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			entities to qualify and become ERISA-regulated plans. Establishes federal solvency standards and preempts state mandated benefit laws. Allows for some state regulation and permits states to impose a premium tax to cover enforcement costs. Requires that regulations be developed through a negotiated rulemaking process.
HEALTH MARTS			
Provision ***[The following 19 states authorize purchasing alliances: California, Colorado, Florida, Georgia, Illinois, Iowa, Kentucky, Maine, Minnesota, Montana, Nevada, New Mexico, North Carolina, Ohio, South Carolina, South Dakota, Texas, Utah, and Vermont.]***	No provision.	No provision.	Similar to "purchasing alliances" authorized under state law, which permits small employers to pool resources to purchase health insurance. Provides that these entities would be regulated by the Department of Health and Human Services and requires that a separate division within the Department be established to regulate Health Marts. Preempts state laws that conflict with the provisions of the Act establishing Health Marts, including small group insurance reforms and mandated benefits.
ACCELERATE 100% TAX DEDUCTIBILITY FOR THE SELF-EMPLOYED/OTHER TAX PROVISIONS			
Provision	No provision.	No provision.	No provision.
COMMUNITY HEALTH ORGANIZATIONS			
Provision	No provision.	No provision.	Provides for federal regulation of Community Health

			Centers, similar to provisions adopted in the Balanced Budget Act of 1997 related to Provider-Sponsored Organizations (PSOs).
CHURCH PLANS			
Provisions	No provision.	No provision.	Would exempt church plans from state insurance laws, including mandated benfits and premium regulation.
RESEARCH PROVISIONS			
Provisions	No provision.	No provision.	No provision.

AFL Health Committee

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National Conference of State Legislatures

106th CONGRESS SENATE MANAGED CARE PROPOSAL COMPARISON

Staff Contact: Joy Johnson Wilson, Director, Health Committee

March 1999

Large file, approx. 64 KB

During the 105th Congress, several managed care bills were introduced. The only piece of legislation that moved was the House GOP proposal, which the GOP Leadership took directly to the House floor for an up or down vote. This session, nine bills have already been introduced--five in the Senate and four in the House. Many of the bills are reintroduced versions of last year's bills with only minor adjustments made. Once again, NCSL supports the Senate Republican approach of limiting federal regulation to Employee Retirement Income Security Act (ERISA) plans. S. 300 would apply only to ERISA plans except for the provisions on grievances and appeals; discrimination based on genetic information; and confidentiality of medical records. Each of the other eight introduced bills would apply to all private health plans.

Most of the bills contain a core of common provisions including: using the prudent layperson standard to determine coverage for emergency room services; point-of-service; disclosure of certain health plan information; direct access to certain medical specialists (usually OB/GYNs and pediatricians); a prohibition on "gag clauses"; continuity of care; grievances and appeals; and confidentiality of medical records. The House and Senate Republican proposals also contain "access" provisions such as expanding the Health Insurance Portability and Accountability Act (HIPAA) Medical Savings Account (MSA) pilot program; acceleration of 100% deductibility for health insurance premiums for the self-employed; and "HealthMarts" or "Association Health Plans". In particular, the primary House proposal (H.R. 448) has reintroduced the concept of "HealthMarts" and "Association Health Plans". NCSL opposes these provisions because they remove more of the insurance market from state regulation. The language has been somewhat revised to appease states, but NCSL still believes that consumers would not be adequately protected as the bill is written.

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106th CONGRESS SENATE MANAGED CARE PROPOSAL COMPARISON

Staff Contact: Joy Johnson Wilson, Director, Health Committee

PROVISION *(State Comparison in this Column)*	CHAFEE/ GRAHAM (S. 374)	LOTT/NICKLES (S. 300) JEFFORDS (S. 326)	SENATE DEMOCRATS (S. 6)
REGULATED ENTITIES			
Regulated Entities	All private health plans.	Primarily applies only to ERISA plans. Grievance and appeals procedures apply to all group health plans and anti-discrimination based on genetic information applies to all plans.	All private health plans.
PLAN CHOICE/ENROLLMENT PROTECTIONS			
Point of Service (POS) Requirements ***[16 states require health plans to offer point-of-service option: Alaska, Georgia, Idaho, Indiana, Iowa, Maryland, Minnesota, Montana, New Jersey, New York, Oklahoma, Oregon, South Carolina, Tennessee (POS or PPO offering), Texas (dental plans only), and Virginia.]***	No provision.	Must offer POS option at time of enrollment. Employers are not required to contribute to the POS option. Exempts non-ERISA small employers. Employers do not have to offer a POS option if they offer: 1. A choice of health insurance through more than 1 issuer; or 2. 2 or more coverage options that differ significantly on their provider networks.	Must offer POS option at time of enrollment. Requires the health plan, not the employer, to make the POS option. Employers are not required to contribute to the POS option. No requirement for guaranteed availability.
INFORMATION DISCLOSURE			
Covered and Excluded Benefits ***34 states have enacted laws or implemented regulations related to disclosure covering a wide range of provisions.***	Required.	Requires description of covered items and services. Specific exclusions are required upon request.	Required.

[23 states require the disclosure of drugs contained on formularies: Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Washington, and Wyoming.]			
Enrollee Financial Obligations	Required.	Required.	Required.
List of Health Plan Providers	Required.	Upon request.	The name, address, and telephone number of participating providers and an indication of whether each provider is available to accept new patients is required.
Prior Authorization/UR Process & Requirements	Required for prior authorization. Utilization review procedures required upon request.	Required for prior authorization. Utilization review procedures required upon request.	Required.
Grievance/Appeals and UR Process/Requirements	Required.	Required.	Required.
Outcomes of Grievance, Appeals, and UR Process	Upon request.	No provision.	Information on the number of grievances and appeals and the aggregate outcomes must be available upon request.
Quality Indicators	Required.	Upon request.	Required.
Enrollee Satisfaction Data	Required.	No provision.	Required.
Enrollee Utilization Data	No provision.	No provision.	No provision.
Provider Selection Standards	Required.	No provision.	No provision.

Provider Financial Incentives/Payment Methods	Required.	Upon request.	Required.
Disclosure of Utilization Criteria/Algorithms	No provision.	No provision.	A description of procedures used and requirements are available upon request.
Data Standardization	Required.	No provision.	Required.
Plan Loss Ratios	Upon request.	No provision.	Required.
DISCRIMINATION			
Anti-Discrimination Provisions *[8 states have enacted legislation. In addition, HIPAA prohibits discrimination based on "health status-related" factors which includes:* • *Health status,* • *Medical condition,* • *Claims experience,* • *Receipt of health care,* • *Medical history,* • *Genetic information,* • *Evidence of insurability (including conditions arising out of domestic violence), and disability]*	Prohibits discrimination based on race, color, ethnicity, national origin, religion, sex, mental or physical disability, sexual orientation, genetic information, or source of payment.	Prohibits health plans from adjusting premiums based on genetic information. Prohibits health plans from requesting genetic information except for diagnosis, treatment, or payment. These provisions apply to all group and individual health plans.	Prohibits discrimination against a participant, beneficiary, or enrollee in the delivery of health care services consistent with law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
ACCESS			
Sufficient Number, Mix, & Distribution of Providers *[At least 10 states have enacted laws requiring access to sufficient numbers and types of providers without unreasonable*	Required.	No provision.	Required.

delay.]			
Special Rules for Underserved Areas	Under the "Sufficient Number, Mix, and Distribution of Providers" provision, includes FQHCs, rural health clinics, migrant health centers, and other essential community providers in the definition of "providers".	No provision.	No provision.
Enrollee Choice of Primary Care Provider	Permits enrollee to receive primary care from any participating provider who is accepting new patients.	No provision.	Permits each enrollee to receive care from any provider who is able to accept the individual.
Emergency Care Access ***[At least 13 states require emergency care access 24 hours per day, seven days per week: California, Colorado, Georgia, Minnesota, Mississippi, Missouri, New Mexico, Nebraska, New Jersey, Ohio, Pennsylvania, Tennessee, and Virginia.]***	No provision.	No provision.	No provision.
Standard for Specialist Access	Plans must provide access to specialists when medically necessary or appropriate, pursuant to a plan's referral procedures.	No provision.	Requires access to specialty care when medically necessary.
Standard for Access to Specialists for Individuals with Chronic Illness ***[7 states allow individuals with chronic illnesses to have specialists as their primary care provider: Indiana, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, and Texas.]***	Consumer with an "ongoing special condition" may receive a referral to a specialist who is responsible for the consumers primary and specialty care. "Ongoing special condition" is defined as a condition or disease that: 1. is life-threatening, degenerative, or disabling; and 2. requires specialized medical care over a prolonged period of time.	No provision.	Consumer with an ongoing special condition may receive a referral to a specialist who is responsible for the consumers primary and specialty care.
Care by Obstetricians and Gynecologists (OB-GYNs)	Requires direct access to OB/GYNs.	Requires direct access to OB/GYNs.	Permits women to designate an OB/GYN as the individual's primary care provider.

***36 states require either direct access to OB/GYNs, OB/GYNs as primary care providers (PCP), or both.* *Direct access: Arkansas, Colorado, Georgia, Illinois, Minnesota, Mississippi, Nevada, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and Washington.* *PCP: Florida, Indiana, Nebraska, New Jersey, and West Virginia.* *Both: Alabama, California, Connecticut, Delaware, Idaho, Louisiana, Maine, Maryland, Missouri, Montana, New Mexico, Oregon, and Utah.]*			If a primary care physician has been established, no authorization or referral by the individual's primary care provider is required for routine gynecological care.
Direct Access to Pediatricians	Pediatricians may be designated as PCPs for children.	Requires direct access to physicians.	Pediatricians may be designated as PCPs for children.
Clinical Trials	Plans must: • Not prevent enrollees from participating in clinical trials or discriminate against them; and • Cover routine costs associated with the trial.	No provision.	Plans may not prevent enrollees from participating in clinical trials nor discriminate against them. Plans must cover routine costs but not costs reasonably expected to be paid for by the clinical trial sponsors.
CONTINUITY OF CARE			
Enrollee Protection when Provider Contract Changes	Provides for "continuity of care" under the following conditions: • For at least for 90 days;	Provides for "continuity of care" under the following conditions:	Provides for "continuity of care" under the following conditions:

[18 states have continuity of care laws that allow enrollees to see non-participating providers when they first join a plan (for certain medical conditions) or when a provider is no longer with a plan: Arkansas, California, Colorado, Florida, Indiana, Kansas, Maryland, Minnesota, Missouri, New Jersey, New York, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin.]	• For institutional care, until discharge; • For pregnancy, includes women in second or third trimester of pregnancy through post-partum care directly related to the delivery; and • For terminal illnesses, for the remainder of the individual's life.	• For at least for 90 days; • For institutional care, until discharge; • For pregnancy, includes women in second or third trimester of pregnancy through post-partum care directly related to the delivery; and • For terminal illnesses, for the remainder of the individual's life.	• For at least for 90 days; • For institutional care, until discharge; • For pregnancy, includes women in second or third trimester of pregnancy through post-partum care directly related to the delivery; and • For terminal illnesses, for the remainder of the individual's life.
EMERGENCY SERVICES			
Coverage of Evaluation and Treatment w/o Prior Authorization *[32 states require coverage: Arizona, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma (out-of-area only), Oregon, Pennsylvania, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.]*	Required, if emergency care is a covered benefit.	Required, if emergency care is a covered benefit.	Required, if emergency care is a covered benefit.
Coverage of Maintenance and Post Stabilization Care	Required.	Required.	Required.
Prudent Layperson Standard	Yes, adopts the Medicare/Medicaid standard established in the Balanced	Yes, adopts the Medicare/Medicaid	Yes, adopts the Medicare/Medicaid

[29 states use "prudent layperson" as defined under the Balanced Budget Act of 1997: Arkansas, Colorado, Connecticut, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, and West Virginia. *Another four states use variations on this definition: Arizona, California, Florida, and New Mexico.]*	Budget Act of 1997.	standard established in the Balanced Budget Act of 1997.	standard established in the Balanced Budget Act of 1997.
Reasonable Payment Standard for Participating and Non-participating Providers	Must cover service in a manner that would not leave enrollee financially liable for more than they would be if the services had been provided within the network.	Requires uniform cost sharing for out-of-network services when prudent layperson standard is used.	Must cover service in a manner that would not leave enrollee financially liable for more than they would be if the services had been provided within the network.
MEDICAL NECESSITY			
Definition	Consistent with generally accepted principles of professional medical practice.	No provision.	Consistent with generally accepted principles of professional medical practice.
GRIEVANCE PROCEDURES, INTERNAL			
Process *[All 50 states require MCOs to have to have grievance and appeals procedures.]*	Must have meaningful grievance procedures to address enrollee complaints on: • failure to cover emergency services; • the denial, reduction, or termination of benefits; or • any decision regarding the clinical necessity, appropriateness, efficacy, or	Health plans must have written procedures for addressing grievances between the plan and enrollees.	Requires a system to address enrollee grievances regarding access and availability to services, quality of care, choice and accessibility of providers, network adequacy, and compliance with the requirements of this

	efficiency of health care services, procedures, or settings.		act.
Timeliness Standard *[At least 32 states require explicit timeframes: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, and Wyoming.]*	• 30 days for a reconsideration regarding a coverage determination; • 60 days for all other routine appeals; and • 72 hours for expedited appeals.	Plan must conclude each appeal as soon as possible, but no later than: • 72 hours after time of receipt of an expedited appeal; and • 30 working days for routine appeals.	Plan must conclude each appeal as soon as possible, but no later than: • 72 hours after time of receipt of an expedited appeal; and • 30 business days for all other appeals. If circumstances occur beyond the control of the issuer, the deadline shall be extended for up to an additional 10 business days.
Professional Qualifications of Reviewers *[At least 22 states address the professional qualifications of reviewers: Arizona, Arkansas, California, Connecticut, Florida, Indiana, Maryland, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, and West Virginia.* *Most states prohibit use of provider involved in prior decision.]*	A physician or other health care professional who holds a non-restricted license in a State and who is appropriately credentialed, licensed, certified, or accredited in the same or similar specialty as manages the medical condition involved.	Reviews must be conducted by an individual with "appropriate" expertise and was not involved in the initial coverage decision.	Reviewers must be a physician or other health care professional who has been selected by the plan and who has not been involved in the appealable decision.

Ombudsman Program	No provision.	No provision.	The role of Ombudsmen is to: • must assist consumers in choosing health insurance coverage; and • provide counseling and assistance to enrollees dissatisfied with treatment by issuers in regards to coverage and respect to grievances and appeals.
Written Documentation of Adverse Determinations ***[At least 21 states require written notification, either automatically or upon commissioner's request: Arizona, Arkansas, California, Colorado, Florida, Georgia, Illinois, Indiana, Maine, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Tennessee, Texas, Vermont, and West Virginia.]***	Requires written notification of the final determination that includes: • Specific reasons for the determination, • Notice of the availability of the clinical review criteria relied upon in making the decision; • A description of the review process established; and • Any other requirements specified by the Secretary.	Requires written notification of the final determination that includes: • information on the reason for the determination, • the procedures for obtaining additional information on the determination, and • notification of the right to an external review.	Requires written notification of the final determination that includes: • information on the reason for the determination; and • how a consumer can appeal that decision to an external entity.
Maintenance of Internal Record of Process ***[Most states require some form of maintenance of internal record of process.]***	No provision.	Plans must maintain written records for at least 6 years.	Plans must maintain written records for at least 3 years.

GRIEVANCE PROCEDURES, EXTERNAL/INDEPENDENT			
Procedures	Elements of process include:	Required when the service is a covered	Required when:

[Varies among 18 states that require independent review. Usually requires exhaustion of all internal review processes first: Arizona, California (experimental or investigational therapy decisions only), Colorado, Connecticut, Florida, Hawaii, Maryland, Minnesota, Michigan, New Jersey, New Mexico, New York, North Carolina (two out of three reviewers on the panel must be external), Ohio (experimental or investigational therapy decisions only), Pennsylvania, Rhode Island, Tennessee, and Vermont.]	• A fair, de novo determination; • An opportunity to submit evidence, have representation, and make an oral presentation; and • Timely access to all the plan's records relating to the matter.	benefit and the benefit was denied because: • it did not meet the plan's requirements for medical necessity and the amount involved exceeds a significant financial threshold; or • it would constitute experimental treatment and there is a significant risk of placing the life or health of the enrollee in jeopardy; and • the enrollee has completed the internal appeals process.	• The amount involved exceeds a significant threshold; or • The patient's life or health is jeopardized. Plans may also condition use of the external appeals process on exhaustion of the internal appeals process.
Certification of Reviewer *[Same as above.]*	State licensing or credentialing must be developed in consultation with the NAIC. A qualified external appeal entity must meet the following requirements: • No conflict of interest that would impede entity's ability to be independent; • Appeal activities must be conducted by clinical peers; • Sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis; and • Any other requirements the Secretary may impose.	The external review entity must be either: • Licensed or credentialed by the state; or • A state agency established to conduct external review; or • Under contract with the federal government to conduct external review; or • Accredited by the Secretary to conduct reviews; or • A fully accredited teaching hospital; or • Any other entity meeting criteria established by the Secretary. The individual	External review entity must be certified by either the state or the Department of Labor.

		reviewers must: • Be appropriately credentialed or licensed in any state to deliver health care services; • Not have any affiliation with the plan, providers, institution, or services involved; • Be experts in the condition involved or be of the same specialty as the treating physician; • Receive only reasonable and customary compensation from the health plan; and • Not be held liable for his or her decision.	
Binding Process *[At least 10 states: Arizona, California, Connecticut, Hawaii, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, and Vermont. In Maryland, the Insurance Commissioner decides if whether or not the decision is binding.]*	Decision is binding on the plan or issuer.	Decision is binding on the plan or issuer.	Decision is binding on the plan or issuer.
UTILIZATION REVIEW			
Utilization Review (UR) Program	Required.	Not required, but sets up procedures for plans that do have UR. Information below only applies if plan has UR.	Required.
Applicable Standards	UR programs must be conducted consistent with written policies and procedures that govern all aspects of the program.	No provision.	Plans must utilize written clinical review criteria developed with the input of appropriate physicians.

Enrollee or Provider Input	Requires physician input.	No provision.	Requires physician input.
Reviewer of Professional Standards	A physician or other health care professional who holds a non-restricted license in a State and who is appropriately credentialed, licensed, certified, or accredited in the same or similar specialty as manages the medical condition involved.	No provision.	Reviewer must be a physician or other health care provider.
Timeliness Standard	Prior authorization within 3 business days. Retrospective review within 30 days.	Prior authorization for routine requests within 30 days. Prior authorization for expedited request within 72 hours. Retrospective review within 30 working days. Continuation of care within 1 business day.	Prior authorization within 3 business days. Continuation of care within 1 business day. Retrospective review within 30 days.
Consistency Standard	UR programs must be conducted consistent with written policies and procedures that govern all aspects of the program.	No provision.	Must be conducted consistent with written policy and procedures.
Notice or Documentation of UR Decisions	Requires written notification of the final determination that includes: • Specific reasons for the determination, • Notice of the availability of the clinical review criteria relied upon in making the decision; • A description of the review process established; and • Any other requirements specified by the Secretary.	Notices of determination must include: • an explanation of the basis of the determination, • the procedures for obtaining additional information concerning the determination, and • notification of the right to appeal the determination and instructions on how to initiate an appeal.	Notices of determination must include: • an explanation of the basis of the determination, • how to initiate an appeal, and • upon request, the availability of the clinical review criteria used in determination.
Other Patient/Provider Protections	No provision.	No provision.	Favorable prior authorization determination must be treated as final for payment purposes.
QUALITY ASSURANCE PROGRAM			

Requirements ***[22 states have laws or regulations requiring quality assurance programs.]***	Plans must establish and maintain an ongoing, internal quality assurance and continuous quality improvement program that includes: • an identifiable unit with responsibility for administration of the program; • a written plan for the program that includes: 1. the activities to be conducted; 2. the organizational structure; 3. the duties of the medical director; and 4. criteria and procedures for the assessment of quality. • Quality criteria; • A system for identifying possible quality concerns by providers and enrollees; • Data analysis; and • Drug utilization review.	No provision.	Plan must have a separate, identifiable unit with responsibility for administration, Must have a written plan for program that is updated annually and; The plan must provide for a systematic review of the type of health services provided, consistency of services provided with good medical practice and patient outcomes.
Data Collection	Plans must collect and submit aggregate data on quality indicators.	No Provision.	Required.
Advisory Board	No provision.	No provision.	Advisory Board must: • Provide information to Congress and Administration on issues relating to quality monitoring and improvement in the health care provided under group health plans and insurance coverage. • Identify, update, and disseminate measures of health care quality for plans and issues including network and non-network plans • Advise Secretary on the development and maintenance of the minimum data and;

			• Advise Secretary on Standardized formats for information on group health plans and insurance coverage.
PRIVACY AND CONFIDENTIALITY			
Safeguards for Individually Identifiable Information ***[Most states have laws on privacy and confidentiality but they vary considerably.]***	Health plans must establish procedures with respect to medical records or other health information maintained regarding enrollees to safeguard the privacy of any individually identifiable information about them.	Individuals may inspect and copy their medical records upon request. Health plans (and any other entities that may possess confidential medical information) must establish appropriate safeguards to protect the confidentiality of medical records. Violation of this section may result in a penalty of up to $500 per violation, capped at $5,000 in the aggregate.	Plans must: • Establish procedures to safe-guard the privacy of individually identifiable enrollee information; • Maintain such records and information in a manner that is accurate and timely; and • Assure timely access of such individuals to such records and information.
PROTECTIONS RELATED TO COVERED BENEFITS			
Mandated Benefit Coverage	Direct access to Ob/GYNs and pediatricians. Mastectomy length of stay.	Direct access to OB/GYNs and pediatricians.	Direct access to OB/GYNs and pediatricians. Mastectomy length of stay.
Drug Formularies ***[11 states require plans to disclose the formulary list: Arizona, California, Florida, Idaho, Kansas, Kentucky, Michigan (upon enrollee request), New Jersey, New York, Rhode Island, and Wyoming. Eleven states require disclosure and the procedure to obtain non-formulary drugs: Arkansas, California,***	If a plan uses a drug formulary, they must: • Ensure participation of participation and pharmacists in the development of the formulary; • Disclose to providers and disclose to enrollees upon request the formulary list; and • Provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.	Plans must disclose (upon request) whether a formulary is used and, if so, a list of the prescription drugs included and any provision for obtaining off-formulary medications.	Plans must disclose whether a formulary is used and, if so, how decisions are made regarding the inclusion of drugs, and provide for exceptions form formulary limitation when a non-formulary alternative is medically indicated.

Connecticut, Georgia, Indiana, Louisiana, Maine, Missouri, North Carolina, Oregon, Vermont (by administrative rule), and Washington. Ohio requires plans to establish a procedure by which an enrollee may obtain a non-formulary drug, but does not require disclosure of the drugs on the formulary.]			
Mastectomy Length of Stay *[18 states require a minimum length of stay following a mastectomy:* *Arkansas, California, Connecticut, Florida, Illinois, Kentucky, Maine, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, and Virginia.]*	Inpatient length of stay following a mastectomy must be determined by the attending physician.	No provision.	Inpatient length of stay following a mastectomy must be determined by the attending physician.
Balanced Billing Limits for Out of Network Services	Prohibits balanced billing for emergency out-of-network services.	No provision.	Prohibits balanced billing for emergency out-of-network services.
ANTI-GAG RULE			
Medical Communications Between Patient and Provider *[44 states ban the use of "gag clauses." The following states have not enacted laws: Alabama, Hawaii, Illinois, Mississippi, South Carolina, and South Dakota.]*	Plans may not penalize a health care professional for advocating on behalf of his or her patient or for providing information or referral for medical care consistent with the health care needs of the patient.	Prohibits plans from restricting communication between providers and patients regarding health status and treatment options.	The plan may not prohibit communications on health status, medical care, treatment options, any UR requirements that may affect treatment options or any financial incentives that may affect the treatment of the patient.
Exceptions Based on	The health care professional may	No provision.	No provision.

Religious or Moral Considerations	provide enrollees information consistent with the code of ethical conduct, professional responsibility, conscience, medical knowledge, and license of the health care provider.		
PROVIDER PROTECTIONS			
Provider Incentive Plans ***[21 states ban the use of financial incentives between managed care plans and providers: Alaska, California, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Maryland, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Texas, Vermont, and West Virginia.]***	Prohibits provider incentive plans as defined by the 1997 BBA.	No provision.	Prohibits provider incentive plans as defined by the 1997 BBA.
Anti-Discrimination	Prohibits discrimination in provider selection on basis of race, color, national origin, religion, gender, age, disability, or sexual orientation.	No provision.	Prohibits discrimination in provider selection on basis of race, color, origin, religion, gender, age, disability, or sexual orientation. Prohibits discrimination in participation, reimbursement, or indemnification against health professional solely on basis of professional's license or certification under applicable state law.
Provider Contracting ***[25 states have laws regarding provider contracting and termination rules: Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri,***	Prohibits plans from transferring liability to providers.	No provision.	Prohibits plans from transferring liability to providers.

Montana, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Vermont, and Virginia.]			
Provider Application/Participation Requirements *[22 states have AWP laws. Five of those apply to physicians and the remainder applies primarily to pharmacies or pharmacists: Alabama, Connecticut, Delaware, Florida, Georgia (broad; BC/BS plans only), Idaho (broad), Illinois (non-institutional providers), Indiana (broad), Kentucky (broad), Massachusetts, Minnesota (independent health care providers), Mississippi, New Hampshire, New Jersey, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee (pharmacy), Texas, Wisconsin, and Wyoming (broad). In addition, at least five other states have "opportunity to apply" laws, which allow providers to apply for inclusion on an MCOs panel but does require the MCO to accept all qualified providers: California, Georgia, Montana, Oregon, and Texas.]*	Plans must have a written process for the selection of participating health care professionals, which includes: • Minimum professional requirements; • Notice of the rules regarding participation; • Written notice of participation decisions that are adverse to professionals; and • A process within the plan for appealing such adverse decisions.	No provision.	Plans must provide: • Notice of the rules regarding participation; • Written notice of participation decisions adverse to providers; and • A process within the plan for appealing adverse decisions.
Payment Timeliness	No provision.	No provision.	No provision.

Provision	Prohibits plans from transferring liability to providers.	No provision.	Prohibits plans from transferring liability to providers.

ASSOCIATION HEALTH PLANS/MEWAS			
Provision	No provision.	No provision.	No provision.

HEALTH MARTS			
Provision *[The following 19 states authorize purchasing alliances: California, Colorado, Florida, Georgia, Illinois, Iowa, Kentucky, Maine, Minnesota, Montana, Nevada, New Mexico, North Carolina, Ohio, South Carolina, South Dakota, Texas, Utah, and Vermont.]*	No provision.	No provision.	No provision.

ACCELERATE 100% TAX DEDUCTIBILITY FOR THE SELF-EMPLOYED/OTHER TAX PROVISIONS			
Provision	No provision.	S. 326 does not contain this provision. S. 300 contains the following language: • Accelerates 100% tax deductibility from 2003 to 2000.	No provision.

COMMUNITY HEALTH ORGANIZATIONS			
Provision	No provision.	No provision.	No provision.

RESEARCH PROVISIONS			
Provisions	No provision.	Creates the Agency for Health care Research and Quality (currently the Agency for Health Care Policy and Research). The purpose of the Agency would be to enhance the quality, appropriateness, and	No provision.

		effectiveness of: • health care services, and • access to such services. This would be accomplished through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practice, including the prevention of diseases and other health conditions.	

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Principles of Accountability in Managed Care Reform

The Center for Patient Advocacy strongly believes that accountability provisions are an essential part of any managed care reform legislation. Such provisions should be guided by the principle that if managed care plans choose to make medical decisions, they should be held legally accountable for those decisions, just as are physicians and other health care professionals. Patients injured by medical decisions made by their managed care insurance plans must have access to the courts to seek appropriate compensation and damages.

This is not to say that employers who provide health insurance should be held legally accountable when managed care plans cause harm. They should not, and responsible managed care reform legislation must address this issue. Responsible legislation should protect employers from liability unless they were the ones who actually made the medical decision that caused the harm.

While accountability is a key aspect of any managed care reform bill, the Center does not believe patients should be forced to access the courts in order to receive the health care they need, deserve and have paid for. Patients in need of care, particularly those with critical conditions, must have timely access to that care, and a long drawn-out court process ultimately will not benefit their health. The Center believes that a strong, enforceable, timely and independent external review process is critical to ensuring patients have access to the treatments their physicians deem medically necessary. Such a process must include definitive time frames for resolving appeals and must allow *all* patients, regardless of the cost of the treatment denied or the reasons for the denial, access to an external appeal following completion of an internal review. The external review should be binding on the health plan, and reviewers, in addition to being independent from the plan, must be physicians who have expertise in the field of medicine that is the subject of the review.

A strong external appeals process should significantly reduce the need for patients to immediately go to court in order to access medically necessary care prescribed by their physicians. Nevertheless, if a managed care plan ignores external review decisions, or continues its negligent and dangerous practices, it is critical that patients have the fundamental right to go to court.

A PATIENTS' BILL OF RIGHTS

Nancy W. Dickey, MD, President,
American Medical Association

The American Medical Association is working aggressively to give Americans basic protection against abuses by some health plans. These protections, known as "The Patients' Bill of Rights," are embodied in legislation now before Congress.

Passage of the Dingell-Daschle legislation - The Patients' Bill of Rights (H.R. 3605 and S. 1890) - is crucial because patients are increasingly concerned about the quality of their medical care. They worry that they will not be able to see the specialists they need. They fear their health plan may deny payment for emergency service. They become enraged when their insurance plans sidestep their physicians and make medical decisions about their care. Above all, they are disturbed that, so far, Washington has been unwilling to act on their behalf.

The fact is, 125 million Americans are unprotected because the federal Employee Retirement Insurance Security Act (ERISA) law preempts state laws that would have provided protection.

ERISA was crafted primarily to protect employee pension plans. A little noted provision at the time also allowed employers to self-insure for employee health care under federal rules that permitted exemption from state insurance regulations. Now more than 50 percent of employees are covered by employer plans that operate outside of state insurance regulation and related consumer protections. Bipartisan State Legislatures have supported, Democratic and Republican Governors have signed into state law meaningful patient protections. However, the ERISA preemption creates a major loophole, thus, federal legislation is needed to extend basic patient rights to all patients in the health care system.

Within the context of other federal guarantees for citizens, this is not an unreasonable request. Consumers are protected by federal rules for fairness in the use of credit cards, for safety in purchased toys for children and for full disclosures when purchasing automobiles. We know patients welcome protections in their health insurance coverage.

In supporting patients' protections, the American Medical Association is not seeking to dismantle managed care.

But we share the public's concern that the quality of care has suffered in some plans where profits seem more important to the managers than the quality of services they offer their patients.

To improve the system and restore the confidence of patients who rely on the system, certain rights must be assured. Patients should receive accurate and easily understood information that enables them to make informed decisions about their health plans.

Legislation also is needed to assure the right to emergency care services. When a patient experiences acute symptoms of a severity that would suggest to a prudent layperson that harm might result if untreated, the patient should be able to seek treatment. Patients have the right to be informed of all treatment options, including the option of no treatment by their physicians, and treatment options not covered under their plans without interference of gag clauses from the plan.

Patients must have a right to fair and efficient processes for resolving differences with their health plans, providers or facilities that serve them. This right should extend to both internal and external review mechanisms in which patients are guaranteed timely notification of medical decisions, a claims review process conducted by appropriately credentialed health care professionals, and a reasonable process for resolving patient complaints. Amendments to ERISA legislation will make it possible to hold health plans accountable for the consequences of their decisions. When health plans engage in medical discriminating, they should be held accountable if patients suffer injuries as a result of treatment denials.

Furthermore, patients are willing to pay more for such protections. In a study conducted by the Luntz Research Companies, commissioned by the Patient Access to Specialty Care Coalition, 67 percent said

they would be willing to spend more for patient protections.

Fortuitously, those protections can be purchased for relatively little, according to independent studies conducted by the Lewin Group, Muse & Associates, Price Waterhouse, and Coopers & Lybrand. All indicate that patient protections are affordable. The Lewin Group examined the cost of external appeals and the cost of information reporting and disclosure - elements believed to be the most costly - and reported that these protections would cost only pennies per person per month.

Not only is the Patients' Bill of Rights the right thing to do, it also is an affordable thing to do. We urge swift passage of the legislation by Congress and a speedy signature by the President in order to bring these protections home to our patients.

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Poll: Less Control of Health Care

By WILL LESTER Associated Press Writer

WASHINGTON (AP) -- Almost as many Americans say their insurance companies play the biggest role in their medical care as those who say their doctors call the shots, a new poll shows.

Women are more critical than men, with 40 percent saying the health care system is in worse shape than it was five years ago, says the poll conducted for The Associated Press. The biggest complaint was the inability of people to choose their own doctors.

As these concerns grow, Congress is again considering how to give people more control over their own health care without substantially increasing costs.

Nine out of 10 Americans said they were very satisfied or somewhat satisfied with their health insurance coverage, the survey found. Just over four out of 10 people in the poll said they thought their insurance companies had more say over their medical coverage than their doctors. Almost half said their doctors had the biggest say.

The poll of 1,008 people taken Jan. 29 through Tuesday was done by ICR of Media, Pa.

Making some changes in the system sounds like a good idea to Thomas Feagley, a 42-year-old father of three, whose health plan required him to change family doctors last year.

"There needs to be an investigation or some kind of fine tuning," said Feagley, the custodian of athletic fields at schools near Huntington, in central Pennsylvania.

For years, he used the team doctor as his family physician for years.

"I would have been a happy camper if I could have gotten my insurance and kept my doctor," he said.

The growing loss of personal control over health care has left Feagley uneasy about the future. He changed doctors a year ago.

When people were asked their biggest concern about health care, the most-mentioned complaint was limits on their ability to pick the doctor of their choice, cited by 28 percent, followed by concerns about cost and quality.

"I know they have to have guidelines," Feagley said, but he noted his

former doctor treats many others in his family. "We had kind of a family thing going on."

The findings reflect some continued frustration with managed care, such as health maintenance organizations, which have controlled health care costs by preventing unnecessary treatment. But Americans also worry they may not get treatments that they some day need.

A big movement to HMOs has taken place over the past two decades. Most Americans who get insurance from an employer are now enrolled in an HMO, said Larry Levitt, director of the changing health care marketplace project at the Kaiser Family Foundation in Menlo Park, Calif.

"For many people, there has been a sea change in how they deal with their insurance companies," Levitt said.

Of the people in the AP poll who said they were very satisfied, the majority said they felt their doctor had the bigger say in their care. Three-fourths of those who said they were dissatisfied cited insurers as more likely to have the leading role.

Older people were among the most satisfied with their health care, while well-educated, middle-aged people between the ages of 35 and 64 were more likely to have concerns with health insurance.

Levitt suggested that those with more education probably have higher expectations, and middle-aged adults grew up with conventional insurance but now must balance family responsibilities and the new health care system.

Almost two-thirds of the people covered by a government plan said they were very satisfied with their health insurance coverage, said the poll, which had an error margin of plus or minus 3 percentage points. Levitt said government plans like Medicare often offer the freedoms of more conventional insurance plans.

One of those who thinks the health care system is getting worse is Connie Branch, a 44-year-old mother and factory worker from Humboldt, Tenn., east of Memphis.

HMOs require people to get a referral to prevent them from seeing expensive specialists when they are not needed.

"I know what a problem is and if I need to go to a certain doctor, I've got to have a referral from a family practitioner," she groused. "If I have trouble with my feet, why should I have to go a family doctor?"

AP-NY-02-06-99 0116EST<

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Debate opens over HMO rights

March 18, 1999
Web posted at: 10:05 a.m. EDT (1005 GMT)

WASHINGTON (AP) -- Differences over how far Congress should go to protect patient rights are on full display as debate begins in earnest over regulating HMOs and other managed health care plans.

Outnumbered Democrats are sure to lose on every major point as legislation works its way through the Senate Health, Education, Labor and Pension Committee, which began debate Wednesday.

President Clinton said the GOP bill, expected to win early committee approval, "falls far short" of what's needed.

"Today represents the first test of whether this new Congress is serious about providing Americans with a strong enforceable patients' bill of rights to assure quality health care," Clinton said in a statement. "I urge the committee to do everything it can to pass this test and give Americans the health care protections they need."

But Sen. Edward Kennedy, D-Mass., was already looking past the committee vote, promising reporters: "We'll win on the floor of the Senate."

The GOP bill would offer a mix of popular protections, including the right to reasonable emergency room payments, direct access to gynecologists for women and prohibition of much-maligned, but virtually nonexistent "gag rules" that prevent doctors from discussing all options with their patients.

But those protections would be given only to 48 million Americans covered by federally regulated health insurance plans. Republicans noted that other patients are covered by state regulations, and numerous states have adopted many of the same provisions.

However, the GOP bill would cover all Americans in employer-sponsored health plans about 75 million with a key provision that would give patients the right to take disputes over payments to an independent group of experts outside the health plan.

Democrats say all Americans should be covered by all of the bill's provisions.

The Democrats also want to give people new rights to sue their health plans over bad decisions and to require plans to pay for what doctors determine to be "medically necessary" care.

Committee Chairman Jim Jeffords, R-Vt., argued that more lawsuits are not needed and emphasized that the GOP bill would add hardly

are not needed and emphasized that the GOP bill would add hardly anything to health insurance premiums.

"Our goal," Jeffords said, "is to give Americans the protections they want and need in a package they can afford and that we can enact."

MORE STORIES:

Thursday, March 18, 1999

- Deputy independent counsel says he wrote 'rough draft indictment' of Hillary Clinton
- Business leaders condemn U.S. election financing
- Democrats say Republican budget sacrifices Medicare for tax cuts
- Court clears way for Justice investigation of Starr
- House OKs missile defense plan
- David Duke files for Congressional race
- Judge dismisses count against Hubbell
- Democrats revive campaign funding bill
- Senate saves independent counsel funding
- Poll: Mrs. Clinton ahead in New York race
- Government estimates Y2K cost at $6.8B
- Debate opens over HMO rights
- Term limits backer rethinks pledge
- Web sites to play role in 2000 race
- House leaders consider pay raise
- GOP budgets, emphasizing tax cuts, Social Security, move forward

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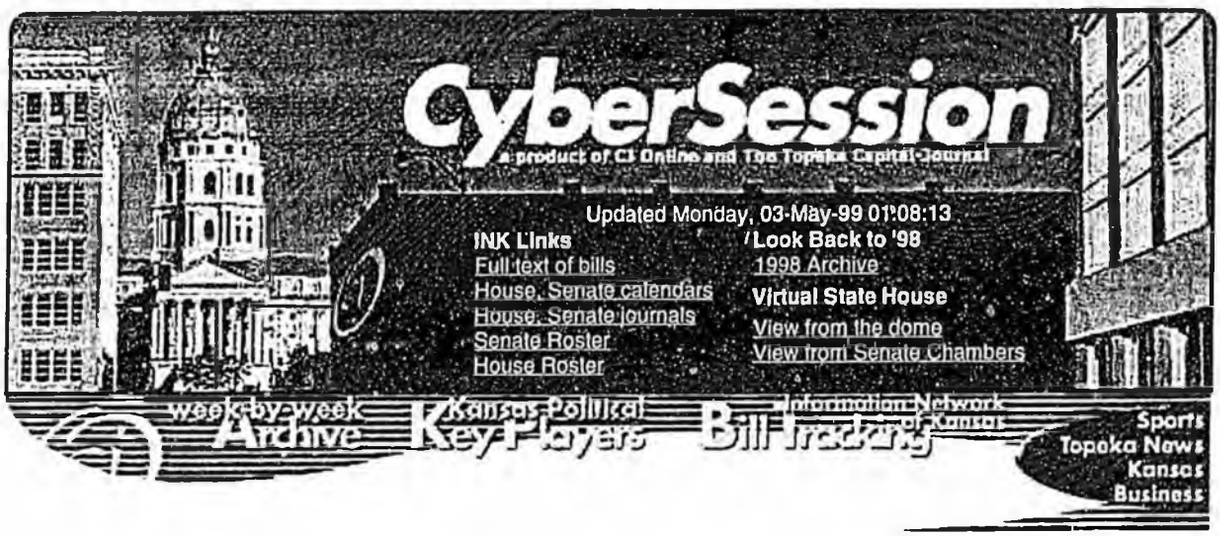

Omnibus bill with review procedure passed

The Associated Press

A bill that would crack down on uninsured motorists and make sure insurance companies don't have the last word on medical claims went Sunday to Gov. Bill Graves.

A joint conference committee of three senators and three House members combined several major insurance bills into a single compromise insurance bill. The House adopted the conference committee's report Saturday, 95-28, and the Senate adopted it Sunday, 31-8.

Both the external review of medical claims and increased penalties for not complying with the state law that mandates all motorists to carry insurance are initiatives from Insurance Commissioner Kathleen Sebelius.

Under the bill, a consumer who was denied medical coverage by an insurance company could go to the Insurance Department and ask to have an independent panel of doctors review the claim. The panel would have to render a decision within three months, and it would be binding on the insurance company.

The bill also increases the fine for a first violation of driving without insurance from $200 to $300. Also, the fee to reinstate vehicle registration would increase from $25 to$100.

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Shawn Hadley, M.D.* ** • Eric Carlsen, M.D. * **
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April 30, 1999

Honorable Norman Rokeberg, Chairman
Labor and Commerce Committee
State of Alaska House of Representatives
State Capitol, Room 24
Juneau, Alaska 99801-1182

MAY 0 7 1999

Dear Rep. Rokeberg:

I am writing regarding HB 211, Regulation of Managed-Care Insurance Plans.

I am a private-practice specialty physician located in Anchorage. I have been in practice since 1984. Many of the patients in my speciality are being treated for physical disabilities.

I would ask that you put yourself in the shoes of a patient covered by a managed-care program and consider the importance of some of the features of this bill:

- It is reasonable to feel that you are being treated fairly and equitably by your managed-care insurance company.

- You would expect that your physician would be able to give you information about all reasonable treatment options for your condition, regardless of whether or not those treatments may be considered "too expensive" by the managed-care company (no "gag clauses").

- You would want managed-care health insurance companies to be accountable for negligence if the insurance company is in fact dictating healthcare decisions. To a physician, the notion of an insurance company making healthcare decisions is distasteful and inappropriate. As a person seeking care from a physician, one should expect decisions with respect to one's care to be made according to sound science and medical practice, not an insurance company's bottom line.

Thank you for your consideration with respect to this important healthcare bill.

Sincerely,

Shawn Hadley, M.D.

SH:smb

2841 DeBarr Road, Suite 11, Anchorage, Alaska 99508 • Telephone (907) 277-6333 • Fax (907) 277-6335
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MAY 0 7 1999

May 4, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-82

RE: HB 211-Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician, specializing in orthopaedic trauma in Anchorage Alaska. I write to you today as an advocate for Alaska 's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of the Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of the lack of medical necessity;

2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies; and

3. Holds managed care health insurance companies accountable for negligent health care decisions, which they might make.

Thank you, for you consideration.

Sincerely,

Bret L. Mason

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Pelvis & Acetabulum
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(907) 279-2970 fax

May 4, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-82

RE: HB 211-Regulation of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a Physician Assistant, employed in an office specializing in orthopaedic trauma in Anchorage Alaska. I write to you today as an advocate for Alaska 's patients.

I urge you to favorably consider those elements of HB 211 that:

1. Provide for fair and equitable treatment of the Alaska's patients by the managed care insurance companies by providing for the appropriate freedom of choice of their treating physicians, the reasonable continuation of care by the patient's physician of choice, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of the lack of medical necessity;

2. Provide for a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies; and

3. Holds managed care health insurance companies accountable for negligent health care decisions, which they might make.

Thank you, for you consideration.

Sincerely,

John R. Roberts, PA-C

USA Today
5/4/99

Today's debate: Paying for emergency care

Patients face big bills as insurers deny emergency claims

OUR VIEW **Industry promises to fix the problem fail. Investigations begin.**

Early last year, a Seattle woman began suffering chest pains and numbness while driving. The pain was so severe that she pulled into a fire station seeking help, only to be whisked to the nearest hospital, where she was promptly admitted.

To most that would seem a prudent course of action. Not to her health plan. It denied payment because she didn't call the plan first to get "pre-authorized," according to an investigation by the Washington state insurance commissioner.

The incident is typical of the innumerable bureaucratic hassles patients confront as HMOs and other managed care companies attempt to control costs. But denial of payment for emergency care presents a particularly dangerous double whammy:

MANAGED CARE CHECKUP

An occasional series

▶ Patients facing emergencies might feel they have to choose between putting their health at risk and paying a huge bill they may not be able to afford.

▶ All patients are put at risk if hospitals, facing uncertainty about payment, are forced to cut back on medical care.

Confronted with similar outrages a few years ago, the industry promised to clean up its act voluntarily, and it does by and large pay up for emergency care more readily than it did a few years ago. In Pennsylvania, for instance, denials dropped to 18.6% last year from 22% in 1996.

That's progress, but not nearly enough. Several state insurance commissioners have been hit with complaints about health plans trying to weasel out of paying for emergency room visits that most people would agree are reasonable — even states that mandate such payments. Examples:

▶ Washington's insurance commissioner sampled claims in early 1998 and concluded in an April report that four top insurers blatantly violated its law requiring plans to pay for ER care. Two-thirds of the denials by the biggest carrier in the state -- Regence BlueShield — were illegal, the state charged, as were the majority of three other plans' denials. The plans say those figures are grossly inflated.

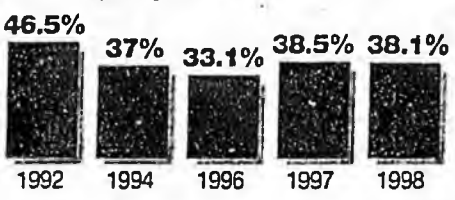
▶ The Maryland Insurance Administration is looking into complaints that large portions of denials in that state are illegal. In a case reported to the state, an insurance company denied payment for a 67-year-old woman complaining of chest pain and breathing problems because it was "not an emergency."

▶ Florida recently began an extensive audit of the state's 35 HMOs after getting thousands

Emergency care

Emergency rooms provide care for a large portion of the population, and most Americans think insurers should be required to pay for it.

Pecentage of households with a member who has visited the emergency room in past year



Should Congress require emergency room coverage if the patient has a good reason to think it's an emergency?

Sources: National Research Corporation, Kaiser Family Foundation/Harvard University survey

emergency treatments.

▶ A report from the New York-based Medicare Rights Center released last fall found that almost 10% of those who called the center's hotline complained of HMO denials for emergency room bills.

▶ ER doctors in California complain that Medicaid-sponsored health plans routinely fail to pay for ER care, despite state and federal requirements to do so. Other states have received similar reports, and the California state Senate is considering a measure to toughen rules against this practice.

The industry has good reason to keep a close eye on emergency room use. Too many patients use the ER for basic health care when a much cheaper doctor's visit would suffice.

But what's needed to address that is better patient education about when ER visits are justified and better access to primary care for those who've long had no choice other than the ER, not egregious denials for people with a good reason to seek emergency care.

Since the early 1990s, more than two dozen states have tried to staunch that practice with "prudent layperson" rules. The idea is that if a person has reason to think his condition requires immediate medical attention, health plans in the state are required to pay for the emergency care. Those same rules now apply for health plans contracting with Medicare and Medicaid.

A national prudent layperson law covering all health plans would help fill in the gaps left by this patchwork of state and federal rules.

At the very least, however, the industry should live up to its own advertised standards on payments for emergency care. Patients in distress should not have to worry about getting

HB

224

ALASKA STATE LEGISLATURE

Interim:
600 East Railroad Avenue
Wasilla, Alaska 99654
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Session:
State Capitol Building , Room 421
Juneau, Alaska 99801-1182
(907) 465-2186
Fax - (907) 465-3818

REPRESENTATIVE VIC KOHRING
DISTRICT 26

Memorandum

Date: February 16, 2000

To: Representative Norm Rokeberg
Chair, Labor and Commerce

From: Representative Vic Kohring

Subject: Committee hearing request

I wish to request a Committee hearing on HB 224, requiring the teacher's union to give 24 hours notice before striking.

RECEIVED
FEB 16 2000

ALASKA STATE LEGISLATURE

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REPRESENTATIVE VIC KOHRING
DISTRICT 26

SPONSOR STATEMENT
HOUSE BILL 224
Representative Vic Kohring

At the request of the Anchorage School District, I am sponsoring HB 224. This bill amends the Public Employment Relations Act (PERA) to require that school districts receive a minimum of three work days advance notice before a strike can be called by a union representing district employees. School districts have been covered by PERA since 1990. Since that time, in Anchorage alone, three labor strikes have been conducted. Prior notice was provided in two of three cases. In January, 1999, the TOTEM Association of Educational Support Personnel called a strike after 10:00pm on a Thursday. The strike began the following morning. The district had no time to provide sufficient notice to parents to enable them to make alternate arrangements for the care of their school-age children. The action caused significant but unnecessary disruption to families and placed children in a safety and health risk. The short notice provided absolutely no tactical or strategic bargaining advantage to the union and had no impact on the final settlement.

Imposition of a requirement to provide advance notice will not grant undue advantage to districts since strike effectiveness in pressuring school boards to grant more generous settlements does not rely on surprise. Employees will retain full use of the strike weapon while protecting families and their school-age children from unnecessary risk.

I encourage your support of HB 224.

ALASKA STATE LEGISLATURE

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REPRESENTATIVE VIC KOHRING
DISTRICT 26

SECTIONAL ANALYSIS
HOUSE BILL 224

Title: An act requiring a public employee labor organization representing employees of a school district, regional educational attendance area, or a state boarding school to give a three day notice before striking.

Section 1. AS 23.40.200 is amended by adding:

(g) Before employees of a school district, a regional educational attendance area, or a state boarding school may engage in a strike under this section, the labor organization representing the employees shall give the employer written notice that the employees intend to strike. The notice must be given at least three days before the strike may begin.

FISCAL NOTE

STATE OF ALASKA **BILL NO. HB 224**

2000 LEGISLATIVE SESSION

Revision Date/Time (Note if Correction): _____
Title: PERA: Notice Before Strike
Sponsor: Representative Kohring
Requestor: (H) HES

Department Affected: Administration
BRU: Centralized Admin. Services
Component: Personnel
COMPONENT SERIAL NO. 56

Expenditures/Revenues: (Thousands of Dollars)
Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2001	FY 2002	FY2003	FY 2004	FY 2005	FY 2006
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 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 2000) cost: $_____

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

No Fiscal Impact.

Prepared by: Sharon Barton, Director
Division: Personnel
Phone: 465-4430
Date 1/24/00

Approved by Commissioner: Robert Poe Jr. for
Agency: Department of Administration
Date: 1/24/00

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OUSE COMMITTEE REPC T

Date Referred to Committee: May 5, 1999 FURTHER REFERRALS: Labor and Commer

Date of Committee Action: 02/15/00

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 2

HOUSE BILL NO. 224 PERA: NOTICE BEFORE STRIK

"An Act requiring a public employee labor organization representing employees of a school district, regional education attendance area, or a state boarding school to give notice before striking."

recommends it be replaced [ ] the same title
with the following committee substitute _____ [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

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

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

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

Adm

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Green	✓			
Dyson				✓
Coghill			✓	
Kemplen				✓
Brice		✓		
	(1)	(1)	(1)	(2)

CHAIR'S SIGNATURE Fred Dyson DYSON 2/15/00

NOTES TO DECISIONS

Applied in Hafling v. Inlandboatmen's Union, 585 P.2d 870 (Alaska 1978).

Sec. 23.40.160. Power to investigate and compel testimony. (a) For the purpose of the investigations, proceedings, or hearings which the labor relations agency considers necessary to carry out the provisions of AS 23.40.070 — 23.40.260, the labor relations agency may issue subpoenas requiring the attendance and testimony of witnesses and the production of relevant evidence.

(b) The labor relations agency may administer oaths, examine witnesses, and receive evidence.

(c) The attendance of witnesses and the production of evidence may be required from any place in the state at any designated place of hearing.

(d) If a person refuses to obey a subpoena issued under AS 23.40.070 — 23.40.260, the superior court in the district in which the person resides or is found may, upon application by the labor relations agency, issue an order requiring the person to comply with the subpoena. (§ 2 ch 113 SLA 1972)

NOTES TO DECISIONS

Applied in Hafling v. Inlandboatmen's Union, 585 P.2d 870 (Alaska 1978).

Sec. 23.40.170. Regulations. The labor relations agency may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the provisions of AS 23.40.070 — 23.40.260. (§ 2 ch 113 SLA 1972)

NOTES TO DECISIONS

Stated in Carter v. Alaska Pub. Employees Ass'n, 663 P.2d 916 (Alaska 1983).

Cited in McGrath v. University of Alaska, 813 P.2d 1370 (Alaska 1991).

Sec. 23.40.180. Penalty for violation of order or decision. A person who violates a provision of an order or decision of the labor relations agency is guilty of a misdemeanor and is punishable by a fine of not more than $500. (§ 2 ch 113 SLA 1972)

NOTES TO DECISIONS

Applied in Hafling v. Inlandboatmen's Union, 585 P.2d 870 (Alaska 1978).

Sec. 23.40.190. Mediation. If, after a reasonable period of negotiation over the terms of a collective bargaining agreement, a deadlock exists between a public employer and an organization, the labor relations agency may appoint a competent, impartial, disinterested person to act as mediator in any dispute either on its own initiative or on the request of one of the parties to the dispute. The parties may also select a mediator by agreement or mutual consent. It is the function of the mediator to bring the parties together voluntarily under such favorable auspices as will tend to effectuate settlement of the dispute, but neither the mediator nor the labor relations agency has any power of compulsion in mediation proceedings. (§ 2 ch 113 SLA 1972)

Sec. 23.40.200. Classes of public employees; arbitration. (a) For purposes of this section, public employees are employed to perform services in one of the three following classes:

(1) those services which may not be given up for even the shortest period of time;

(2) those services which may be interrupted for a limited period but not for an indefinite period of time; and

(3) those services in which work stoppages may be sustained for extended periods without serious effects on the public.

(b) The class in (a)(1) of this section is composed of police and fire protection employees, jail, prison, and other correctional institution employees, and hospital employees. Employees in this class may not engage in strikes. Upon a showing by a public employer or the labor relations agency that employees in this class are engaging or about to engage in a strike, an injunction, restraining order, or other order which may be appropriate shall be granted by the superior court in the judicial district in which the strike is occurring or is about to occur. If an impasse or deadlock is reached in collective bargaining between the public employer and employees in this class, and mediation has been utilized without resolving the deadlock, the parties shall submit to arbitration to be carried out under AS 09.43.030.

(c) The class in (a)(2) of this section is composed of public utility, snow removal, sanitation, and educational institution employees other than employees of a school district, a regional educational attendance area, or a state boarding school. Employees in this class may engage in a strike after mediation, subject to the voting requirement of (d) of this section, for a limited time. The limit is determined by the interests of the health, safety, or welfare of the public. The public employer or the labor relations agency may apply to the superior court in the judicial district in which the strike is occurring for an order enjoining the strike. A strike may not be enjoined unless it can be shown that it has begun to threaten the health, safety, or welfare of the public. A court, in deciding whether or not to enjoin the strike, shall consider the total equities in the particular class. "Total equities" includes not only the impact of a strike on the public but also the extent to which employee organizations and public employers have met their statutory obligations. If an impasse or deadlock still exists after the issuance of an injunction, the parties shall submit to arbitration to be carried out under AS 09.43.030.

(d) The class in (a) (3) of this section includes all other public employees who are not included in the classes in (a) (1) or (2) of this section. Employees in this class may engage in a strike if a majority of the employees in a collective bargaining unit vote by secret ballot to do so. However, if an impasse or deadlock is reached in collective bargaining negotiations between a municipal school district, a regional educational attendance area, or a state boarding school and its employees, the parties shall submit to advisory arbitration before the employees may engage in a strike. The arbitrator selected to conduct the advisory arbitration must be a member of the American Arbitration Association Panel of Labor Arbitrators or the Federal Mediation and Conciliation Service. In selecting the arbitrator, the parties shall request a list of arbitrators who have knowledge of and recent experience in the local conditions in the school district, regional educational attendance area, or state boarding school. A list containing at least five nominees who meet the qualifications of this subsection is a complete list for the purpose of striking names and selecting the arbitrator.

(e) Notwithstanding the provisions of (b), (c) and (d) of this section, the employees with the concurrence of the employer may agree in writing to submit a dispute arising from interpretation or application of a collective bargaining agreement to arbitration.

(f) The parties to a collective bargaining agreement may provide in the agreement a contract for arbitration to be conducted solely according to AS 09.43.010 — 09.43.180 (Uniform Arbitration Act) if the Act is incorporated into the agreement or contract by reference. (§ 2 ch 113 SLA 1972; am §§ 3, 4 ch 1 SLA 1992; am §§ 17, 18 ch 113 SLA 1997)

Effect of amendments. — The 1992 amendment, effective March 26, 1992, in subsection (c), deleted "public school and other" preceding "educational institution" and added "other than employees of a school district, a regional educational attendance area, or the state boarding school" in the first sentence, and, in

subsection (d), added the last four sentences.

The 1997 amendment, effective September 30, 1997, made minor stylistic changes in subsections (c) and (d).

Opinions of attorney general. — Fish hatchery employees and area management biologists have a right to strike under paragraph (a)(3) and subsection (d). May 18, 1987 Op. Att'y Gen.

NOTES TO DECISIONS

I. General Consideration.
II. Arbitration.

I. GENERAL CONSIDERATION.

Certain teachers not covered by section. — Teachers, who are not "public employees" for purposes of this article, are not covered by this section. Anchorage Educ. Ass'n v. Anchorage Sch. Dist., 648 P.2d 993 (Alaska 1982) (decided under former law).

Strikes by teachers. — Issuance of injunction to end teachers' strike, without separate finding of irreparable harm was not error, since by making these strikes illegal, the legislature has decided that a teachers' strike would cause irreparable harm. Anchorage Educ. Ass'n v. Anchorage Sch. Dist., 648 P.2d 993 (Alaska 1982) (decided under former law).

"Impasse" in negotiations. — The state may implement unilateral contract changes when negotiations reach an impasse. For Class II employees, an impasse is reached when the parties have reached a good faith impasse and the mediation process has been exhausted. For Class III employees, an impasse is reached when negotiations are deadlocked. Alaska Pub. Employees Ass'n v. State, Dep't of Admin., 776 P.2d 1030 (Alaska 1989).

State's unilateral contract changes upheld. — Unilateral contract changes imposed by the state during an impasse in negotiations with public employees, which changes included an extension of work hours, did not deprive the employees of a property interest protected by Alaska Const., art. I, § 18. Alaska Pub. Employees Ass'n v. State, Dep't of Admin., 776 P.2d 1030 (Alaska 1989).

Applied in Hafling v. Inlandboatmen's Union, 585 P.2d 870 (Alaska 1978).

II. ARBITRATION.

Not exclusive remedy. — The fact that an arbitrator cannot grant the relief afforded by a statute is an indication that holding arbitration to provide an exclusive remedy would conflict with the statutory purpose. Public Safety Employees Ass'n v. State, 658 P.2d 769 (Alaska 1983).

Applicability of Uniform Arbitration Act. — Even though this section does provide that interest arbitration shall be conducted under AS 09.43.030, the section of the Uniform Arbitration Act (UAA) providing for appointment of arbitrators by agreement of the parties, or, in the absence of an agreement, by the superior court, the entire UAA is not applicable to this section. State v. Public Safety Employees Ass'n, 798 P.2d 1281 (Alaska 1990).

Applicability of legislative approval. — The legislative appropriation requirement of AS 23.40.215(a) applies to arbitration awards under subsection (b). Fairbanks Police Dep't Chapter v. City of Fairbanks, 920 P.2d 273 (Alaska 1996).

Matter for courts. — Arbitrability is a question for the courts unless the parties clearly and unmistakably provide otherwise. State v. Public Safety Employees Ass'n, 798 P.2d 1281 (Alaska 1990).

Only nonstriking employees entitled to compulsory arbitration. — This section unambiguously extends the right to compulsory arbitration only to those employees who are forbidden from striking, i.e., class (a)(1) employees. Class (a)(2) and (a)(3) employees are not entitled to binding arbitration simply because they happen to be in a bargaining unit with class (a)(1) employees. Alaska Pub. Employees Ass'n v. City of Fairbanks, 753 P.2d 725 (Alaska 1988).

Issues arbitrable. — The duty to maintain fit premises under a collective bargaining agreement providing for bush housing is one for which a contract remedy is available and is thus arbitrable. Public Safety Employees Ass'n v. State, 658 P.2d 769 (Alaska 1983).

Issues not arbitrable. — The legality of a clearly expressed and plainly applicable contract formula was held not arbitrable under the terms of a contract clause providing for arbitration in disputes involving the meaning or application of the express terms of the contract. Public Safety Employees Ass'n v. State, 658 P.2d 769 (Alaska 1983).

Because of the explicit nonwaiver provisions of AS 34.03.040, the right to sue under the Uniform Residential Landlord and Tenant Act, AS 34.03, cannot be prospectively bargained away in a collective bargaining agreement which provides for arbitration. Public Safety Employees Ass'n v. State, 658 P.2d 769 (Alaska 1983).

Standard of review. — Appellate courts should apply the arbitrary and capricious standard when reviewing awards in compulsory interest arbitrations; in voluntary interest arbitrations, the standard of review is gross error. State v. Public Safety Employees Ass'n, 798 P.2d 1281 (Alaska 1990).

Sec. 23.40.205. Family leave. Notwithstanding any provision of AS 23.40.070 — 23.40.260 to the contrary, an agreement between the employer subject to AS 23.10.500 — 23.10.550 and an employee bargaining organization that does not contain benefit provisions at least as beneficial to the employee as those provided by AS 23.10.500 — 23.10.550 shall be considered to contain the benefit provisions of those statutes. (§ 7 ch 96 SLA 1992)

Revisor's notes. — Enacted as AS 23.40.200(g),

Was faxed to all media, on 5-11-99, p.m.

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REPRESENTATIVE VIC KOHRING
DISTRICT 26

FOR IMMEDIATE RELEASE
May 10, 1999

For further information, contact:
Rep. Vic Kohring, at
(800) 468-2186

Kohring files bill requiring advance strike notice

House Bill 224 would mandate three day notification by unions

Juneau -- Rep. Vic Kohring (R-Wasilla/Peters Creek) has filed legislation requiring that a school district be given three days notice by a striking union. The Anchorage School District requested that Kohring file the bill.

House Bill 224 was filed in response to the recent strike against the ASD, forcing the shutdown of schools. ***'It was unfair for the union to strike at the Eleven O' Clock Hour, because it didn't give parents and students a chance to react," said Kohring. "Children were turned away at the door the next morning, because they had no idea schools were suddenly shut down a few hours before. That's a very unprofessional way to treat people."***

Kohring has also expressed concern about the possibility of a strike by the Mat-Su Education Association Union, given their dissatisfaction over recent contract negotiations. He said he trusts the MSEA will extend the courtesy to the School District of letting them know well in advance of any potential strike. If not, Kohring said it will further justify his bill.

In addition to the Anchorage School District, the Association of Alaska School Boards supports House Bill 224. (See attached Statement.)

###

ASSOCIATION OF ALASKA SCHOOL BOARDS

Advocates for Alaska's Youth

Statement of Support
HB 224 School District Strike Notification

The Association of Alaska School Boards supports HB 224, by Rep. Kohring, requiring that school districts receive a minimum of three work days advance notice before a strike can be called by a union representing district employees.

AASB's membership passed a resolution back in 1995 calling for similar legislation, a few years after educators were granted the legal right to strike. The strike notification resolution has been passed by the membership of AASB every year since.

Specifically, AASB supports legislation which would require employees and/or their bargaining agencies to give a school district a 72-hour advance notice when a strike to the district will occur, and that would require the district to give employees and/or their bargaining agency a 72-hour advance notice of its intent to impose a contract on the bargaining agency.

Rationale: Unannounced strikes undermine public confidence in public education and do not serve our communities well. Strikes create security problems for facilities. The safety of school children would be compromised in the event school employees walked off their jobs without adequate notice. Also, union members should have equal advance notification in the event a District decided to impose a contract.

May 6, 1999

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1-16-99

School strike

Few days' grace would have helped

Anchorage parents of public-school children woke up to an ambush Friday morning. School district office workers and teacher aides voted 788-102 Thursday night to strike, then on a voice vote called the strike for Friday. The decision came too late for the evening news, and the Anchorage School District, which had warned that a strike would close schools, didn't get the word until 10:40 Thursday night that the strike would begin Friday.

Parents who have paid attention knew a strike and school closing were possible. They didn't expect to learn of a strike at the school doors or the bus stop, or while they were getting their children ready for school.

Many parents and students didn't get the word until Friday morning. That left them scrambling for child care and disrupted work and transportation schedules.

Parents who have paid attention knew a strike and school closing were possible. They didn't expect to learn of a strike at the school doors or the bus stop, or while they were getting their children ready for school.

While the union's timing got the community's attention, it's no way to win community support.

Ellen Gamel, president of Totem Association, apologized Friday afternoon for the disruption. She said union members are tired and frustrated at the district's stand in their contract dispute. The decision to walk out Friday reflects the depth of that frustration.

But the union would have served its own cause and the community better by giving Anchorage parents a weekend's warning and time to make child care, work and transportation arrangements. The strike could have begun Tuesday, after the King holiday. Blindsiding thousands of families Friday morning served no one's interests.

1-16-99 DB

ANCHORAGE DAILY NEWS EDITORIAL
JANUARY 16, 1999

ANCHORAGE SCHOOL DISTRICT

Anchorage School Board
P.O. Box 196614, Anchorage, Alaska 99519-6614 • (907) 333-9561

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House HESS Testimony
HB 224
January 25, 2000
Kathi Gillespie, Anchorage School Board Member

I come before you today to ask that you support requiring school unions to give parents, students, employers and community members three school days notice before going to strike.

Last year, on one of the coldest and darkest days of the year, children were put in danger and the Anchorage community was disrupted by a strike of school district employees. This strike occurred without reasonable notice and purposefully without giving parents an opportunity to make arrangements for the care of their children. All of the students of the Anchorage School District were affected, even the very young and those who have significant physical and emotional needs.

Across our city, parents on their way to work dropped off kids at schools that were not open, employers were told that working parents would need emergency leave to stay home with their kids because that had not been able to make arrangements for them, day care workers and child care providers were swamped with calls from concerned parents trying desperately to find a place to send their child, and many, many kids were left home alone because their parents had to work and no arrangements could be made for their care and supervision.

Today, we are asking for your help to make this common sense change in PERA allowing parents and our community to provide a safe environment for students in the unfortunate event of a strike of school personnel. We respect the right to strike and in no way want to gain an unfair advantage in labor negotiations, however we feel that children should not be placed in an unsafe situation to gain a strategic negotiating advantage either.

This proposal would require no fiscal note but would certainly be of great value to the parents, children, employers and communities of this state. Please help us to remedy this risk to our children and support three days notice before shutting down schools by strike.

1-15-99 A-1, A-1

Strike shuts schools

Office workers, aides walk off job

1-15-99 A-1

By ROSEMARY SHINOHARA and PETER PORCO
Daily News reporters

A union representing school district office workers and teacher aides will strike this morning, prompting district administrators to cancel school today for all Anchorage public school students.

Members of the Totem Association, which represents those school employees, and the Teamsters, which presents district bus drivers, voted Thursday night to authorize strikes. Teamster leaders said they would not strike today.

The strike votes came after months of failed negotiations. The vote by secret ballot was 788-102 by Totem members and 104-7 by the Teamsters Union Local 959.

The union informed Lee Wilson, the district's chief labor negotiator, at 10:40 p.m. that union members would be on strike this morning, Wilson said. The call came too late for news of today's walkout to make the 10 p.m. news.

"We're disappointed at the short notice," said Wilson, who said it "will aggravate many, many people."

Superintendent Bob Christal called the strike votes disappointing. He said the district has made offers to both employee groups that represent its "best shot. I don't think it's going to change."

The district had announced that if the nearly 1,000 secretaries, administrative assistants and teacher aides walked out, the district would close all schools, affecting 49,000 students. Sports events and other extracurricular activities will not be affected, Wilson said early today.

1-15-99 A-1

Nonstriking staffers should report to work as normal today, Christal said.

Christal said the closure is necessary to ensure the safety of students, especially those with disabilities. More than 400 of the Totem members are aides who work with disabled children.

Wilson said district officials will begin today to assess how the district can go about providing services to students and reopen schools during the strike.

Following Thursday night's votes, the workers were angry, frightened, defiant and exuberant. Loud whoops and applause erupted when members of each union learned how the other union

Please see Back Page, SCHOOLS

STRIKE: Employees walk off job; schools closed in Anchorage

Continued from Page A-1

d voted.

"Is that a statement or what!" bus iver Vikki Gross exclaimed at :amsters headquarters when ion leaders announced the result the Totem vote. "That's solidari- "

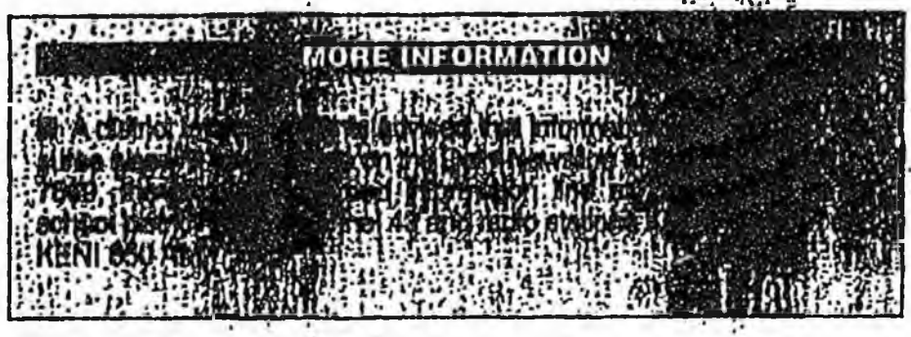
Hundreds of Totem members ayed at West High School after the te to sign up for picketing and gn-making sessions, and some said ey'd be working late to prepare r a coming strike.

The drivers voted twice Thursday ght. In the first ballot, they voted 12-6 to reject the district's final ntract offer. Workers soon fol- wed with a second vote authoriz- g a strike.

A driver strike would eliminate ansportation for students at 29 :hools in the East and Service high :hool attendance areas. Disabled udents who ride special buses to l district high schools and most el- nentary schools also would be ithout busing.

The district's drivers handle one- ird of the district's routes. The st are covered by a private con- actor, Laidlaw Transit, whose dri- ers are also Teamsters but work un- er a separate contract. Laidlaw bus utes are unaffected if the district's rivers strike.

Drivers and Totem members said eir major concern is the amount of oney the district is offering in the ree-year contract. Instead of three annual raises for experience, Totem members would get two such raises, and the increases wouldn't cover the increased cost of their health insurance, they say.



Drivers complained that the district's offer did not give them enough base pay.

The district says its bus drivers may not earn as much an hour as other commercial bus drivers in the area. However, "their total compensation package includes many benefits not provided to school bus drivers employed by private contractors," Christal and School Board president Harriet Drummond wrote in an op-ed essay in Wednesday's Daily News.

The Teamsters Union sought raises of 20 to 25 cents an hour for the 115 drivers and bus attendants for each of three years. The district offered step raises for experience but no increase in the base pay.

Totem members make $10.90 to $17.30 hourly. Bus drivers make $9.75 to $15.50, and bus attendants $7.35 to $12.90. Many of them work part time.

For some workers, strikes will hit twice as hard. Teamsters business agent Dave Mitchell said he knows of at least a half-dozen couples who have members in one or both unions.

One of those couples is Tim and Susan Morgan of Anchorage.

Tim Morgan has been a district bus driver for 21 years; Susan Morgan is a special education teaching assistant at Mears Middle School. Living with them are a middle school-age daughter, a 20-year-old son, a daughter who enters college in fall, and an infant grandchild.

"Yes, we are definitely in a situation where we're looking at the fact of losing both our incomes," Susan Morgan said.

"You just hope. You make a stand and deal with what you've decided. There's nothing more you can do."

The Totem union is the district's second largest. Members of the biggest union, the teachers, are filing petitions urging the School Board to continue bargaining until it reaches agreements with Totem and the Teamsters, said Rich Kronburg, president of the Anchorage Education Association.

Totem officials said they won't be able to offer striking members financial aid but they have begun collecting canned food for anyone who needs it.

Teamsters members who need financial or other support will get it from the union during the strike, leaders said.

Some members of both unions said they are scared.

"This is my income," said Margie Day, a 52-year-old widow who's been driving a district bus for 12 years and who supports one of her nine children and two grandchildren. "But we feel like they're cheating us."

"I feel hurt that the district is not feeling that we're important," said Shirley Payette, a special education teaching assistant at Whaley Center, which serves emotionally disturbed children.

"This is the biggest thing some of these people have ever done," said Benny Joy, a 66-year-old retired state worker and substitute bus driver. After the Teamsters meeting broke up, Joy scuffed his boot across the snow in the parking lot.

"But you've got to draw the line," he said.

□ Reporter Rosemary Shinohara can be reached at rshinohara@adn.com. Reporter Peter A. Porco can be reached pporco@adn.com.

1-15-99 A-14

HB

226

(7) ..OUSE COMMITTEE REPC..T

Date Referred to Committee: May 13, 1999 FURTHER REFERRALS: Finance

Date of Committee Action: _____

The LABOR AND COMMERCE Committee considered: HB 226

HOUSE BILL NO. 226 CREDITED SERVICE FOR ON-THE-JOB INJURIES

"An Act relating to credited service under the teachers' retirement system for education employees on leave without pay or receiving workers' compensation benefits because of certain on-the-job injuries."

recommends it be replaced with the following committee substitute CS #B 226(HES) [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

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

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [ ] zero fiscal note(s) DOA

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Norman Rokeby	✓			
[illegible]	✓			
[illegible]	✓			
[illegible]	✓			
[illegible]	✓			
[illegible] HARRIS	✓			
[illegible]	✓			

CHAIR'S SIGNATURE Norman Rokeby 5-14-99

Alaska State Legislature

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Representative John Coghill

Date: May 11, 1999

To: Representative Norm Rokeberg

From: Representative John Coghill JBC

Re: HB 226 Education Employees and On-The-Job Injuries

I am requesting that HB 226 be heard in House Labor & Commerce Committee. This legislation is very basic and accomplishes two things:

- Provides equity of credited service between TERS and PERS
- Provides that when an employee of a public school losses work time from a physical assault on the job, the employer would contribute to the employee's credited service.

The House HESS Committee adopted a committee substitute that addressed some clarity issues brought out by Retirement & Benefits.

I have attached the legislation, sponsor statement, sectional, fiscal note, and letters of support.

Thank you for your assistance in this matter.

Alaska State Legislature

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Representative John Coghill

Date: May 11, 1999

To: House HESS Committee Members

From: Representative John Coghill JBC

Re: Committee Substitute for HB 226

My office met with Guy Bell and Bill Church of Retirement and Benefits this morning to go over the language of HB 226. The purpose of the meeting was to make sure the language in the bill was clean and workable and the intent of the legislation was accomplished.

The original intent of this legislation was do two things:

- To provide for equity of credited service between TERS and PERS
- To provide that when an employee of a public school lost work time from a physical assault on the job, the employer would contribute to the employee's credited service.

Because of the manner in which legislative legal wrote Section 5 of HB 226, the intent was expanded to include policemen and firefighters. The language also does not explicitly mention "physical assault".

The existing legislation puts language applicable to leave of absences for PERS employees who work for public schools in AS 39.35.120 **Commencement of participation**, when in fact, the language should be inserted in AS 39.35.330 **Leave of Absence.**

The term of eligibility in the existing language would be until the eligible person is eligible for normal retirement. The eligibility would also terminate if the employee obtains a disability pension.

For these reasons, I recommend the committee adopt a committee substitute with the attached amendments.

Alaska State Legislature

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Representative John Coghill

HB 226 Education Employees and On-The-Job Injuries

Sectional Analysis

***Section 1.** Amends AS 14.25.040, **TERS Membership,** to provide that if a teacher is injured on the job as a result of a physical assault, the teacher is entitled to accrue credited service. This entitlement would end when the teacher is eligible for retirement or is placed on disability because of the injury.

***Section 2.** Amends AS 14.25.050(a), **Contribution by teachers**, to provide for an exception to the teacher contributing to TERS when that teacher has been physically assaulted, in which case the employer contributes.

***Section 3.** Amends AS 14.25.050, **Contribution by teachers,** by adding subsections (c) & (d).

Subsection (c) provides that the employer shall pay for the teacher's contributions when the teacher is off the job because of an on-the-job physical assault injury.

Subsection (d) provides a teacher who is placed in a leave of absence status because of an on-the-job injury or occupational illness other than an physical assault injury, with the same option as employees in PERS to buy credited service for the period of time the teacher is off the job for the on-the-job injury, receives normal retirement, or receives a disability pension.

***Section 4.** Amends AS 39.35.120, **Commencement of participation** in PERS, puts a limit on an employee receiving credited service bring paid by the employer from an assault injury under PERS.

***Section 5.** Amends AS 39.35.160(a), **Amount of employee contributions.** This provides that the employer not the employee who is on a leave of absence due to an on-the-job injury from a physical assault will make contribution at the prevailing rate.

***Section 6.** Amends AS 39.35.160, **Amount of employee contributions,** to provide that that the employer shall pay for a public school employee's contributions to PERS when the employee is off the job because of an on-the-job assault injury.

***Section 7.** Provides that credited service will be applicable only to injuries received on the day of or after the effective date of HB 226.

AMENDMENT #5

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: HB 226

Page 3, line 16, after the words "because of"

Delete: "an"

Insert: **a physical**

AMENDMENT #5

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: HB 225

Page 3, line 5

Delete: ""Except as provided in (c) of this section, beginning"

Insert: **Beginning**

Page 3, line 8

Delete: "Beginning"

Insert: **Except as provided in (c) of this section, beginning**

AMENDMENT #4

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: HB 226

Page 2, Line 26:

Delete: "39.35.120"

Insert: **39.35.120**

Page 2, line 27:

Delete: "(c)"

Insert: **(d)**

Page 2, line 28, after the words "who is"

Insert: **physically**

Page 3, line 2, after the word "eligible":

Delete: "to be appointed to normal retirement under AS 39.35.370(a)."

Insert: **to receive benefits under AS 39.35.370(a) or AS 39.35.410(a).**

AMENDMENT #3

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: HB 226

Page 2, line 12

Delete: "takes more than 10 days"

Insert: "is placed in a"

Page 2, line 19, after the word "working"

Insert: :

Delete: "less the sum of contributions that the teacher made for those periods of time and an amount equal to contributions that would have been made for the first 10 days of leave without pay."

AMENDMENT #2

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: HB 226

Page 2, line 8, after the words "because of an":

Insert: **physical**

AMENDMENT #1

OFFERED IN THE HOUSE HESS BY REPRESENTATIVE COGHILL

TO: HB 226

Page 1, line 6, after the word "is":

Insert: **physically**

Page 1, line 6, after the word "job":

Insert: **, who files for benefits under AS 23.30,**

Page 1, lines 11-12:

Delete all and insert:

under this subsection ends when the teacher is eligible to receive benefits under AS 14.25.110(a) or AS 14.25.130(a).

Alaska State Legislature

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Fairbanks, AK 99701
(907) 456-5081 - Phone
(907) 456-8245 - Fax

Session:
State Capitol, Room 416
Juneau, AK 99801
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(907) 465-3258 - Fax

Representative John Coghill

HB 226 - On-the-Job Assault Injuries
Sponsor Statement

In recent years, parents and educators have been looking for ways to ensure the safety of the children and employees of the schools. I introduced HB 226 to address on-the-job safety of school employees.

This legislation provides for a teacher or other employee of the public school system placed on leave without pay because of injuries received from an on-the-job assault to accrue credited service. While the individual is on unpaid leave or receiving workers' compensation benefits, the employer would pay the employee's contributions to credited service.

This legislation also amends the Teacher's Retirement System (TERS) so a teacher unable to work due to an on-the-job injury or occupational illness for which the teacher is receiving workers' compensation may opt to purchase credited service. Public employees already have this option under Public Employees Retirement System (PERS).

Alaska State Legislature

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Representative John Coghill

HB 226 Education Employees and On-The-Job Injuries

Sectional Analysis

***Section 1.** Amends AS 14.25.040, **TERS Membership,** to provide that if a teacher is injured on the job as a result of a physical assault, the teacher is entitled to accrue credited service. This entitlement would end when the teacher is eligible for retirement or is placed on disability because of the injury.

***Section 2.** Amends AS 14.25.050(a), **Contribution by teachers**, to provide for an exception to the teacher contributing to TERS when that teacher has been physically assaulted, in which case the employer contributes.

***Section 3.** Amends AS 14.25.050, **Contribution by teachers,** by adding subsections (c) & (d).

Subsection (c) provides that the employer shall pay for the teacher's contributions when the teacher is off the job because of an on-the-job physical assault injury.

Subsection (d) provides a teacher who is placed in a leave of absence status because of an on-the-job injury or occupational illness other than an physical assault injury, with the same option as employees in PERS to buy credited service for the period of time the teacher is off the job for the on-the-job injury, receives normal retirement, or receives a disability pension.

***Section 4.** Amends AS 39.35.120, **Commencement of participation** in PERS, puts a limit on an employee receiving credited service bring paid by the employer from an assault injury under PERS.

***Section 5.** Amends AS 39.35.160(a), **Amount of employee contributions**. This provides that the employer not the employee who is on a leave of absence due to an on-the-job injury from a physical assault will make contribution at the prevailing rate.

***Section 6.** Amends AS 39.35.330, **Amount of employee contributions,** to provide that that the employer shall pay for a public school employee's contributions to PERS when the employee is off the job because of an on-the-job assault injury.

***Section 7.** Provides that credited service will be applicable only to injuries received on the day of or after the effective date of HB 226.

FISCAL NOTE

STATE OF ALASKA **BILL NO. HB 226**

1999 LEGISLATIVE SESSION

Revision Date:

Department Affected: Administration

Title: An Act relating to credited service under the teachers' retirement system for education employees

BRU: Centralized Administrative Services

Component: Retirement and Benefits

Sponsor: Representative Coghill

Requestor: Health, Education and Social Services

COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL EXPENDITURES	0	0	0	0	0	0
CHANGE IN REVENUES ( )	0	0	0	0	0	0

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1037 GF/Mental Health	0	0	0	0	0	0
OTHER (1029 P/E Retire)	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

Estimate of any current year (FY 99) cost: $ 0

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary.)

This legislation will have no material financial impact on the Public Employees' Retirement System or the Teachers' Retirement System.

Prepared by: Guy Bell

Phone: 465-4471

Division: Retirement and Benefits

Date

Approved by Commissioner: Robert Poe, Jr.

Agency: Department of Administration

Date: 5/11/99

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NEA-ALASKA

Affiliated with the National Education Association

HB 226 –Education Employees and On-the-Job Injuries

May 11, 1999

NEA-Alaska supports HB 226. The bill will prevent, either a loss of retirement service credit or out of pocket expense for school personnel injured through physical assault while at work. We offer the following thoughts in support of HB 226.

The 30th Annual Phi Delta Kappa/Gallup Poll of Public Attitudes Toward the Public Schools showed that concern about fighting and violence replaces lack of discipline, need for more control, and lack of financial support as the top problems facing local public schools.

School personnel are equally concerned about safety, order and discipline within schools and classrooms. The number of violent incidents against school staff has increased. School districts seek to identify ways to control and reduce violent acts within schools. The responsibility for control of classrooms falls directly on teachers and support personnel.

Because of the dedicated work of school staff, schools remain the safest place for students. However, as school personnel work to make our schools safe for all children, occasionally a staff member will sustain an injury as a result of a physical assault. If this should occur, an employee on worker's compensation as a result of injury or on an unpaid leave of absence associated with this type of injury will either lose money or service time in their respective retirement systems.

HB 226 provides a element of relief for a school staff person assaulted while in the line of duty by requiring the employer to pay either the TRS or PERS contribution for school personnel on leave due to on-the-job physical assault. HB 226 will eliminate a break in service retirement credit.

NEA-Alaska appreciates the work of Representative John Coghill in correcting a weakness in the PERS and TRS statutes for school personnel who work each day to make our schools safe places for children and families.

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Cheryl Rankin

Dean Whaley School

April 29, 1999

It was a cold January day in 1993 and I was a special education secondary teacher at Whaley School. Whaley School is a specialized educational school for students who are certified severely emotionally disturbed. My secondary class was in physical education and because they had been somewhat unruly that day I was assiting the physical education teacher. One11th grade boy was verbally and physically threatening another student. The 11th grader (I'll call him X) had a bat in his hand and was swinging it around in an extremely dangerous way. The boy he was threatening was yelling for assistance. I intervened on behalf of the victim and tried to talk the 11th grader into leaving the area. At that point I was approximately 6 feet away from X. X began walking towards the door and I followed him at that same distance when, without any warning he swung around and charged me catapulting me into the air like a rag doll. According to two staff memberswho witnessed the incident, I flew approximately 10 feet into the air and 15 feet across the gymnasium before landing on my lower spine with my head snapping back and cracking on the gymnasium floor. (At this point I should say X. was about 5'10" and weighed approximately 215 lbs. I am 5'2" and weight approximately 110 lbs). My body felt paralyzed and I was unable to move at all for several minutes. I laid there completely unable to move while staff worked on me. The rest of my students were extremely agitated at what had happened and other staff members worked with them also. 911 was called an an ambulance arrived shortly to transport me to Providence Hospital. The paramedics placed me on a backboard and immobilized me for transportation. On a level of 0 - 10 for pain, with 0 being no pain and 10 being the worst pain you have ever experienced, I would have to say the pain was a 10 and covered my entire body. I was kept at the hospital for several hours and was finally released with a diagnosis of trauma to the back. The hospital gave me anti-inflammatories and pain medication that I took daily until I was able to return to work two weeks later.

Within 2 days of my returning to work, I again was put in a situation where I had to intervene between students and reinjured causing me to be off work for another week.

I received Workman's Compensation for the time lost from work due to these injuries, however, because at that time Workman's Comp is based on an average of the three previous years salary (and I had worked as a substitute teacher during one of these years) my average salary was not an accurate reflection of what I actually made. Therefore, monies contributed to my retirement account were, again, not an accurate reflection of my true earnings. I feel that due to my being injured on the job, I have lost money from my retirement account. Also, due to the cronic nature of my injury, I have lost, every year since my injury, approximately 4 - 6 sick days yearly. Because those days are generally not consecutive, Workemn's Comp. does not cover them and I must use my personal sick days. I seldom use my personal or sick days, however, sick days lost through this act of aggression towards me, while I was doing my job, are sick days lost and cannot be applied towards my retirement or cashed out.

I am continually plagued by this injury and spend many of my own hours making doctor's and physical therapy appointments. I am no longer able to cross country ski and have difficulty sitting for more than a half hour at a time.

HB

247

3/6/00 Halcro - working document unanimous

1-LS0676\I
Bannister
3/3/00

CS FOR HOUSE BILL NO. 247( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE KOTT

A BILL

FOR AN ACT ENTITLED

"An Act requiring certain nonprofit corporations to make certain filings."

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

*** Section 1.** AS 10.20.585 is amended to read:

Sec. 10.20.585. Revocation of certificate of authority. The certificate of authority of a foreign corporation to transact business in the state may be revoked by the commissioner when

(1) the corporation fails to file its biennial report within the time required by this chapter, or fails to pay fees or penalties prescribed in this chapter when they are due and payable;

(2) the corporation fails to appoint and maintain a registered agent in this state;

(3) the corporation fails, after change of its registered office or registered agent, to file with the commissioner a statement of the change as required by this chapter;

(4) the corporation fails to file with the department an amendment to

its articles of incorporation or articles of merger within the time prescribed by this chapter;

(5) a misrepresentation has been made of a material matter in an application, report, affidavit, or other document submitted under this chapter; [OR]

(6) the corporation is 90 days delinquent in filing a notice of change of an officer or director as required by this chapter; **or**

(7) the corporation fails to make a filing as required by AS 10.20.633 within the time prescribed by AS 10.20.633.

*** Sec. 2.** AS 10.20.590 is amended to read:

Sec. 10.20.590. Limitations on revocation of certificate of authority. The commissioner may not revoke a certificate of authority of a foreign corporation unless

(1) the commissioner has given the corporation at least 60 days' notice by mail addressed to its registered office in the state; and

(2) the corporation fails, before revocation, to file the annual report, [OR] pay the fees, [OR] file the required statement of change of registered agent or registered office, [OR] file the articles of amendment or articles of merger, [OR] correct the misrepresentation, **or make a filing as required by AS 10.20.633**.

*** Sec. 3.** AS 10.20.615 is amended to read:

Sec. 10.20.615. Liability to state for transacting business without certificate of authority. A foreign corporation **that** [WHICH] transacts business in the state without a certificate of authority is liable to the state, for the years or portions of years during which it transacted business in the state without a certificate of authority, in an amount equal to all fees **that** [WHICH] would have been imposed by this chapter on the corporation if it had applied for and received a certificate of authority to transact business in the state as required by this chapter, [AND] filed all reports required by this chapter, **and made the filings as required by AS 10.20.633,** plus all penalties imposed by this chapter for failure to pay the fees, **the penalty for failure to make the filings as required by AS 10.20.633,** and a penalty of up to $5,000 per year or fraction of a year of operating without a certificate of authority. The attorney general shall bring proceedings to recover amounts due the state under this section.

*** Sec. 4.** AS 10.20 is amended by adding a new section to article 7 to read:

Sec. 10.20.633. Filing required. (a) A foreign corporation transacting business in the state and a domestic corporation shall file with the department on or before July 1 of each year a copy of the most recent Form 990 filed by the foreign or domestic corporation with the federal government.

(b) If a foreign corporation transacting business in the state or a domestic corporation is not required by 26 U.S.C. (Internal Revenue Code) to file a Form 990, the corporation shall file a statement with the department on or before July 1 of each year that lists the gross amount of money received by the corporation from each source during the previous tax year of the corporation and the identity of each source.

(c) When making a filing required by this section, the corporation shall pay the department a fee established by the department by regulation.

(d) A form filed under this section is not confidential and is a public record under AS 09.25.100 - 09.25.220.

(e) In this section,

(1) "Form 990" means the form required by the federal government for organizations exempt under 26 U.S.C. (Internal Revenue Code) from federal income tax;

(2) "transacting business" includes, notwithstanding AS 10.20.460, engaging in activities listed in AS 10.20.460(2) - (8).

* **Sec. 5.** AS 10.20.645 is amended by adding new subsections to read:

(c) If a domestic corporation fails or refuses to make a filing as required by AS 10.20.633, the commissioner may revoke the certificate of incorporation issued to the corporation under AS 10.20.156(a).

(d) If a foreign corporation is not required to obtain a certificate of authority under AS 10.20.455 because its activities are not considered to be transacting business in this state under AS 10.20.460, or if a foreign corporation fails to obtain a certificate of authority that it is required to obtain under AS 10.20.455, the foreign corporation is subject to a penalty of $1,000 for each failure to make a filing as required by AS 10.20.633 if the foreign corporation engages in activities in this state. Each year's failure to make a filing as required by AS 10.20.633 constitutes a separate failure for which a penalty may be imposed under this subsection. In this subsection, "engages

in activities" has the meaning given to "transacting business" in AS 10.20.633.

Alaska State Legislature
House of Representatives

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ALASKA STATE CAPITOL
JUNEAU, AK 99801

Memorandum

RECEIVED
FEB 28 2000

TO: Representative Norm Rokeberg, Chairman
House Labor & Commerce Committee

FROM: Representative Pete Kott

SUBJECT: Request for Hearing, HB 247

DATE: February 27, 2000

I request that HB 247, an Act requiring certain nonprofit corporations to file a certain form, be heard as soon as possible. Enclosed with this request is the following:

- Blank CS for HB 247
- Sponsor Statement

Backup material and teleconference requirements will be provided well before the hearing. Pat Harman of my staff will be handling this bill, he may be reach at x6841

Representative Pete Kott
JUNEAU OFFICE (907) 465-3777 TOLL FREE 1-800-861-KOTT(5688) FAX (907) 465-2819
EAGLE RIVER OFFICE (907) 694-8944 FAX (907) 694-8945 E-MAIL: representative_pete_kott@legis.state.ak.us

Sponsor Statement
HB 247

Non-profit corporations are essentially tax exempt corporations. This is a privileged position that non-profits receive due to their mission of public good. HB 247 will require non-profits to validate their status by filing annual reports stating where they get their funding and how they spend it. Non-profits already submit a form 990 annually with the Internal Revenue Service. Filing this form with the State should place little additional burden on non-profit corporations. HB 247 also requires foreign corporations (those non-profits doing business in Alaska without a certificate of authority) to file with the state.

There is a legitimate State interest in ensuring that non-profit corporations really should qualify for that tax-exempt status. At the present time it is difficult to gather information about non-profits that should be a matter of public information, HB 247 will resolve this problem.

1-LS0676\H
Bannister
2/22/00

CS FOR HOUSE BILL NO. 247( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE KOTT

A BILL

FOR AN ACT ENTITLED

"An Act requiring certain nonprofit corporations to file a certain form."

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

* **Section 1.** AS 10.20.585 is amended to read:

Sec. 10.20.585. Revocation of certificate of authority. The certificate of authority of a foreign corporation to transact business in the state may be revoked by the commissioner when

(1) the corporation fails to file its biennial report within the time required by this chapter, or fails to pay fees or penalties prescribed in this chapter when they are due and payable;

(2) the corporation fails to appoint and maintain a registered agent in this state;

(3) the corporation fails, after change of its registered office or registered agent, to file with the commissioner a statement of the change as required by this chapter;

(4) the corporation fails to file with the department an amendment to

its articles of incorporation or articles of merger within the time prescribed by this chapter;

(5) a misrepresentation has been made of a material matter in an application, report, affidavit, or other document submitted under this chapter; [OR]

(6) the corporation is 90 days delinquent in filing a notice of change of an officer or director as required by this chapter; **or**

(7) the corporation fails to file a form required by AS 10.20.633 within the time prescribed by AS 10.20.633.

* **Sec. 2.** AS 10.20.590 is amended to read:

Sec. 10.20.590. Limitations on revocation of certificate of authority. The commissioner may not revoke a certificate of authority of a foreign corporation unless

(1) the commissioner has given the corporation at least 60 days' notice by mail addressed to its registered office in the state; and

(2) the corporation fails, before revocation, to file the annual report, [OR] pay the fees, [OR] file the required statement of change of registered agent or registered office, [OR] file the articles of amendment or articles of merger, [OR] correct the misrepresentation, **or file a form as required by AS 10.20.633**.

* **Sec. 3.** AS 10.20.615 is amended to read:

Sec. 10.20.615. Liability to state for transacting business without certificate of authority. A foreign corporation **that** [WHICH] transacts business in the state without a certificate of authority is liable to the state, for the years or portions of years during which it transacted business in the state without a certificate of authority, in an amount equal to all fees **that** [WHICH] would have been imposed by this chapter on the corporation if it had applied for and received a certificate of authority to transact business in the state as required by this chapter, [AND] filed all reports required by this chapter, **and filed the forms as required by AS 10.20.633,** plus all penalties imposed by this chapter for failure to pay the fees, **the penalty for failure to file the form as required by AS 10.20.633,** and a penalty of up to $5,000 per year or fraction of a year of operating without a certificate of authority. The attorney general shall bring proceedings to recover amounts due the state under this section.

* **Sec. 4.** AS 10.20 is amended by adding a new section to article 7 to read:

Sec. 10.20.633. Filing required. A foreign corporation transacting business in the state and a domestic corporation shall file with the department each year a copy of the Form 990 filed by the foreign or domestic corporation with the federal government within 30 days after the deadline under federal law for the foreign or domestic corporation to file the Form 990 with the federal government. A form filed under this section is not confidential and is a public record under AS 09.25.100 - 09.25.220. In this section,

(1) "Form 990" means the form required by the federal government for organizations exempt under 26 U.S.C. (Internal Revenue Code) from federal income tax;

(2) "transacting business" includes, notwithstanding AS 10.20.460, engaging in activities listed in AS 10.20.460(2) - (8).

* **Sec. 5.** AS 10.20.645 is amended by adding new subsections to read:

(c) If a domestic corporation fails or refuses to file a form as required by AS 10.20.633, the commissioner may revoke the certificate of incorporation issued to the corporation under AS 10.20.156(a).

(d) If a foreign corporation is not required to obtain a certificate of authority under AS 10.20.455 because its activities are not considered to be transacting business in this state under AS 10.20.460, or if a foreign corporation fails to obtain a certificate of authority that it is required to obtain under AS 10.20.455, the foreign corporation is subject to a penalty of $1,000 for each failure to file a form as required by AS 10.20.633 if the foreign corporation engages in activities in this state. Each year's failure to file the form constitutes a separate failure for which a penalty may be imposed under this subsection. In this subsection, "engages in activities" has the meaning given to "transacting business" in AS 10.20.633.

* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. This Act only applies to a corporation if the corporation is required under 26 U.S.C. (Internal Revenue Code) to file a Form 990 on or after the effective date of this Act.

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MEMORANDUM February 15, 2000

SUBJECT: CSHB 247( ) regarding nonprofit corporations (Work Order 21-LS0676\G)

TO: Representative Pete Kott
Attn: Pat

FROM: Theresa Bannister
Legislative Counsel

This memo accompanies a draft of the bill described above.

1. Interstate commerce clause. Imposing the filing requirement of this bill on foreign corporations operating in this state places a burden on interstate commerce. When a bill's requirements place a burden on interstate commerce, this raises the issue whether the burden is permissible under the federal commerce clause (Sec. 8, cl. 3, United States Constitution). The restrictions in a bill will be valid under the commerce clause unless the burden they impose on interstate commerce "is clearly excessive in relation to the putative local benefits." See Carlson v. State, 919 P.2d 1337, 1340 n.9 (Alaska 1996). In this case, among the burdens imposed on interstate commerce would be having to review Alaska law to determine what is required and having to file a copy of a federal form with a state department. If these burdens are not clearly excessive in relation to the value of the benefits that would accrue to persons living in the state, the bill would not be considered to violate the interstate commerce clause. The burdens on the interstate providers do not, at least on the surface, appear to be very onerous. Therefore, the interstate commerce issue may not present a serious problem for your bill. But you need to be aware that the issue is present.

2. Freedom of speech. The draft imposes a filing requirement on nonprofit corporations that transact business in the state, including making grants and advocating issues. This raises an issue under the freedom of speech protected under the first amendment to the constitution of the United States and Article I, Section 5 of the constitution of the State of Alaska.

An attempt to require issue advocacy groups to file federal reporting forms and disclose their funding sources may be susceptible to a first amendment challenge. In 1945, the Supreme Court wrote: "[a]s a matter of principle a requirement of registration in order to make a public speech would seem generally incompatible with an exercise of the rights of free speech and free assembly." Thomas v. Collins, 323 U.S. 516 (1945). More recently, the fourth circuit invalidated a North Carolina statute requiring "political committees" to register as such and keep records of contributions and expenditures. The court found that the statute