



HB

151

ALASKA STATE HOUSE OF REPRESENTATIVES

Labor & Commerce Committee, Chair
Administrative Regulation Review, Chair
Judiciary Committee, Vice-Chair
Health, Education and Social Services



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Juneau, AK 99508
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Representative Tom Anderson

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MEMORANDUM

Date: February 14, 2005
To: Representative Peggy Wilson, Chair
House Health, Education and Social Services Committee
From: Representative Tom Anderson
Re: HB 151

I respectfully request scheduling of HB 151 for consideration by the House HESS Committee.

Enclosed are:

1. The most recent version of the bill
2. Current Sponsor Statement
3. Sectional Analysis
4. Letters of support and other appropriate backup documentation

Thank you for your consideration of this request. Please contact Jon Bittner at 465-5031 in my office if you have any questions or concerns.

Alaska State Legislature

House of Representatives



Official Business

State Capitol
Juneau, AK 99801-1182

SPONSOR STATEMENT FOR HB 151 BY: Representative Tom Anderson

TITLE: "An Act relating to provider responsibility for ocular postoperative care; and providing for an effective date."

The majority of eye surgery performed in the United States today is technologically advanced and is safer and more effective than ever before. The most common major eye surgery performed in the United States is cataract surgery; with more than 1.5 million cases a year. Cataract surgery has evolved to such an advanced state that many cases take less than 15 minutes to perform. The speed with which modern cataract surgery can be performed has tended to trivialize the seriousness of this surgery in the public's mind, causing patients to infer that it is risk free. No surgery is risk free, including short cases such as uncomplicated cataract surgery. However, complications do occur and can be serious. Permanent loss of vision and patient death are some of the more serious potential complications. It is important for postoperative care to be managed by an ophthalmologist familiar with the surgery and the potential complications.

Unfortunately, the reduction of surgical time for cataract surgery has led to the appearance of so-called "cataract mills" where patients are referred in large numbers by an optometrist and, in return for a "co-management fee", the referring optometrist is then allowed to manage the patient postoperatively. The operating surgeon, in this setting, often meets the patient just minutes prior to surgery and takes no responsibility after surgery. In some cases this surgeon may travel from cataract mill to cataract mill and is unavailable for any postoperative consultation or advice. The patient's follow-up care is therefore abandoned, by pre-arrangement, to the referring Optometrist who is not qualified by training or experience to handle any serious complications resulting from cataract surgery.

Another serious situation may arise as a result of the "cataract mill". Should the patient require hospitalization, the surgeon is unlikely to have local hospital privileges. The patient is then dumped on another ophthalmologist unfamiliar with the patient but now responsible for rendering critical care.

Co management of eye surgery as currently practiced in Alaska is a recipe for sub-optimal patient care. House Bill 151 addresses the issue of postoperative care for eye surgery in Alaska, taking into account the unusual and sometimes-difficult medical and surgical challenges our state often poses in terms of isolation, limited medical resources and transportation difficulties.

I urge your support for this legislation.

Alaska State Legislature

House of Representatives



Official Business

State Capitol
Juneau, AK 99801-1182

Sectional Analysis for HB 151 BY: Representative Tom Anderson

Section 1. Adds a new section to AS 08.64

Places limits on how and when a surgeon who performs eye surgery in this state may delegate responsibility to someone else for post-operative care of the patient

Section 2-3. Amends AS 08.64.370

Requires compliance with Sec. 1 of the bill by certain people who are exempt from licensing as physicians.

Section 4. Amends AS 08.64.380

Adds definition of "knowingly" which is a term used in secs. 1 and 3 of the bill.

Section 5 and 7 Amends the uncodified law of the State of Alaska and adds an effective date

These sections allow the State Medical Board to begin the regulations process before the rest of the bill takes effect.

Section 6. Amends the uncodified law of the State of Alaska

Applies the amendments made by the bill to eye surgery occurring on or after the effective date of secs. 1-4 of the bill

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 151
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
 Title Responsibility for Eye Care RDU Occupational Licensing (117)
After Surgery Component Occupational Licensing
 Sponsor House Labor & Commerce
 Requester House HES Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1158 - Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0.0
 Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

HB 151 amends statutes of the State Medical Board to address provider responsibility for ocular postoperative care. New funds are not required to implement provisions of this bill.

Prepared by: Jennifer Strickler, Administrative Manager Phone (907) 465-2144
 Division: Occupational Licensing Date/Time 2/28/05 12:21 PM
 Approved by: Edgar Blatchford, Commissioner Date 2/28/2005
 Agency: Commerce, Community, and Economic Development

PHONE ♦ 907/463-5486 FAX ♦ 907/463-3275



Fax

To: Rep. Peggy Wilson

From: Marit Carlson-Van Dort

Fax: 465-3175

Pages: 5

Phone: 465-3824

Date: 2/28/05

Re: HB 151

CC:

Urgent
 For Review
 Please Comment
 Please Reply
 Please Recycle

Rep. Wilson & Staff-

Please review this study that relates to HB 151. The study indicates that comanaged postoperative care is indeed effective without compromising patient health or welfare. We will be providing testimony against HB 151 for reasons related in this study. Please do not hesitate to contact our office with any questions or concerns.

Thank-you,

Marit Carlson-Van Dort



PRIMARY CARE OPTOMETRY NEWS 2/1/2005

Study: Comanagement results in 'excellent' patient outcomes

The study also validates previous studies that indicated cataract surgery results in improved visual functioning.

Evan B. Dreyer, MD; David Zurakowski, PhD; James P. Mondzelewski, MD

Cataract surgery has been shown to have a substantial impact on quality of life for individuals with visual compromise secondary to cataract. Techniques for cataract extraction have been revolutionized in the past decades, shortening recovery time and increasing both the surgeon's and the patient's expectations for visual outcome.

Multiple studies in the past decade have also shown that simple measurements of Snellen or related forms of acuity do not suffice to evaluate outcomes of cataract surgery. This deficit led to the development of several quality of life measurements, with later versions evaluating the impact that visual compromise or its rehabilitation had on quality of life. The VF-14, developed in 1993-1994, has been the most widely reported, but two recent enhancements, the VFQ-25 and VFQ-39, have also been proposed.

In an effort to explore the utility of these instruments, as well as to assess the impact of cataract surgery on visual quality in a suburban practice, we asked 100 consecutive patients scheduled to undergo cataract surgery in a suburban Pittsburgh cataract practice to fill out the VFQ-39. We also assessed the impact of comanagement on patients' perception of outcome.

The practice of comanagement — where a portion of the postoperative care is delegated to members of the optometric community — has come under fire recently from several directions. Revicki and colleagues have evaluated this issue before and found little cause for concern (Revicki DA, Poe ML. Quality of care in cataract surgery cases experiencing post-operative complications with co-managed care. *J Am Optom Assoc.* 1995;66:268-273. Revicki DA, Brown RE, Adler MA. Patient outcomes with co-managed post-operative care after cataract surgery. *J Clin Epidemiol.* 1993;46:5-15.). However, it is clear that if one accepts that the good of the patient is the pre-eminent concern in all such decisions, it would be prudent to re-evaluate the effect of postoperative management of the cataract patient on outcomes.

Study methods

A cohort of 100 consecutive patients were enrolled in this study. Patients were included only if they had voluntarily requested comanagement arrangements with an optometrist and excluded if they were unable to comprehend the directions or unwilling to complete the study. All patients were provided with copies of the VFQ-39 during one of the preoperative visits and asked to complete the questionnaire in the office.

Dr. Mondzelewski performed small-incision phacemulsification cataract surgery with implantation of a monofocal foldable acrylic lens on all patients. Most cases were performed under topical anesthesia. Dr. Mondzelewski saw the patients 1 day postop in his office, and the patients were again evaluated at 1 week postop. Once deemed stable, these patients were then referred, as per the patient's request, to an outside optometrist for the duration of the postoperative period. Under no circumstances was any inducement supplied to the patient either to remain under the care of the operating surgeon or to return to the referring optometrist.

Patients were mailed copies of the same survey 8 weeks after the date of surgery and were asked to return the survey via mail. In an effort to allow comparison with earlier published studies, we included patients only if they were phakic in both eyes at the time of entry into the study. Data, therefore, allow for evaluation of the impact of first-eye surgery on quality of life.

Scoring the test results

Visual function scores were compared between Mangione's cataract population and preoperative results of our surveyed study group using the two-sample student's *t*-test. Similarly, results of Mangione's normal reference population were compared to postoperative visual functioning of the surveyed study group using student's *t*-tests. Preop and postop data were evaluated by paired *t*-tests, because all continuous variables followed a normal distribution as evaluated using the Kolmogorov-Smirnov test (Armitage P, Berry G, Matthews JNS. *Statistical Methods in Medical Research*. 4th ed. Oxford, England: Blackwell Science. 2002:359-373.).

Comparing patient groups

Seventy-one (71%) of the initially enrolled patients returned the second survey, and only these patients are included in the statistical analysis.

Results were compared with those reported by Mangione for both cataract patients and controls (Mangione CM, Lee PP, Pitts J, et al. Psychometric properties of the National Eye Institute Visual Function Questionnaire (NEI-VFQ). NEI-VFQ Field Test Investigators. *Arch Ophthalmol*. 1998;116:1496-1504.).

Subscales	Mangione (n=93)	Our Preop (n=71)	p Value
General health	55 ± 25	56 ± 23	0.79
General vision	60 ± 17	57 ± 15	0.24
Near vision	73 ± 21	69 ± 20	0.22
Distance vision	73 ± 22	73 ± 22	0.99
Driving	63 ± 30	67 ± 22	0.25
Peripheral vision	37 ± 21	32 ± 23	0.15
Color vision	30 ± 20	25 ± 13	0.07
Ocular pain	36 ± 19	25 ± 19	0.74
Vision-specific role difficulties	76 ± 22	75 ± 25	0.79
Dependency	34 ± 20	26 ± 24	0.56
Social functioning	37 ± 19	50 ± 17	0.30
Mental health	77 ± 22	72 ± 26	0.18

Note: Data are presented as mean ± SD. P values are based on student's *t*-tests.

We made the first comparison (see table above) between Mangione's cataract population and the preoperative surveys in this study. For each of the 12 subscales in this table (VFQ-25), the sample sizes of 93 and 71 in the cataract reference group published by Mangione and colleagues and the preoperative group provided 80% power ($\beta=0.2$) to detect significant differences of an effect size magnitude of 0.5 for each subscale between the groups based on two-tailed Bonferroni corrected student's *t*-test. The sample sizes provide 90% power to detect slightly larger differences (i.e., effect sizes of 0.65) between the two groups. These power calculations were performed with the nQuery Advisor software program (version 5.0, Statistical Solutions, Boston).

An effect size in power analysis is defined as the mean difference divided by the estimated average standard deviation of the two groups. Effect sizes of 0.5 and 0.65 are considered small, and given that no significant differences were detected (all $p>0.05$) with respect to any of the subscales in the first table, one can safely conclude that the groups are essentially comparable. Therefore, the cataract patients included in this study are similar to the Mangione cataract group (Mangione CM, Lee PP, Pitts J, et al. Psychometric properties of the National Eye Institute Visual Function Questionnaire (NEI-VFQ). NEI-VFQ Field Test Investigators. *Arch Ophthalmol*. 1998;116:1496-1504.).

Subscales	Preoperative (n=71)	Postoperative (n=71)	p Value
General health	56 ± 23	58 ± 21	0.43
General vision	57 ± 15	81 ± 16	<0.001
Near vision	69 ± 20	87 ± 20	<0.001
Distance vision	73 ± 22	90 ± 17	<0.001
Driving	67 ± 22	85 ± 17	<0.001
Peripheral vision	32 ± 23	93 ± 18	<0.001
Color vision	95 ± 13	97 ± 8	0.24
Ocular pain	35 ± 19	92 ± 11	<0.001
Vision specific role difficulties	75 ± 25	90 ± 20	<0.001
Dependency	36 ± 24	93 ± 18	<0.01
Social functioning	30 ± 17	97 ± 12	<0.001
Mental health	72 ± 26	88 ± 19	<0.001

Note: Data are presented as mean ± SD. P values are based on paired t-tests.

Subscales	Preoperative (n=71)	Postoperative (n=71)	p Value
General health	65 ± 22	69 ± 19	0.32
General vision	58 ± 16	81 ± 17	<0.001
Near vision	73 ± 19	89 ± 17	<0.001
Distance vision	77 ± 20	92 ± 16	<0.001
Driving	67 ± 22	85 ± 17	<0.001
Peripheral vision	32 ± 23	93 ± 18	<0.001
Color vision	35 ± 13	97 ± 8	0.24
Ocular pain	35 ± 19	92 ± 12	<0.001
Vision-specific role difficulties	78 ± 24	90 ± 18	<0.001
Dependency	35 ± 23	93 ± 18	<0.01
Social functioning	30 ± 16	97 ± 12	<0.001
Mental health	73 ± 26	88 ± 18	<0.001

Note: Data are presented as mean ± SD. P values are based on paired t-tests.

The two tables above indicate the effect of cataract surgery on quality of life using the VFQ-25 and VFQ-39. Both instruments revealed a significant improvement in every subscale except color vision and general health.

The table below compares Mangione's normal population with the postoperative visual functioning of our study group (Mangione CM, Lee PP, Pitts J, et al. Psychometric properties of the National Eye Institute Visual Function Questionnaire (NEI-VFQ). NEI-VFQ Field Test Investigators. *Arch Ophthalmol.* 1998;116:1496-1504.).

Subscales	Mangione Reference (n=122)	Postoperative (n=71)	p Value
General health	69 ± 24	58 ± 21	<0.01
General vision	83 ± 15	31 ± 16	0.38
Near vision	92 ± 15	97 ± 20	<0.05
Distance vision	93 ± 11	90 ± 17	0.14
Driving	87 ± 18	35 ± 17	0.45
Peripheral vision	97 ± 10	93 ± 18	<0.05
Color vision	98 ± 9	97 ± 8	0.24
Ocular pain	90 ± 15	32 ± 11	0.33
Vision-specific difficulties	93 ± 15	90 ± 20	0.21
Dependency	99 ± 5	93 ± 18	<0.001
Social functioning	99 ± 3	97 ± 12	0.08
Mental health	92 ± 12	38 ± 19	0.07

Note: Data are presented as mean ± SD. P values are based on student's t-tests.

We did find differences with respect to certain subscales listed in the table comparing Mangione and colleagues' reference group (n=122) with our postoperative group (n=71). Cataract surgery appears to have restored normal visual functioning in all categories except general health, near vision, peripheral vision and dependency. Power was excellent to detect even small mean differences, as shown in the table (general health, near vision, peripheral vision, dependency). Again, we are referring to small differences of an effect size magnitude of 0.5.

For example, for general health, the mean difference between the two groups was 11 points, and the common or pooled standard deviation was $(24+21)/2$ or approximately 22 points. Hence, the effect size is $11/22=0.5$. Clearly, with sample sizes of 122 and 71, there was sufficient power for detecting "small," but clinically meaningful differences.

Previous results validated

Our study appears to validate, in part, Mangione's VFQ-25 and VFQ-39 inasmuch as cataract surgery resulted in detectable measurable improvement in visual functioning, a finding noted in multiple prior studies. The population studied here was not different from Mangione's cataract population. Most interestingly, cataract surgery restored normal visual functioning in all except two vision-based categories (near vision and peripheral vision). It must be noted that this comparison was between an age group that has undergone cataract surgery with a younger, otherwise healthy population. This may account for these differences as well as the failure to improve general health and dependency.

A secondary outcome of this study was the impact of comanagement on the outcome of surgical intervention for cataract surgery. It was not possible in this study to compare a non-comanaged group with the study population. This will be undertaken in future work. However, given that the intervention performed here restored normal visual functioning in nearly all categories, it is difficult to imagine that greater improvement will be seen in patients who are not comanaged. Therefore, it is a reasonable conclusion that comanagement does not lessen the quality of the outcome after cataract surgery, and in fact seems to result in excellent patient outcomes.

For Your Information:

- Evan B. Dreyer, MD, and James P. Mondzelewski, MD, are staff members at Glaucoma and Cataract Consultants in Pittsburgh and can be reached at Glaucoma-Cataract Consultants, 1050 Bower Hill Rd., Suite 104, Pittsburgh, PA 15243; (412) 572-6121; fax: (412) 571-1327; e-mail: dreyer@fastmail.fm.
- David Zurakowski, PhD, is from the departments of orthopaedic surgery and biostatistics, Children's Hospital, Harvard Medical School, Boston.

ALASKA OPTOMETRIC ASSOCIATION

FACSIMILE TRANSMITTAL SHEET

TO: Representative Wilson **FROM:** Alaska Optometric Association

COMPANY: **DATE:** 2/28/05

FAX: 907-465-3175 **PAGES:** 7

PHONE:

RE: HB 151 - Co-Management Study

COMMENTS:

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QUALITY OF CARE IN CATARACT SURGERY CASES EXPERIENCING POST-OPERATIVE COMPLICATIONS WITH CO-MANAGED CARE

DENNIS A. REVICKI, PH.D.
MARY L. POE, B.S.

ABSTRACT

Background: The quality of co-managed services and the ability of community optometrists to diagnose complications following cataract surgery were investigated in a previous study of 2,458 cases. Questions were raised about the quality of co-managed care in 50 of the cases; this study evaluates the care received by these patients.

Methods: Medical records for 44 cases (6 cases could not be located) were reviewed to determine whether community optometrists diagnosed post-surgical complications and whether cases were effectively managed. All reviews were performed by two optometrists and an ophthalmologist. Six cases were excluded because of no complication or attribution to underlying disease.

Results: In 34 of the 38 remaining cases (89.5%), co-management was successful in diagnosing complications and in managing the patient to maximize vision function. 99.8% (2,454 of 2,458) of co-managed cases contained evidence that the optometrists provided high quality post-operative care and were able to diagnose complications. Using physician evaluations as the standard, the sensitivity of detection of complications by optometrists was 95.9% and the specificity was 99.5%.

Conclusions: Co-managing optometrists provide quality care and can diagnose post-operative complications.

KEY WORDS: Quality of care, co-managed care, cataract surgery, post-operative complications, optometrists

Revicki DA, Poe ML. Quality of care in cataract surgery cases experiencing post-operative complications with co-managed care. *J Am Optom Assoc* 1993; 66(3): 268-73

Cataract surgery is one of the most frequent outpatient procedures performed in the United States. It has been estimated that 1,350,000 cataract surgeries were performed on persons covered by Medicare in 1991 and that \$3.5 billion was expended by Medicare for cataract surgery related services in that year.¹ Given the large number of cataract surgeries performed annually, the quality of care received by patients undergoing these procedures is an important health care issue. In 1993, the Agency for Health Care Policy and Research published clinical practice guidelines for cataract surgery.²

An important development in cataract surgery has been the use of co-managed services during the post-operative period. Co-management allows optometrists and ophthalmologists to coordinate the delivery of services to patients following cataract surgery. In the usual case, a patient is referred by the optometrist to the ophthalmologist when the need for cataract surgery is indicated. The ophthalmologist evaluates the patient and performs the surgery, and the patient is thereafter followed by the ophthalmologist and optometrist. The co-management of post-surgical care is allowed in all states. This expansion of services provided by optometrists has been viewed by some as controversial. Questions have been raised concerning the quality of care delivered by optometrists, with special emphasis on the ability of optometrists to detect and diagnose post-operative problems.^{3,4}

Revicki et al.⁵ examined 2,458 cases involving co-managed care after cataract surgery. The vision outcomes in these cases and the rates of post-operative complication were comparable to those in the published medical literature. In 87% of these cases vision outcomes of 20/40 or better were obtained; for cases with no evidence of pre-existing ocular conditions or chronic medical problems, 92% had successful vision outcomes. For the study, successful outcomes were defined as a visual acuity of 20/40 or better. Post-operative complications occurred in 7% of cases. The rate of complications ranged from 0.04% (for endophthalmitis/hypopyon) to 2.0% (for bullous keratopathy/significant corneal edema), with most rates under 1%.⁶ A recent comprehensive review of outpatient cataract surgery found that the rate of different complications occurring after cataract surgery ranged from 0.1% to 2.4%.⁴

The study by Revicki et al.⁵ noted that the overall accuracy of the assessment of post-operative complications by optometrists was 95.8% (using ophthalmologist examinations as the standard). Community optometrists — practitioners not working directly for the surgical centers — detected complications in 72 of

122 cases in which the complications occurred after the patient was released by the surgeon for follow-up care. For the remaining 50 cases with complications, however, there was uncertainty about the quality of care, given the data collected, and whether the community optometrists detected the complications. This issue is important since failure to identify and effectively manage post-operative complications may result in patient pain and discomfort, vision loss, and blindness.

This study was designed to examine the medical records of the 50 cataract surgery cases in which there was some uncertainty about the quality of co-managed care. The records of co-managing ophthalmologists and optometrists were obtained and reviewed to determine whether the optometrists detected post-operative complications, the pattern and use of co-managed services, the vision outcomes, and whether these cases were effectively managed after surgery.

Methods

DATA SOURCE

This study is an extension of a larger retrospective study of the outcomes of co-managed services in cataract surgery in five ambulatory eye centers in the United States.⁵ In the previous study, data were collected on consecutive cataract surgery procedures with intraocular lens (IOL) implant during the seven month period between January 1 and July 31, 1988. Cataract surgery cases were identified from surgical logs, while data on vision outcomes, post-operative complications, and post-operative services were collected from medical records. Co-managed care was defined as at least one post-operative care visit to a community optometrist within 90 days following cataract surgery.

In the current study, we identified the 50 cases in which post-operative complications occurred and there was uncertainty about the process of co-managed care. These cases represented 2% of the total co-managed cases in the previous study. The ambulatory eye care centers were contacted and, for each case, we requested the complete pre-operative evaluation records and all notes and records describing post-operative medical services provided by the ambulatory eye care center. In addition, we contacted the community optometrists and requested copies of all records on post-operative services delivered for the 120 days after cataract surgery. In 6 cases full sets of records could not be obtained. This study is based on the 44 (88%) cases in which optometrist and center records could be located.

DATA COLLECTION PROCEDURES

Data on demographic characteristics, pre-existing ocular

and medical conditions, and the surgical procedure used for cataract extraction were obtained from the original study data files. Forms were developed to collect data on all post-operative services, post-operative complications, and visual acuity outcome measurements for the 120 days after the surgery. A trained research nurse abstracted information from eye care center and community optometrist records using this standardized data collection form.

DEMOGRAPHIC & MEDICAL CHARACTERISTICS

Age (in years) and gender of patients was recorded. Data were collected on the presence of pre-existing ocular conditions (i.e., glaucoma, diabetic retinopathy, macular degeneration, corneal guttata/Fuch's dystrophy) that could be related to visual acuity outcome.⁷ Data were also gathered on the presence of several chronic medical conditions (i.e., cardiovascular disease, diabetes mellitus, renal disease, pulmonary disease) as indicators of general health status. Co-morbidity, when combined with age, preoperative visual acuity, and frequency of reading, has been demonstrated to predict surgical success in cataract patients.^{2,8}

CATARACT SURGERY PROCEDURE

Information was collected on the method of lens extraction used, the eye operated on, and the date of surgery.

POST-OPERATIVE MANAGEMENT

The date, eye care provider and main actions for each visit within 120 days of surgery were collected for each eye included in the study. The provider of services was either the practitioner at the ambulatory eye care center or the community optometrist. Actions taken by practitioners included referral to the center, telephone consultation with the center ophthalmologist, further diagnostic evaluations, and scheduling of a follow-up visit.

VISUAL ACUITY MEASUREMENTS

Pre- and post-operative visual acuity measurements were recorded for all cases. For the majority of these patients, potential acuity meter and super pinhole test results were recorded. The corrected visual acuity for each post-operative visit during the 120 days following cataract surgery was abstracted from the records. Successful vision improvement was defined as a visual acuity of 20/40 or better.^{2,6}

POST-OPERATIVE COMPLICATIONS

There are a number of complications which may follow cataract surgery; some are temporary and do not result in

impaired vision, some cause discomfort with little long-term vision effects, while others are serious and may result in decreased vision.²⁴ Complications, notably corneal edema and hemorrhage in the anterior chamber, frequently occur immediately following surgery but resolve spontaneously. Persistence of these conditions, however, may indicate a serious problem. The medical records were examined to identify the onset of complications which may result in poor visual acuity outcomes. The complications included were:

- endophthalmitis/hypopyon
- chronic uveitis
- bullous keratopathy/significant corneal edema
- secondary glaucoma
- wound rupture (e.g., iris prolapse)
- pupillary block
- detached retina
- cystoid macular edema
- lens dislocation

Data on posterior capsule opacification or secondary capsulotomy were also collected. For this study, if a complication occurred at any time within 120 days of surgery, it was recorded as present. Complications were recorded as present if there was clear evidence of the complication in provider notes or in test results contained in the medical record.

QUALITY OF CARE REVIEWS

An ophthalmologist and two optometrists who were not part of the original study but who were experienced in conducting quality of care reviews of community optometrists and of ambulatory eye care center medical records were recruited to evaluate each case. The reviewers were asked to evaluate whether the community optometrist recorded signs and symptoms of the post-operative complication; how accurately the optometrist assessed the complication; and the overall quality of post-operative care delivered to the patient. The overall quality of care was scored on a five-point scale ranging from outstanding (1) to poor (5).

After the three practitioners completed their independent reviews, a telephone conference call was scheduled to reach consensus on all ratings. During this meeting the discussion continued until consensus was reached. However, consensus was not required for the overall rating of the quality of co-managed care.

DATA ANALYSIS

Descriptive statistics (e.g., means, standard deviations, frequency distributions) were calculated for all study variables. Comparisons were made between the cases under study and the complete study with respect to vision outcomes and service utilization. We examined the

pattern and content of visits to center providers and community optometrists. Best visual acuity outcomes within 120 days of cataract surgery were determined, with 20/40 acuity or better being used to define success. Sensitivity and specificity of the detection of post-operative complications by community optometrists were calculated, using the 1,322 cases from the complete study in which there were ophthalmologist evaluations following management by an optometrist. Physician evaluations were used as the standard for the sensitivity and specificity calculations.⁸

Results

Ambulatory eye care center and community optometrist records were located for 44 of the 50 cases (88%). The 6 cases that could not be located did not differ from the 44 that were located in terms of demographic and medical characteristics.

Descriptive information on the 44 cases is summarized on Table 1. The average age of each patient was 74.9 years (SD = 8.1); 61% of patients were women. Cataract surgery was performed on both eyes in 11% of cases during the 7 month study; 89% of the cataract surgeries involved phacoemulsification while the remaining 11% were extracapsular procedures. In 82% of the cases there was a pre-existing ocular or chronic medical condition. Compared to the total group of co-managed cases, these patients were slightly older and more likely to have one or more pre-existing ocular conditions (Table 1).

POST-OPERATIVE COMPLICATIONS

The reviewers identified 2 cases in which no post-operative complication occurred, 2 cases in which the complication occurred but was due to a pre-existing medical condition, and 2 cases in which the complication occurred outside of the 120 day evaluation period. Signs and symptoms of macular degeneration in one case and of diabetic retinopathy in another case were thought to be secondary to pre-existing medical conditions and thus did not constitute post-operative complications. In one case, conjunctivitis was diagnosed 5 months after the surgery, while in another symptoms of uveitis were noted 6 months after the surgery; both complications occurred well after the 120 day evaluation period. Thus 6 cases were excluded from further evaluation in the study.

The post-operative complications observed in the 38 remaining cases included cystoid macular edema (39.5%), chronic uveitis or iritis (15.8%), and bullous keratopathy or significant corneal edema (10.5%). Increased intraocular pressure was observed in 7 cases (18.4%). Lens dislocation occurred in one case and wound ruptures occurred in 6

cases (15.8%). Posterior capsule opacification occurred in 34.2% of these cases.

CO-MANAGED POST-OPERATIVE CARE

Review of the surgical center and community optometrist records indicated that 34 of the 38 cases (89.5%) were successfully managed (Table 2). Center providers diagnosed 41.1% of the complications and community optometrists diagnosed 57.9%. In 12 of these cases (31.6%), the center providers noted a post-operative complication before returning the patient to the optometrist's care. The community optometrist diagnosed or noted a problem in 19 of the 26 remaining cases. In 3 of these 26 cases, the medical records contained evidence of either telephone consultation, referral to the ambulatory eye care center, or both, for management of complications.

Thus, there were 4 cases out of the total of 2,458 (0.16%) in which the evidence suggested that the community optometrist may not have detected a complication which was later diagnosed by a center provider. In 2 cases, the post-operative complications (secondary glaucoma and cystoid macular edema) were diagnosed a month after the last visit to the optometrist. In the 2 other cases bilateral uveitis (which was considered to constitute 2 cases) was diagnosed by center providers in a bilateral

pseudophakic patient one week after a follow-up visit to a community optometrist. There is some indication, however, based on telephone conversations, that the patient was sent to the surgical center for care after the community optometrist suspected a complication.

The post-operative problems diagnosed by center providers after a one month interval were most likely not present when the optometrist last evaluated the patient. If this is a reasonable assumption, then in only 0.08% (2 of 2,458) cases is there any question about the accurate detection of post-operative complications by community optometrists following cataract surgery. Therefore, in 29 of the 38 cases the community optometrists noted the signs and symptoms of the post-operative complication.

QUALITY OF CARE REVIEW

The reviewers determined that in 92% of the cases the quality of care was judged as average or better; in 68% of cases the care was rated as good or outstanding.

SENSITIVITY AND SPECIFICITY OF DIAGNOSES

There were 1,316 cases in which an ophthalmologist examined the eye after management by a community optometrist.

Using ophthalmologist examinations as the standard, the sensitivity of the diagnosis of complications by community optometrists was 95.9%; the specificity was 99.5%. The positive predictive value was 94.0% and the negative predictive value was 99.7%. The overall accuracy of the assessment of post-operative complications by optometrists was 99.2%.

POST-OPERATIVE SERVICE USE

The average number of post-operative visits was 5.88 (SD = 2.13; range, 3 to 14 visits) for these 38 cases compared to an average of 4.73 (SD = 1.64) visits for cases without complications and 6.23 (SD = 2.05) visits for all cases with complications. Eighty-two percent of the 38 cases had five or more post-operative visits. There was an average of 2.88 (SD = 2.11) center visits and 3.00 (SD = 1.41) optometrist visits for these 38 cases. Optometrists provided all medical care as indicated for all patients. Scheduled follow-up appointments were noted for 86.8% of the visits.

VISION OUTCOMES

Eighty-four percent of the 38 cases had a

Table 1. DEMOGRAPHIC AND MEDICAL CHARACTERISTICS OF TARGET AND TOTAL CO-MANAGED CASES

	Target Cases	Co-Managed Cases
Patients		
Number	44	2,034
Mean age (standard deviation)	74.9 (8.1)	72.9 (10.4)
Women (%)	61.4	62.5
Eyes		
Number	44	2,408
Pre-Existing Ocular Conditions (%)		
Glaucoma	9.1%	5.4%
Diabetic retinopathy	0.0%	2.6%
Macular degeneration	18.2%	13.1%
Corneal guttata	9.1%	6.1%
Pre-Existing Medical Conditions (%)		
Diabetes mellitus	11.4%	16.6%
Cardiovascular disease	63.6%	55.9%
Renal disease	2.3%	3.5%
Pulmonary disease	9.1%	9.6%

final visual acuity of 20/40 or better within 120 days of cataract surgery. This vision outcome compares with 87% for cases not experiencing post-operative complications and 71% for those patients with post-operative complications from the previous study.⁵

Discussion

This study evaluated the quality of co-managed care in 44 cases derived from a large retrospective study of 2,458 post-surgical cases. In these 44 cases there was some uncertainty about the quality of care provided by optometrists. After careful review it was determined that 6 of the 44 cases did not contain evidence of valid post-operative complications. The findings of this study indicate that for 95% of the remaining 38 cases, co-management was successful in detecting complications and in properly managing the patients so as to maximize vision function. Eighty-four percent of the cases had successful vision outcomes.

There were only 4 cases in which there was some uncertainty about whether the community optometrist correctly detected or suspected a post-operative complication. In 2 of these cases, the complication was diagnosed by center providers one month after the patient's last visit to the optometrist. It is possible that at the time of the optometrist's evaluation, no signs or symptoms of the complication were present. For the remaining 2 cases (involving one patient), there was some evidence that the

patient was sent to the eye care center for further diagnostic evaluation and treatment of suspected uveitis, but the records of the optometrist did not clearly document this action. Based on these data and data from the larger study,⁹ 99.8% (2,454 of 2,458) of cases evaluated contained evidence that the providers involved in co-management provided quality post-operative care.

The overall accuracy of the diagnosis of post-cataract surgery complications by optometrists was 99.2%, with a specificity of 99.5% and a sensitivity of 95.9%. These data suggest that community optometrists can and do diagnose complications with satisfactory accuracy when they occur in patients following cataract surgery.

When a complication was identified or suspected, follow-up visits were scheduled or the patient was referred to the eye care center for diagnostic evaluation and treatment. There was also evidence that co-managing optometrists made telephone contact with the center ophthalmologist to discuss the condition of the patient's eyes. There was also documentation in many of the eye care center records, including copies of letters, concerning the information supplied by the center providers to the community optometrists about the condition of patients and scheduled follow-up evaluations.

There were some caveats which should be taken into account when interpreting the results of this study. First, we could locate both eye center and community optometrist records for only 44 of 50 cases (88%). This percentage is comparable to the percentages reported in other studies using hospital or medical records.¹⁰ Although the

remaining 6 cases might contain information which documents poor quality co-managed care, there are no differences between the demographic characteristics of these 6 cases and the 44 cases that were used for the study. Even if all the missing cases contained evidence of poor quality co-managed care (a highly unlikely circumstance), 99.6% of the total number of cases (2,448 of 2,458) would still suggest that quality care was rendered.

Second, the data for this study came from a retrospective review of community optometrist and ambulatory eye care center records. Problems associated with retrospective data collection from medical records (e.g., missing or incomplete data, unstandardized measurements) are shared by this research. The records used for this study were not collected for research purposes and therefore may incompletely describe the actual delivery of post-operative services.

In summary, the findings suggest

Table 2. SUMMARY OF CLASSIFICATION OF CO-MANAGED CATARACT SURGERY CASES FROM TARGET SAMPLE AND TOTAL SAMPLE

	Target Sample n (%)	Total Sample n (%)
Number of Cases	50 (100%)	2,458 (100%)
Status of Cases		
No complications	6 (12.0%)	2,294 (93.3%)
Complications	38 (76.0%)	164 (6.7%)
Unknown status	6 (12.0%)	6 (0.25)
Total cases	50 (100.0%)	2,458 (100.0%)
Cases with complications ¹⁰	38 (100.0%)	164 (100.0%)
Physician diagnosed before co-management	12 (31.6%)	60 (36.6%)
Optometrist diagnosed or suspected	22 (57.9%)	94 (57.3%)
Not diagnosed by optometrist	4 (10.5%)	4 (2.4%)
Total cases	38 (100.0%)	164 (100.0%)

that community optometrists participating in the co-managed post-operative follow-up of cataract surgery cases delivered high quality services. They were able to detect post-operative complications in 99% of cases. More importantly, successful vision outcomes were achieved in 84% of cases in which there were post-operative complications, a result which is comparable to other studies of vision outcomes in cataract surgery.^{1,2,4,7}

Prospective studies with random assignment and systematic and blinded outcome assessment are needed to document whether co-managed care produces vision outcomes and complication rates comparable to those attained by ophthalmologist managed post-cataract surgical care. The findings of this study suggest, however, that optometrists participating in co-management can detect complications and deliver quality post-operative care to cataract surgery patients.

Acknowledgments

This study was made possible by a grant from the American Optometric Association.

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Submitted 11/94; Accepted 3/95

From the Battelle Centers for Public Health Research and Evaluation, Arlington, VA and the Department of Health Policy and Administration, University of North Carolina, Chapel Hill, NC.

From: John Demske [mailto:johndemske@hotmail.com]
Sent: Sunday, February 27, 2005 11:20 AM
To: Rep. Peggy Willson
Cc: Rep. Kurt Olson; Rep. Mike Chenault
Subject: HB 151

Hello Representatives Wilson, Chenault and Olson,

I'm writing regarding HB 151, which is presently in the House HESS committee.

If this bill was in the court system, it would be thrown out as a frivolous lawsuit.

It is nothing more than a vendetta against Bob Ford, an excellent surgeon who resides in the state of Washington and does cataract surgery in Alaska. And the well-heeled Alaska surgeons who introduced this bill saw their piece of the pie get a little smaller. His fees are also lower than any of the eye surgeons in Alaska.

Just this morning while reading journals, I read an article written by two private ophthalmologists from Pittsburgh and a Ph.D. researcher from Harvard Medical School. Their conclusion: **"Therefore, it is a reasonable conclusion that comanagement does not lessen the quality of the outcome after cataract surgery, and in fact seems to result in excellent patient outcomes."**

And yes, I refer patients to Dr. Ford routinely. I asked my mother to travel to Alaska from Wisconsin so he could do her cataract surgery. There are patients who would rather travel from Homer, Kenai & Soldotna to Anchorage to see Dr. Ford than see one of the Peninsula surgeons.

It's my humble opinion that this bill is nothing more than an attempt by a bunch of surgeons to increase their piece of the pie.

Respectfully,

John A. Demske, O. D.

Soldotna Optometry Clinic
155 Smith Way, Suite 202
Soldotna, Alaska
99669

CC: Representative Mike Chenault, Representative Kurt Olson

Alaska Society of Eye Physicians & Surgeons
6100 Kalmia Drive
Anchorage, Alaska 99507
907-563-8526

2/27/05

State House of Representatives
House Health Education & Social Services Committee:

Dear Representative

Spain Wilson

I am writing this letter to express the support of the Alaska Society of Eye Physicians & Surgeons for HB 151. The American Academy of Ophthalmology, the national association of ophthalmologists, also endorses HB 151. HB 151 would establish necessary guidelines in Alaskan state law for provider responsibility for ocular post-operative care. The bill is intended to close a loophole in the existing law that allows for potential abuses of co-management arrangements between providers due to incentives not related to the care of the patient.

The scope of this bill is thoughtfully limited to ocular post-operative care. Ocular care is one of the rare areas in medicine where non-physicians inappropriately perform post-operative care. Specifically, this bill would prevent itinerant surgeons from allowing non-medical personnel to provide inappropriate post-operative care after eye surgery.

It makes common sense. The operating surgeon, a medical doctor or doctor of osteopathy, should examine patients for infections, other diseases, and complications that might occur in the post-operative period following surgery in order to prevent potential loss of vision. However, irresponsible delegation of post-operative care to an optometrist, who can neither accurately diagnose nor treat complication and emergencies, is a gamble that no patient should have to face.

This legislation would have no fiscal impact to consumers or to health care costs. In fact, patients would receive better and safer treatment at no additional costs.

BRIEFING: HB 151

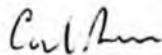
HB 151 would establish necessary guidelines in Alaskan state law for provider responsibility for ocular post-operative care. The bill is intended to close a loophole in the existing law that allows for potential abuses of co-management arrangements between providers due to incentives not related to the care of the patient.

- HB 151 takes into account the unique challenges of performing eye surgery in Alaska.
- HB 151 does not prohibit legitimate co-management of surgical patients and would have no effect on responsible surgical practices in Alaska.

- HB 151 is consistent with the principles of the Joint Position Paper of the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgeons on Ophthalmic Post-operative care.
- ***HB 151 provides that unless a surgeon enters into a written co-management agreement with the patient, the bill requires a surgeon to be physically available to the patient for post-operative care in the community in which the operation was performed for 120 hours after surgery.***
- **HB 151 PERMITS CO-MANAGEMENT IF:**
 - The distance that patient would have to travel to the regular office of the operating surgeon would result in an unreasonable hardship for the patient, as determined by the patient;
 - The surgeon will not be available for post-operative care as a result of the surgeon's personal travel, illness, travel to an area of the state for occasional practice of medicine, or travel to an area of a state designated as a physician shortage area; or
 - Other justifiable circumstances exist, as determined by the Alaska State Medical Board.
- ***HB 151 PROTECTS BOTH PATIENTS AND THE OPERATING SURGEON*** by prohibiting co-management arrangements:
 - In which a fee is paid to the person to whom the care is delegated that does not reflect the fair market value of the services performed by that person;
 - That are entered into as a matter of routine and not on a case-by-case basis;
 - That are not clinically appropriate for the patient;
 - That is made with the intent to induce surgical referrals;
 - That is based on economic considerations affecting the surgeon.
- **HB 151 CONTAINS EXTRA FLEXIBILITY** for both the patient and the operating surgeon by allowing the surgeon to delegate post-operative care of a patient without a written co-management agreement because of unanticipated circumstances that were reasonable foreseeable before the surgery was performed.

Please feel free to call me at anytime at 907-563-8526 if you have any additional questions.

Cordially,



Carl Rosen, M.D.

President

Alaska Society of Eye Physicians & Surgeons

6100 Kalmia Drive

Anchorage, Alaska 99507

907-563-8526

cc: All members of the House HESS Committee

From: Aharon Sternberg [aharonsternberg@yahoo.com]

Sent: Tuesday, March 08, 2005 10:27 AM

To: Rep. Peggy Wilson; Rep. Tom Anderson; Representative_Paul_Seeaton@legis.state.ak.us;
Representative_Lesil_McGuire-@legis.state.ak.us; Rep. Sharon Cissna; Rep. Vic Kohring; Rep. Berta
Gardner

Dear Members of the Hess Committee -

Last year I finished serving 8 years on the Alaska Board of Examiners in Optometry. I would like to comment on HB 151 which is up for hearing today.

I'm sure you have heard enough about the merit of the Bill, the reasons to table it, pass it etc. In my opinion, regardless of the merits of the Bill - if there are any, **THIS KIND OF BILL/REGULATIONS SHOULD BE A PART OF THE MEDICAL BOARD AND ITS REGULATIONS** rather than being part of a state statues. It seems that this bill is a **SPECIAL PRIVATE BILL** introduced to limit a competition in only one are of medicine. Why not do the same to the Neurosurgeons, Urologists or any other specialty?

I'm personally not aware of any problems with the status quo and I don't see any problem that has to be fixed.

I'm glad that this Bill is scheduled with the L&C com. so anti trust and anti consumer aspects of this Bill can be discussed.

Thank you for your considerations, Aharon Sternberg, O.D.,F.A.A.O.

p.s. I have been practicing in Alaska since 1976 and have always been a part of Ophthalmic Associates which includes my self and 5 Ophthalmologists.

Do You Yahoo!?

Tired of spam? Yahoo! Mail has the best spam protection around
<http://mail.yahoo.com>

From: tim mclaughlin [tbmclaughlin@yahoo.com]
Sent: Tuesday, March 08, 2005 9:18 AM
To: Rep. Peggy Wilson; Rep. Tom Anderson; Rep. Vic Kohring; Rep. Lesil McGuire; Rep. Sharon Cissna; Rep. Berta Gardner
Subject: HB151

Dear Representative Lynn,

As a lifelong Alaskan and an Optometric Physician currently practicing in Alaska, as I have for the past 30 years, I ask for your support to strongly OPPOSE HB151. This is an example of the worst type of legislation narrowly focused to promote the self interest of a small group at the disservice to a large population of Alaskans who have been well cared for and have enjoyed their options to experience this choice for their ocular care. Throughout the history of Alaska and its rural population, surgeons have practiced successfully in similar settings in all branches of health care without complications or having to restrict services of the surgeon to satisfy the anti-competitive wishes of a small self interest group. Please review this legislation and see it as not an advancement to benefit the Alaskan but as a poor attempt to limit competition for services that have successfully treated thousands of patients without complication.

Thanking you in advance for your opposition on this most important subject.

Tim McLaughlin O.D.

Celebrate Yahoo!'s 10th Birthday!

Yahoo! Netrospective: 100 Moments of the Web <http://birthday.yahoo.com/netrospective/>

ALASKA OPTOMETRIC ASSOCIATION

FACSIMILE TRANSMITTAL SHEET

TO: Representative Wilson **FROM:** Alaska Optometric Association

COMPANY: **DATE:** 3/7/05

FAX: 907-465-3175 **PAGES:** 2

PHONE: _____

RE: American Optometric Association Co-Management Fact Sheet

COMMENTS:

CONFIDENTIALITY NOTICE-

The information contained in this FAX is confidential and intended only for the designated recipient. If you receive this transmission in error you are hereby notified that review, dissemination, distribution or copying of this information is prohibited.

**Legislation Seeking to Restrict or Prohibit Co-Management of Surgical Patients by
Ophthalmologists and Optometrists**

- The Office of the Inspector General (OIG) of the United States has established guidelines for appropriate co-management of surgical patients under the Medicare program by optometrists and ophthalmologists. The OIG has no plans at this time to reevaluate these guidelines.
- The American Optometric Association (AOA) has adopted a formal policy on co-management strictly following the Federal guidelines.
- Because there are already sufficient Federal guidelines regarding what constitutes appropriate co-management of ophthalmic surgical patients, there is no need to address this issue further in state law. Efforts to go beyond the Federal guidelines are anti-consumer in nature and are aimed at driving up healthcare costs.
- Co-management of surgical patients by optometrists and ophthalmologists is permitted in every state.
- In general, legislation proposing to restrict or further define parameters for the co-management of ophthalmic surgical patients is not supported by the rank and file member of the state ophthalmologic societies. Optometrists and ophthalmologists have historically had good professional working relationships.
- In Nevada the optometric association enacted legislation in 2001 establishing similar parameters for ophthalmic co-management of surgical patients as are provided for by the OIG, in fact making the legislation unnecessary, but the Association elected to pass such a law anyway. If the OIG were ever to revise any of the guidelines, the Nevada legislature would most likely have to go back and change the law to bring it into compliance with Federal policy – a poor use of the legislatures' time and energy – when in fact the Federal policy alone suffices in this area.
- The vast majority of primary eye care examinations are provided annually by optometrists. It follows that the main source of referrals to ophthalmologists for surgical services is from optometrists. And, in fact, it could easily be viewed that ophthalmologists are actually the ones co-managing the optometrist's patients, and not the other way around.
- In today's healthcare delivery system primary healthcare professionals such as internists, family practice doctors, general dentists, and optometrists often refer their long-time patients to many different types of specialists for care when warranted and based on the needs of each patient. At the appropriate time in the course of such care, the patients are sent back to the primary care provider for continued care. This is often the most efficient and cost-effective care for the patient, as well as the best clinical option.

Last Revised January 15, 2004

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 4, 2005

House Health Education and Social Services Committee Members
Alaska State Legislature
State Capitol
Juneau, AK 99801

Re: HB 151 - Ocular Postoperative Care

Dear House Health Education and Social Services Committee Members:

Chair Percy Wilson:

The Alaska State Medical Association (ASMA) represents physicians from across the State and is primarily concerned with the health of all Alaskans.

ASMA is writing in support of HB 151. Appropriate postoperative care following ocular surgery by an "EYE MD", an ophthalmologist, is imperative for good patient care.

Today's technology makes many surgical procedures, including ocular surgeries, appear to be routine. Most often, such surgeries have a high rate of success. So high, the public loses sight of the seriousness of the surgery and the complications that might occur.

HB 151 provides for appropriate ocular postoperative care by the appropriate professional. ASMA supports HB 151 and urges you to do so as well.

Sincerely,

Paul Worrell, MD

By: Paul Worrell, MD President
For: The Alaska State Medical Association

Members HESS Committee
House of Representatives
State of Alaska

28 February 2005

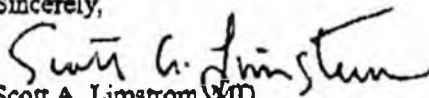
Dear Sirs:

I am writing in support of HB 151. I have been a practicing eye surgeon in the state of Alaska for over eight years. I am also one of two retinal surgeons practicing in Alaska. As a retinal specialist I treat disorders of the retina and vitreous, such as retinal detachment, vitreous hemorrhage, severe eye trauma, infections, and complications from eye surgery.

Many of our patients come from outlying areas, making appropriate follow-up of post-surgical patients a difficult task. In general, we keep patients in Anchorage until stable, before allowing them to return to their home. Many times patients will be required to stay for 1 to 2 weeks before they are stable enough to return to home. Serious complications requiring further surgery can arise in this critical post-operative period. The average time for a sight-threatening infection to occur after uncomplicated cataract surgery is 5 days post-operatively. Endophthalmitis, or infection of the inside of the eye occurring after eye surgery, is an absolute emergency requiring surgical vitreous biopsy and injection of antibiotics into the eye. It is the responsibility of the surgeon to manage the patient in this critical post-operative period. If for some reason the surgeon is not available, he or she must refer the patient to another surgeon who can manage a post-operative emergency.

In Ophthalmology, patients from outlying areas may be left in the hands of an Optometrist, an eye care provider who is not a surgeon, for some of their post-operative care. This arrangement is called "co-management" of the patient's care. I occasionally rely upon many of my Optometric colleagues to help manage patients from outlying areas. I do not release the patient to be followed by the Optometrist until they are out of the critical post-operative period where complications can still occur. Myself, or my partner are always available thereafter, 24 hours per day 7 days per week, should the patient develop further problems. HB 151 simply defines the critical post-operative period during which a surgeon must be available to provide care for his or her patient. In Alaska it is sometimes necessary for patients from outlying areas to receive care in a co-management type of arrangement, such as exists between Ophthalmologists and Optometrists. It is imperative the management of the patient be done in an ethical manner and not endanger the patient in any way.

Sincerely,


Scott A. Limstrom, MD
3500 LaTouche, Suite 250
Anchorage, Alaska 99508
(907)561-1530



American Academy of Ophthalmology

1101 Vermont Ave. NW, Suite 700, Washington DC 20005 (202) 737-6662

Comanagement of Surgical Patients

Introduction

Why Is It In The News

Facts & Statistics

Conclusions

References

Introduction

Comanagement occurs when a surgical patient receives surgical care from one physician and postoperative care from another healthcare provider. This type of arrangement most commonly occurs with cataract and refractive surgery.

Why Is It In The News?

The American Academy of Ophthalmology and the American Society of Refractive & Cataract Surgery have issued voluntary guidelines for physicians considering comanaging patients.

Legislation to limit comanagement was introduced in Florida and Missouri in 2001.

Facts & Statistics

American Medical Association and American College of Surgeons guidelines disapprove of comanagement arrangements that exist if economic considerations drive the arrangement.^{1,2}

The Office of the Inspector General of the Dept. of Health and Human Services has expressed concern about comanagement based on economic considerations rather than clinical appropriateness and has refused to provide safe harbor protections (from anti-kickback regulations) for such arrangements, preferring to review cases on an individual basis.

In 2000, the American Academy of Ophthalmology and the American Society of Cataract & Refractive Surgery issued voluntary guidelines for surgeons engaging in comanagement arrangements. Key provisions of the guidelines state:

a.. The surgeon has primary responsibility for preoperative assessment and postoperative care for patients, regardless of the type of surgery.

b.. Comanagement of patients is ethical and appropriate in some circumstances, such as:

The surgeon is unavailable to provide postoperative care (due to travel, illness, leave, itinerant surgery in a rural area or surgery performed in a designated physician shortage area.)

The patient cannot travel to the surgeon's office because of distance or the development of another illness.

a.. When comanagement is practiced for economic reasons (specifically as an inducement for surgical referrals) or is the result of coercion by the referring practitioner, it is unethical, and in many jurisdictions, illegal.

b.. The surgeon, prior to surgery, must inform the patient if there are any prearranged postoperative management plans, and the patient must voluntarily consent to this in writing. This consent process, which should be documented in the medical record, should include the reason for the transfer of care, the qualifications of the health care provider who will render the postoperative care and any special risks that may result from this arrangement.

If an unanticipated transfer of postoperative care is required, the patient should be informed and this information documented in the medical record.

a.. The surgeon should inform the patient of the financial implications resulting from the comanagement arrangement, particularly with regard to the patient's payment obligations and the postoperative provider's reimbursement.

b.. The transfer of care must not occur unless it is clinically appropriate and in the patient's best interest.

c.. The surgeon should confirm that the comanager is legally entitled and professionally trained to provide the particular services.

d.. The comanagement must not be done as a matter of routine policy on all patients.

e.. The surgeon should follow the patient until postoperatively stable, and there is no fixed time when the patient is sent back to the referring provider.

f.. The patient should be reassured that he/she has access to the surgeon, if necessary, during the postoperative period at no additional cost. (If a Medicare/Medicaid patient returns to the surgeon, both the surgeon and postoperative care provider must file a corrected claim.)

g.. Any fees must reflect an appropriate fair market value for the services performed.

Conclusions

Quality medical care can only be achieved when the welfare of the patient is placed above all other considerations. Patients' interests must never be compromised as a result of comanagement.

References

1.. American Medical Association. Ethical Opinion 8.043: Ethical Implications of Surgical Co-Management. Chicago: American Medical Association; 2000.

2.. American College of Surgeons. [ST-25] Statement on Principles Underlying Perioperative Responsibility. Bulletin of the American College of Surgeons 1996; 81 (9):39.

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March 15, 2005

The Honorable Peggy Wilson
Chair, Health, Education, and Social Services Committee
Alaska State Capitol
Juneau, Alaska 99801-1182

Suite 700
1101 Vermont Avenue, NW
Washington, DC 20005-3570

Tel. 202.737.6662
Fax 202.737.7061
http://www.aao.org

Dear Chair Wilson:

I would like to compliment the House Health, Education and Social Services Committee for the time the Committee members have taken to review HB 151. HB 151 addresses a particular problem unique to surgical eye care. As you are aware, co-management is the sharing of postoperative responsibilities between the operating surgeon and another health care provider. In theory, this arrangement is to be entered into only in cases when it is in the best interests of the patient, for example, when it is too far for the patient to safely travel. If this were the only kind of co-management around, we would not require corrective legislation. In practice, there is abuse, and there are times when this behavior is unethical.

In the interest of patient safety, the enactment of HB 151 will eliminate the pressure between surgeons and allied health professionals to enter into such agreements that are not in the best interest of patient quality of care. This bill would eliminate the unethical behavior by carefully regulating when post-operative co-management is appropriate and is in the patient's best interest.

The Committee had specifically asked for information as to the possible complications that can occur in the immediate post-operative period. Below, I have listed several of the most common complications that can occur:

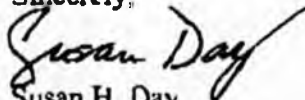
COMMON SURGICAL COMPLICATIONS IN THE IMMEDIATE POST-OPERATIVE PERIOD (48 hours) AFTER EYE SURGERY

- Hyphema (bleeding within the eye)
- Flat chamber (anterior part of the eye collapses)
- Iris incarceration (Iris stuck in the wound)
- Choroidals (blood between the retina and sclera, causes flat anterior chamber.)
- Wound Infection
- Elevated Eye Pressure

The enactment of HB 151 will ensure that patients have access to a surgeon within the 48 hour window in which the above complications from eye surgery could occur.

HB 151 does not ban co-management of patients, but it ensures that such arrangements are truly in the best interests of patients. It recognizes unique challenges of delivering health care services to the citizens of Alaska. In addition, the bill permits flexibility in cases of emergencies and unexpected circumstances. HB 151 is a patient-friendly bill, and I urge the committee's support of this important patient care legislation.

Sincerely,


Susan H. Day
President

Katie Shows

From: Rep. Paul Seaton
Sent: Thursday, March 10, 2005 3:05 PM
To: Katie Shows
Subject: FW: HB 151

Ian Laing
Rep. Paul Seaton
Legislative Staff
(907) 465-2689

-----Original Message-----

From: homereye@xyz.net [mailto:homereye@xyz.net]
Sent: Thursday, March 10, 2005 1:38 PM
To: Rep. Paul Seaton
Subject: HB 151

Subject: HB 151

Dear Representative Seaton:

I would like to bring to your attention the following points regarding HB 151 and the hearing on Tuesday.

1. The proponents of this bill (ophthalmologists) made this sound as if the bill was to control the actions of surgeons. Obviously, no group asks the government to control their actions---especially surgeons. The thrust of this bill is to limit optometry, NOT ophthalmology. Certainly, they would like to limit one ophthalmologist so throwing in the 120 hour limitation will hurt him, but everyone else in the state is really unaffected by that in that they can say their partner or friend is covering for them. All of the conditions placed upon comanagement and the required paperwork are simply there to discourage optometric involvement. If this bill were really to control surgeons, it would contain only one sentence: "All eye surgeons will remain available to their patients for a period of 120 hours after surgery, either in person or by delegation of that responsibility to another qualified eye surgeon".

2. I may not have made myself clear on this item. I hear the ophthalmologists saying that optometrists are receiving payment just for the act of referring a patient. That is NOT the case. Yes, optometrists are paid for the services they render (as are the ophthalmologists if they do the post operative care) and that payment is determined by insurance carriers and Medicare. It is not a kickback for making the referral.

3. The medical board has the power to control the actions of all physicians, whether they choose to do it is up to them. If they choose not to perform their duty as a regulatory body for medicine, why should the legislature do it for them? If this were really a quality of care or safety issue, one would expect the medical board would be obligated to act.

4. The ophthalmologists try very hard to make everyone think that because they are M.D.s (medical doctors) that they are the only providers of "medical care". Obviously, Rep. Wilson does not even realize that optometrists do have a Dr. in front of their name after eight years of training, but none of the ophthalmologists was addressed as Mr. There are numerous doctors that have both M.D. and O.D. degrees, who certainly understand the training of both disciplines. Would the testimony of one of these individuals be of benefit in disclosing to the HESS committee just how ophthalmology is trying to mislead you?

5. Neither of the two ophthalmologists who testified are cataract surgeons. The case described by Dr. Rosen in his testimony was not even a postoperative complication. The

patient had LASIK surgery almost three weeks before the incident, and he was struck in the eye while chipping ice. Dr. Rosen also failed to disclose that the surgeon who lives in Seattle cancelled his patients and flew to Anchorage just to treat this patient (without charge to the patient). Certainly, he is not the ruthless surgeon that the Anchorage ophthalmologists make him out to be. Furthermore, I have not yet been able to identify a single case where a postoperative patient has gone to any Anchorage emergency room for care for a postoperative complication. There is a lot of smoke and mirrors hiding the real motivation of this proposed legislation.

6. You may be aware of this, however, it is worth noting that all health care providers EXCEPT medical doctors are considered limited license practitioners. That is to say that the scope of practice is limited by laws and regulations placed upon them by the legislative body. In the case of optometry, we are presently limited to the use of drugs that are administered through a topical delivery system as opposed to a systemic medication. Most other states allow the use of systemic drugs that are rational to the treatment of eye disease IF the practitioner has the training and has passed the national board examination pertaining to the use of same. You probably have seen the present HB relating to this issue. The point of all this being that medical doctors do not need to ask the legislature for anything. They have unlimited privilege to perform any medical procedure or prescribe any drug, whether that procedure or drug even existed when they underwent training. Therefore, fo!

r a piece of legislation to further limit the license of an optometrist without any evidence of a public safety issue (or any other valid reason) serves only to reduce competition in favor of the ophthalmologist.

7. Are all of these hearings skewed toward the proponents of a bill? I was told that I had 3 minutes to present my views and then Dr. Coulter was given unlimited time to testify and respond to questions.

I would like to discuss this bill with you prior to the next committee meeting if that would be possible.

Sincerely,
Byd L. Walker, O.D.



Southern California College of Optometry

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
2575 YORBA LINDA BOULEVARD
FULLERTON, CALIFORNIA

OFFICE OF THE PRESIDENT
(714) 449-7450 FAX (714) 526-3907 EMAIL: leswalls@scco.edu

March 11, 2005

To: Members of the Alaska State Legislature, HESS Committee

Re: **OPPOSITION to HB 151 "An Act relating to provider responsibility for ocular postoperative care; and providing for an effective date"**

Members of the HESS Committee:

First of all, thank you for the opportunity to write a letter explaining why I am opposed to HB 151. I understand the proposed legislation would preclude the outstanding optometrists in your great State from participating in post-surgical care to their own patients that they refer for needed ocular surgical procedures. It is indeed a pleasure to offer you my opinion on the appropriate role of the optometrist in the post-surgical care of their patients.

As a licensed practitioner of both optometry and medicine, I write in opposition to HB 151 as I believe with all my heart that Alaska's optometrists are well-trained and qualified to provide post-surgical care. Indeed, such care is very parallel to other areas of medicine such as a Family Physician rendering care to their own patients after an appendectomy or gall bladder operation, or other types of surgeries.

I personally practiced family medicine in Hartville, Ohio, after having completed a Family practice Residency in Akron, Ohio. The only professional eye care in our community at that time was provided by an optometrist. He and I exchanged patients freely and comfortably for primary care and the co-management in rendering high quality eye care.

Let me offer some specific observations of my own regarding optometric and medical education.

Medical school traditionally prepares the student in general medical and surgical background for post-graduate training programs. Detailed anatomy and physiology of organs such as the eye is not emphasized during medical school. As well, during surgical rotation in medical school, it is uncommon to be exposed to ocular surgery. Because heart disease, cancer, and stroke are the biggest killers of the U.S. population, medical school clinical training is heavily devoted to general internal medicine, general surgery, obstetrics-gynecology, and pediatrics. There are usually fourth-year electives in 4 to 12 week blocks where a student may increase his/her exposure to subspecialty medical and

surgical areas such as ophthalmology, ear/nose and throat, urology, pulmonary medicine, cardiology, etc. In my experience, a small minority of students choose ophthalmology as a clinical rotation.

By a small personal survey in the area of California in which I now reside, most primary care physicians (general practitioners, family practice, internists, and pediatricians) admit that they had from one to three weeks of medical school devoted to ophthalmological care. This includes both didactic course work and clinical experience. I do not need to remind you that these physicians may legally treat eye diseases on an unrestricted basis. But without appropriate education and training and the proper instrumentation, how can the public health be served?

On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. Included with the systemic disease education is the specific education and training in the use of systemic medications and medication interactions, especially in regard to medications utilized in the management of ocular conditions. The detailed ocular anatomy, ocular physiology, ocular pathology, and ocular pharmacology training in optometry school is far superior to the same ocular topics in any general medical school course in the country.

A Doctor of Optometry or Optometric Physician is a physician with a four year doctorate degree just as for dentistry, podiatry and medicine. During the course of study to become a doctor of optometry, there is detailed training in ocular diseases including the management of pre-operative and post-operative care for patients undergoing all forms of ocular surgery. For the optometrists in practice, continuing education courses and practical, hands-on clinical training with patients is the mechanism utilized for assuring that patients receive the highest quality of care possible. In fact, there is testing by the National Board of Examiners in Optometry that tests for these needed skills and graduates must pass these rigorous tests before becoming licensed to care for patients.

This is not to slight medical education; there is simply not enough medical school curriculum time to devote to the eye because of training in vital organ systems such as the heart, lung, vascular system, etc. Additionally, the prerequisites for optometry school meet or exceed the requirements for medical school admission and the Optometry Admission Test parallels that of the Medical College Admission Test. With all the prerequisites and the primary care doctoral program in optometry school, the graduate is trained to make professional judgments and is quick to consult with other health care providers when a patient requires needed services outside the scope of practice. Optometrists now routinely work with medical specialists and subspecialists in the interest of the highest quality patient care.

The clinical education of an optometrist does not have to parallel the education and training of an ophthalmologist anymore than the education and training of a family physician needs to parallel that of a surgeon. Likewise, in my opinion, hospital inpatient

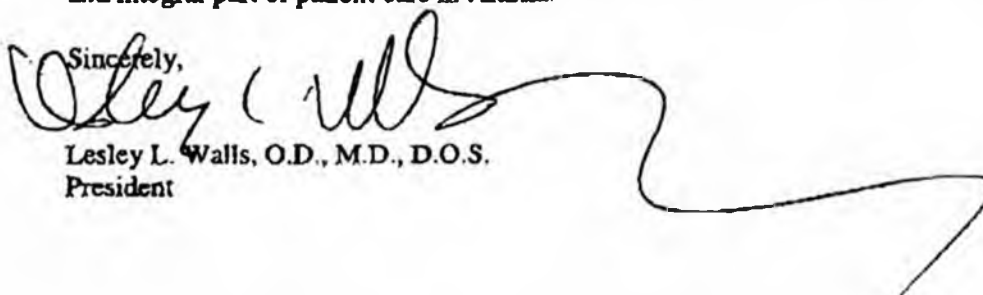
experience is not needed for treating primary open angle glaucoma by the primary care optometrists as patients requiring such extensive treatment will be referred for that level of specialty care. Just as family physicians can safely utilize medications that are also utilized by surgeons, so can optometrists utilize medications that are utilized by ophthalmologists. The education and training for an optometrist includes the safe, effective use of all pharmaceutical agents for ocular diseases in the clinical setting which includes subsequent follow-up. Optometrists are also more than qualified to use an Alger brush, a basic instrument that does not itself remove foreign bodies from the eye, but cleans off particles and residue after a foreign body has been removed.

I would like to point out that ophthalmologists are vitally needed. Patients would be in sad shape without their advanced expertise in the areas of severe ocular trauma, cataract surgery, retinal surgery, complicated ocular infections, etc. These are all vital secondary and tertiary care conditions which optometrists do not propose to treat. I do regret that the opposition resorts to "scare tactics" in this legislative issue. In my opinion, risk to the public is not an issue and the safe use of these therapeutic pharmaceutical agents by optometrists has been well documented in other states.

I also feel strongly that optometrists are vitally needed. There is no question but that the Alaska Board of Examiners in Optometry will protect the people of Alaska by insuring adequate education, continuing education and training for any optometrist allowed to utilize these oral and topical medications. It is unfair to patients and a waste of resources to prevent optometrists from providing care at the highest level of their education and training. Constraints on the profession contribute to an increase in health care costs. When primary care is provided by specialists it is well known that the delivery of health care adds expense to the system.

In summary, in my professional opinion, the implication that Doctors of Optometry provide "lesser care" and are "not qualified" to co-manage post-surgical cases related to the eye is simply not true! In fact, the National Institute of Health has released two studies by Medical Doctors that proved that Doctors of Optometry provide "EXCELLENT" co-managed care for ocular surgeries. Further, co-management between Ophthalmologist and Optometrists is recognized and well-defined federally through Medicare and this is acknowledged by the American Academy of Ophthalmology in the Clinical Practice Guidelines entitled "Cataract in the Adult Eye" under the "Postoperative Guidelines". Lastly, the American Medical Association recognizes co-management with allied healthcare professionals in the AMA Policy Statement #E303 "Allied health Professionals". Therefore, with all this in mind, I feel strongly that the record will prove that co-management for ocular surgeries has been and should continue to be a successful and integral part of patient care in Alaska.

Sincerely,



Lesley L. Walls, O.D., M.D., D.O.S.
President

Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.

Doctors of Optometry
110 S. Willow, #108
Kenai, Alaska 99611

MAR 21 2005

Telephone: (907) 283-7575

March 14, 2005

Dear Representative Peggy Wilson:

HB 151 is Pathetic.

HB 151 is a blatant attempt to stifle health care in Alaska orchestrated by the State Ophthalmologists, nothing more, nothing less.

HB 151 is aimed at one (1) provider, Pacific Cataract & Laser Institute, and one profession - Optometry.

Pacific Cataract & Laser Institute (PCLI) is a world class eye institute that provides world class eye care, happily in downtown Anchorage. Oh, and one other thing, eye care at a very competitive price.

I have practiced on the Kenai Peninsula for 28 years. I have provided post-operative care for every eye surgeon, including Dr. Rosen, president of the Alaska Society of Eye Physicians and Surgeons, herewith known as the ASPS - not to be confused with the snakes.

Dr. Rosen and his fellow ASPS would like Pacific Cataract & Laser Institute as well as Optometry to go away. Dr. Rosen and his club want dear old Grandma Bea to drive from her home in Nikiski to Anchorage for her 10 minute post-op check.

Grandma Bea is going to have to get up early because its snowing and her tires are worn and drive to Anchorage. She wants to get there early because she knows her eyes will be dilated and she wants to get home before dark. You know it's snowing and she'll have to drive slow and the moose on the road. Who can afford to stay in Anchorage, it's expensive and she's trying to save money for her grandchildren's Christmas gifts. Oh, how she wishes she could be checked in Kenai like when the first eye was done. Dr. Rosen says this is impossible, she can only be checked by an Ophthalmologist. Optometrists are too stupid.

So What! Who cares about an old woman and her bald tires? Not the ASPS, they don't want to split the surgical fee with anyone else. Well, maybe if they have to, but only if it's another ASPS member. Most Ophthalmologists live in Anchorage, kind of like a fraternity.

The surgeons of Pacific Cataract & Laser Institute provide an excellent service to this state. Optometry has served this state for over 100 years and has done an outstanding job. The argument that Optometrists are incapable of detecting post surgical problems is inane.

Voting for HB 151 will do the following:

- 1) Raise the income of the ASPS.
- 2) Raise the cost of surgery for Alaskans
- 3) Limit the choice of surgeons for Alaskans
- 4) Decrease surgery quality in Alaska
- 5) Increase waiting time for eye surgery in Alaska
- 6) Greatly increase peripheral costs to Alaskans for eye surgery

The authors crafting of HB 151 is an attempt, by fiat, to suppress competition in the health care market. It would be comical if it were not for the human cost of this bill.

Why would anyone, other than the ASPS, be for this bill?

Ethically, no one should support HB 151.

Thank you,


Robert D. O'Connell, O.D.



Member

American Optometric Association



Alaska Native Brotherhood Camp 2

March 17, 2005

Honorable Representative Peggy Wilson
Chair, Health Education & Social Services Committee
Alaska State Legislature
State Capitol
Juneau, AK 99801

Dear Representative Wilson,

You have an excellent opportunity this year to pass legislation that would significantly enhance patient safety when it comes to Alaskans seeking cataract and other types of ocular surgery. Once more by passing House Bill 151 you will increase the safety threshold without necessarily increasing the costs of delivering that service.

It seems that few itinerant surgeons feel that unlike any other form of surgery, it is okay to entrust immediate post-operative care of a patient to an optometrist that is not schooled or trained in post-surgical care. They lack the foundation to identify infections, diseases and other medical complications that could arise following a surgical procedure.

This practice of entrusting post-operative care to non-medically trained optometrists is not endorsed by any society, association or academy of professions that practice eye surgery and Alaska should pass HB 151 to end that practice here. If an eye surgeon is too busy to provide his or her own post-operative care, then they must be required to arrange for an equal level of care for that patient through a co-management agreement with another eye surgeon, for that all important 48-hour period of time. Please pass HB 151.

Sincerely,
Alaska Native Brotherhood Camp 2

Robert W. Loescher, Chair
Legislative Affairs Committee

Cc: Representative Seaton
Representative Kohring
Representative Anderson
Representative McGuire
Representative Cissna
Representative Gardner

ATTN: Rep Peary Wilson FAX 465-3175

Alaska State House of Representatives
HESS Committee Members
Juneau, Alaska 99801

Dear Members:

Thank you for considering HB 151. I follow the Alaska legislature thru media coverage and a daily monitoring of the Alaska Legislature thru it's website and that is where I noticed HB 151. I did some further research by entering the American Academy of Ophthalmology website.

Despite position papers from groups such as the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgeons that call for ocular surgeons to provide either hands on post-operative care or to enter into a co-management care agreements with a similarly qualified medical doctor for post-operative care, some doctors offering this service have chosen to ignore these guidelines and entrust post-operative follow-up to non-medical personnel.

As these procedures continue to increase in volume the risks to the patient will continue to increase as well, unless something is done to quell the complacency of a few when it comes to post-operative follow-up. HB 151 sets into law that which is already in practice by most people in this profession, but it protects our patients from those few that continue to put profit above proscribed procedure. I urge you to pass HB 151.

Sincerely,



Gwen Norton
P.O. Box 141796
Anchorage, Alaska 99514

Cc: Wilson, Seaton, Cissna, Kohring, Gardner, McGuire, Anderson

HB

156

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: February 18, 2005

FURTHER REFERRALS: Finance

Date of Committee Action: March 17, 2005

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 156

HOUSE BILL NO. 156

COMMISSION ON AGING

"An Act relating to the membership of the Alaska Commission on Aging; and providing for an effective date."

Recommends it be replaced with HCS or CS for HB 154 (HSS)
 For Senate Bills with new title: Technical Title New Title: HCR _____ Same Title New Title

attach amendments

add new referral to _____ Committee

Letter of Intent _____ Committee

List of Abbrev for Depts.:
 ADM
 CED
 COR
 CRT
 EED
 DEC
 DFG
 GOV
 HSS
 LEG
 LAW
 LWF
 MVA
 DNR
 DPS
 REV
 DOT
 UA

NEW FISCAL NOTES				
*Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
HSS				✓

PREVIOUS FISCAL NOTES				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
<i>[Signature]</i>	Cissna	✓			
<i>Berta Gardner</i>	Gardner	X			
<i>[Signature]</i>	Anderson	X			
<i>[Signature]</i>	Kohring	X			
<i>[Signature]</i>	McGuire	X			
<i>Paul Keaton</i>	Keaton	X			
Chair: <i>Beggy Wilson</i>	Wilson	X			

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB156-DHSS-FMS-02-23-05
 () Publish Date: _____
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): _____

Title MEMBERSHIP OF THE ALASKA COMMISSION RDU Boards and Commissions
ON AGING Component Commission on Aging

Sponsor HOLM
 Requester HOUSE (HES) Component No. 2674

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
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 (0)						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This proposed legislation removes the Commissioner of Administration from the Commission and instead adds a regular member from the public to the Commission (from 7 to 8). This change has no fiscal impact on DHSS

Prepared by: Janet Clarke, Assistant Commissioner
 Division Finance and Management Services
 Approved by: Joel S. Gilbertson, Commissioner
 Agency Department of Health and Social Services

Phone 465-1630
 Date/Time 02/11/2005
 Date 02/23/2005

STATE OF ALASKA

Interim:

119 North Cushman St., Rm. 205
Fairbanks, Alaska 99701
(907) 456-7423
Fax: (907) 451-9293


Session:

State Capitol Building
Juneau, Alaska 99801
(907) 465-3466
Fax: (907) 465-2937

REPRESENTATIVE JIM HOLM DISTRICT 9

DATE: March 2, 2005

TO: Representative Peggy Wilson, Chair
House Health and Social Services Committee

FROM: Representative Jim Holm 

RE: HB 156, ALASKA COMMISSION ON AGING

Please schedule HB 156, ALASKA COMMISSION ON AGING, for hearing in the HSS Committee at your earliest convenience.

Attached is a blank CS I would like to offer to replace the original bill. The change is due to a decision made by the Alaska Commission on Aging at its board meeting last month to replace the vacated seat with a grant recipient rather than making it an open public seat.

Thanks so much for your help with this bill.

24-LS0615F
Mischel
3/2/05

Rep Holm
Cap 513

CS FOR HOUSE BILL NO. 156()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY

Offered:

Referred:

Sponsor(s): REPRESENTATIVE HOLM

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the membership of and quorum requirements for the Alaska**
2 **Commission on Aging; and providing for an effective date."**

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

4 *** Section 1. AS 47.45.200(a) is amended to read:**

5 (a) The Alaska Commission on Aging is established in the Department of
6 Health and Social Services. The members of the commission include

7 (1) the commissioner of health and social services or the
8 commissioner's designee;

9 (2) the commissioner of commerce, community, and economic
10 development or the commissioner's designee;

11 (3) a senior services provider who is, at the time of appointment, a
12 current recipient of a grant awarded under the senior grant program operated
13 by the department [THE COMMISSIONER OF ADMINISTRATION OR THE
14 COMMISSIONER'S DESIGNEE];

1 (4) the chair of the Alaska Pioneers' Homes Advisory Board under
2 AS 44.29.500; and

3 (5) seven persons selected on the basis of their knowledge and
4 demonstrated interest in the concerns of older Alaskans, appointed by the governor in
5 accordance with (b) of this section.

6 * Sec. 2. AS 47.45.210(b) is amended to read:

7 (b) The member [MEMBERS] of the commission listed in
8 AS 47.45.200(a)(2) [AND (3)] may not vote on matters before the commission. A
9 majority of the members of the commission listed in AS 47.45.200(a)(1) and (3) - (5)
10 [AS 47.45.200(a)(1), (4), AND (5)] constitutes a quorum for conducting business and
11 exercising the powers of the commission.

12 * Sec. 3. This Act takes effect immediately under AS 01.10.070(c).

Representative Jim Holm

Alaska State Legislature

District 9

Session

Capitol Building, Room 110
Juneau, AK 99801
Phone: (907) 465-3466
Fax: (907) 465-2937



Interim

119 N. Cushman St.
Fairbanks, AK 99701
Phone: (907) 456-7423
Fax: (907) 451-9293

HB 156

Sponsor Statement

2/28/05

"An Act relating to the membership of the Alaska Commission on Aging"

The mission of the Alaska Commission on Aging (ACoA) is to ensure dignity and independence for Alaska's seniors and to assist them, through programs and services funded by the Commission, in leading useful and meaningful lives.

In 2003, Executive Order No. 108 transferred the Alaska Commission on Aging from the Department of Administration to Health and Social Services.

In 2004, my HB 394 implemented that change and also extended the Commission's sunset date from 2004 to 2008. This year, HB 156 makes one change to ACoA's membership.

The Commissioner of the Department of Administration has indicated he is not able to participate as a member of the ACoA and supports removing DOA's seat. At its February 2005 quarterly meeting, the ACoA passed a motion requesting that the seat vacated by DOA be filled by "a senior services provider, regardless of age, and that the provider be a recipient of a Division of Senior and Disabilities Services grant under the Senior Grant Program." HB 156 simply makes this change, and I urge your support.

Representative Jim Holm

Alaska State Legislature

District 9

Session

Capitol Building, Room 110
Juneau, AK 99801
Phone: (907) 465-3466
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Interim

119 N. Cushman St.
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HB 156

Sectional Analysis

3/3/5

"An Act relating to the membership of the Alaska Commission on Aging"

Section 1 Amends existing statute governing members of the Alaska Commission on Aging

Removes the Department of Administration member

Replaces that seat with a Senior Program grant recipient

Section 2 Makes conforming changes

Section 3 Makes the bill effective immediately upon passage

State of Alaska**Office of Boards and Commissions**

AGING COMMISSION

BOARD: Alaska Commission on Aging

BOARD IDENTIFICATION NUMBER: 071

DEPARTMENT: Department of Health and Social Services

AUTHORITY: AS 47.45.200

STATUS: Active

SUNSET DATE: 6/30/2008

REQUIREMENTS: No Legislative Confirmation or Financial Disclosure required

PROHIBITIONS: Cannot serve more than two consecutive terms or 8 consecutive years, whichever is longer.

TERM: 4 years

DESCRIPTION: 11 Members - Seven persons appointed by the Governor based on their knowledge and demonstrated interest in the concerns of older Alaskans; plus the chair of the Pioneers Homes Advisory Board; the commissioner of the Dept. of Administration or designee; the commissioner of the Dept. of Community and Economic Development or designee; and the commissioner of the Dept. of Health and Social Services or designee. Names of persons qualified for and interested in serving will be requested from senior citizens' organizations. Appointments shall be made to assure representation of low-income and minorities and rural/urban areas and statewide geographical representation. At least 6 persons appointed by the Governor shall be 60 years of age or older, 2 of whom shall be 65 years of age or older. Each must be a resident of the State of Alaska. Non-voting members include the Commissioners or their designees of the Dept. of Community and Economic Development, and the Dept. of Health and Social Services. Commission elects chair.

FUNCTION: Formulates a comprehensive statewide plan that identifies the concerns and needs of older Alaskans and prepares and submits to the Governor and Legislature an annual analysis and evaluation of the services that are provided to older Alaskans. Makes recommendations to the Governor and Legislature regarding legislation, regulations, and appropriations for programs or services that benefit older Alaskans. Encourages the development of programs and services which benefit older Alaskans, helping them to lead dignified, independent, and useful lives. Evaluates grant applications and makes grant awards under federal and state programs. Provides to the Alaska Mental Health Trust Authority recommendations concerning the integrated comprehensive mental health program for older Alaskans who suffer major mental illness as a result of senility (AS 47.30.056(b)(4)).

CHAIR: Commission selects.

SPECIAL FACTS: Serve at the pleasure of the Governor. Quorum - majority of voting members.
Meetings: four quarterly meetings per year

COMPENSATION: Standard Travel and Per Diem.

MEETINGS: At call of chair or majority of members; at least 4 times each year.

FOR FURTHER INFORMATION CONTACT:

Ms. Linda Gohl

Director

Alaska Commission on Aging

DHSS, P.O. Box 110693

Juneau, AK 99811-0693

Phone: (907) 465-3250, FAX: (907) 465-1398

Aging Commission Roster

Go to the Aging Commission Home page

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Alaska Commission on Aging

FRANK H. MURKOWSKI
GOVERNOR

P.O. BOX 110693

JUNEAU, ALASKA 99811-0693

PHONE: (907) 465-3250

FAX: (907) 465-1398

March 3, 2005

The Honorable Representative Jim Holm
State Capitol, Room 513
Juneau, AK 99811

Re: HB 156, Change to ACoA Membership

Dear Representative Holm:

On behalf of the ACoA, thank you very much for your willingness to sponsor Legislation that would change the membership of the ACoA. Initially, the ACoA requested that legislation be introduced that would change the Department of Administration (DOA) seat to a public member seat. However, the ACoA took action during its meeting on February 24th to request an amendment to HB 156 that replaces the DOA membership with a senior services provider. The motion as stated below passed by unanimous consent:

That HB 156 be amended, so that one ACoA member be a senior services provider regardless of age, and that the provider be a recipient of a Division of Senior and Disabilities Services grant

The ACoA took this action after reconsidering a request from AGENET, an advocacy organization of senior services agencies. AGENET has emphasized that other boards representing individuals with disabilities, mental illness, or who have chemical dependencies, have at least one service provider seat on their board or council.

Adding a provider seat to the ACoA would not cause a conflict of interest if the provider applied for a senior services grant. AS 47.45.240(a)(7) requires the Commissioner of the Department of Health & Social Service's approval to allow the ACoA grant evaluation and award responsibilities, and that authority is not delegated to the ACoA. These grant process functions remain within the department, and only the DHSS Commissioner or his designee approves grant awards.

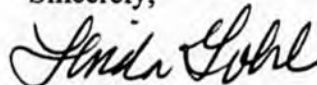
Also, I have contacted Ray Matiashowski, Commissioner of the Department of Administration (DOA) and have asked that he send you a letter of support for passage of HB 156. Mr. Matiashowski has indicated in the past that he would support legislation that removes the Department of Administration on the ACoA.

Page 2
HB 156

On behalf of the ACoA, thank you for introducing HB 156 and considering this request to amend HB 156. Please feel free to contact me at 465-4879 if you need any other information. Also, once the bill is scheduled for a Committee hearing, I would be happy to testify on behalf of the Commission, as well as enlist the support of AGENET members to testify.

Thank you for your continued support of the Commission's activities and issues impacting older Alaskans.

Sincerely,

A handwritten signature in cursive script that reads "Linda Gohl".

Linda Gohl
Executive Director

HB

161



State of Alaska
Representative Peggy Wilson
Health Education and Social Services Committee

State Capitol, Room 106
Juneau AK 99801
Phone 907-465-3824
Fax: 907-465-3175
Representative.Peggy.Wilson@legis.state.ak.us

Fax transmittal sheet

To: Barbara Craver

Fax # 2029

Date April 13, 2005

2 pages

From: Kathy Hope Erickson  for Representative Peggy Wilson

Barbara -- As we discussed, Peggy would like to put language in the CSHB 161 (HES) that provides for sharing the past service cost ~

In the Amendment Y.3 -- on line 8, insert "one half" after "retired teacher at." Also add a section that conveys that: Each teacher rehired under the authority of AS 14.20.135 shall make contributions to the unfunded liability of the system at one-half the rate that the employer is making contributions to the unfunded liability of the system for other teachers.

Same changes for PERS.

Attached is Y.3 of CSSSSB 24.

Thanks so much.



**State of Alaska
Representative Peggy Wilson
House District 2**

State Capitol, Room 108
Juneau AK 99801
Representative.Peggy.Wilson@legis.state.ak.us

Phone 907-465-3824
Toll Free: 800-686-3824
Fax: 907-465-3175

Fax transmittal sheet

To Barbara Craver
Fax # 465-2029
From: Kathy Hope Erickson for
Representative Peggy Wilson
Re: HB 161, Retirement for Retirees

Date April 14, 2005
2 pages

Comments:

HESS Committee has passed HB 161 (F) out of committee, and has made two conceptual amendments:

- 1) Section 7 subsection (h) (pg 4 ln 29) amend to include all PERS participant employers.
- 2) Section 13 page (pg 5 ln 22) include the PERS employers. Please add the attached language to the second amendment - pg 5 ln 24 - following the words "on the retirement system(s)."

I am also requesting a final. Thank you for everything.

24-LS0211\Y.4
Craver
4/11/05

AMENDMENT

OFFERED IN THE SENATE

TO: CSSSSB 24(HES)

1 Page 5, line 1, following "systems.":

2 Insert "The administrator of the public employees' retirement system shall
3 include information in the report regarding the efforts of employers in the executive
4 branch to address the recruitment difficulties in job classes in which retired members
5 have been rehired."

To: Rep Wilson
Fr: Kathy
Dt: 4/13/2005
Re: HB 161

Barbara Craver from Leg Legal called to get permission to get a HES CS for HB 161 with the changes Mike Tibbles gave her. Besides reflecting SB 24, the CS will include a 2008 sunset, and the elimination of double health coverage.

Katie Shows from Rep Seaton's office stopped in to say that she had contacted Leg Legal Barbara Craver and Melanie in Retirement & Benefits, who both gave a guarded nod to the idea of shared expense for past service cost rate.

Katie Shows

From: melanie Millhorn [melanie_millhorn@admin.state.ak.us]
Sent: Wednesday, April 13, 2005 10:16 AM
To: Katie Shows
Cc: Michael A Tibbles
Subject: HB 161
Follow Up Flag: Follow up
Flag Status: Red

Katie:

I talked with Mike Tibbles this morning about HB 161. Mike is the lead contact on this legislation from our Commissioner's Office. I mentioned to Mike to three areas you addressed with me: (1) employer making a contribution to the past service rate (2) members making a contribution to pay for the (thought you said normal rate the first time); however, we later discussed the past service rate and (3) members enrolling under this legislation would defer medical coverage under the retiree plan (active medical coverage only) until they separated from service. In other words, the retiree who returns would not have secondary coverage under the retiree medical plan.

Could you please refer any questions regarding this legislation to Mike.

Thanks. Melanie

--
Melanie Millhorn, Director
State of Alaska
Department of Administration - Division of Retirement & Benefits
PO Box 110203
Juneau, AK 99811-0203
(907) 465-4408 (voice)
(907) 465-3655 (fax)
(800) 821-2251 Toll-Free

Confidentiality Statement

This message (including any attachments) contains confidential information intended

24-LS0645\F
Craver
4/14/05

CS FOR HOUSE BILL NO. 161(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): REPRESENTATIVE ELKINS

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to reemployment of and benefits for or on behalf of retired teachers
 2 and public employees and to teachers or employees who participated in retirement
 3 incentive programs and are subsequently reemployed as a commissioner; repealing secs.
 4 5, 7, and 9, ch. 58, SLA 2001; providing for an effective date by amending the delayed
 5 effective date for secs. 3, 5, 9, and 12, ch. 57, SLA 2001, and repealing sec. 13, ch. 58,
 6 SLA 2001, which is the delayed effective date for secs. 5, 7, and 9, ch. 58, SLA 2001; and
 7 providing for an effective date."

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

9 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
 10 to read:

11 **FINDINGS AND INTENT.** (a) The legislature finds that provisions of ch. 57, SLA
 12 2001, ch. 58, SLA 2001, and ch. 15, SLA 2003 that provide for the reemployment of certain
 13 retired members of the teachers' and public employees' retirement systems provide a valuable

1 tool for school districts and public employers to manage workforce shortages, especially in
2 teaching positions and job classes that require specialized knowledge and skills.

3 (b) The legislature also finds that school districts and public employers must plan to
4 meet their future workforce needs without reliance on retired workers. In extending the
5 termination date of the reemployment provisions, it is the intent of the legislature to allow
6 school districts and public employers to continue to use this management tool, while
7 developing plans that address the knowledge, skills, and abilities that need to be transferred or
8 developed to assure the work can be accomplished when the reemployment provisions
9 terminate. It is the intent of the legislature that all participation in the retiree reemployment
10 provisions by employers and reemployed retirees will end on July 1, 2008, unless that date is
11 extended by law.

12 (c) It is the intent of the legislature that employers that benefit from the provisions of
13 the retiree reemployment provisions pay any increase in unfunded liability that results to the
14 retirement systems.

15 * **Sec. 2.** AS 14.20.135 is amended by adding a new subsection to read:

16 (e) A school district or regional educational attendance area that hires a retired
17 teacher in accordance with this section shall provide, and the retired teacher shall
18 accept, the same health and medical benefits provided to other active teachers. If a
19 retired teacher who has been rehired elects to continue receiving benefit payments
20 during the period of reemployment under AS 14.25.043(b), the teacher may not
21 receive retirement medical coverage if that person is an active member employed by a
22 school district or regional educational attendance area.

23 * **Sec. 3.** AS 14.25.043(a) is amended to read:

24 (a) If a retired member again becomes an active member, benefit payments
25 may not be made during the period of reemployment [UNLESS THE TEACHER
26 MAKES AN ELECTION UNDER (b) OR (e) OF THIS SECTION]. The retirement
27 benefit must be suspended for the entire school year if the teacher is reemployed as an
28 active teacher for a period equivalent to a year of service. During the period of
29 reemployment, [THE MEMBER IS SUBJECT TO AS 14.25.050, AND] deductions
30 from the member's salary will be made in accordance with AS 14.25.050.

31 * **Sec. 4.** AS 14.25.043(b) is amended to read:

1 (b) A school district or regional educational attendance area that has adopted a
2 policy that permits the employment of retired teachers in accordance with
3 AS 14.20.135 shall notify the administrator that it is hiring retired teachers under
4 AS 14.20.135. A teacher who retired under AS 14.25.110(a) and subsequently
5 becomes an active member under a policy adopted in accordance with AS 14.20.135
6 may, within 30 days after the date of reemployment, elect to continue receiving benefit
7 payments during the period of reemployment by filing a waiver of coverage with the
8 administrator on a form provided by the administrator. An election under this
9 subsection waives coverage for the period of reemployment and is irrevocable during
10 the period of reemployment. A teacher making the election to continue to receive
11 benefit payments may not receive retirement medical benefits during
12 reemployment but, instead, shall be covered under the medical coverage
13 provided by an employer to active members. Deductions from the member's salary
14 may not be made under AS 14.25.050 during the period of reemployment, and the
15 member may not receive credited service for the period of reemployment. A member
16 who participated in a retirement incentive program under ch. 26, SLA 1986; ch. 89,
17 SLA 1989; ch. 65, SLA 1996; ch. 4, FSSLA 1996; or ch. 92, SLA 1997, is not eligible
18 to make an election under this subsection.

19 * Sec. 5. AS 14.25.070 is amended by adding a new subsection to read:

20 (b) Each employer of a retired teacher rehired under the authority of
21 AS 14.20.135 shall make contributions to the unfunded liability of the system on
22 behalf of that retired teacher at the rate that the employer is making contributions to
23 the unfunded liability of the system for other teachers.

24 * Sec. 6. AS 39.35.150(b) is amended to read:

25 (b) A member who retired under AS 39.35.370(a) and subsequently becomes
26 an active member may, within 30 days of the date of reemployment, elect to continue
27 receiving benefit payments during the period of reemployment by filing an election
28 with the administrator on a form provided by the administrator. An election under this
29 subsection waives coverage for the period of reemployment and is irrevocable during
30 the period of reemployment. A member making the election to continue to receive
31 benefit payments may not receive retirement medical benefits during

1 **reemployment but, instead, will be covered under the medical coverage provided**
2 **by an employer to active members.** During the period of reemployment, deductions
3 from the member's salary may not be made under AS 39.35.160 and the member may
4 not receive credited service. A member who participated in a retirement incentive
5 program under ch. 26, SLA 1986; ch. 89, SLA 1989; ch. 65, SLA 1996; ch. 4, FSSLA
6 1996; or ch. 92, SLA 1997, is not eligible to make an election under this subsection
7 unless the member is reemployed as a commissioner.

8 * Sec. 7. AS 39.35.150 is amended by adding new subsections to read:

9 (f) Notwithstanding (b) of this section, a member employed by a political
10 subdivision or a public organization may not make the election provided in (b) of this
11 section unless the member's employer has adopted a policy that permits the
12 employment of retired employees in accordance with (g) of this section. The
13 administrator shall accept the election of a member subject to this subsection if the
14 governing body or the person with hiring authority for the political subdivision or
15 public organization certifies that the appointment to the position being filled by the
16 retired member was the result of a competitive hiring process.

17 (g) In accordance with this section, a political subdivision or a public
18 organization that has or anticipates having a shortage of employees qualified for
19 particular job classes may, by resolution, adopt a policy that permits the employment
20 of employees who retired under AS 39.35.370(a), who have been separated from
21 employment for at least 30 days, and who are qualified for particular job classes. The
22 policy adopted by resolution must describe the circumstances that constitute the
23 shortage. If a shortage of qualified employees exists as described in the policy, the
24 political subdivision or the public organization shall notify the administrator that it is
25 hiring retired members under (f) of this section and shall provide a copy of the
26 resolution and policy adopted by the resolution to the administrator of the public
27 employees' retirement system (AS 39.35).

28 (h) Notwithstanding (b) of this section, an employer in the executive branch of
29 state government may not allow a member to make the election provided in (b) of this
30 section unless

31 (1) the employer conducted an initial recruitment for at least 15 days

1 for the position to be filled by the member making an election under (b) of this section
2 resulted in fewer than five qualified, eligible, and available applicants, including the
3 retired member; and

4 (2) the employer then conducted an additional recruitment and the
5 additional recruitment resulted in fewer than five qualified, eligible, and available
6 applicants, including the retired member. This additional recruitment period added to
7 the initial recruitment period must be at least 30 days total.

8 * **Sec. 8.** AS 39.35.270 is amended by adding a new subsection to read:

9 (b) Each employer of a retired member rehired under the authority of
10 AS 39.35.150(b) shall make contributions to the unfunded liability of the system on
11 behalf of that retired member at the rate that the employer is making contributions to
12 the unfunded liability of the system for that employer's other members.

13 * **Sec. 9.** Section 12, ch. 57, SLA 2001, as amended by sec. 6, ch. 15, SLA 2003, is
14 amended to read:

15 Sec. 12. AS 14.20.135; AS 14.25.043(b), 14.25.043(e), added by sec. 3, ch.
16 15, SLA 2003 [OF THIS 2003 ACT]; AS 39.35.120(b)(2), 39.35.150(b), as amended
17 by sec. 4, ch. 15, SLA 2003 [OF THIS 2003 ACT], and 39.35.150(c) are repealed
18 July 1, 2008 [2005].

19 * **Sec. 10.** The uncodified law of the State of Alaska enacted in sec. 13, ch. 57, SLA 2001,
20 is amended to read:

21 Sec. 13. REPORT TO LEGISLATURE. Annually, beginning in 2002 and
22 ending in 2009 [2006], the administrator of the teachers' retirement system shall report
23 to the legislature by the 30th day of the regular legislative session concerning the
24 effect of this Act, as amended, on the retirement system.

25 * **Sec. 11.** AS 14.25.070(b) and AS 39.35.270(b) are repealed July 1, 2008.

26 * **Sec. 12.** Sections 5, 7, and 9, ch. 58, SLA 2001, are repealed.

27 * **Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to
28 read:

29 **CONDITIONAL RETROACTIVITY.** If secs. 9, 12, and 15 of this Act take effect
30 after July 1, 2005, secs. 9, 12, and 15 of this Act are retroactive to July 1, 2005.

31 * **Sec. 14.** Section 15, ch. 57, SLA 2001, is amended to read:

- 1 Sec. 15. Sections 3, 5, 9, and 12 of this Act take effect July 1, 2008 [2005].
- 2 * **Sec. 15.** Section 13, ch. 58, SLA 2001, is repealed.
- 3 * **Sec. 16.** Section 3 of this Act takes effect July 1, 2008.
- 4 * **Sec. 17.** Except as provided in sec. 16 of this Act, this Act takes effect immediately under
- 5 AS 01.10.070(c).

ALASKA STATE LEGISLATURE

INTERIM

50 Front Street
Suite 203
Ketchikan, Alaska 99901
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Fax : (907) 225-8546



SESSION

Suite 416
State Capitol Building
Juneau, Alaska 99801
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Fax: (907) 465-3793

REPRESENTATIVE JIM ELKINS

MEMORANDUM

February 23, 2005

To: Representative Mark Neuman, Chairman
House Special Committee on Education

From: Representative Jim Elkins 

Subject: Hearing Request for House Bill 161

I respectfully request House Bill 161, extending the sunset date for the rehire of retired PERS and TRS members, be scheduled for a hearing at the earliest possible date.

Attached please find the sponsor statement and a copy of the legislation.

I have requested letters of support from various PERS and TRS employers from within my district.

Thank you.

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REPRESENTATIVE ELKINS Sponsor Statement

House Bill 161 extends the sunset date of legislation enacted by HB 242 (2001) and SB 94 (2003) to **July 1, 2009**. This legislation allows certain PERS and TRS members who retired with a normal retirement to return to work, continue to receive normal retirement benefits, and waive participation in the retirement systems if the employee:

- Is a retired teacher hired under the "teacher shortage" program (AS 14.20.135)
- Is a retired public employee who retired under normal retirement.
- Is an individual who retired under the Retirement Incentive Program and is subsequently re-employed as a commissioner
 - Relieves commissioners of the requirement to refund incentive credit and re-employment indebtedness.

During this period of employment, no contributions are required from the employer or the employee. The current legislation under HB 242 (2001) and SB 94 (2003) is scheduled to sunset on July 1, 2005.

According to a report issued on February 10th by the Department of Administration, Division of Retirement and Benefits entitled **Results of the Retiree Return Program**, the following information was noted:

Testimony in 2001 on HB 242 in the House State Affairs Committee, stated that in the years 2008-2009, a large portion of the "baby boomers" were scheduled to retire en masse, creating a large void in the state work force. Some of the shortages would be critical, such as in education and law enforcement. Other testimony indicated:

- Alaska has needed to recruit 12,000 to 13,000 new teachers each year but at the largest job fair that year there were less than 300 applicants.
- Employers would have the opportunity to offer less salary to returning retirees.
- HB 242 was a component of a workforce development initiative that the state and a number of other employers undertook to address workforce shortages already being experienced.

An analysis of the TRS Rehire Program contained in the report shows that between July 1, 2001 and November 30, 2004 a total of 187 waivers were received, 56% of all TRS employers participated in the program and as of November 30, 2004 a total of 124 retirees were still working.

On the PERS side, between July 1, 2001 and November 30, 2004 a total of 297 waivers were received, 21% of all PERS employers participated in the program and as of November 30, 2004 211 retirees were still working.

Mr. Chairman, as of November 30, 2004 a total of 335 retirees were employed statewide under the current legislation. It provides Human Resources managers with an excellent tool to retain workers for hard to fill positions and we urge passage of this extension.

Proposed Changes to House Bill 161
CS HB 161(HES)

Insert new section AS 39.35.655

Requires political subdivisions or public organizations to adopt a policy by resolution prior to rehiring retired members. Policy must include a period of separation from employment for at least 30 days for retirees and a description of the circumstances that constitute a shortage of employees qualified for particular job classes.

This requirement is similar to the requirement imposed on TRS employers in the original HB 242.

Insert new section AS 39.35.150(h)

Requires the State of Alaska and other PERS employers (political subdivisions or public organizations) to recruit for a minimum 30 days and result in an applicant pool of fewer than five qualified, eligible, and available applicants.

Insert new sections AS 14.20.135 and AS 39.35.150

Requires a PERS or TRS employer to provide the same health insurance to a rehired retiree as provided to all other members.

Also requires a retired member to suspend their retirement health coverage prior to returning to employment.

Provision will restrict an employer from achieving a cost savings by shifting health care costs from the employer's active health insurance to the retirement system. Also restricts an individual's ability to receive double health care coverage as a result of being rehired for the period of reemployment.

Amends bill language in AS 14.25.070 and AS 39.35.270

Requires employers to contribute to the retirement system for rehired retirees at the same rate they contribute to the unfunded liability of the system for other members.

Provision will ensure there is no additional cost to the system.

Amends uncodified law enacted in sections 13, Ch. 57, SLA 2001

Requires the administrator of the PERS system to include information in the annual report to the Legislature regarding the efforts of employers in the executive branch to address the recruitment difficulties in job classes in which retired members have been rehired.

Amends sunset date

Reduces sunset extension from 2009 to 2008.

24-LS0211\Y.1
Craver
4/11/05

AMENDMENT

OFFERED IN THE SENATE
TO: C S S S S B 24(HES)

1 Page 2, following line 14:

2 Insert a new bill section to read:

3 **** Sec. 2.** AS 14.20.135 is amended by adding a new subsection to read:

4 (e) A school district or regional educational attendance area that hires a retired
5 teacher in accordance with this section shall provide, and the retired teacher shall
6 accept, the same health and medical benefits provided to other active teachers. If a
7 retired teacher who has been rehired elects to continue receiving benefit payments
8 during the period of reemployment under AS 14.25.043(b), the retirement health
9 benefits are secondary to the health benefits provided to all active teachers."

10

11 Renumber the following bill sections accordingly.

12

13 Page 3, following line 18:

14 Insert a new subsection to read:

15 (h) An employer that hires a retired member in accordance with this section
16 shall provide, and the retired member shall accept, the same health and medical
17 benefits provided to other active members. If a retired member who has been rehired
18 elects to continue receiving benefit payments during the period of reemployment
19 under (b) of this section, the retirement health benefits are secondary to the health
20 benefits provided to all active teachers."

21

22 Page 3, line 28, following "AS 14.20.135":

23 Insert "as amended by sec. 2 of this 2005 Act"

24-LS0211\Y.1

- 1
- 2 Page 4, line 3:
 - 3 Delete "SECTION 3"
 - 4 Insert "SECTION 4"
 - 5
- 6 Page 4, line 15:
 - 7 Delete "SECTION 5"
 - 8 Insert "SECTION 6"
 - 9
- 10 Page 5, line 2, following "39.35.150(g),":
 - 11 insert "39.35.150(h),"
 - 12
- 13 Page 5, line 7:
 - 14 Delete "3 - 8, 11, and 13 of this Act"
 - 15 Insert "4 - 9, 12, and 14 of this Act"
 - 16
- 17 Page 5, line 8:
 - 18 Delete "3 - 8, 11, and 13"
 - 19 Insert "4 - 9, 12, and 14"
 - 20
- 21 Page 5, line 12:
 - 22 Delete "Section 2"
 - 23 Insert "Section 3"
 - 24
- 25 Page 5, line 13:
 - 26 Delete "sec. 15"
 - 27 Insert "sec. 16"

24-LS0211Y.2
Craver
4/11/05

AMENDMENT

OFFERED IN THE SENATE
TO: CSSSSB 24(HES)

1 Page 3, following line 18:

2 Insert a new subsection to read:

3 "(h) Notwithstanding (b) of this section, an employer in the executive branch
4 of state government may not allow a member to make the election provided in (b) of
5 this section unless

6 (1) the employer's initial recruitment for the position to be filled by the
7 member making an election under (b) of this section resulted in fewer than five
8 qualified, eligible, and available applicants, not including the retired member; and

9 (2) the employer then conducted an additional recruitment for a period
10 of not less than 15 days and the additional recruitment resulted in fewer than five
11 qualified, eligible, and available applicants, not including the retired member."

12

13 Page 5, line 2, following "39.35.150(g),":

14 Insert "39.35.150(h),"

24-LS0211V.3
Craver
4/11/05

AMENDMENT

OFFERED IN THE SENATE

TO: CSSSSB 24(HES)

1 Page 1, line 1, following "for":

2 Insert "or on behalf of"

3

4 Page 2, lines 24 - 29:

5 Delete all material and insert:

6 "(b) Each employer of a retired teacher rehired under the authority of
7 AS 14.20.135 shall make contributions to the unfunded liability of the system on
8 behalf of that retired teacher at the same rate that the employer is making contributions
9 to the unfunded liability of the system for other teachers."

10

11 Page 3, lines 20 - 25:

12 Delete all material and insert:

13 "(b) Each employer of a retired member rehired under the authority of
14 AS 39.35.150(b) shall make contributions to the unfunded liability of the system on
15 behalf of that retired member at the same rate that the employer is making
16 contributions to the unfunded liability of the system for other members."

24-LS0211\Y.4
Craver
4/11/05

AMENDMENT

OFFERED IN THE SENATE
TO: CSSSSB 24(HES)

- 1 Page 5, line 1, following "systems.":
- 2 Insert "The administrator of the public employees' retirement system shall
- 3 include information in the report regarding the efforts of employers in the executive
- 4 branch to address the recruitment difficulties in job classes in which retired members
- 5 have been rehired."

In Senate Bill

Draft amendments to HB 161

Add a new section 2 to the bill:

* **Sec. 2.** AS 39.35 is amended by adding a new section to article 7 to read:

Sec. 39.35.655. Employment of certain retired members because of shortages. (a) The governing body of a political subdivision or public organization that has or anticipates having a shortage of employees qualified for particular job classes may, by resolution, adopt a policy that permits the employment of members who retired under AS 39.35.370(a), have been separated from employment with an employer for at least 30 days, and are qualified for the particular job classes, in accordance with this section. A policy adopted by a political subdivision or public organization under this section must describe the circumstances that constitute the shortage. If a shortage of qualified employees exists as described in the policy, the political subdivision or public organization shall provide a copy of the policy to the administrator, and notify the administrator that it is hiring retired members under AS 39.35.150(b).

(b) The administrator will accept an election to continue to receive retirement benefits and waive coverage of the retirement system from an employee hired by a political subdivision or public organization under AS 39.35.150(b) only upon receipt from the governing body, or person with hiring authority for the political subdivision or public organization, of certification that the appointment to the position resulted from a competitive hiring process.

Renumber remaining bill sections accordingly.

Add a new section to the bill:

* **Sec. X.** AS 39.35.655 is repealed.

Renumber remaining bill sections accordingly.

Change current section 8 of bill (which will be renumbered) to include section X
(repeal of AS 39.35.655 takes effect 7/1/09).

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: CSHB 161(EDU)
 (H) Publish Date: 4/6/2005

Revision Date/Time (Note if correction): n: _____ Dept. Affected: Statewide
 Title An act relating to reemployment of retired RDU Statewide
teachers and public employees... Component Statewide
 Sponsor Representative Elkins
 Requester House State Affairs Component No. _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

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--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0.0
 Check this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill will extend the Retiree Return to Work Program (HB 242 2001) for teachers and public employees scheduled to sunset on July 1, 2005. SB 24 would extend this program to continue until to July 1, 2009.

For the Public Employees' Retirement System, the actuarial consultant has computed this legislation to have no effect on employer contribution rates until the number of members electing the waiver reaches 500. For the Teacher's Retirement System, our actuarial consultant has computed this legislation to increase TRS employer contribution rate with only 100 participants. A detailed analysis is attached.

Prepared by: Melanie Millhorn, Director Phone 465-4408
 Division Retirement and Benefits Date/Time 4/4/05 12:00 PM
 Approved by: Michael Tibbles, Deputy Commissioner Date 4/4/2005
 Agency Department of Administration

FISCAL NOTE #1

**STATE OF ALASKA
2005 LEGISLATIVE SESSION**

BILL NO. CSHB 161(EDU)

ANALYSIS CONTINUATION

Examples of impact on PERS and TRS employers are as follows:

Number of Members Electing the Waiver	PERS		TRS	
	Increase in Average PERS Employer Contribution Rate	Members Currently On Waiver	Increase in Average TRS Employer Contribution Rate	Members Currently On Waiver
100	negligible	211	0.02%	124
500	0.01%		0.10%	
1,000	0.02%		0.20%	

Note: The fiscal amount noted below represents the number of retirees presently enrolled for the period of 2001 to November 30, 2004. Should the membership levels increase the fiscal cost would increase based on the table shown above.

PERS	Salaries (in 000's)	rate increase %	Annual cost (in 000's)
State of Alaska	732,429.5	0.00%	0.00
Juneau Borough and School District	50,947.0	0.00%	0.00
Anchorage Municipality and School District	194,930.9	0.00%	0.00
University of Alaska	113,096.2	0.00%	0.00
Fairbanks Borough and School District	44,610.4	0.00%	0.00
North Slope Borough and School District	58,321.6	0.00%	0.00
Mat-Su Borough and School District	27,578.6	0.00%	0.00
All other PERS employers	238,256.3	0.00%	0.00
Total	\$ 1,460,170.5		0.00

Reflects membership of 211 which results in a negligible cost.

TRS	Salaries (in 000's)	rate increase %	Annual cost (in 000's)
All School Districts TRS salaries	525,614.0	0.02%	105.12
State of Alaska TRS salaries	7,015.9	0.02%	1.40
Total			106.53

Reflects membership of 124 which results in a .02% increase in employer rates.

Total Annual Cost to PERS and TRS 106.53

AS 24.03.036 FISCAL NOTES ON BILLS AFFECTING STATE RETIREMENT SYSTEMS, requires an additional analysis of the long term and short term costs to the state if a bill is adopted, as well as the impact of the bill on the actuarial soundness of the funds. The annual cost is as indicated above.

From: Rep. Peggy Wilson
Sent: Thursday, April 14, 2005 10:50 AM
To: Kathy Hope Erickson
Subject: FW: HB161

From: Dan Young [mailto:dyoung@ci.kenai.ak.us]
Sent: Wednesday, April 13, 2005 1:36 PM
To: Rep. Peggy Wilson
Subject: HB161

Representative Peggy Wilson

My name is Dan Young I live in Kenai. I am a life long Alaskan. My thoughts on the rehire bill.

The rehire bill has merit, I see where it can be a useful tool to keep well trained people around to fill the jobs when there are no others. The program in effect at this time needs to close, a new version of the bill needs to continue with better working guidelines. The people that are in the program at this time need to be grandfathered in, simply because that is how the program was given to us. Many decisions were made by many people that could be catastrophic to them if the program sunsets. If there is a misunderstanding of how the program was to work, it is clearly a blunder on the law makers side. Some people say the program was abused. I say it was used just like it was given to us, if there was what they call abuse, again it was because of the lawmakers blunder of not making it right in the first place. On the pers side there are many jobs that require any one of or combinations of "licenses, certifications, on the job time, endorsements, continuing education etc." All pers jobs are not "no-brainer jobs" like a couple of Senators would like to think. I believe there would be a large liability to the State of Alaska if the inplace program was to sunset and the retirement checks stopped to the people that are in the program now. The argument of people not being able to move up because someone hired back on after retiring is a point, but you must know that there was no guarantee that they would have been moved into that job. Pers, in trouble financially, maybe in the past they should not have given an extra three years for early retirement. That is a few hundred dollars per month per person that was not paid into the system. There are so many pros and cons to this situation, that make it a hard one to figure out. Good luck. There is one question I would like to get an answer ,and that is, will the people in the system now be grandfathered in. An answer to this question would be appreciated.

Thanx
Dan Young
dyoung@ci.kenai.ak.us
northcountry@alaska.com