency. DNR has put in place a good system of checks and balances to ensure that only appropriate fire suppression expenditures occur. In addition, both OMB and legislative audit examine the fire suppression component annually.

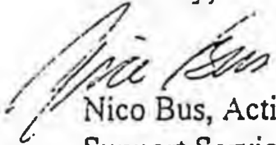
The idea of a fiscal note which shows the existing federal receipt authority as an expenditure was discussed. We believe that showing this existing spending authority for SB201 would in effect be a double counting of this funding as it already has been appropriated in SLA94, SB363, Sec.10, line23). SB201 enable us to us the village crews for prescribed burns but it does not mandate any funding on its own. We plan to approach the legislature each year with request for these projects when we are made aware of funding from federal or other agencies.

There was discussion of utilizing the authority in SB201 for the expenditure of federal funds only. Limiting the flexibility for this very cost-effective program would put unnecessary

constraints on state agencies such as the Department of Fish & Game who may have appropriated funding for such projects as controlled burns for habitat improvement. Even if SB201 becomes law, emergency firefighters could only be used for projects for which there has been an appropriation. DNR would only use emergency firefighters where there is an appropriation, the use is allowed by law, and it is cost-effective.

Thank you for giving this your attention. Please let me know of any further questions you may have. DNR strongly supports SB201.

Sincerely,



Nico Bus, Acting Director
Support Services Division

cc: Members of Senate Resource Committee
Tom Boutin
Carol Carroll

Fax Transmittal Memo 7672

To: Paula Terrel		From: JD King	
Co./Dept.: Senator Georgianna Lincoln		Co.: AFCA	
Location: Room 510		Admin	
Fax #: 465-2652	Telephone #: 465-2847	Fax #: 488-6118	Telephone #: 488-3400
No. of Pages: 2	Today's Date: 3/8/96	Time: 1441	

Comments: Original to follow via mail

Original Disposition: ☐ Destroy ☐ Return ☐ Call for pickup

Alaska Fire Chief's Association

2358 Bradway Road • North Pole, Alaska 99705 • (907) 488-3400 • Fax: (907) 488-6118

TIMOTHY J. BIGGANE
President

MICHAEL G. MCGOWAN
1st Vice President
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Past President
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March 8, 1996

Senator Georgianna Lincoln
Attn: Paula Terrel
State Capital, Room 510
Juneau, AK 99801-1182

Dear Paula,

Please accept this as a letter of support for SB201. It is a great pleasure to support such real common sense legislation. So often details such as fire prevention activities usually lack the necessary glamor to attract the attention of the legislature. Not only has your support been noticed by the emergency services it is appreciated.

Attached is our resolution 96-03 strongly supporting SB201. If there is anything else we can do to support this or other pending legislation please let us know.

Respectfully,

ALASKA FIRE CHIEF'S ASSOCIATION

Timothy Biggane
President

TJB:jdk

Alaska Fire Chief's Association

2358 Bradway Road • North Pole, Alaska 99705 • (907) 488-3400 • Fax: (907) 488-6118

TIMOTHY J. BIGGANE
President

Resolution 96-03

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A RESOLUTION OF THE ALASKA FIRE CHIEF'S ASSOCIATION SUPPORTING SENATE BILL 201 WHICH PROVIDES THE COMMISSIONER OF NATURAL RESOURCES WITH THE NECESSARY AUTHORITY TO HIRE EMERGENCY FIREFIGHTERS AND TO ASSIGN THEM TO FIRE PREVENTION RELATED TASKS.

WHEREAS, the Alaska Fire Chief's Association is dedicated to educating the public in matters of fire prevention,

AND WHEREAS, existing law authorizes the Commissioner of Natural Resources to hire emergency firefighters but does not expressly authorize their use for fire prevention or hazard reduction,

AND WHEREAS, in FY 95, the Division of Forestry received approval to receive and expend up to $500,000 in federal receipts to supply emergency firefighting crews for use in fire prevention activities to federal agencies on a reimbursable basis.,

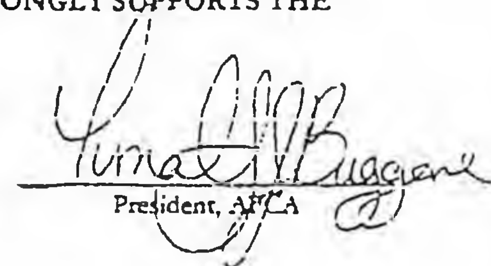
AND WHEREAS, SB201 would clarify that emergency firefighting personnel could be employed by the Department of Natural Resources in non-emergency circumstances to construct and maintain fire breaks and trails, remove brush and timer deadfall, conduct prescribed burns, etc..

AND WHEREAS, SB201 would enable these federal dollars to be utilized by already trained firefighting crews for these projects.

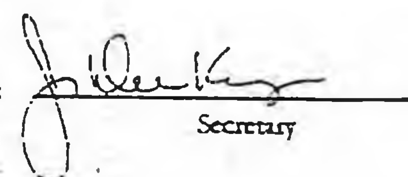
NOW THEREFORE BE IT RESOLVED THAT,

THE ALASKA FIRE CHIEF'S ASSOCIATION STRONGLY SUPPORTS THE SIGNING OF SENATE BILL 201 INTO LAW.

ADOPTED, THIS 6th DAY OF FEBRUARY, 1996.



President, AFCA

ATTEST: 

Secretary

ALASKA FEDERATION OF NATIVES, INC.
1577 C Street, Suite 201, Anchorage, Alaska 99501
907-274-3611 - Fax 907-276-7939

March 18, 1996

The Honorable Georgianna Lincoln
Alaska State Senate
State Capitol
Juneau, Alaska 99801-2652
Via Fax Mail: (907)-465-2652
3 Page Fax. No Hard Copy to follow

RE: SB 201

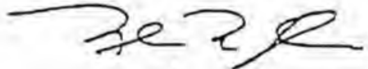
Dear Senator Lincoln:

Please be advised that the Alaska Federation of Natives (AFN) supports SB 201 as it presently stands. AFN supports and continues to support the mitigation of wildfire hazards as evidenced by the enclosed AFN Convention Resolution 92-96.

This bill will not only authorize the Commissioner of Department of Natural Resources to conduct fire suppression, fire hazard reduction, among others, it will provide employment opportunities for fire fighting crews who reside in rural/bush Alaska where such opportunities are very limited.

If you have any questions concerning this letter or the attached resolution, please call me at AFN.

Sincerely,



Nelson N. Angapak, Sr.
Special Assistant, Lands

Attachment

ALASKA FEDERATION OF NATIVES, INC.

1992 ANNUAL CONVENTION

RESOLUTION 92 - 96

TITLE: WILDLIFE FIRE HAZARD MITIGATION PROPOSAL

WHEREAS: annually the State of Alaska, Department of Natural Resources, Division of Forestry, spends an average of $11.6 million on wildland fire suppresion activities; and

WHEREAS: this amount is above the regular operating, pre-suppression, budget; and

WHEREAS: the fire season fluctuates dramatically from year to year; and

WHEREAS: of the expenses, an average of $4 million is paid to village fire fighting crews, and the Bureau of Land Management expends an average of $4.2 million in fire fighting wages, thus combined expenditures average $8 million in wages; and

WHEREAS: wildland fires routinely threaten man-made improvements, villages and communities, yet little is done in terms of mitigation near villages; and

WHEREAS: mitigation measures would enable villages, communities, and other valuable properties to be made fire safe by the creation of defensible space over a period of time; and

WHEREAS: mitigation measures would eventually reduce suppression costs; and

WHEREAS: village fire fighting crews could be hired on a rotational basis to perform hazard reduction and resource management activities such as fuel break construction, prescribed burning, tree planting, timber sale layout, insect infestation control, tree pruning, cone collection, seed orchid planting, etc.; and

WHEREAS: a more stable income could be provided to village fire fighting personnel during slow suppression years, thus aiding in reducing the long term cost of subsequent public assistance expenditures; and

WHEREAS: village fire fighting crews would be better trained, managed, and conditioned as a result of this additional work;

NOW THEREFORE BE IT RESOLVED that delegates to the 1992 Annual Convention of the Alaska Federation of Natives, Inc. request that during years of limited fire suppression activity the State of Alaska and the Bureau of Land Management research and consider the concept of expending 25% of the annual average suppression costs for hazard reduction projects throughout the state.

SUBMITTED BY: MTNT, Limited / Vicki Clayman

COMMITTEE RECOMMENDATIONS: Do Pass

CONVENTION ACTION: Do Pass

73 crews plus
2 Hotshot crews (20 each)
1 Tazlina EF crew (20 each)

APPENDIX B

INTERAGENCY EFF CREW LOCATION LIST (1994)-95

LOCATION	16 PERSON CREWS	AGENCY*	3-LETTER DESIGNATION
Allakaket/Alatna	2	AFS (TZ)	AET
Ambler	1	AFS (GZ)	ABL
Angoon	1	USFS (CMF)	ANG
Aniak	1	DOF (SWA)	ANI
Beaver	1	AFS (UYZ)	WBQ
Big Lake/Wasilla	1	DOF (MSA)	BGQ
Buckland	1	AFS (GZ)	7KS
Chalkyitsik	1	AFS (UYZ)	CIK
Chevak	2	DOF (SWA)	VAK
Copper River	2	DOF (VCRA)	CZC
Delta	2	DOF (DA)	BIG
Eagle	2	AFS (UYZ)	EAA
Fairbanks	2	DOF (FA)	FAI
Fort Yukon	3	AFS (UYZ)	FYU
Galena	1	AFS (GZ)	GAL
Grayling	1	AFS (GZ)	KGX
Holy Cross	1	AFS (GZ)	4Z4
Hooper Bay	3	DOF (SWA)	HPB
Hughes	1	AFS ([illegible])	[illegible]
Huslia	2	AFS (GZ)	HSL
Kalskag, Lower	1	DOF (SWA)	KLG
Kalskag, Upper	1	DOF (SWA)	KLG
Kaltag	2	AFS (GZ)	KAL
Kiana	2	AFS (GZ)	IAN
Koyuk	1	AFS (GZ)	KKA
Koyukuk	1	AFS (GZ)	KYU
Marshall	1	AFS (GZ)	MLL
Mentasta	1	DOF (TA)	MEN
Minto	1	AFS (TZ)	51Z
Mountain Village	1	AFS (GZ)	MOU
Nenana	1	DOF (FA)	ENN
New Stuyahok	1	DOF (SWA)	KNW
Nikolai	1	DOF (SWA)	5NI
Nondalton	1	DOF (SWA)	5NN
Noorvik	2	AFS (GZ)	ORV
Northway	2	DOF (TA)	ORT
Nulato	2	AFS (GZ)	NUL
Pilot Station	1	AFS (GZ)	PST
Rampart	1	AFS (TZ)	RMP
Ruby	1	AFS (GZ)	RBY

INTERAGENCY EFF CREW LOCATION LIST (1994)

LOCATION	CREWS	AGENCY*	3-LETTER DESIGNATION
Scammon Bay	1	DOF (SWA)	SCM
Selawik	2	AFS (GZ)	WLK
Shageluk	1	DOF (SWA)	SHX
Shungnak	1	AFS (GZ)	SHG
Sleetmute	1	DOF (SWA)	SLQ
Stebbins	2	AFS (GZ)	WBB
Stevens Village	1	AFS (UYZ)	SVS
St. Marys	1	AFS (GZ)	KSM
St. Michael	1	AFS (GZ)	SMK
Tanacross	1	DOF (TA)	TSG
Tanana	2	AFS (TZ)	TAL
Tetlin	1	DOF (TA)	5TE
Tok	1	DOF (TA)	6K8
Venetie	1	AFS (UYZ)	VEE

* AFS Zones:
- GZ - Galena Zone, Galena
- TZ - Tanana Zone, Tanana
- UYZ - Upper Yukon Zone, Central

* DOF Areas:
- SWA - Southwest Area, McGrath
- MSA - Mat-Su Area, Big Lake
- VCRA - Valdez/Copper River Area, Glennallen
- TA - Tok Area, Tok
- DA - Delta Area, Delta Junction
- FA - Fairbanks Area, Fairbanks

* USFS Areas:
- CMF - U.S. Forest Service, Chatham Area, Sitka

Summary:

AFS	44
DOF	28
USFS	1
Total	73 crews

There are also 2 HOTSHOT CREWS by Alaska Fire Service 20 each
1 Type I EFF Crew - Tazlina 20

1994 Fire Statistics

Fires statewide: 643

Acres burned: 265,721.6

Fire Activity by Landowner

Landowner	Number	Acres
State	122	52,960.3
Borough/City	30	6.5
Private	242	1,127.8
Bureau of Land Mgmt.	75	93,675.4
National Park Service	15	10,331.6
Fish & Wildlife Service	59	74,879.5
Bureau of Indian Affairs	4	410.2
Native Claims Act Lands	55	20,393.2
Military	7	11,914.2
Forest Service	34	22.9
Total	643	265,721.6

1994 Fires by Cause on State Protected Land

Cause	Number	Acres
Lightning	73	85,274.1
Smoking	24	16.3
Campfires	85	4,126.6
Trash/debris	28	64.6
Land clearing	75	1,059.2
Children	30	206.5
Fireworks	22	11.1
Equipment use	12	11.8
Incendiary/arson	16	7.1
Structures	18	3.5
Other	43	46.0
Total	446	90,826.3

Emergency Firefighter Wages

Year	State	Federal	Total
1980-85	$4,689,081	$9,861,933	$14,551,014
1986	2,515,750	2,832,208	5,347,958
1986[1]	561,770	——	561,770
1987	646,674	5,352,799	5,999,473
1987[2]	643,932	——	643,932
1988	4,474,107	5,146,861	9,620,968
1988[3]	907,865	——	907,865
1989	1,805,955	2,276,175	4,082,130
1990	7,398,211	5,765,547	13,163,758
1991	5,344,384	3,741,521	9,085,905
1992	786,747	612,048	1,398,795
1993	3,699,629	580,866	4,280,495
1994	5,952,942	3,654,245	9,607,187
1995	904,492	207,958	1,112,450
Total	$40,331,539	$40,032,161	$80,363,700

[1] Special appropriation due to Fair Labor Standards Act.

[2] U.S. Dept. of Labor ruling required payment at time-and-one-half when week exceeded 40 hours. Amount shown was paid in 1990.

[3] U.S. Dept. of Labor ruling required payment at time-and-one-half when week exceeded 40 hours. Amount shown was paid in 1991.

Emergency Out-of-State Crew Use

Number of 20-person crews sent outside of Alaska to fight fires.*

Year	Crews
1985	39
1986	22
1987	59
1988	54
1989	61
1990	7
1991	0
1992	5
1993	0
1994	83
1995	1

*Wages are paid by other states or suppression agencies.

SB
253

SENATOR JIM DUNCAN

ALASKA STATE LEGISLATURE

Alaska State Senate

State Capitol • Room 119 • Juneau, Alaska 99801-1182 • (907) 465-4766 • Fax 465-4748

February 2, 1996

SB 253

Mandating Insurance Coverage for Prostate Antigen Blood Tests

Senator Jim Duncan today introduced legislation which will require that insurance companies doing business in Alaska include Prostate-Specific Antigen (PSA) screening as a covered benefit.

Many insurers do not cover this blood test which the American Cancer Society recommends be performed annually on all men 50 years of age and older as a part of an annual prostate examination. The American Cancer Society also recommends that PSA screening begin at the age of 40 for men at high risk.

"I believe providing coverage for this important test can save lives or improve the quality of life for many Alaskan males," Duncan, a Juneau Democrat, said. "In 1991, the Legislature mandated insurance coverage for mammograms, and SB 253 represents a similar step towards preventative health care for men."

According to the National Cancer Institute, prostate cancer is the most common malignant cancer in American men. Prostate cancer is now the second leading cause of death in men, the first being lung cancer. The PSA test clearly increases the detection rate of early stage cancers, thus resulting in better, less invasive medical treatment for the patient.

-30-

FISCAL NOTE

No. 3

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Version: CS SB 253(FIN)
(S) Publish Date: 4-3-96

Revision Date:
Title: An Act relating to insurance coverage for costs of prostate cancer detection.
Sponsor: Duncan
Requestor: (S) FIN

Department Affected: All Agencies
BRU: All Agencies
Component: All Agencies
COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
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
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE: (Thousands of Dollars)

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
1002 Federal Receipts	0.0	0.0	0.	0.0	0.0	0.0
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 96) cost: $ zero

POSITIONS:

	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Currently the State's plan pays for the Prostate Specific Antigen (PSA) test only when there are clinical signs or symptoms of prostate disease. This bill would expand health coverage to include routine prostate cancer screening. The State's health insurance premiums are based on the experience of the plan. We anticipate an increase in health costs of approximately $60,000 per year.

This bill also mandates the coverage of PAP tests. These tests are already covered under the State's plan; therefore, there will be no increased cost for that coverage.

Prepared by: Robert F. Stalnaker [signature]
Division: Retirement & Benefits
Phone: 465-4470
Date:

Approved by Commissioner: Mark Boyer [signature]
Agency: Department of Administration
Date: 4/2/96

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Rev: 11/95

No. 1

Bill Version: SB 253

(S) Publish Date: 3-14-96

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date:

Title: Insurance for Prostate Cancer Testing

Sponsor: Senator Duncan

Requestor: Labor & Commerce Committee

Department: Commerce and Economic Development

BRU: Insurance

Component: Operations

COMPONENT SERIAL NO. #354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
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						
CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 96) cost: $ 0.0

POSITIONS

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

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact.

Prepared by: Joan Brown, Administrative Officer — Phone: 465-2597

Division: Insurance — Date: 2/9/96

Approved by Commissioner: William L. Hensley — Date: 2-13-96

Agency: Commerce and Economic Development

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Senator Jim Duncan

Alaska State Legislature

Alaska State Senate

State Capitol • Room 119 • Juneau, Alaska 99801-1182 • (907) 465-4766 • Fax 465-4748

Memorandum

Date:	April 16, 1996
To:	Representative Con Bunde, Co-Chair Representative Cynthia Toohey, Co-Chair House Health, Education & Social Services Committee
From:	Senator Jim Duncan
Subject:	SB 253, An Act relating to insurance coverage for costs of prostate cancer or cervical cancer detection.

I request that you schedule SB 253, relating to insurance coverage for costs of prostate cancer or cervical cancer detection, for a hearing in the House Health, Education & Social Services Committee as soon as possible.

Prostate cancer is a serious health concern to men over the age of fifty. Prostate Specific Antigen (PSA) blood tests can be done to detect the presence of cancer and alert men of potential health problems. Currently, insurance companies are not required by Alaska law to include this test in their coverage package. SB 253 will require that insurance companies cover the PSA on annual physical exams when appropriate.

The importance of screening for malignant cancer is well documented. Prostate cancer accounts for 36% of all male cancers and is the second leading cause of death in men after lung cancer as reported by the National Cancer Institute. Although often presumed to develop slowly, nearly two thirds of new cancer cases have spread beyond the prostate gland by the time of diagnosis.

In addition to coverage of the PSA, SB 253 would require coverage of cervical cancer screening. Early detection of cervical cancer involves the Pap Smear, a test that takes a small sample of cervical cells. The American Cancer Society recommends that all women who are sexually active or over the age

REQUEST FOR HEARING

of eighteen should have a Pap test each year. About 90% of cervical cancer cases can be detected early through the use of Pap smears. If discovered early, cervical cancer is almost 100% curable.

SB 253 makes health issues a priority. I would welcome your support in requiring that insurance companies cover the cost of prostate and cervical cancer screening and request that you schedule this bill for a hearing in the House Health, Education & Social Services Committee as soon as possible.

Attachments

Wall Street Journal
Oct. 18, 1995 p. B6

New Cancer Test For the Prostate Appears Promising

By Ron Winslow
Staff Reporter of The Wall Street Journal

Medical researchers said a new version of a widely used screening test for prostate cancer appears to improve its accuracy in detecting the disease.

If the results are borne out in further studies, the test may yield fewer false positive readings for cancer and thus reduce by 31% to 76% the number of men who undergo unnecessary biopsies and other examinations to confirm whether they have cancer.

Use of the current test, known as PSA, for prostate-specific antigen, has increased among men over 50. But it also has provoked controversy in part because only one in three men who have positive readings turns out to have cancer. That means the tests cause two out of three to undergo unnecessary and sometimes painful biopsies and other tests.

The high rate of false positive results occurs because PSA is also elevated in older men with a common noncancerous condition called benign prostatic hyperplasia.

The new test measures two forms of PSA, one that binds to certain blood proteins and another that is free-floating in the blood stream. For reasons not understood, men with prostate cancer have significantly lower levels of free PSA than men with BPH, said William J. Catalona, chief of urologic surgery at Washington University School of Medicine, St. Louis, and lead author of the study. As a result, the study indicated, the new test can better distinguish between men with prostate cancer and those with BPH.

In the study, published in today's Journal of the American Medical Association, researchers used frozen blood samples taken from 113 men over 50 whose original readings were between four and 10. Among those, who had also undergone biopsies and rectal exams, 63 had been diagnosed with BPH and 50 had prostate cancer.

— included in this packet of articles
see JAMA Oct. 18.

In general, researchers found that men whose free-floating PSA was significantly below 20% of their total PSA levels were more likely to have cancer than those with free PSA levels above 20%.

The study found that the free PSA test would have eliminated 76% of unnecessary biopsies among men who didn't have BPH and 38% of the biopsies among those with the benign condition. In a third group, who had BPH and no cancerous symptoms when doctors felt the prostate during a rectal exam, the free PSA test would have eliminated 31% of unnecessary biopsies.

Dr. Catalona said a new national trial to involve 12,000 patients at eight medical centers around the U.S. has been launched in an effort to verify the results.

BACKGROUND - PROSTATE CANCER

Evaluation of Percentage of Free Serum Prostate-Specific Antigen to Improve Specificity of Prostate Cancer Screening

William J. Catalona, MD; Deborah S. Smith, PhD; Robert L. Wolfert, PhD; Tang J. Wang, PhD; Harry G. Rittenhouse, PhD; Timothy L. Ratliff, PhD; Robert B. Nadler, MD

Objective.—To evaluate measurement of percentage of free prostate-specific antigen (PSA) in serum to improve the specificity of prostate cancer screening in men with serum PSA levels between 4.1 and 10.0 ng/mL.

Design.—Retrospective, nonrandomized analysis using a research assay for measuring free PSA in frozen serum from men with a spectrum of prostate sizes and digital rectal examination results.

Setting.—General community outpatient prostate cancer screening program at a university center.

Patients.— One hundred thirteen men aged 50 years or older, 99% of whom were white, with serum PSA concentrations of 4.1 to 10.0 ng/mL, including 63 men with histologically confirmed benign prostatic hyperplasia, 30 with prostate cancer with an enlarged gland, and 20 with cancer with a normal-sized gland. All study volunteers had undergone prostatic ultrasonography and biopsy.

Main Outcome Measures.—Percentage of free PSA in serum and percentage of free PSA cutoff that maintained at least 90% sensitivity for prostate cancer detection.

Results.—Median percentage of free PSA was 9.2% in men with cancer and a normal-sized gland, 15.9% in men with cancer and an enlarged gland, and 18.8% in men with benign prostatic hyperplasia ($P<.001$). The percentage of free PSA cutoff was higher in men with an enlarged gland and in those with a palpably benign gland. In men with an enlarged, palpably benign gland, a free PSA cutoff of 23.4% or lower detected at least 90% of cancers and would have eliminated 31.3% of negative biopsies.

Conclusions.—Measurement of percentage of free serum PSA improves specificity of prostate cancer screening in selected men with elevated total serum PSA levels and can reduce unnecessary prostate biopsies with minimal effects on the cancer detection rate; however, further studies are needed to define optimal cutoffs. Final evaluation of PSA screening also must consider the ability of current treatments to improve the prognosis of screen-detected prostate cancer.

(*JAMA*. 1995;274:1214-1220)

MEASUREMENT of serum prostate-specific antigen (PSA) concentrations is widely used as an aid in the early detection of prostate cancer.[1] Although concern has been expressed that screening with PSA may detect insignificant cancers, this has not been borne out. The large majority of cancers detected have the pathological features of progressive cancers.[1-5] Recent studies using frozen serum samples from more than a decade ago have shown that me[illegible]ho developed prostate cancer 5 to [illegible]ars after their serum was drawn could have been identified with high accuracy based on their initial serum PSA levels.[6,7]

In screening studies, most men with elevated serum PSA concentrations have PSA levels in the 4.1 to 10.0 ng/mL range, and many have enlarged, palpably benign prostate glands on digital rectal examination. Overall, only one quarter of these men have cancer detected by an initial prostatic needle biopsy.[1,2] However, rebiopsy of these patients within 6 to 12 months shows that the initial biopsy missed cancers and that closer to one third of patients in this group actually had prostate cancer.[8] Most prostate cancer patients with slightly elevated PSA concentrations have early-stage disease, whereas more than half of patients with PSA concentrations higher than 10.0 ng/mL have advanced disease.[1,2] Thus, the detection of prostate cancer in its curable stages requires the use of relatively low PSA cutoffs (4.0 ng/mL) for screening. Unfortunately, the use of low PSA cutoffs produces high false-positive rates, leading to unnecessary biopsies (ie, negative for cancer). The most common causes of false-positive PSA elevations are benign prostatic hyperplasia and prostatitis.[9] One potential way of reducing false-positive results is measurement of the free and bound forms of PSA in serum.[10-13]

From the Division of Urologic Surgery, Department of Surgery, Washington University School of Medicine, St Louis, Mo (Drs Catalona, Smith, Ratliff, and Nadler), and Department of Research and Development, Hybritech Incorporated, San Diego, Calif (Drs Wolfert, Wang, and Rittenhouse).

Reprint requests to Division of Urologic Surgery, 4960 Children's Pl, St Louis, MO 63110 (Dr Catalona).

ostate-specific antigen in serum is d predominantly to the protease itors α_1-antichymotrypsin (PSA-) and α_2-macroglobulin (PSA-AMG); n PSA also binds in trace amounts -antitrypsin and inter-alpha tryp- nhibitor.[10-12] Most complexed PSA sured in commercial immunoassays A-ACT. Virtually all of the remain- neasurable PSA in serum is in the form. Failure to detect PSA-AMG e to the concealment of the relevant genic epitopes.[11-13]

xperimental immunoassays have developed for separate measure- t of free PSA and PSA-ACT. Pre- nary evidence in heterogeneous ent populations suggests that (for nown reasons) the proportion of free is lower with prostate cancer than benign prostatic hyperplasia, and measurements of PSA forms could distinguish between hyperplasia cancer.[6,11-13]

the current study, we examined usefulness of free PSA measure- ts in men with serum PSA concen- ions of 4.1 to 10.0 ng/mL. We also uated the free PSA cutoffs needed naintain at least 90% sensitivity in cting cancer in subsets of men with rent ultrasonographically measured tate sizes and findings on digital al examination.

THODS

jects and Procedures

rom July 1989 through March 1995, measured total serum PSA levels in 49 ambulatory men aged 50 years or r (range, 50 to 90 years; mean [±SD] , 62.7 [±6.9] years).[2,14] These men ponded to a press release asking lthy men to participate in a study of A measurement as a screening test prostate cancer. None had a history rostate cancer, and those with a his- y of prostatitis were excluded. Men h symptoms of benign prostatic hy- plasia were not excluded. We did not form a digital rectal examination at time of the blood test.

We have previously described the dy protocol, which was approved by Human Studies Committee of Wash- ton University.[2,14] We obtained in- med consent from all study subjects. men whose initial serum PSA levels re 4.0 ng/mL or lower, no further luation was performed. Rather, their A levels were measured again at onth intervals for the duration of study unless the PSA level increased higher than 4.0 ng/mL. If the value s higher than 4.0 ng/mL, another blood nple was collected within 1 to 2 weeks verify the elevation. Men who had two serum PSA concentrations higher than 4.0 ng/mL within the 1- to 2-week period underwent both digital rectal examination and prostatic ultrasonography. If either or both of these procedures revealed abnormal or suspicious findings, we performed a needle biopsy of the prostate under ultrasound guidance. If the PSA concentration was higher than 4.0 ng/mL but the rectal and ultrasound examinations yielded normal findings, no biopsy was performed. Men whose biopsy specimens did not show cancer had serum PSA measurements at 6-month intervals. Repeated rectal examination, ultrasonography, and biopsy, if indicated, were recommended for men whose PSA levels were again higher than 4.0 ng/mL at a later evaluation. Fewer than 1% of the screening volunteers were African American, Asian, or Hispanic.

We measured serum PSA concentrations using an immunoenzymetric assay (Tandem-E PSA, Hybritech Inc, San Diego, Calif). We used the normal range recommended by the manufacturer (0 to 4.0 ng/mL) and considered PSA values higher than 4.0 ng/mL grounds for suspecting prostate cancer. The performance characteristics of the assay have been reported.[12,14]

The following data were recorded: (1) findings on digital rectal examination, which were categorized as normal, abnormal but benign (including enlargement), or suspicious for cancer (including induration, asymmetry, and irregularity); (2) ultrasound findings, categorized as normal, abnormal but benign (including enlargement, asymmetry, calculi, and transition-zone hypoechoic areas), or suspicious for cancer (hypoechoic area in the posterior peripheral zone); (3) PSA level in serum drawn before each rectal examination, ultrasonographic examination, or biopsy; (4) results of biopsy; (5) clinical and pathological tumor stage; and (6) tumor grade.

Monoclonal Antibody Immunoassay Specific for Free PSA.—A sandwich immunoassay was developed using a monoclonal antibody highly specific to free PSA and a second monoclonal antibody recognizing free and bound PSA equally. In this format, less than 0.7% cross-reactivity to PSA-ACT was demonstrated.

The solid-phase capture antibody was incubated with 200 mL of sample for 2 hours at room temperature, washed, and then incubated for an additional 2 hours with the second monoclonal antibody conjugated to alkaline phosphatase. Beads were washed, incubated for 1 hour with the chemiluminescent substrate 4-methoxy-4-(3-phosphatephenyl)spiro [1,2-dioxetane-3,2'-adamantane] disodium salt (LumiPhos 480, Lumigen, Inc, Southfield, Mich), and read in a luminometer (MGM Instruments, Inc, Hamden, Conn). The free PSA calibrators, with the range of 0 to 10.0 ng/mL, were value assigned by the Tandem-R PSA assay to obtain mass-weight values. The analytical detection limit of the free PSA immunoassay was 0.05 ng/mL. The intra-assay coefficient of variation was between 2.5% and 12.5% across the calibrator range. The interassay coefficient of variation was 6.3% at 0.77 ng/mL concentration and 4.8% at 3.98 ng/mL concentration.

Measurement of Free PSA in Selected Subgroups.—Serum samples had been routinely frozen at −80°C and stored for all study volunteers enrolled from July 1989 through January 1991. We systematically selected a sample of study volunteers for whom frozen stored serum samples were available for measurement of free and total PSA concentrations. Because men with borderline PSA elevations (4.1 to 10.0 ng/mL) frequently pose a diagnostic dilemma, we first identified all men enrolled before January 1991 whose initial PSA screening measurements were in this range. Since the purpose of our study was to determine the percentage of free PSA in men with a spectrum of ultrasonographically measured prostate sizes with or without detectable prostate cancer, this sample was further subdivided according to estimated prostate volume and biopsy results. Prostate volume was calculated via the prolate spheroid formula[15] using the transrectal ultrasound scan from the first biopsy.

Using these additional parameters, we identified the following study groups: (1) 67 men with biopsy-verified benign prostatic hyperplasia as determined by three or more sets of prostatic biopsy specimens (four to six biopsy cores in each set) that were negative for prostate cancer (ultrasonographically estimated gland volume of ≥40 cm^3); (2) 33 men with biopsy-verified prostate cancer and an enlarged prostate gland (ie, ultrasonographically estimated gland volume of ≥40 cm^3) with prostate cancer detected within 24 months of the initial screening visit (to include the cancers that were missed on the initial biopsies); and (3) 21 men with prostate cancer and a relatively normal-sized gland (ie, ultrasonographically estimated gland volume <40 cm^3) with prostate cancer detected within 24 months of the initial screening visit. In total, frozen serum samples from 121 men were selected for further study. All of the men with prostate cancer had clinically localized cancer, and all but one were treated with radical prostatectomy.

Using the Hybritech research assay

specific for free PSA and the Tandem-E PSA assay for measurement of total PSA, we measured free PSA and reassessed total PSA in the stored serum samples from the initial screening visit in the three study groups.

Since other researchers[6] have reported loss of detectable PSA immunoreactivity following long-term storage of serum samples, we evaluated the stability of total serum PSA as measured in fresh and frozen stored serum samples. The mean coefficient of variation (±SD) for total serum PSA concentration in all fresh and stored pairs was 9.2% (±16.6%). Overall, total PSA as measured in stored serum decreased in 82.6% (100 of 121) of the samples and increased in the remainder. The mean ratio (±SD) of stored to fresh total PSA (ie, [total PSA measured in stored serum]/[total PSA measured in fresh serum]) was 0.88 (±0.14) for the 100 cases in which the total PSA decreased and 1.05 (±0.06) for the 21 cases in which the total PSA increased when reassessed in stored serum. For the cases in which PSA decreased, outliers that fell below 1 SD of the mean ratio of stored to fresh total PSA (ie, the stored total PSA was <74% of total PSA as measured in fresh serum) were eliminated from further analyses (n=5). Similarly, for cases in which total PSA increased, outliers that increased more than 1 SD above the mean ratio of stored to fresh total PSA (ie, the stored total PSA was >111% of fresh total PSA) also were eliminated (n=3). Overall, 6.6% of cases were eliminated from further analysis (final n=113); elimination of cases was uniform across the three study groups described above (generalized Fisher's exact test,[16] $P=.80$).

Pathological Tumor Staging.—Pathological staging was performed as previously described.[3] For this analysis, study volunteers whose cancer was confined to the prostate and had clear margins were categorized as having pathologically organ-confined cancer (stage pT1 or pT2). Those with microscopic periprostatic cancer extension and those whose resected prostate gland contained cancer at the margins (stage pT3a), those with cancer invading into the seminal vesicles (stage pT3b), and those with lymph node metastases (stage N1) were classified as having pathologically advanced cancer.

Tumor Grading.—Gleason score was recorded for the radical prostatectomy specimens (49 [98%] of 50 of the included cancer cases were treated with radical prostatectomy). In three cases (6%), the pathologist recorded only the tumor grade (ie, well, moderately, or poorly differentiated). To estimate Gleason score for these cases, we graded the remainder of the tumors as well (Gleason score of 2 to 4), moderately (Gleason score of 5 to 7), or poorly (Gleason score of 8 to 10) differentiated and calculated the median Gleason score for each grade. This value was substituted for Gleason grade when Gleason score was not recorded.

Statistical Analysis

We calculated one-way analysis of variance, Mann-Whitney U tests, and χ^2 tests to assess differences in the study groups with regard to clinical characteristics (ie, age at first screening visit, proportion with digital rectal examination results suspicious for prostate cancer at the most recent biopsy, and estimated prostate volume at first biopsy).

Since previous studies have suggested that the percentage of free PSA (vs the absolute free PSA value) best discriminates between prostate cancer and benign hyperplasia,[13] we calculated the percentage of free PSA as the ratio of free PSA to total PSA multiplied by 100. The total PSA concentration was that measured in the repeated assay performed on the stored serum samples. We compared total PSA and the percentage of free PSA across the three study groups via a Kruskal-Wallis test. We used Mann-Whitney U tests for post hoc pairwise comparisons. To reduce the likelihood of type I error, the significance level for the post hoc comparisons was corrected for the number of comparisons (ie, Bonferroni correction = α divided by the number of comparisons).[17] Therefore, we considered a P value ≤.02 (.05/3) significant for all post hoc pairwise comparisons.

Combining the two study groups of men with cancer, we used hierarchical logistic regression analysis to assess the importance of percentage of free PSA in predicting prostate cancer while controlling for age at first screening visit, presence of suspicious findings on rectal examination, and total serum PSA concentration (estimated prostate volume was not included in this model since by design our study groups differed in prostate volume). We report the Wald statistic and the adjusted odds ratio (OR) with 95% confidence interval (CI) for the percentage of free PSA.[18]

To determine whether the percentage of free PSA remained a significant predictor of prostate cancer in the subset of men with an enlarged prostate gland (ie, ultrasonographically estimated gland volume of ≥40 cm³), we computed a second logistic model excluding the study group of men with prostate cancer and a relatively normal-sized gland. Similar to the first logistic model, the significance of the percentage of free PSA in predicting prostate cancer was assessed after controlling for age at first screening visit, presence of suspicious findings on rectal examination, and total serum PSA concentration. Since the estimated prostate volume differed between those with and without prostate cancer, estimated volume was included as an additional predictor.

Before we calculated the logistic models, the assumption of a linear relationship with presence of prostate cancer was confirmed for each continuously scaled predictor. We determined quartiles for the distribution of each predictor (ie, age, total serum PSA concentration, estimated prostate volume, and percentage of free PSA) and calculated the ORs for the prediction of cancer based on the comparison of each quartile to the lowest quartile. We then plotted the log of the OR against the midpoint of each quartile to assess the shape of the relationship.[18] Visual inspection indicated that none of the continuously scaled predictors were associated with the presence of prostate cancer in a markedly nonlinear manner. Consequently, we modeled these predictors as simple linear effects in the logistic models.

To assess whether using the percentage of free PSA as a screening test for prostate cancer would increase the specificity of PSA-based screening, we preset sensitivity to at least 90% and determined the cutoffs for percentage of free PSA for the combined study groups of men with prostate cancer, for the study group with cancer and a gland 40 cm³ or larger, and for the study group with cancer and a gland smaller than 40 cm³ (here "sensitivity" is used in the context of specific subgroups and not the general screening population; that is, we do not include the full range of normal and elevated serum PSA concentrations). We then computed specificity (ie, the proportion of men without prostate cancer who would have been considered to have a negative screening test) using each percentage of free PSA cutoff. We repeated this analysis in the subsample of men without findings suspicious for prostate cancer on digital rectal examination (all had serum PSA concentrations between 4.1 and 10.0 ng/mL initially).

Finally, we calculated a point biserial r to assess the relationship between the presence of pathologically advanced cancer and the percentage of free PSA. A Pearson correlation coefficient was calculated to assess the relationship between Gleason score and the percentage of free PSA.

RESULTS

Comparison of Clinical Characteristics Across Study Groups

Table 1 summarizes the clinical characteristics (ie, age at first screening visit,

able 1.—Clinical Characteristics of Study Groups

Characteristic	Benign Prostatic Hyperplasia (n=63)	Cancer With Gland ≥40 cm³ (n=30)	Cancer With Gland <40 cm³ (n=20)	P*
ge in years, mean (±SD)	66.3 (±5.6)	68.5 (±6.5)	66.2 (±4.3)	.20
ectal examination findings suspicious for prostate cancer, No. (%)†	14/62 (22.6)	14/30 (46.7)	10/20 (50.0)	.02
edian (±SIR‡) prostate volume	60.8 (±11.0)	49.5 (±7.2)	30.1 (±3.9)	.005

*P values for age and digital rectal examination results represent three-way comparisons via one-way analysis of variance and χ^2, respectively. The P value for prostate volume represents a Mann-Whitney U test comparing men with benign prostatic hyperplasia and men with prostate cancer with an enlarged gland (≥40 cm³).
†Findings from digital rectal examination were unavailable for one study volunteer.
‡SIR indicates semi-interquartile range ([75th percentile − 25th percentile]/2).

able 2.—Median Total Serum PSA Concentration and Percentage of Free Serum PSA Concentration for Study Groups*

Concentration	Benign Prostatic Hyperplasia (n=63)	Cancer With Gland ≥40 cm³ (n=30)	Cancer With Gland <40 cm³ (n=20)	P†
Median (±SIR) total PSA	6.0 (±1.4)	6.6 (±1.5)	5.3 (±1.3)	.60
Median (±SIR) % free PSA	18.8 (±6.8)	15.9 (±3.9)	9.2 (±3.3)	<.001

*PSA indicates prostate-specific antigen; and SIR, semi-interquartile range ([75th percentile − 25th percentile]/2).
†P values represent three-way comparisons via Kruskal-Wallis tests. For the percentage of free PSA, all Mann-Whitney U pairwise comparisons between groups were significant at P<.002.

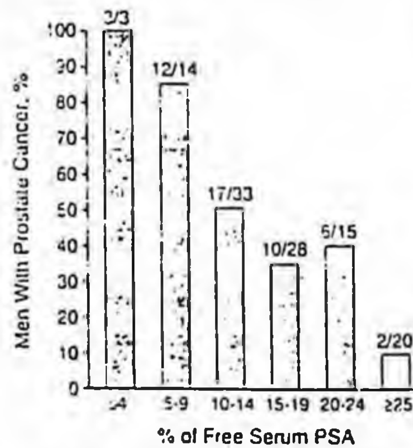


Figure 1.—Decreasing simple proportion of men in the combined study groups found to have prostate cancer on biopsy with each 5% increase in the percentage of free prostate-specific antigen (PSA) in serum (ratio of free PSA to total PSA multiplied by 100).

digital rectal examination results at the time of the most recent biopsy, and estimated prostate volume at first biopsy for the three study groups. The study groups did not differ with regard to mean age (P=.20). As expected, men with prostate cancer were significantly more likely to have digital rectal examination findings suspicious for prostate cancer (χ^2[2]=8.0; P=.02). As defined by our selection criteria, the study groups also differed significantly with regard to estimated prostate volume. A pairwise comparison indicated that the men with benign prostatic hyperplasia had significantly larger prostate glands than the men with prostate cancer and an enlarged prostate gland (Mann-Whitney U P=.005).

Distribution of Total PSA and the Percentage of Free PSA in Stored Samples

As shown in Table 2, total PSA as measured in stored samples did not differ across study groups (Kruskal-Wallis P=.60). In contrast, the percentage of free PSA differed significantly across groups (Kruskal-Wallis P<.001). Men with prostate cancer (with a normal-sized or an enlarged prostate) had a significantly lower percentage of free PSA than men with benign prostatic hyperplasia only (all Mann-Whitney U P values <.002). Additionally, men with prostate cancer and a normal-sized prostate had a significantly lower percentage of free PSA than men with prostate cancer and an enlarged prostate (P=.002).

Use of Percentage of Free PSA for Differentiating Benign Prostatic Hyperplasia From Prostate Cancer

The results of the logistic regression model including both study groups of men with prostate cancer (113 men) indicated that the percentage of free PSA added significantly to the prediction of cancer in men with elevated PSA levels, even after controlling for age, suspicious findings on rectal examination, and total serum PSA (Wald χ^2[1]=19.3; P<.001; adjusted OR, 0.4 [95% CI, 0.3 to 0.6] for each 5% increase in the percentage of free PSA).

Similar results were found for the logistic model that included only the 93 men with an enlarged prostate gland. Measurement of the percentage of free PSA added significantly to the prediction of prostate cancer, even after controlling for age, findings suspicious for cancer on rectal examination, total serum PSA, and estimated prostate volume (Wald χ^2[1]=4.6; P=.03; adjusted OR, 0.6 [95% CI, 0.4 to 0.9] for each 5% increase in the percentage of free PSA).

These results indicate that measurement of the percentage of free PSA gives predictive information about the presence or absence of prostate cancer above that provided by other clinical indexes such as age, total PSA level, suspicious results on rectal examination, and prostate size. Figure 1 illustrates for our combined study groups the systematic decrease in the simple proportion of men with prostate cancer with each 5% increase in the percentage of free PSA.

Percentage of Free PSA as a Screening Test for Prostate Cancer

To determine whether assessment of percentage of free PSA could increase the specificity of PSA-based prostate cancer screening in men with serum PSA levels of 4.1 to 10.0 ng/mL, we calculated percentage of free PSA cutoff points that would predict cancer with at least 90% sensitivity. As shown in Table 3, we calculated a percentage of free PSA cutoff point combining both study groups of men with prostate cancer. Cutoff points for percentage of free PSA also were calculated separately for each study group. As expected, the percentage of free PSA cutoff point was lower in the men with prostate cancer and a normal-sized gland.

Setting sensitivity to at least 90% would have resulted in five missed cancers in the combined cancer study groups. All five men had clinically localized cancer and underwent radical prostatectomy; two were pathologically upstaged to grade pT3. Two of the men had well-differentiated tumors and three had moderately differentiated tumors.

The proportion of men in the benign prostatic hyperplasia study group that would exceed the percentage of free PSA cutoffs and therefore would be considered "true negatives" also is presented in Table 3. Using a free PSA cutoff of 20.3% or lower (which would result in 90% sensitivity if both prostate cancer study groups were combined) would have resulted in negative screens in 38.1% of the benign prostatic hyperplasia group. Consequently, if this cutoff had been used as a criterion for prostatic biopsy, 38.1% of the men with benign prostatic hyperplasia would have been spared biopsy (see Figure 2, patients with benign prostatic hyperplasia above the cutoff line).

Since current standard medical practice mandates the performance of prostatic biopsies in men with rectal examination findings suspicious for prostate cancer, we determined the percentage of free PSA cutoffs (and resultant specificity) for prediction of cancer in men with nonsus-

Table 3.—Percentage of Free PSA Cutoff Points and Resultant Specificity for Predicting Cancer With at Least 90% Sensitivity*

Variable	No. With Cancer	No. Without Cancer	% Free PSA Cutoff	Specificity (95% CI)†
In All the Men				
All cancers	50	63	≤20.3	38.1 (25.4-50.8)
Cancer with gland ≥40 cm³	30	63	≤20.5	38.1 (25.4-50.8)
Cancer with gland <40 cm³	20	63	≤13.7	76.2 (64.8-87.6)
In Men With Nonsuspicious Findings on Digital Rectal Examination				
All cancers	26	48	≤23.4	31.3 (17.2-45.4)
Cancer with gland ≥40 cm³	16	48	≤23.4	31.3 (17.2-45.4)
Cancer with gland <40 cm³	10	48	≤13.8	79.2 (66.8-91.6)

*PSA indicates prostate-specific antigen; and CI, confidence interval.

†Proportion of biopsies with findings negative for prostate cancer that could be eliminated using the percentage of free PSA cutoff as a criterion for performing the biopsy.

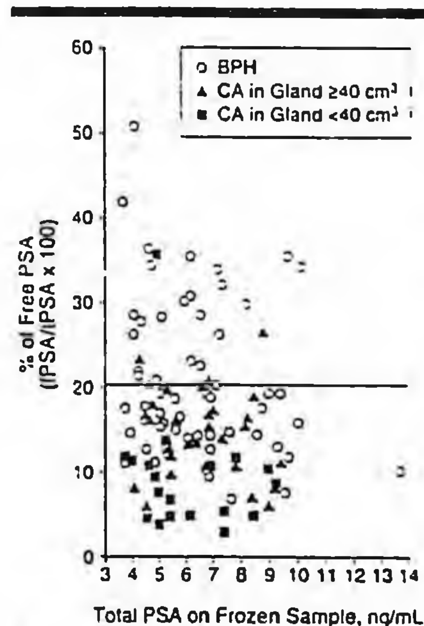


Figure 2.—Percentage of free prostate-specific antigen (PSA) and total PSA (tPSA) concentration in frozen serum from men with benign prostatic hyperplasia (BPH) and men with prostate cancer (CA), regardless of findings of rectal examination. Cutoff point of 20.3% for greater than 90% sensitivity eliminates 38.1% of biopsies in BPH group.

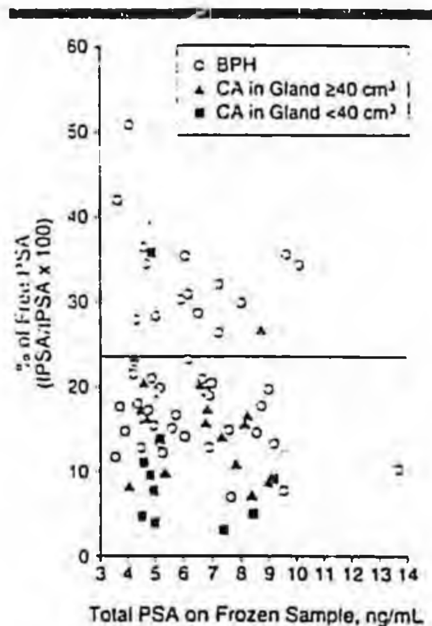


Figure 3.—Percentage of free prostate-specific antigen (PSA) and total PSA (tPSA) concentration in frozen serum from men with benign prostatic hyperplasia (BPH) and men with prostate cancer (CA). The group includes only men without suspicious findings on rectal examination. Cutoff point of 23.4% for greater than 90% sensitivity eliminates 31.3% of biopsies in BPH group.

picious digital rectal examination results (Table 3). Overall, a free PSA cutoff point of 23.4% or lower would have eliminated 31.3% of the biopsies while maintaining 90% sensitivity (Figure 3).

Correlation of Percentage of Free PSA With Cancer Stage and Grade

Within the relatively narrow range of cancer stages represented in our study population, the percentage of free PSA was not associated with the presence of pathologically advanced cancer (r=.10; P=.50). Similarly, the percentage of free PSA was not correlated with Gleason score (r=-.07; P=.60). Pathological stage and tumor grade were missing for one man who did not undergo radical prostatectomy.

COMMENT

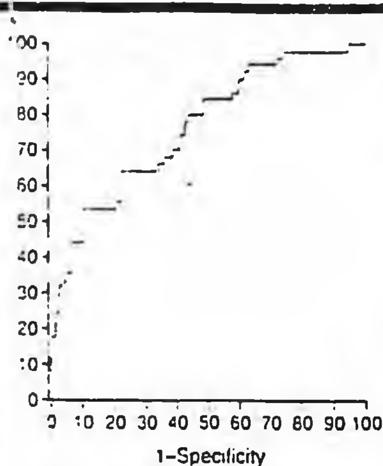
Serum PSA testing for early prostate cancer detection is widely used. Recent studies have shown that measurements of PSA in frozen serum samples drawn more than a decade ago can identify accurately men who developed prostate cancer within 5 to 10 years after the blood samples were drawn.[6,7] These cancers had a high lethal potential, with those patients having high initial serum PSA levels being most likely to have incurable disease.

Prostate-specific antigen may prove to be a valid screening test for early prostate cancer, and a reduction in prostate cancer mortality rates may be achieved by detecting and treating early-stage prostate cancer in men whose life expectancy exceeds 10 years. However, to prove the utility of screening, a reduction in mortality or increase in quality of life in screened patients would have to be demonstrated in prospective studies with length and quality of life as end points.

The chance of achieving cure can be high only with the use of low total serum PSA cutoffs for screening, but low cutoffs (4.0 ng/mL) produce appreciable false-positive results (ie, the positive predictive value is only about 35%) caused by benign hyperplasia or prostatitis. This is particularly true with PSA levels of 4.1 to 10.0 ng/mL in men with findings of benign enlargement on digital rectal examination. Only about 20% of such men have cancer diagnosed by biopsy; however, some men also will have cancer detected by repeated biopsies.[8]

Alternative measures proposed to increase the specificity of serum PSA testing include measuring the rate of change of the serum PSA concentration, called PSA velocity[19,20]; assessing the ratio of blood PSA concentration to ultrasonographically measured gland volume, called PSA density[21]; and using age-specific PSA reference ranges.[22,23] Each of these measures has its own sensitivity-specificity trade-offs that result in either missing a substantial proportion of curable cancers or yielding a high false-positive rate.[24-26] Although it was beyond the scope of this study, we computed sensitivity and specificity in our study groups using published standards for PSA density (ie, 0.15)[27] and PSA age-specific reference ranges (ie, age 50 through 59 years, >3.5 ng/mL; age 60 through 69 years, >4.5 ng/mL; age ≥70 years, >6.5 ng/mL).[22] These calculations show low sensitivity for both measures (48% and 72%, respectively), high specificity for PSA density (87%), and low specificity for age-specific reference ranges (16%). However, these findings cannot be considered a direct comparison with the results reported for the percentage of free PSA because we preset sensitivity for this measure. In a separate logistic model, including age, total PSA, rectal examination results, PSA density, and percentage of free PSA (with both PSA density and percentage of free PSA entered as continuously scaled predictors), both PSA density and percentage of free PSA independently contributed significantly to the prediction of prostate cancer (data not shown). Prospective studies are needed to further compare these methods.

Previous studies have demonstrated that the percentage of serum PSA that exists in the free form is lower in patients with prostate cancer than in those



ure 4.—Receiver operating characteristic curve detection of prostate cancer based on the percentage of free prostate-specific antigen in frozen um from men with benign prostatic hyperplasia men with prostate cancer, regardless of findings on digital rectal examination.

ith benign hyperplasia; this disparity n be exploited clinically to distinguish tween cancer and hyperplasia.[6,10-12] enman et al[6,11] and Leinonen et al[12] ported that the use of the ratio of SA-ACT to total PSA could eliminate lf of the false-positive results without ppreciable loss of sensitivity in a study oup of men whose total serum PSA ncentrations ranged from 2.5 to 25.0 g/mL. Christensson et al[13] reported milar results in 66 men with untreated rostate cancer: specificity was increased using a cutoff level of less than 3% free PSA with only a 10% loss of nsitivity. However, these studies both cluded heterogeneous patient populaons with a wide spectrum of total serm PSA concentrations, prostatic sizes, nd digital rectal examination findings.

Currently there is little argument bout the need for performing prostatic opsies in men with very high serum SA concentrations (>10 ng/mL) or hose whose rectal examination findings re suspicious for cancer. For men with hese findings, measurement of free PSA oes not materially influence the decion-making process. However, it is imortant to examine the results of free erum PSA measurements in men with SA concentrations of 4.1 to 10.0 ng/mL nd benign findings on digital rectal examination for whom some physicians ay not recommend biopsy. These men equently present a diagnostic dilemma.

The results from our logistic regreson models confirm the findings of preious studies, showing that within the ange of PSA concentrations tested (4.1 10.0 ng/mL), the percentage of free SA provides independent predictive nformation about the presence of prosate cancer. Our results extend these observations, showing that the free PSA cutoff required to maintain at least 90% sensitivity of cancer detection was higher in men with an enlarged prostate gland and those with a benign-feeling gland. For example, in men whose prostate size was relatively normal (<40 cm³), a free PSA cutoff of 13.7% or less would have detected at least 90% of the cancers while eliminating 76.2% of the unnecessary biopsies; however, a cutoff of 20.5% or less was required to detect at least 90% of the cancers in men with a larger gland. This higher cutoff still would eliminate 38.1% of the unnecessary biopsies. For free PSA measurements to be helpful in men whose prostate gland was both enlarged and palpably benign (and whose PSA level was 4.1 to 10.0 ng/mL), the cutoff would have to be increased to 23.4% to detect at least 90% of the cancers. If this cutoff had been used, 31.3% of unnecessary biopsies could have been eliminated. However, under present practice, some physicians would not perform biopsies on older men or men with very large glands.

While avoiding unnecessary biopsies is desirable, missing 10% of the cancers is still of concern. Additionally, not pursuing the diagnosis in men with elevated PSA levels may be more psychologically problematic to some physicians and patients as compared with not pursuing diagnosis in men with normal PSA levels. It has been suggested that this loss of sensitivity may be acceptable because of the general slow development of prostate cancer[5]; however, not all cancers missed are low grade and indolent, and the consequences in terms of missing opportunities for cure also may be greater than for men with normal PSA levels.

We evaluated the reciprocal relationship between sensitivity and specificity by plotting true-positive (sensitivity) vs false-positive (1 − specificity) results in a receiver operating characteristic curve. As shown in Figure 4, sensitivity could have been increased in our sample (ie, >90%) with a modest loss in specificity.

In our study, measurements of the percentage of free PSA did not distinguish between early and advanced cancers, nor did they correlate with Gleason score; however, the range of cancer stages and grades represented in our study was narrow.

Our results should be interpreted with caution. Our study is not definitive in that our sample size is small, especially when cases with suspicious rectal examination findings and/or prostate cancer with a small gland are removed for subset analysis. Additionally, possible loss of detectable PSA immunoreactivity may have occurred from long-term storage of the serum samples. Stenman et al[6] compared the geometric mean of PSA concentrations in fresh control serum samples with those of comparable men whose serum samples had been stored at −20°C for 9 to 13 years (and thawed and refrozen once during that interval) and found a 38% lower mean PSA concentration in the frozen samples. Stenman et al concluded that measurable PSA was lost with prolonged freezing and that the PSA-ACT form was preferentially lost. In contrast, our samples were kept frozen at −80°C, were frozen for 3 to 5 years, and were not thawed and refrozen before testing. As a result, our repeated analyses of total PSA levels showed a much more modest loss in immunoreactivity.

Furthermore, preliminary studies performed in 11 serum samples (excluding one outlier) indicate that both the free PSA and total PSA immunoreactivity remained stable for at least 3 months when stored at −20°C or −70°C. The mean (±SD) free PSA immunoreactivity was 93.1% (±3.7%) of the initial baseline value when serum was stored at −20°C and 99.9% (±3.3%) of baseline when stored at −70°C. The mean (±SD) total PSA immunoreactivity was 97.7% (±2.8%) and 95.4% (±4.6%) of the baseline value when stored at −20°C and −70°C, respectively. The free-to-total ratio (96.4% [±5.5%] of the baseline value when stored at −20°C and 105.3% [±8.5%] when stored at −70°C) also remained stable. Serum specimens (n=4) subjected to five freeze-thaw cycles showed a mean recovery of 99.8% (±4.6%) of baseline values. However, serum samples stored at 2°C to 8°C lost approximately 30% of free PSA and about 15% of total PSA immunoreactivity after 15 days. Further studies of the stability of PSA forms are in progress. In addition, initial sample handling is important: samples frozen within 24 hours showed minimal loss of reactivity, whereas those stored at 4°C for longer periods showed considerable decay. In the current study, samples that showed the greatest divergence on repeated analysis (in either a positive or negative direction) were eliminated; however, our results should be verified using fresh serum samples.

Another caveat in interpreting the results of our study is that our volunteers were selected from a small geographic area and examined by selected clinicians. Since our study groups were neither a randomly selected nor a consecutive series, a selection bias also could have been introduced. For example, our volunteer sample may have been enriched for men with symptoms of benign hyperplasia.

s may have exaggerated the ability ercentage of free PSA to distinguish ween benign prostatic hyperplasia ı prostate cancer in the 4.1 to 10.0 mL range. Although we did not col- t symptom information in the study pulation from which our samples were iwn, we can estimate likely symptom evalence from a second PSA screen- r study currently ongoing at our in- tution.[4] In a population of community lunteers recruited in a similar fash- ı, approximately 50% of the men with- t prostate cancer and with PSA levels tween 4.1 and 10.0 ng/mL reported one or more symptoms at study entry. For these reasons, the extrapolation of our results to other patient populations is not established and should be con- firmed in prospective studies of repre- sentative groups of men.

Our results suggest that the use of mea- surements of free PSA concentrations can reduce unnecessary biopsies in selected men with elevated total serum PSA lev- els who are undergoing evaluation for prostate cancer. Further studies are needed to define appropriate cutoffs for men with modest total serum PSA el- evations and enlarged, palpably benign findings on digital rectal examination, to evaluate the percentage of free PSA in fresh serum samples, and to examine cost- effectiveness of screening with the per- centage of free PSA. Ultimately, final evaluation of PSA screening in general also must consider the ability of current treatments to improve the prognosis of men with screen-detected cancers.

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CURRENT CONCEPTS

SCREENING FOR PROSTATE CANCER WITH PROSTATE-SPECIFIC ANTIGEN

An Examination of the Evidence

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AFTER lung cancer, prostate cancer is the leading cause of deaths from cancer among men in the United States. It will claim 40,000 lives in 1995.[1] Studies in the early 1990s demonstrated that levels of prostate-specific antigen (PSA), a serine protease, are elevated in most men with clinically important prostate cancer and that measuring them is the best means for early detection of the disease.[2-5] In 1993, the American Cancer Society recommended that clinicians measure PSA in all men 50 years of age and older as part of an annual prostate examination and that PSA screening should begin at the age of 40 in men at high risk.[6] The American Urological Association issued similar recommendations. Support for PSA screening is not universal, however. Recommendations against PSA screening have been issued by the U.S. Preventive Services Task Force, the Canadian Task Force on the Periodic Health Examination, and the Canadian Urologic Association.[7,8] Recommendations by the American College of Physicians and the American Academy of Family Physicians are currently under review. Physicians in practice have opposing views about PSA screening.[9]

The debate about whether to perform PSA screening has important implications for both individual and public health, but the setting of appropriate policy has been hindered by inadequate data. Screening may reduce morbidity and mortality associated with prostate cancer, but this hypothesis is unproved. On the other hand, widespread testing may set off a cascade of diagnostic and treatment procedures with potentially serious complications, but the magnitude of these risks is uncertain. The overall balance of benefits and harms is therefore unclear. The economic implications of PSA screening are also unknown: testing all men over the age of 50 could cost the country billions of dollars, but the investment might be justified if suffering from prostate cancer could be reduced.

This article reviews the central scientific arguments in the controversy over PSA screening. The discussion is organized around the principal scientific questions that should be asked when one is evaluating any screening test: Is the target condition serious? Is the screening test accurate? Does early detection improve outcome? Is screening or treatment harmful? Does screening do more good than harm?

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ANALYTIC ISSUES

Is Prostate Cancer Serious?

There is little doubt about the seriousness of progressive prostate cancer (tumors that spread beyond the capsule or metastasize). Thousands of men suffer painful complications and die prematurely from such tumors. Ten-year survival rates are 75 percent when the cancer is confined to the prostate, 55 percent with regional extension, and 15 percent with distant metastases.[10] Age-adjusted mortality from prostate cancer has increased by 24 percent in recent years[11] and, largely because of increased screening, the incidence of new cases has risen by 40 percent.[12]

Not all prostate cancers are serious, however, because of the frequently indolent behavior of the disease. Autopsy studies report that about 30 percent of men over the age of 50 have histologic evidence of prostate cancer.[13] Extrapolation of these rates to U.S. census data suggests that as many as 9 million men could harbor latent prostate cancers (Table 1). Since there are about 40,000 deaths each year from the disease,[1] it seems likely that most prostate cancers in the population are not clinically important. Most men with latent prostate cancer die with, rather than from, the disease.

Is PSA Screening Accurate?

Because it might be unethical for researchers to perform biopsies on men with normal PSA results, the true sensitivity and specificity of PSA screening are unknown. The test has a reported sensitivity of up to 80 percent in detecting prostate cancer in screened men,[4] but it lacks specificity. False positive results due to the presence of benign prostatic hypertrophy or prostatitis are common; 25 to 46 percent of men with benign prostatic hypertrophy have elevated PSA values.[23,24] PSA values may also fluctuate by as much as 30 percent for physiologic reasons.[25] The reported positive predictive value of PSA in screening studies is 28 to 35 percent, which means that one third of men with elevated PSA levels (>4 mg per milliliter) will be found to have prostate cancer on biopsy and two thirds will not (i.e., will have false positive results).[3,2,4,5] Participants in these studies were either patients seen at urology clinics or community volunteers, which has caused some to question whether the positive predictive value might be lower when screening occurs in primary care settings.

Promising techniques to improve the accuracy of PSA screening include measuring PSA density[26] (the PSA concentration divided by the volume of the gland) or the rate of change in PSA over time.[27] A third approach is to use age-adjusted reference ranges,[28] since PSA values increase with age. Finally, some advocate measuring the ratio of free to complexed PSA.[29] PSA bound to alpha$_1$-antichymotrypsin accounts for a larger proportion of total PSA in patients with prostate cancer than in those with benign prostatic hypertrophy. No single approach has yet been proved to be more accu-

rate than another. For now, the best way to reduce the frequency of false positive results is to combine PSA screening with the digital rectal examination, which increases the positive predictive value from 32 to 49 percent if the results of both are abnormal.[1]

A more fundamental problem than false positive results, however, has been how to determine whether cancers detected through PSA screening (true positives) are clinically important. As has already been noted, autopsy studies suggest that 30 percent of men over the age of 50 have latent prostate cancers that are unlikely to produce symptoms or affect survival. It has long been feared that population screening would preferentially identify these latent cancers (rather than aggressive disease) and that thousands of men who are more likely to die of other causes (e.g., coronary artery disease) would be subjected to unnecessary testing and treatment for prostate cancer. Recent evidence suggests, however, that cancers detected through PSA screening may be more aggressive and clinically important than latent cancers found on autopsy. About 31 to 38 percent of cancers identified through PSA screening and radical prostatectomy have evidence of extracapsular extension, poorly differentiated cells, large volume, or metastases.[1,30,31] These features are associated with an increased risk of progression, although they are not pathognomonic of aggressive disease. Autopsy studies also report capsular penetration, local tissue invasion, and diffuse or poorly differentiated cells in 10 to 88 percent of men with no antemortem prostate history.[16,19,32] For now, neither PSA values nor histologic findings can predict with certainty whether a newly diagnosed prostate cancer will progress or remain latent.

Does Early Detection of Prostate Cancer Improve Outcomes?

Ultimately, accuracy is less important than clinical outcomes in judging the efficacy of screening. Debates about the relative superiority of density, rate-of-change, and other indexes in improving the accuracy of PSA screening are irrelevant unless early detection improves the patient's health. PSA screening is often defended incorrectly on the basis of what has been discussed thus far, with the evidence that the test can detect organ-confined cancer cited as sufficient grounds for screening. Screening cannot be justified unless patients who are screened have better health outcomes than those who are not. The literature provides such evidence for breast, cervical, and colorectal cancer screening.[7]

There is little direct evidence, however, that screening for prostate cancer reduces morbidity or mortality. Indeed, few controlled studies have ever addressed this question. Observational studies of screening by digital rectal examination reported no benefit,[33,34] and no controlled study of health outcomes after PSA screening has yet been reported. Randomized, controlled trials addressing the health benefits of screening are under way in the United States and Europe, but the results will be unavailable for more than a decade.[35]

There is some indirect evidence that early detection may be beneficial. Men who undergo PSA screening are more likely to have early-stage disease at diagnosis (a phenomenon known as "stage shift") than unscreened men, and the proportion of cancers that are clinically or pathologically advanced appears to decrease with each successive year of testing.[21] Survival data suggest that men with localized tumors at diagnosis live longer than those with more advanced disease.[1] It is unclear, however, whether these findings reflect lead-time and length biases rather than an actual improvement in outcome. (Lead-time bias occurs when survival appears to be lengthened because the diagnosis was made earlier, rather than because death was delayed. Length bias refers to the tendency of screening to generate favorable outcomes by preferentially detecting slowly growing, indolent tumors, as opposed to aggressive tumors that are present in the population relatively briefly.)

One reason for questioning the effectiveness of early detection is the lack of direct evidence that treatment for prostate cancer improves outcomes. Arguments for the effectiveness of the principal treatments for prostate cancer — radical prostatectomy, radiation therapy, and hormonal treatment — are supported mainly by uncontrolled observational reports. The lack of controls and other design flaws limit the persuasiveness of this evidence. A randomized, controlled trial conducted in the 1970s reported that radical prostatectomy did not improve 15-year survival, but the trial suffered from numerous methodologic problems.[36] Well-designed randomized, controlled trials of treatment are now under way in the United States and Europe, but the results will be unavailable for more than a decade.[37]

Skepticism about the efficacy of treatment has been heightened in recent years by evidence that patients with early-stage prostate cancer have good outcomes even without treatment. Johansson[38] and colleagues followed a population-based cohort of 223 Swedish men with initially untreated prostate cancer. After 12.5 years, only 10 percent had died of prostate cancer and 56 percent had died of other causes: the 10-year disease-specific survival rate was 85 percent. Critics argued that survival may have been inflated by the inclusion of a large proportion of older men with small, well-differentiated tumors.[39] Moreover, of the patients

Table 1. Estimated Prevalence of Latent Prostate Cancer in the United States, According to Age.*

Age (yr)	U.S. Population†	Reported Prevalence of Latent Prostate Cancer (%)‡	Projected No. of U.S. Men with Latent Prostate Cancer
50–59	10,632,000	22.1	2,349,672
60–69	9,710,000	36.1	3,505,310
70–79	5,849,000	37.8	2,210,922
≥80	2,155,000	53.7	1,157,235
Total	—	—	9,223,139

*Values are for men over the age of 50, the population for which screening is typically considered. Autopsy studies indicate that the prevalence of latent carcinoma in men 40 to 49 years of age is about 8 percent, and one autopsy study of men 30 to 49 years of age reported a prevalence of 30 percent.[29] Thus, the total population of American men with latent prostate cancer may be larger.

†Data are from the U.S. Bureau of the Census.

‡Values are weighted, age-specific means for cases of latent carcinoma as reported in seven autopsy studies that used systematic step-section analysis of prostate-gland specimens from a total of 918 patients.[[illegible]]

who were alive at 10 years, 45 percent had tumor growth or metastasis, prompting speculation that a survival disadvantage might have become apparent if the follow-up period had been longer.

More recent studies of conservative treatment have failed to resolve the issue. A review of all men with prostate cancer who died between 1988 and 1990 in Göteborg, Sweden, reported that men with conservatively treated localized tumors had mortality rates of 50 to 100 percent, but the retrospective and selective study design (which included, for example, only decedents, rather than all men with prostate cancer, in the denominator) limits the utility of the data.[40] In the United States, an analysis of prostate cancer cases in Connecticut estimated that, after a mean follow-up of 16 years, life expectancy with conservative treatment of localized prostate cancer (either no treatment or hormonal therapy) was unchanged from that of the general population if the tumor was of low grade but was reduced by as much as 4 to 5 years or 6 to 8 years if the tumor was of moderate or high grade, respectively. These data derive from a retrospective chart review of cases diagnosed between 1971 and 1976, however, and include only patients 65 to 75 years of age.[41]

Researchers have pooled study data to model the natural history of untreated prostate cancer, but their findings have also been criticized. On the basis of data from 144 articles, Wasson et al.[42] estimated that the annual risks of metastasis and death from untreated prostate cancer were low (1.7 percent and 0.9 percent, respectively). This study was criticized for including a large proportion of patients with well-differentiated tumors and patients receiving androgen-deprivation therapy. On the basis of six major studies, Chodak et al.[43] reported that conservative management (delayed hormone therapy but no surgical or radiation therapy) was associated with a 10-year disease-specific survival rate of 87 percent for men with well-differentiated or moderately differentiated tumors and 34 percent for men with poorly differentiated tumors. For patients alive after 10 years, the probability of having metastatic disease was 19 percent, 42 percent, and 74 percent, respectively, for well-, moderately, and poorly differentiated cancers. Although critics disagree with the study's probability estimates,[44] the findings underscore the role of cell differentiation in predicting future tumor progression.

Is Screening or Treatment Harmful?

The potential benefits of any screening test must be weighed against the potential harm of testing and treatment. In the case of PSA screening, the physical effects of venipuncture are trivial, but the consequences of false positive (and false negative) results deserve consideration. If the reported positive predictive value of 28 to 35 percent is assumed to be correct, two out of three men with abnormal results on routine PSA screening will not have cancer. Before cancer can be ruled out, however, they must undergo the inconvenience and discomfort of follow-up testing (e.g., repeat PSA testing, ultrasonography, and biopsy) and the anxiety of waiting for results. Needle biopsy is performed in about 20 percent of screened men and is complicated by infection or bleeding in 0.1 to 4 percent of patients and by discomfort and anxiety in 58 to 68 percent of patients.[45-48]

A more serious source of concern than testing is the potential complications of treatment (e.g., impotence, incontinence, and death), the probabilities of which are summarized in Table 2. Although experts report anecdotally that their complication rates are lower than those in published reports, complication rates in the community are thought to be higher (Table 3). Reported mortality rates for radical prostatectomy are 0.2 to 2 percent, with lower rates reported by urologists at specialized centers and in studies involving patients under the age of 65.[47,49-51]

Does Screening Do More Good Than Harm?

Ultimately, the most important question about PSA screening is whether it improves the overall health and well-being of patients. As has already been noted, clinical trials that will provide this information are currently in progress. In the meantime, researchers have used decision analysis to try to estimate the net effect of benefits and risks on quality-adjusted survival, but both the methods and results of these analyses are controversial. Decision analyses of screening[52,53] have even suggested that quality-adjusted survival is reduced by screening, but the models' assumptions have been challenged.[54] Other decision analyses have focused on the effects of treatment. Fleming et al.[55] concluded that treatment, when compared with observation, increases quality-adjusted survival by less than one year and decreases survival in men over the age of 70 and those

Table 2. Reported Complication Rates for Radical Prostatectomy and External-Beam Radiation Therapy.*

Complication	Reported Incidence (%)
Radical prostatectomy	
Impotence	20–85
Incontinence	1–27
Urethral stricture	10–18
Thromboembolism	2–30
Permanent rectal injuries	1–3
Perioperative death	0.3–2
Radiation therapy	
Acute gastrointestinal or genitourinary complications	7–67
Chronic complications requiring surgery or prolonged hospitalization	1–2
Anorectal complications	2–22
Impotence	40–67
Urethral or bladder complications	3–17
Incontinence	1–3
Death	0.2–0.5

*Data were collated from 23 studies, 11 of which were published between 1993 and 1995 (citations are available from the author on request). Reported rates vary partly because definitions of complications vary from study to study and because some symptoms (e.g., impotence) are common preexisting conditions in this age group. Experts report anecdotally that current complication rates are lower than in published reports. Surgical complications have been reduced to some extent by the use of bilateral nerve-sparing techniques and by limiting the operation to younger and healthier men. Improvements in radiation therapy (e.g., three-dimensional conformal radiotherapy) may also produce fewer side effects.

Table 3. Adverse Outcomes of Radical Prostatectomy Reported by a National Probability Sample of Medicare Patients.*

Condition	% of Men Reporting
Attributable 30-day postoperative mortality	[illegible]
Cardiopulmonary complications (congestive heart failure, myocardial infarction, pulmonary embolism, or respiratory failure)	4–5
Incontinence	
Wore pads or other devices for incontinence	31
Dripped more than a few drops daily	23
Underwent surgical treatment for incontinence	6
Had a catheter	[illegible]
Impotence	
Was able to have erections before surgery	[illegible]
Had no full or partial erections since surgery	[illegible]
Had erections firm enough for intercourse in previous month	[illegible]
Underwent medical or surgical treatment for stricture, two to four years after surgery	20

*Data are from Fowler et al.[47] as reproduced with additional material in a publication of the U.S. Office of Technology Assessment.[48]

with well-differentiated disease. Critics questioned the probability estimates and the inclusion of a relatively older population of men with small, well-differentiated tumors.[56,57]

In assessing whether PSA testing does more good than harm, one must consider the effect of screening on other health care services. Screening typically occurs in the primary care setting, where busy clinicians are concerned with other preventive services (e.g., breast-cancer screening, immunizations, and smoking cessation) and caring for sick patients. Time devoted to prostate screening may come at the expense of other conditions that pose a greater threat to individual and public health. A similar phenomenon can occur on a national level, where other health care services could be affected by the provision of prostate screening and follow-up to the 28 million American men over the age of 50 to whom the recommendations of the American Cancer Society apply. The first year of screening could cost an estimated $12 billion to $28 billion,[13,58] and subsequent screening might cost $3 billion per year.[59] If screening can reduce the disease burden from prostate cancer, this large investment might be worthwhile,[60] but its ability to do so remains unproved.[48]

Is There Enough Evidence?

Definitive evidence of whether prostate screening and treatment improve health will be unavailable until the turn of the century, when current clinical trials will be completed. For now, the debate centers on what the appropriate policy should be in the meantime, a period during which thousands of men will die of prostate cancer. Since screening has the potential to save lives (although its actually doing so is unproved), few would question the appropriateness of screening were it not for its potential harm. Proponents and critics of PSA screening differ in the ways they balance the benefits and risks.

Proponents believe that the benefits outweigh the risks: they argue that waiting for better evidence is unnecessary and that withholding screening while men die of prostate cancer is unethical. Critics of screening worry that the risks may outweigh the benefits. They believe that current evidence does not ensure safety and that encouraging screening without this evidence is unethical (*primum non nocere*). Until better data become available, the true balance of benefits and risks remains a matter of opinion.

How to Advise the Patient

These uncertainties must be acknowledged when physicians counsel patients. Physicians should neither recommend nor discourage PSA testing without, first, ensuring that patients have complete information about potential benefits and risks, and second, determining their personal preferences. Although it is advisable to obtain informed consent for any screening test, it is especially important for PSA screening, because the data are unclear and patients face potentially serious consequences to health and survival by either accepting or declining the test. Patient education is also important, because most men receive incomplete or inaccurate information about PSA from acquaintances, advertisements, and the lay media.

Therefore, the first step in counseling patients is to present the facts about the benefits and harm that can result from testing and treatment. Fact sheets[61] and videotapes[62] can help provide an unbiased summary of both sides. The second step is to assess the patient's preferences. This step is necessary because the fear of cancer, the potential impact of iatrogenic complications on the quality of life, and the absence of "proof" from controlled studies mean more to some men than others. Before deciding on testing, the patient should consider the procedures that would necessarily follow an abnormal screening result and whether he would want to be treated if cancer were diagnosed. In particular, men with a life expectancy of less than 10 years should be advised that screening and treatment are unlikely to be helpful and may worsen the quality of their lives.

Once fully informed about the consequences, some patients find it difficult to make this decision and prefer instead to seek the doctor's advice. Offering an opinion in response to this invitation is entirely appropriate, but physicians who uniformly encourage or discourage PSA testing without first reviewing the facts and exploring preferences are unfairly imposing their values on the patient. For this reason, adding a PSA measurement to a panel of other tests, as one would add a potassium or hemoglobin measurement, is inappropriate if it is not preceded by the kind of discussion described above. It is equally inappropriate for a physician opposed to PSA screening to avoid the topic when patients do not request the test. Patients who are unfamiliar with PSA testing have a right to know about the availability of the test and the recommendations of groups that encourage screening.

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