HOUSE BILL 749

Introduced by Hanson, M., et al.

2/21	Introduced
2/22	Referred to Human Services & Aging
2/28	Fiscal Note Requested
3/07	Fiscal Note Received
3/08	Hearing
3/09	Fiscal Note Printed
3/15	Tabled in Committee

HOUSE BILL NO. 749

INTRODUCED BY M. Hanson, Bruce D. Nelson, Harry

A BILL FOR AN ACT ENTITLED: "THE MONTANA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ACT; PROVIDING REGULATION OF OBSTETRICAL MEDICAL MALPRACTICE INSURANCE; PROVIDING A NEW REMEDY FOR BIRTH-RELATED NEUROLOGICAL INJURIES; APPROPRIATING MONEY TO THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES TO PROVIDE FOR REVIEW AND DETERMINATION OF CLAIMS SUBMITTED UNDER THIS ACT; AND PROVIDING EFFECTIVE DATES."

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

NEW SECTION. **Section 1.** **Short title.** [Sections 1 through 22] may be cited as the "Montana Birth-Related Neurological Injury Compensation Act".

NEW SECTION. **Section 2.** **Definitions.** As used in [sections 1 through 22], the following definitions apply:

(1) (a) "Birth-related neurological injury" means injury to the brain or spinal cord of an infant that:

(i) was caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital; and

(ii) renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living.

(b) The term applies to live births only.

(2) "Claimant" means a person who files a claim pursuant to [section 5] for compensation for a birth-related neurological injury to an infant.

(3) "Department" means the department of health and environmental sciences provided for in 2-15-2101.

(4) "Director" means the department director provided for in 2-15-2102.

(5) "Fund" means the Montana birth-related neurological injury compensation fund.

(6) "Participating hospital" means a licensed hospital that at the time of the injury had:

(a) in force an agreement with the director or his designee, in a form prescribed by the director, in which the hospital agreed:

(i) to participate in the development of a program to provide obstetrical care to patients who are eligible for medical assistance services or who are indigent; and

(ii) upon approval of the program by the director, to participate in its implementation;

(b) in force an agreement with the department in which the hospital agreed to submit to review of its obstetrical service, as required by [section 5(5)]; and

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(c) paid the assessments required pursuant to [sections 20 and 21] for the year in which the injury occurred.

(7) "Participating physician" means a physician who is licensed to practice medicine in Montana, who practices obstetrics or performs obstetrical services, either full or part time, and who at the time of the injury had:

(a) in force an agreement with the director or his designee, in a form prescribed by the director, in which the physician agreed:

(i) to participate in the development of a program to provide obstetrical care to patients who are eligible for medical assistance services or who are indigent; and

(ii) upon approval of the program by the director, to participate in its implementation;

(b) in force an agreement with the Montana state board of medical examiners in which the physician agreed to submit to review by the board of medical examiners as required by [section 5(4)]; and

(c) paid the assessments required pursuant to [sections 20 and 21] for the year in which the injury occurred.

(8) "Program" means the Montana birth-related neurological injury compensation program established by [sections 1 through 22].

(9) "Program officer" means the person who determines a claim pursuant to [sections 7 through 13].

NEW SECTION. **Section 3. Program -- exclusive remedy -- exception.** (1) There is established the Montana birth-related neurological injury compensation program.

(2) The rights and remedies granted in [sections 1 through 22] to an infant on account of a birth-related neurological injury exclude all other rights and remedies of the infant or his personal representative, parent or parents, or next of kin at common law or otherwise arising out of or related to a medical malpractice claim with respect to the injury.

(3) Except as otherwise provided in [sections 1 through 22], a civil action is not foreclosed against a physician or a hospital if there is clear and convincing evidence that the physician or hospital intentionally, willfully, or negligently caused or intended to cause a birth-related neurological injury, except that the suit must be filed prior to and in lieu of payment of an award under [sections 1 through 22]. The suit must be filed before the award of the program officer becomes conclusive and binding as provided in [section 12].

NEW SECTION. **Section 4. Program officer authorized to hear and determine claims.** The program officer is authorized to hear and pass upon all claims filed pursuant to [sections

1 1 through 22] and may exercise the power and authority
2 necessary to carry out the purposes of [sections 1 through
3 22].

4 NEW SECTION. **Section 5. Filing of claims -- review --**
5 **filing of responses.** (1) Claims may be filed by any legal
6 representative on behalf of an injured infant. In the case
7 of a deceased infant, the claim may be filed by an
8 administrator, executor, or other legal representative.
9 (2) In all claims filed under [sections 1 through 22],
10 the claimant shall file with the program officer a petition,
11 setting forth the following information:
12 (a) the name and address of the legal representative
13 and the basis for his representation of the injured infant;
14 (b) the name and address of the injured infant;
15 (c) the name and address of any physician providing
16 obstetrical services who was present at the birth and the
17 name and address of the hospital at which the birth
18 occurred;
19 (d) a description of the disability for which claim is
20 made;
21 (e) the time when and place where the injury occurred;
22 (f) a brief statement of the facts and circumstances
23 surrounding the injury and giving rise to the claim;
24 (g) all available relevant medical records relating to
25 the infant who allegedly suffered a birth-related

1 neurological injury and an identification of any unavailable
2 records known to the claimant and the reasons for their
3 unavailability;
4 (h) appropriate assessments, evaluations, and
5 prognoses and such other records and documents as are
6 reasonably necessary for the determination of the amount of
7 compensation to be paid to or on behalf of the injured
8 infant on account of a birth-related neurological injury;
9 (i) documentation of expenses and services incurred to
10 date and documentation of whether and by whom the expenses
11 and services have been paid; and
12 (j) documentation of any applicable private or
13 governmental source of services or reimbursement relative to
14 the alleged impairments.
15 (3) The claimant shall furnish the program officer
16 with as many copies of the petition as required for service
17 upon the program, any physician and hospital named in the
18 petition, the Montana state board of medical examiners, and
19 the department and shall pay a filing fee of $15. Upon
20 receipt of the petition, the program officer shall
21 immediately serve the petition by certified mail upon the
22 agent designated to accept service on behalf of the program
23 and shall mail copies of the petition to any physician and
24 hospital named in the petition, the board of medical
25 examiners, and the department.

(4) Upon receipt of the petition, the board of medical examiners shall evaluate the claim. If it determines that there is reason to believe that the alleged injury resulted from or was aggravated by substandard care on the part of the physician, it shall take any appropriate action consistent with the authority granted to the board in Title 37, chapter 3.

(5) Upon receipt of the petition, the department shall evaluate the claim. If it determines that there is reason to believe that the alleged injury resulted from or was aggravated by substandard care on the part of the hospital at which the birth occurred, it shall take any appropriate action consistent with the authority granted to the department in Title 50, chapter 5.

(6) The program officer shall, within 30 days of the date of service, file a response to the petition and submit relevant written information relating to the issue of whether the alleged injury is a birth-related neurological injury.

NEW SECTION. **Section 6. Tolling of statute of limitations.** With respect to any civil action that may be brought by or on behalf of an injured infant allegedly arising out of or related to a birth-related neurological injury, the statute of limitations is tolled by filing a claim in accordance with [section 5]. The time the claim is

pending is not computed as part of the period within which the civil action may be brought.

NEW SECTION. **Section 7. Hearing -- parties.** (1) Immediately after the petition has been received, the program officer shall set the date for a hearing, which may not be held sooner than 45 days or later than 120 days after the filing of the petition, and shall notify the parties to the hearing of the time and place of the hearing. The hearing must be held in the city or county where the injury occurred or in a contiguous city or county unless otherwise agreed to by the parties and authorized by the program officer.

(2) Parties to the hearing required under this section include the claimant and the program officer.

NEW SECTION. **Section 8. Interrogatories and depositions.** Upon application to the program officer setting forth the materiality of the evidence to be given, a party to a proceeding under [sections 1 through 22] may serve interrogatories or cause depositions of witnesses residing within or outside the state to be taken. The costs must be taxed as expenses incurred in connection with the filing of a claim, in accordance with [section 10(2)(d)]. The depositions must be taken after giving notice and in the manner prescribed by law for depositions in actions at law, except that they must be directed to the program officer

before whom the proceedings are pending.

NEW SECTION. **Section 9. Determination of claims -- presumption -- finding binding on participants -- medical advisory panel.** (1) The program officer shall determine, on the basis of the evidence presented, the following issues:

(a) whether the injuries claimed are birth-related neurological injuries. A disputable presumption arises if it has been demonstrated to the satisfaction of the program officer that the alleged injury is a birth-related neurological injury. If either party disagrees with that presumption, that party has the burden of proving that alleged injuries are not birth-related neurological injuries.

(b) whether obstetrical services were delivered at the birth by a participating physician;

(c) whether the birth occurred in a participating hospital; and

(d) the amount of compensation, if any, awardable pursuant to [section 10].

(2) The program officer shall immediately send a copy of the determination to the parties by certified mail if he determines that:

(a) the alleged injury is not a birth-related neurological injury;

(b) obstetrical services were not delivered at the

birth by a participating physician; or

(c) the birth did not occur in a participating hospital.

(3) By becoming a participating physician or participating hospital, each participant is bound for all purposes, including any suit at law against the participating physician or participating hospital, by the finding of the program officer (or any appeal from the finding) with respect to whether the injury is a birth-related neurological injury.

(4) The Montana state board of medical examiners shall develop a plan in which each claim filed with the program officer is reviewed by a panel of three qualified and impartial physicians. At least 10 days prior to the date set for the hearing pursuant to [section 7], the panel shall file with the program officer its report and recommendations as to whether the alleged injury is a birth-related neurological injury. At the request of the program officer, at least one member of the panel must be available to testify at the hearing. The program officer shall consider but is not bound by the recommendation of the panel.

NEW SECTION. **Section 10. Awards for birth-related neurological injuries -- criteria -- notice of award.** (1) The program officer shall award compensation upon determining that:

(a) an infant has sustained a birth-related neurological injury;

(b) obstetrical services were delivered at the birth by a participating physician; and

(c) the birth occurred in a participating hospital.

(2) Compensation must be awarded for the following items relative to the injury:

(a) except as provided in subsection (3), actual medically necessary and reasonable expenses of medical, hospital, rehabilitative, residential, and custodial care and service; special equipment or facilities; and travel related to such care and service;

(b) expenses under subsection (2)(a), which are limited to the charges that prevail in the community where the birth occurred for similar treatment of injured persons of a like standard of living when the treatment is paid for by the injured person;

(c) loss of earnings beginning at 18 years of age. An infant found to have sustained a birth-related neurological injury is conclusively presumed to have been able to earn income from 18 years of age to 65 years of age, if he had not been injured, in the amount of 50% of the average weekly wage in the state of workers in the private, nonfarm sector.

(d) reasonable expenses incurred in connection with filing a claim under [sections 1 through 22], including

reasonable attorney fees. These expenses are subject to the approval and award of the program officer.

(3) Expenses provided for in subsection (2)(a) may not include:

(a) expenses for items or services that the infant has received or is entitled to receive under the laws of any state or the federal government, except to the extent prohibited by federal law;

(b) expenses for items or services that the infant has received or is contractually entitled to receive from any prepaid health plan, health maintenance organization, or insurer;

(c) expenses for which the infant has received reimbursement or is entitled to receive reimbursement under the laws of any state or the federal government, except to the extent prohibited by federal law; and

(d) expenses for which the infant has received reimbursement or is contractually entitled to receive reimbursement pursuant to the provisions of any disability insurance policy or other private insurance program.

(4) A copy of the notice of award must be sent immediately by certified mail to the parties.

NEW SECTION. **Section 11. Review or rehearing on determination or award.** If an application for review is made to the program officer within 20 days from the date of a

determination pursuant to [section 9 (1)(a) through (1)(c)] or within 20 days from the date of an award by the program officer pursuant to [section 10], the program officer shall review the evidence. If considered advisable and as soon as practicable, the program officer may again hear the parties, their representatives, and witnesses and shall make a determination or award, as appropriate. A report of a review or determination made under this section, together with a statement of the findings of fact, conclusions of law, and other matters pertinent to the questions at issue, must be filed with the record of the proceedings and must be sent immediately to the parties.

NEW SECTION. **Section 12. Conclusiveness of determination or award -- appeal.** (1) The following determinations or awards are conclusive and binding as to all questions of fact:

(a) the determination of the program officer pursuant to [section 9(1)(a) through (1)(c)];

(b) the award of the program officer, as provided in [section 10], if not reviewed before expiration of the time limits provided in [section 11]; or

(c) a determination or award of the program officer upon review, as provided in [section 11].

(2) Appeals of the determination or award of the program officer must be made to the district court in the

manner provided in the Montana Administrative Procedure Act.

(3) The notice of appeal must be served by certified mail upon the program officer within 30 days from the date of the determination or award or within 30 days after receipt by the parties of the notice of determination or award. A copy of the notice of appeal must be filed in the office of the clerk of the district court as provided in the Montana Administrative Procedure Act.

(4) Cases appealed must be expedited by the district court. If a case is appealed from an award of the program officer to the district court, the appeal operates as a stay of the award and the program is not required to pay the award involved in the appeal until the issue on appeal is fully determined in accordance with [sections 1 through 22].

NEW SECTION. **Section 13. Enforcement of orders and awards.** The program officer has full authority to enforce his orders and awards and to protect himself from deception.

NEW SECTION. **Section 14. Limitation on claims.** A claim under [sections 1 through 22] that is filed more than 10 years after the birth of an infant alleged to have a birth-related neurological injury is barred.

NEW SECTION. **Section 15. Applicability -- scope of coverage.** [Sections 1 through 22] apply to all claims for birth-related neurological injuries occurring in the state on or after July 1, 1989. [Sections 1 through 22] do not

apply to disability or death caused by genetic or congenital abnormalities.

NEW SECTION. **Section 16. Fund.** There is a Montana birth-related neurological injury compensation fund to finance the program created by [sections 1 through 22].

NEW SECTION. **Section 17. Board of directors -- powers and duties -- appointments -- vacancies -- term.** (1) The program is governed by a board of five directors.

(2) Directors are appointed for a term of 3 years or until their successors are appointed.

(3) The directors are appointed by the governor as follows:

(a) one citizen representative;

(b) one representative of participating physicians;

(c) one representative of participating hospitals;

(d) one representative of liability insurers; and

(e) one representative of physicians other than participating physicians.

(4) The governor may select, but is not bound to appoint, nominees from a list of at least three names recommended by each of the following:

(a) the Montana society of obstetrics and gynecology, to represent participating physicians;

(b) the Montana hospital association, to represent participating hospitals;

(c) the American insurance association, the alliance of American insurers, and the national association of independent insurers, each recommending one nominee, to represent liability insurers; and

(d) the Montana medical association, to represent physicians other than participating physicians.

(5) If a vacancy occurs on the board prior to expiration of a term, the governor shall promptly notify the appropriate nominating association or group and nominations may be made by that association or group, pursuant to subsection (4), to represent its interest. The governor shall appoint the nominee in the same manner as provided in subsection (4).

(6) The board of directors shall act by majority vote, with five directors constituting a quorum for the transaction of any business or the exercise of any power of the program. The directors shall serve without salary, but each director must be reimbursed for actual and necessary expenses incurred in the performance of his official duties. The directors are not subject to any personal liability with respect to the administration of the program.

(7) The board of directors established by this section has the power to:

(a) administer the program;

(b) administer the fund;

(c) appoint a service company or companies to administer the payment of claims on behalf of the program;

(d) direct the investment and reinvestment of any surplus over losses and expenses in the fund, provided any investment income generated by investment remains in the fund; and

(e) reinsure the risks of the fund in whole or in part.

NEW SECTION. **Section 18. Plan of operation.** (1) On or before May 1, 1989, the board of directors of the program shall submit to the commissioner of insurance for review a proposed plan of operation consistent with [sections 1 through 22].

(2) The plan of operation must provide for the efficient administration of the program and for the prompt processing of claims made against the fund pursuant to an award under [sections 1 through 22]. The plan must contain other provisions, including:

(a) establishment of necessary facilities;

(b) management of the fund;

(c) appointment of a service company or other service arrangements to administer the processing of claims against the fund;

(d) initial and annual assessments of the persons and entities listed in [section 20] to pay awards and expenses,

which assessments must be on an actuarially sound basis; and

(e) any other matters necessary for the efficient operation of the program.

(3) The plan of operation is subject to approval by the commissioner of insurance after consultation with representatives of interested individuals and organizations. If the commissioner disapproves all or any part of the proposed plan of operation, the board of directors shall within 30 days submit for review an appropriate revised plan of operation. If the directors fail to do so, the commissioner shall promulgate a plan of operation. The plan of operation approved or promulgated by the commissioner becomes effective and operational upon order of the commissioner.

(4) Amendments to the plan of operation may be made by the board of directors, subject to the approval of the commissioner .

NEW SECTION. **Section 19. Assessments to be held in restricted cash account.** All assessments paid pursuant to the plan of operation must be held in a separate restricted cash account under the sole control of an independent fund manager selected by the board of directors. The fund and any income from it must be disbursed for the payment of awards as provided in [sections 1 through 22] and for the payment of expenses of administration of the fund.

NEW SECTION. **Section 20. Initial assessments.** (1) On or before July 1, 1989, the following persons and entities shall pay into the fund an initial assessment in accordance with the plan of operation:

(a) A physician who wishes to participate in the program and who otherwise qualifies as a participating physician under [sections 1 through 22] shall pay an initial assessment of $5,000. A physician employed by the state who wishes to participate in the program and who otherwise qualifies as a participating physician may pay the assessment required by this subsection on or before July 31, 1989, if he has notified the program on or before July 1, 1989, of his desire to participate.

(b) A hospital that wishes to participate in the program and that otherwise qualifies as a participating hospital under [sections 1 through 22] shall pay an initial assessment of $50 per delivery for the prior year, as reported to the department in the most recent annual licensure survey of hospitals, not to exceed $150,000 per hospital in any one 12-month period. A state-owned hospital that wishes to participate in the program and that otherwise qualifies as a participating hospital may pay the assessment required by this subsection on or before July 31, 1989, if it has notified the program on or before July 1, 1989, of its desire to participate.

(c) Each physician licensed by and practicing in the state as of May 1, 1989, other than a participating physician, shall pay an initial assessment of $250, in the manner required by the plan of operation.

(2) A physician who comes within one of the following categories is exempt from paying the initial and annual assessments imposed upon physicians other than participating physicians pursuant to [sections 1 through 22]:

(a) a physician who is employed by the state and whose income from professional fees is less than an amount equal to 10% of his annual salary;

(b) a physician who is enrolled in a full-time graduate medical education program accredited by the American council for graduate medical education; or

(c) a physician who has retired from active practice.

NEW SECTION. **Section 21. Annual assessments.** (1) Beginning July 1, 1989, each person and entity listed in [section 20(1)] shall pay an annual assessment in the amount equal to the initial assessment, in the manner required by the plan of operation.

(2) Taking into account the annual assessment collected pursuant to subsection (1) and until the fund becomes actuarially sound, each insurer authorized to transact and engaged in transacting liability insurance in the state as of July 1, 1989, shall pay an annual

assessment, in an amount determined by the commissioner of insurance pursuant to [section 22(1)], in the manner required by the plan of operation. For purposes of this section, liability insurance includes the classes of insurance defined in 33-1-206(1)(b), (1)(j), and (1)(n).

(a) The annual assessment against each liability insurer must be made on the basis of net direct premiums written for the business activity in the state that forms the basis for each liability insurer's inclusion as a funding source for the program during the prior year ending December 31, as reported to the commissioner. The annual assessment must be in the proportion that the net direct premiums written by each liability insurer on account of the business activity forming the basis for its inclusion in the program bear to the aggregate net direct premiums for all such business activity written in the state by all liability insurers. For purposes of [sections 1 through 22], "net direct premiums written" means gross direct premiums written in the state on all policies of liability insurance less:

(i) all return premiums on the policy;

(ii) dividends paid or credited to policyholders; and

(iii) the unused or unabsorbed portions of premium deposits on liability insurance.

(b) An entity listed in subsection (2) is not individually liable for an annual assessment in excess of

1/4 of 1% of that entity's net direct premiums written.

(c) A liability insurer is entitled to cover its initial and annual assessments through:

(i) a surcharge on policies written after [the effective date of this act];

(ii) a rate increase applicable prospectively; or

(iii) a combination of a surcharge and a rate increase, at the discretion of the commissioner of insurance.

NEW SECTION. **Section 22. Actuarial investigations -- valuation -- notice if assessments prove insufficient.** (1) The commissioner of insurance shall undertake an actuarial investigation of the requirements of the fund, based on the fund's experience in the first year of operation, including without limitation the assets and liabilities of the fund. Pursuant to the investigation, the commissioner shall establish the rate of contribution of the entities listed in [section 21(2)] for the tax year beginning January 1, 1990.

(2) Following the initial valuation, the commissioner shall make an actuarial valuation of the assets and liabilities of the fund at least biennially. Pursuant to the results of those valuations, the commissioner shall prepare a statement as to the contribution rate applicable to entities listed in [section 21(2)]. However, the rate may not be greater than 1/4 of 1% of net direct premiums written.

(3) If the commissioner finds that the fund cannot be maintained on an actuarially sound basis subject to the maximum assessments listed in [sections 20 and 21], the program officer shall promptly notify the legislature.

NEW SECTION. **Section 23.** **Appropriation.** There is appropriated from the general fund to the department of health and environmental sciences $33,799 for the fiscal year ending June 30, 1990, and $33,860 for the fiscal year ending June 30, 1991, for one staff position to review and determine claims submitted pursuant to [this act].

NEW SECTION. **Section 24.** **Extension of authority.** Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 25.** **Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 26.** **Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 27.** **Effective dates.** (1)

[Sections 1, 2, and 16 through 22 and 24 through 27] are effective on passage and approval.

(2) [Sections 3 through 15 and 23] are effective July 1, 1989.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for HB749, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

A bill for an Act entitled: "The Montana Birth-Related Neurological Injury Compensation Act; providing regulation of obstetrical medical malpractice insurance; providing a new remedy for birth-related neurological injuries; appropriating money to the Department of Health and Environmental Sciences to provide for review and determination of claims submitted under this Act; and providing effective dates."

ASSUMPTIONS:

1. That 50% of all farm owner, home owner, and commercial multiple peril policies relate to liability insurance and are subject to assessment per Section 21.
2. That the Section 21 liability premiums written in calendar year 1989 amounted to $90,715,000.
3. That liability premiums will increase by 7 1/2% in calendar years 1988 and 1989.
4. That the maximum assessments of .0025 of liability premiums written will be levied in the latter half of calendar years 1989 and 1990, per Sections 21 and 22, based on calendar year 1988 and 1989 premiums, respectively.
5. That the State Auditor will require actuarial studies, per Section 22, costs to be reimbursed from the fund.
6. That all assessments collected must be earmarked in a special fund.
7. The Board of Directors' expenses and costs will come from the Insurance Commissioner's office.

FISCAL IMPACT:

	FY90			FY91		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Revenue:	$ -0-	$244,000	$244,000	$ -0-	$262,000	$262,000
Expenditures:	$ -0-	$ 91,229	$ 91,229	$ -0-	$ 82,585	$ 82,585
Net Effect:						
General Fund	$ -0-	$152,771	$152,771	$ -0-	$179,415	$179,415

Note: Provisions of this Act require actuarial services, the State Auditor is assuming that our actuarial services costs will be reimbursed from the General Fund. We estimate these costs to be from $10,000 - $12,000 per year. $12,000 was included in the expenditures for the actuarial services.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:

Increase at or above inflation.

Ray Shackleford DATE 3/6/89
RAY SHACKLEFORD, BUDGET DIRECTOR
OFFICE OF BUDGET AND PROGRAM PLANNING

Marian W. Hanson DATE 3/8/89
MARIAN W. HANSON, PRIMARY SPONSOR

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