DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Legislative & Regulatory Initiatives

Date: February 7, 2017

Consistent with the request of the SCPD and GACEC, I am providing analyses of twelve (12) legislative and regulatory initiatives in anticipation of the February 9 meeting. Given time constraints, the analyses should be considered preliminary and non-exhaustive.

1. DMMA Final Delaware Healthy Children Program Premium Reg. [20 DE Reg. 639 (2/1/17)]

The SCPD and GACEC commented on the proposed version of this regulation in December, 2016. A copy of the December 14, 2016 SCPD memo is attached for facilitated reference. The Councils endorsed the initiative since it benefitted families by raising the income threshold for assessment of the monthly DHCP premium.

The Division of Medicaid & Medical Assistance is now acknowledging the SCPD endorsement and adopting a final regulation which conforms to the proposed version.

Since the regulation is final, and DMMA adopted a final regulation in a form endorsed by the Councils, no further commentary appears warranted. However, since DMMA does not acknowledge receipt of the GACEC's December 22, 2016 comments, the GACEC may wish to follow up to confirm receipt.

2. DSS Prop. Purchase of Care-Licensed Exempt Provider Reg. [20 DE Reg. 614 (2/1/17)]

The Department of Health & Social Services published the original proposed version of this regulation in December, 2016. The SCPD and GACEC submitted similar comments on the proposed regulation. A copy of the December 14, 2016 SCPD memo is attached for facilitated reference.

DHSS is now reissuing the proposed regulation since it was inadvertently published as a DMMA initiative:

DSS published this proposed regulation in the December 2016 Delaware Register. These regulations were erroneously published under the Division of Medicaid and Medical Assistance. In order to promote transparency and ensure that all applicable parties have a opportunity to participate in the public comment process, DSS has chosen to republish these regulations for further public review and comment.

At 615.

The February version of the regulation is identical to the December version with one (1) exception, i.e., the effective date is changed from February 11 to May 11, 2017. Therefore, the Councils' earlier comments remain apt subject to revising references to pages of the regulation and substituting "DSS" for "DMMA". The SCPD letter could be updated and resubmitted with the same attachments as follows:

As background, the federal Child Care and Development Block Grant funds child care for low income families who are working or participating in education or training activities. In 2016, new federal regulations were adopted which are prompting ~~DMMA~~ DSS to revise its provider standards. The changes will be effective on ~~February~~ May 11, 2017. At ~~413~~614.

One significant change is curtailing the scope of providers exempt from licensing. At ~~414~~615-616. Persons who come into the child's home and relatives who provide care in their own homes remain exempt from licensing. Id. However, the following entities would no longer be exempt:

(1) public or private school care;
(2) preschools and kindergarten care; and
(3) before and after school care programs.

~~DMMA~~ DSS recites that "(t)he final rule requires that all providers receiving Purchase of Care (POC) funding must now be licensed, including those that were previously license exempt, in order to continue receiving POC funding." I could not verify the accuracy of this recital which, read literally, would disallow the exemption of persons coming into a child's home and relatives providing care in their homes. At ~~414~~615. The federal regulation, with commentary, exceeds 600 pages so it is difficult to confirm the accuracy of the statement without extensive review. It is published at https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-22986.pdf The attached federal regulations (§§98.2 and 98.40) do not categorically require Delaware to remove the current licensing exemption of the above 3 types of entities. However, §98.40 does require DHSS to describe the rationale for any exemptions in its Plan. The regulation does not provide the rationale for retaining the exemption for persons coming into a child's home and relatives who provide care in their home apart from a bare listing of some health and safety standards.

A second change is deletion of an authorization category of "double time (D) which is two days". At ~~415~~617. The specific rationale for this change is also not provided.

SCPD did not identify any inconsistencies or facial issues in the proposed regulation. However, SCPD has the following observations and recommendations.

First, the regulation could be improved by including the rationale for retaining the 2 exemptions in §11004.4.1 consistent with the attached federal §98.40.

Second, SCPD recommends that ~~DMMA~~ DSS resolve the inconsistency between reciting that "all providers receiving Purchase of Care (POC) funding must now be licensed...." and still exempting 2 classes of providers.

Third, SCPD recommends that ~~DMMA~~ DSS provide the rationale for deleting the authorization category "double time (D) which is two days".

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations and recommendations on the proposed regulation.

3. DMMA Prop. Del. Healthy Children Program Vision Coverage Reg. [20 DE Reg. 610 (2/1/17)]

Delaware implements the federal Child Health Insurance Program (CHIP) through the State Delaware Healthy Children Program (DHCP). The DHCP provides health care services to children under age 19 whose families have countable income below 200% of the Federal Poverty Level (FPL). See DMMA Prop. Reg. 17-005b Amendment, §3.1.

The current proposal would expand vision services available to a subset of DHCP beneficiaries. In a nutshell, DMMA plans to contract with a non-profit Medicaid provider to offer free eye exams and glasses on site at Title I Delaware schools in which at least 51% of the student body receives free or reduced price meals. At 611. In FY17, it estimates that 600 children will receive vision exams and 408 children will receive glasses. In FY18, it estimates that 579 children will receive vision exams and 579 children will receive glasses. At 611. The cost to the State would be minimal since the current federal match is 90.94%. At 612. For example, in FY17 DMMA projects a State cost of $6,719 matched by $67,441 in federal funds. Id.

DMMA offers the following justification for the initiative:

> Access to vision exams and glasses is critical for students' educational achievements and health outcomes; 80% of all learning during a child's first 12 years is visual. It comes as no surprise that students with vision problems tend to have lower academic performance, as measured by test scores and grades, and that students' performance in school impacts future employment earnings, health behaviors, and life expectancy. As such, Delaware seeks to use the health services initiative (HIS) option to improve the health of low-income children by increasing their access to needed vision services and glasses through a targeted school-based initiative.

At 611.

Since vision services would benefit low-income children, and the proposal leverages significant federal funds, the SCPD may wish to consider support.

4. DMMA Prop. E&D Waiver Provider Policy Manual Reg. [20 DE Reg. 612 (2/1/17)]

The Division of Medicaid & Medical Assistance proposes major revisions to its Elderly & Disabled Waiver Provider Manuel. The primary impetus for the revisions is to promote conformity with the CMS HCBS settings rule. Overall, the initiative mirrors CMS standards and provides helpful, affirmative guidance to MCOs and providers.

I have the following observations.

First, DMMA provided an early draft of the revised policy to the DLP in December, 2015 which prompted the DLP to share 3 pages of recommendations in January, 2016. The current draft reflects approximately nine (9) amendments based on the recommendations.

Second, the Elderly and Disabled Waiver no longer exists. It was merged into the DSHP+ program in 2012. See, e.g., attached excerpt from DMMA May 18, 2011 overview. See also §1.0, deleting reference to E&D waiver. The title to the Provider Manual should therefore be revised. Consistent with §1.0, the following title could be considered: "Long Term Care Community Services (LTCCS) Provider Policy Manual" or "Long Term Care Community Services/Diamond State Health Plan Plus Provider Policy Manual".

Third, §2.2.1 does not match the formatting in the balance of the section and is merely a non-directive statement. Consider the following substitute:

> 2.2.1. The LTCCS setting must be integrated and support full access of LTCCS recipients to the greater community, including:...

Fourth, §§2.2.6 and 2.2.7 recite that recipients "should" have the freedom and support to control their own schedules... and be able to have visitors of their choosing at any time. This is not co-terminus with the federal regulation, 42 C.F.R. 441.530, which recites that states "must" make available a list of supports, including the following:

> Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
>
> Individuals are able to have visitors of their choosing at any time.

For consistency with §§2.2.2-2.2.5, DMMA may wish to use the term "must" rather than "should", i.e., "individuals must have the freedom" and "individuals must be able to have visitors...".

Fifth, §3.1.5 requires providers to provide DHSS with access to participant records. DMMA may wish to consider adding a provision addressing access by DHSS authorized representatives to provider-owned or leased settings (e.g. day habilitation; adult day services) in which covered services are provided. This is a DHSS statutory right for licensed residential LTC facilities. See Title 16 Del.C. §1105(a)(5), 1107 and 1134(d)(11). However, day programs are not covered by the residential LTC statutes so DHSS may wish to include the right in the policy manual.

Sixth, DMMA should correct the grammar in §3.3.2.6. The section recites that the person centered planning process is required to include nine (9) listed features. All of the items in the list begin with a verb. Subsection 3.3.2.6 is inconsistent. See Delaware Legislative Drafting Manual, Rule 27, published at http://legis.delaware.gov/docs/default-source/Publications/legislative-drafting-manual.pdf?sfvrsn=4

Seventh, in §3.4.2,, DMMA should consider replacing "authority" with "authorities" since there may be more than 1 entity to which critical incidents must be reported. For example, the DHSS PM 46 policy, §V.K.2 (Rev. 8/16) contemplates covered entities reporting to both the police and DHSS for conduct amounting to a crime. There is also overlapping jurisdiction between the Ombudsman (§3.4.2.2.2) and DLTCRP (§3.4.2.2.3).

Eighth, §§3.4.2.2.3 and 3.4.2.2.4 merit review. I understand that licensing of acute and outpatient health care was switched when the DPH OHFLC was placed under the DLTCRP effective July 1, 2016. See http://www.dhss.delaware.gov/dhss/dltcrp/

Ninth, DMMA may wish to add a reference to the requirement of critical incident reporting concerning patients of psychiatric hospitals and residential centers to the Protection & Advocacy agency pursuant to 16 Del.C. §5162. See also DHSS PM 46 policy, §V.K.2 (Rev. 8/16).

Tenth, §6.2, entitled "Available Services", omits some services included in the MCO contract, including minor home modifications, home-delivered meals, transition services, and nutritional supplements. Each of these services enhance community-based living as much as the listed personal emergency response system. DMMA should consider adding the omitted services.

Eleventh, §6.2.1 and 6.2.2 contain specific references to additional services for individuals with brain injuries in the contexts of adult day services and attendant services:

> Members with an acquired brain injury (ABI) or traumatic brain injury (TBI) will receive additional prompting and/or intervention as needed, and as indicated in the person-centered service plan.

This merits endorsement.

The SCPD may wish to share the above observations with the Division.

5. DOE Proposed Unit Count Regulation [20 DE Reg. 602 (2/1/17)]

The Department of Education (DOE) proposes to readopt its current unit count regulation with no changes. At 602.

I have the following observations.

First, the DOE indicates that public comment was already received on this regulation:

> Public comment was received for this regulation in which the Department of Education was asked to include language that provides more control over how local education agencies use the units they receive. The Department cannot mandate the requested change. Therefore, the regulation is being readopted in its current form.

At 602.

This is an "odd" recital since the regulation has not been published with a solicitation for comments since 2011. See attachment.

Second, the SCPD and GACEC commented on the same regulation in 2011. The Councils endorsed it at that time. See 15 DE Reg. 68 (7-1/11) (final) and attached May 31, 2011 SCPD letter. However, current review has revealed a few contexts in which revision may be warranted as follows.

A. Section 2.3 recites that "(s)tudents not assigned to a specific grade shall be reported in a grade appropriate for their age or their instructional level for purposes of the unit count." I recommend striking "or their instructional level". For example, if a student in a special school (e.g. Leach;; Ennis) is functioning several years below age expectations, the student could be reported as a much younger student. A high-school age student could therefore be reported as an elementary level student. Moreover, given the disjunctive "or", schools have the option of reporting based on age or instructional level. This will result in lack of uniformity in statistics. It would simply be preferable to report a student not assigned to a specific grade based on age.

B. Section 4.1.7 addresses pre-kindergarten children. The reference to "7.1" should be revised since there is no §7.1 in the regulation. I suspect the reference should be to "7.0".

C. Section 4.1.5 allows a district or charter school from including students in the unit count if temporarily in Stevenson House or the NCC Detention Center if expected to return to school prior to November 1. The DOE may wish to consider adding an analogous reference covering 18-21 year old students in Department of Correction pre-trial settings.

D. The regulation does not appear to address the operation of the unit count for the adult prison population. The DOE is responsible for provision of special education to students in prison. Cf. 14 DE Admin Code 923.75 I assume such services would be funded in part through qualifying unit count funds.

The SCPD may wish to share the above observations with the DOE.

6. H.B. No. 14 (Motorcycle Helmets)

This legislation was introduced on December 15, 2016. As of February 5, 2017, it awaited action by the House Public Safety & Homeland Security Committee.

As background, I attach a copy of the current statute [Title 21 Del.C. §4185(b)] which requires adults over 19 years of age to have a helmet in their possession while riding a motorcycle. Riders under 19 must actually wear the helmet. The bill would amend the statute to require riders of all ages to actually wear a helmet. Additional background is contained in the attached Delaware News Journal article, "Legislation proposed on motorcycle helmet use, violent dogs" (December 26, 2016).

Similar bills have been introduced in the past. See, e.g, bills introduced in 2007 (S.B. No. 46); and 2015 (H.B. No. 54). The 2015 bill was not released from committee despite wide-ranging support. See attached March 27 and April 2, 2015 New Journal articles. The State Council for Persons with Disabilities, which is statutorily designated the "primary brain injury council for the State" [29 Del.C. §8210(b)], has historically endorsed such initiatives.

If enacted, Delaware would join the majority of states in the Northeast in establishing a "universal" law requiring riders to wear helmets regardless of age. Currently, the neighboring states of New Jersey and Maryland have universal helmet laws. They are joined by New York, Massachusetts, Vermont, Virginia, West Virginia, and District of Columbia. See attachment. This leads to an anomaly for riders in the I-95 corridor. A rider traveling from D.C. to New Jersey would be required to wear the helmet for the entire route except for Delaware.

Clinical and highway safety agency support for universal helmet laws is overwhelming. See attachments. Consider the following:

The CDC reports that helmets reduce the risk of deaths by 37% and head injuries by 69%.

The National Highway Traffic Safety Administration (NHTSA) concluded that an annual $1.1 billion could have been saved in economic costs, and $7.2 billion in comprehensive costs, if all motorcyclists wore helmets in a single year.

Advocates for Highway & Auto Safety quote a GAO report which concluded that "laws requiring all motorcyclists to wear helmets are the only strategy proved to be effective in reducing motorcyclist fatalities."

Public Health Law Research (PHLR) reviewed the results of 69 studies resulting in the following "bottom line":

> According to a Community Guide systemic review, there is substantial evidence to support the effectiveness of universal helmet laws in increasing helmet use among motorcyclists, and to support that universal helmet laws reduce deaths, injuries and economic costs attributable to motorcycle crashes. Partial laws do not achieve any reduction in deaths, injuries or costs.

Finally, the fiscal burden imposed on Delaware State government and the Medicaid program is often overlooked in considering the value of universal helmet laws. A NHTSA report based on past studies concluded as follows:

> A number of the reviewed studies examined the question of who pays for medical costs. Only slightly more than half of motorcycle crash victims have private health insurance. For patients without private insurance, a majority of medical costs are paid by the government. Some crash patients are covered directly through Medicaid or another government program. Others, who are listed by the hospital as "self-pay" status, might eventually become indigent and qualify for Medicaid when their costs reach a certain level.

NHTSA, "Costs of Injuries Resulting from Motorcycle Crashes: A Literature Review, published at https://one.nhtsa.gov/people/injury/pedbimot/motorcycle/motorcycle_html/overview.html.

The SCPD may wish to share the above analysis with policymakers. Parenthetically, courtesy copies of communication could be shared with the Departments of Health & Social Services, Transportation, and Safety & Homeland Security.

7. H.B. No. 21 (Organ Transplant Discrimination)

This legislation was introduced on January 5, 2017. It was released by the House Health & Human Development Committee on January 18.

Background is contained in the attached January 5 press release. It recites that there were 471 Delawareans awaiting organ transplants on December 30, 2016. There is nationwide concern over disability-based discrimination in qualifying and receiving an organ transplant. Consistent with the attached articles, New Jersey enacted a ban in 2013 on discrimination in the organ transplant system based on a mental or physical disability with no significant relationship to the transplant. The July 18, 2013 article described the problem as follows:

> Individuals with mental or physical disabilities sometimes face discrimination in organ transplant scenarios because of assumptions regarding their quality of life or their ability to comply with complex post-transplant medical requirements, regardless of whether the individual has an effective support system in place to ensure compliance.

H.B. No. 21 would disallow a "covered entity" from engaging in discrimination in the organ transplant system. Discrimination would include refusal to refer an individual to a transplant center, refusal to place an individual on a waiting list, or placing the individual at a lower priority position on a waiting list (lines 66-77). H.A. No. 1 was placed with the bill on January 19. It would authorize judicial enforcement by the Attorney General or an aggrieved person. Remedies would include a civil penalty and the availability of damages.

The SCPD may wish to consider a general endorsement of the bill with a separate communication to the prime sponsors with the following observations:

1. Lines 76-77 disallow a "covered entity" from declining "insurance coverage" for a transplant or post -transplantation care. However, the definition of "covered entity" (lines 61-64) does not cover health insurers. If the sponsor wished to reach State-regulated insurers, it may be preferable to consider amending the Insurance Code, Title 18. For example, the Insurance Code includes discrimination bans based on mental illness (18 Del.C. §§ 3343, 3576 and 3578) and pre-existing conditions (18 Del.C. §§3361 and 3573). Conceptually, a ban on insurer discrimination in organ transplants based on disability could be added to the Insurance Code.

2. I identified two (2) concerns with the amendment.

A. There is a significant inconsistency between lines 5 and 17. Line 5 only authorizes an individual to file an action "for injunctive or other equitable relief" while line 17 authorizes the court to award monetary damages. This creates ambiguity in the law concerning the authority of the Chancery Court to award damages.

B. The focus of most litigants seeking to challenge discrimination under the bill would likely be injunctive relief to obtain access to a transplant rather than damages. The most critical aid in this context would be the availability of attorney's fees to a successful litigant. The availability of attorney's fees should preferably be made explicit at line 17 of HA. No. 1.

These overlapping concerns could be addressed as follows:

a. Amend line 5 as follows: "the Court of Chancery for ~~injunctive or other equitable~~ relief authorized by subsection © of this section.

b. Amend lines 17-18 as follows: "Award such other relief as the court considers appropriate, including monetary damages and attorney's fees to aggrieved persons.

8. H.S. No. 1 for H.B. No. 12 (Basic Special Education Unit)

This legislation was introduced on January 5, 2017. It was released from the House Education Committee on January 18 and assigned to the Appropriations Committee on January 19. It is similar to legislation (H.B. No. 30) introduced in 2015 which was endorsed by the SCPD and GACEC. The current bill however, has a more restrained fiscal note and incorporates a few technical amendments suggested by the Councils.

The bill addresses some anomalies in the current unit count system for students who qualify for special education.

First, special education students of all ages (Pre-K to 12) with "deep-end" needs are funded through "Intensive" or "Complex" units (lines 15-16). In contrast, special education students with "basic" needs are funded through the following units: Preschool (pre-kindergarten) and Basic Special Education (grades 4-12). There is an obvious gap, i.e, there is no distinct special education unit for students with basic needs in grades K-3. The K-3 special education students with basic needs are merged into a K-3 unit with all other students (line 10).

Second, the result of the above system is reduced funding for K-3 special education students with basic needs. The aberration is illustrated in the following table:

"BASIC NEEDS" SPECIAL EDUCATION STUDENT FUNDING

GRADE	UNIT COUNT (number of students needed to generate a unit)
Preschool (pre-K)	12.8
K-3	16.2
4-12	8.4

It is "odd" to have "richer" unit counts for very young (pre-K) students and students in higher (4-12) grades. Moreover, the difference in funding is dramatic. Identical K-3 students generate roughly half of the funding of the 4-12 students (16.2 versus 8.4).

The impact of the anomaly is difficult to measure. A district's duty to identify students with disabilities and provide a free, appropriate public education is not statutorily diminished by lower funding for the K-3 special education population (14 Del.C. §§3101, 3120, and 3122). However, it is logical to assume that reduced funding may influence the availability of services and supports for this cadre of students. Moreover, as highlighted in the attached January 25, 2017 News Journal article, the K-3 grades are critical to student success:

> A 2015 study by the National Center for Analysis of Longitudinal Data in Education Research identifies grade three as a crucial pivot. Between pre-K and third grade, about 41 percent of students were able to "graduate" from special services, the study found. After grade three, only about 26 percent of students transition out. The rest remain in special education for the rest of their academic careers.

The 2015 legislation (H.B. No. 30) proposed a modification of the special education "basic" unit so grades K-3 students with a current 16.2 funding ratio would have the same 8.4 funding ratio as grades 4-12 students. The fiscal note for this initiative was approximately $11 million. See attached fiscal note. The 2017 bill is more fiscally restrained. It gradually adjusts the basic special education unit count for grades K-3 over a 4-year period as illustrated in the following table:

PHASED IN "BASIC NEEDS" SPECIAL EDUCATION STUDENT FUNDING FOR GRADES K-3

SCHOOL YEAR	UNIT COUNT	STATE SHARE OF COSTS
2017-18	14.2	$1.759 MILLION (FY18)
2018-19	12.2	$4.173 MILLION (FY19)
2019-2020	10.2	$7.636 MILLION (FY20)
2020-2021	8.4	$12.294 MILLION (FY21)

The SCPD may wish to share the above analysis with policymakers.

9. H.B. No. 55 (Compulsory School Attendance)

This legislation was introduced on January 25, 2017. As of February 5, it awaited action by the House Education Committee.

Background is compiled in the attached January 26, 2017 article. H.B. No. 55 would raise the compulsory school attendance age from 16 to 18 over the next few years. The compulsory attendance age would rise to 17 effective September 1, 2018 and 18 effective September 1, 2019 (lines 12-16 and 22-25). Related Code sections addressing waivers of attendance and police detention of "off campus" students are also revised. Similar or overlapping legislation is also pending. For example, H.B. No. 17 is a simpler bill which would raise the compulsory school attendance age to 17. H.B. No. 23 would require students over 16 seeking to withdraw from school to have parental consent and an exit interview.

Similar legislation (H.B. No. 244) was introduced in 2012 to increase the compulsory school attendance age from 16 to 18. At that time, the fiscal note for raising the age to 18 reflected an estimated State cost of $879,000 - $1,551,000. The 2017 legislation is earmarked for a fiscal note but it is not posted on the legislative website.

I have the following observations on H.B. No. 55.

First, the attached National Center for Education Statistics table reveals that Delaware's neighboring states had the following compulsory age standards as of 2015:

- New Jersey: 16
- Pennsylvania: 17
- Maryland: 17

The overall national picture is compiled in the following table:

NCES Statistics (2015)

Compulsory Education Age	Number of States (& D.C.)
16	15
17	11
18	25

Consistent with the above statistics, Delaware is in a minority in maintaining 16 as the compulsory education age.

Second, the SCPD's comments on the 2012 legislation included materials describing the pros and cons of raising the age of compulsory school attendance. National organizations have generally endorsed raising the compulsory education age if accompanied by other strategies and resources to promote student success. The SCPD's 2012 commentary remains apt:

> (T)here are pros and cons to raising the compulsory school attendance age. The attached National Conference of State Legislatures ("NCSL") summary identifies perceived advantages and disadvantages. Advantages include encouraging more students to attend college and decreasing dropout rates, juvenile crime, and teen pregnancy. Disadvantages include financial costs and devotion of resources to truancy and disruption linked to students who do not wish to be in school. In 2010, the National Association of Secondary School Principals ("NAASP") adopted the attached position statement endorsing compulsory education to age 18. However, both the attached NAASP and CLASP materials and January 28, 2012 News Journal editorial stress the importance of adopting additional strategies to promote effective implementation of higher-age compulsory attendance. For example, the NAASP statement included the following recommendation:
>
> > Provide funding for graduation coaches, counselors who focus solely on at risk students. They monitor student's academic progress and attendance and work with teachers to identify those who are falling behind or at risk of doing so. Graduation coaches also focus on getting parents involved and will make home or workplace visits with parents.

Third, the sponsors may wish to review a technical observation in the context of exemptions. A student can qualify for an exemption by having an alternative learning plan approved by the head of the district or charter school of enrollment. See lines 35-37, 45-47, 78-79, and 88-90. However, a student's appeal of denial of a waiver is not filed with the board of the district or charter school of enrollment. It is filed with the board of the district of residence (line 50 and 62) which has had no involvement with the decision. Thus, a student who has opted for a "choice" program in a different district would submit a waiver to the "choice" district superintendent but appeal a denial to the board of the district of residence. Perhaps this is the intended model but it may merit review.

The SCPD may wish to consider endorsing an increase in the compulsory education age if accompanied by targeted supports such as graduation coaches.

10. H.B. No. 23 (Student Withdrawal from School)

This legislation was introduced on January 5, 2017. It was released by the House Education Committee on January 25, 2017.

The bill would explicitly condition the withdrawal of a student over the age of 16 from school prior to graduation on the following: 1) written parental consent; and 2) an exit interview. The exit interview would include disclosure of information about the effects of dropping out of school and the availability of support services to assist the student in remaining enrolled in school. The requirement of parental consent is ostensibly already required by law. See Title 14 Del.C. §2722(b):

> (b) No pupil who could otherwise legally fail to attend school pursuant to §2702(a) of this title may do so without the written consent of such person or persons having the legal control of that pupil.

I have the following observations.

First, the requirement of an exit interview is a prudent measure which should promote informed decision-making.

Second, the sponsors may wish to consider limiting the parental consent requirement to minors. Literally, a student aged 18-21 would be required to have parental consent to withdraw from school. Since the student is an adult, requiring parental consent to withdraw from school is not appropriate. Indeed, the definition of "parent" for purposes of school attendance only extends to students under age 18. See Title 14 Del.C. §2721. Moreover, the truancy law [§2722(b)] only contemplates parental/guardian consent if there is "legal control" of a student. Finally, special education students generally assume parental rights upon attainment of age 18. See 14 Del.C. §3101(7). Cf. Title 1 Del.C. §701.

Third, there is no fiscal note accompanying the bill. The synopsis describes the intent as lowering the dropout rate and encouraging students to complete high school. Other legislation with the expected effect of deterring withdrawal from school has been accompanied by a fiscal note. See, e.g., current H.B. No. 17 and H.B. No.55.

Fourth, the sponsors may wish to consider expanding the bill to remove an existing incentive to drop out of school. Under Department of Education regulation, a student is not permitted to take a GED test unless the student has formally withdrawn from school. See 14 DE Admin Code 910. Some students who are "on the fencepost" regarding pursuit of a GED versus diploma might stay in school if allowed to pursue a GED without the necessity of dropping out. For example, some "older" students may have so few credits towards graduation that it is highly unlikely that they could qualify for a diploma by age 21.

The SCPD may wish to consider endorsement of the legislation subject to an amendment clarifying that parental consent is only necessary for minors.

11. H.B. No. 47 (Absentee Voting)

This legislation was introduced on January 24, 2017. As of February 5, the bill awaited action by the House Administration Committee.

The synopsis succinctly describes the purpose and effect of the bill:

> This bill removes the notary requirement for requests for absentee ballots. Delaware is the only state that requires a notary to authorize a voter's affidavit for an absentee ballot. In some cases, the potential voter may have to pay for the notary and Delaware essentially charges them to vote.

I have the following observations.

First, the legislation would benefit individuals with disabilities who may disproportionately rely on absentee ballots given variable health or difficulty traveling to polling sites.

Second, the notary requirement has already been "diluted" in the Delaware Code. Absentee ballots are authorized based on eight (8) discrete scenarios/justifications. See 15 Del.C. §5502. The Code already authorizes "self-administration" of an absentee ballot affidavit for at least half of the scenarios/justifications:

> (e) Notwithstanding any other provision of this section to the contrary, the affidavit of any elector desiring to receive an absentee ballot because the person qualifies under any of the reasons set forth in §5502 (1), (2), (4) or (7) of this title or because a person's business or occupation is providing care to his or her parent, spouse, or child who is living at home and requires constant care due to illness, disability, or injury, may be self-administered.

Title 15 Del.C. §5503. As a result, the existing process may be confusing to the public. The bill has the salutary effect of making the process for requesting an absentee ballot uniform which reduces confusion and facilitates administration by the Department of Elections.

Second, criminal penalties for submitting a false request are ostensibly still applicable. The application must be "subscribed and sworn to by the elector" (line 19). The Election Code authorizes prosecution resulting in fines and imprisonment if an individual engages in the following:

> (7) Knowingly, wilfully or fraudulently does any unlawful act to secure an opportunity for himself or herself or for any other person to vote.

Title 15 Del.C. §5128. Moreover, false swearing in a written instrument may qualify as perjury. See Title 11 Del.C. §§1221,1222, and 1224.

Consistent with the above observations, the SCPD may wish to consider sharing positive commentary with policymakers.

12. H.B. No. 39 (Mental Health Commitment)

This legislation was introduced on January 18, 2017. As of February 5, it awaited action by the House Judiciary Committee.

As background, the legislation is almost identical to legislation which passed the House in 2016, H.S. No. 1 for H.B. No. 310 with H.A. No. 1. The SCPD had shared an analysis on the initial version of the legislation (H.B. No. 310) which identified several concerns. The 2016 substitute bill and the current H.B. No. 39 address some of the concerns.

In a nutshell, the legislation would extend Family Court jurisdiction in the mental health commitment context. If an individual is subject to mental health commitment as an adult, the case would automatically be transferred from Superior Court to Family Court if the individual were in DSCY&F custody at age 18 and identified or diagnosed with a mental condition (as defined in 16 Del.C. §5001) as a minor. See lines 7-12. The Family Court would utilize and apply the same procedures and legal standards contained in Chapter 50 (lines 28-30).

I have the following observations.

First, there could be some benefit to extending Family Court jurisdiction if the Family Court has active mental-health related proceedings at the time a youth in DSCY&F custody is turning 18. The Court would have familiarity with the individual which would be correlated with more informed dispositions. On the other hand, the bill would cover individuals with no recent mental health related proceedings in Family Court and no recent diagnosis. For example, an individual who had a qualifying mental diagnosis at age 6 which resolves would still be "captured" by the bill if a commitment proceeding is initiated at age 25 based on a new diagnosis.. It may therefore be preferable to consider amending lines 9-10 as follows:

> ~~Prior to~~ At the time of attaining 18 years of age, the youth has been identified or diagnosed with a mental condition as defined in §5001 of Title 16.

Second, extending Family Court jurisdiction to age 26 is an anomaly. In other contexts in which Family Court jurisdiction is extended into adulthood, the limit is generally age 21. Compare Title 10 Del.C. §§928 (juvenile delinquency) and 929 (abused, dependent or neglected youth). See also Title 10 Del.C. §921(12) and 14 Del.C. §3101(1) (special education students). Indeed, the bill (line 17) explicitly envisions "concurrent" jurisdiction with §§928 and 929. The sponsors may therefore wish to consider changing references from "26" to "21" in lines 11, 14, and 23.

Third, there may be circumstances in which it would be preferable for the Superior Court to retain jurisdiction. For example, there may be pending Superior Court adult criminal charges or proceedings related to competency or insanity related to an individual's mental status. Unfortunately, the bill establishes a "brittle" standard in which commitment proceedings involving a covered individual must be transferred from Superior to Family Court (line 20). The sponsors could consider changing alternate approaches to address this anomaly:

A. The word "shall" could be changed to "may" in line 20.

OR

B. Line 19-20 could be amended as follows:

(1) In any proceeding under Chapter 50 of Title 16 involving a youth who meets the criteria of this section, the Superior Court shall, in the absence of countervailing considerations, upon notification by the youth or its own initiative, transfer the case to the Family Court...

The latter alternative would provide a presumption of transfer while giving the Superior Court some discretion to consider other factors (e.g. other proceedings pending in Superior Court).

Fourth, juveniles are generally committed through parental consent rather than involuntary commitment proceedings. See, e.g., Title 50 Del.C. §5003(f). Therefore, there are typically few State costs (e.g. appointed counsel; expert witnesses) related to commitment of minors. Adult commitment proceedings, on the other hand, typically involve State costs. See, e.g., Title 16 Del.C. §§5007(3)(4). While the Superior Court may have an existing fund for such costs, it is unclear if the Family Court would have such a fund to cover the costs of its extended jurisdiction. The bill has no fiscal note and there is no provision addressing Family Court costs attributable to its enhanced jurisdiction.

Fifth, identification of individuals subject to the bill may be difficult. It applies to youth "identified or diagnosed with a mental condition as defined in §5001 of Title 16" (lines 9-10). That statute does not provide a discrete list of qualifying conditions. Rather, it contains several imprecise functional criteria:

(13) "Mental condition" means a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, capacity to control behavior, or capacity to recognize reality. Unless it results in the severity of impairment described herein, "mental condition" does not mean simple alcohol intoxication, transitory reaction to drug ingestion, dementia due to various nontraumatic etiologies or other general medical conditions, Alzheimer's disease, or intellectual disability. The term "mental condition" is not limited to "psychosis" or "active psychosis," but shall include all conditions that result in the severity of impairment described herein.

Query whether the courts or the DSCY&F will be able to validly and reliably identify persons who have met the above standard at any time between ages 1-18.

Sixth, it is unclear what advantages are contemplated for diverting jurisdiction over some adult commitment proceedings to the Family Court. In other contexts in which the Family Court is authorized to extend its jurisdiction into adulthood, the Court is explicitly given a role in promoting access to services. See, e.g., Title 10 Del.C. §929:

c) The purpose of extended jurisdiction is to enable youth who are provided developmentally appropriate, comprehensive independent living services from age 14 to 21 to assist with their successful transition into adulthood under the John H. Chafee Independence Act (P.L. 106-169) or the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351), and other relevant services, to have a legal mechanism for Family Court review of the appropriateness of such services. Extended jurisdiction may continue until the youth attains 21 years of age. Notwithstanding extended jurisdiction, the youth shall attain the age of majority at age 18, and DSCYF custody shall terminate at that time by operation of law.

H.B. No 39 has no analogous provision describing the advantages of Family Court jurisdiction versus Superior Court jurisdiction. The Family has historically been authorized to entertain broad injunctive relief: See, e.g. Title 10 Del..C. §925, which grants the following general power:

15) In any civil action where jurisdiction is otherwise conferred upon the Family Court, it may enter such orders against any party to the action as the principles of equity appear to require.

It is unclear if the Family Court could order DSAMH , a Medicaid MCO, or other State or State-contacted entity to provide needed support services. The bill could be improved by including a description of the Family Court's role and authority in directing or arranging remedial services. Without such a component, the bill grants the Family Court authority to restrict adult liberties without countervailing authority to prompt State agencies to provide necessary support services identified by the Court.

The SCPD may wish to consider sharing the above observations with policymakers, including Attorney General Matt Denn; Sarah Goncher, DAG; the Honorable Michael Newell, the Family Court Chief Judge; and Richard Morse, Esq., Delaware ACLU.

Attachments

E:legis/2017/217bils
F:pub/bjh/legis/2017/217P&L

STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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MEMORANDUM

DATE: December 14, 2016

TO: Ms. Kimberly Xavier, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 20 DE Reg. 416 [DMMA Proposed Delaware Healthy Children Program Premium Regulation (12/1/16)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to amend its regulations regarding the Delaware Healthy Children Program. The proposed regulation was published as 20 DE Reg. 416 in the December 1, 2016 issue of the Register of Regulations.

The Delaware Healthy Children Program represents the State's implementation of the federal SCHIP program which provides health assistance to uninsured, low income children. Delaware has included a premium requirement in it program from its inception. In 2014, DMMA proposed and ultimately adopted some changes to its premium standards. DMMA then collaborated with CMS to update the provisions in the CHIP State Plan and reconcile them with federal law during 2015-2016. DMMA is now issuing a proposed regulation to conform to the consensus reached with CMS.

SCPD did not identify any shortfalls with the proposed standards. They uniformly benefit families since they raise the thresholds which trigger the premium requirement. For example, the $15/month premium previously applied to families with countable income at or above 143% of the Federal Poverty Level. That threshold has been raised to families with countable income at or above 177% of the Federal Poverty level.

SCPD endorsed the proposed regulation since the changes are being prompted by CMS and benefit families.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position or observations on the proposed regulation.

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council
20reg416 dmma-delaware healthy children program premium 12-14-16

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MEMORANDUM

DATE: December 14, 2016

TO: Ms. Kimberly Xavier, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 20 DE Reg. 412 [DMMA Proposed Purchase of Care-Licensed Exempt Provider Regulation (12/1/16)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to amend its regulations applicable to Purchase of Care Providers. The proposed regulation was published as 20 DE Reg. 412 in the December 1, 2016 issue of the Register of Regulations.

As background, the federal Child Care and Development Block Grant funds child care for low-income families who are working or participating in education or training activities. In 2016, new federal regulations were adopted which are prompting DMMA to revise its provider standards. The changes will be effective on February 11, 2017.

One significant change is curtailing the scope of providers exempt from licensing. Persons who come into the child's home and relatives who provide care in their own homes remain exempt from licensing. Id. However, the following entities would no longer be exempt:

(1) public or private school care;
(2) preschools and kindergarten care; and
(3) before and after school care programs.

DMMA recites that "(t)he final rule requires that all providers receiving Purchase of Care (POC) funding must now be licensed, including those that were previously license exempt, in order to continue receiving POC funding." SCPD could not verify the accuracy of this recital which, read literally, would disallow the exemption of persons coming into a child's home and relatives providing care in their homes. At 414. The federal regulation, with commentary, exceeds 600 pages so it is difficult to confirm the accuracy of the statement without extensive review. It is published at https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-22986.pdf

The attached federal regulations (§§98.2 and 98.40) do not categorically require Delaware to remove the current licensing exemption of the above 3 types of entities. However, §98.40 does require DHSS to describe the rationale for any exemptions in its Plan. The regulation does not provide the rationale for retaining the exemption for persons coming into a child's home and relatives who provide care in their home apart from a bare listing of some health and safety standards.

A second change is deletion of an authorization category of "double time (D) which is two days". At 415. The specific rationale for this change is also not provided.

SCPD did not identify any inconsistencies or facial issues in the proposed regulation. However, SCPD has the following observations and recommendations.

First, the regulation could be improved by including the rationale for retaining the 2 exemptions in §11004.4.1 consistent with the attached federal §98.40.

Second, SCPD recommends that DMMA resolve the inconsistency between reciting that "all providers receiving Purchase of Care (POC) funding must now be licensed...." and still exempting 2 classes of providers.

Third, SCPD recommends that DMMA provide the rationale for deleting the authorization category "double time (D) which is two days".

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations and recommendations on the proposed regulation.

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

20reg412 dmma-purchase of care-licensed exempt provider 12-14-16

learning and strengthen and retain (including through financial incentives and compensation improvements) the child care workforce.

3. Amend § 98.2 as follows:

a. Revise the definition of *Categories of care*;

b. Add in alphabetical order definitions for *Child experiencing homelessness, Child with a disability,* and *Director*;

c. Revise the definition of *Eligible child care provider*;

d. Add in alphabetical order a definition for *English learner*;

e. Revise the definition of *Family child care provider*;

f. Remove the definition of *Group home child care provider*; and

g. Revise the definitions of *Lead Agency, Programs,* and *Sliding fee scale*; and

h. Add in alphabetical order a definition for *Teacher.*

The revisions and additions read as follows:

§ 98.2 Definitions.

* * * * *

Categories of care means center-based child care, family child care, and in home care;

* * * * *

Child experiencing homelessness means a child who is homeless as defined in section 725 of Subtitle VII–B of the McKinney-Vento Act (42 U.S.C. 11434a);

Child with a disability means:

(1) A child with a disability, as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401);

(2) A child who is eligible for early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 *et seq.*);

(3) A child who is less than 13 years of age and who is eligible for services under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794); and

(4) A child with a disability, as defined by the State, Territory or Tribe involved;

* * * * *

Director means a person who has primary responsibility for the daily operations and management for a child care provider, which may include a family child care provider, and which may serve children from birth to kindergarten entry and children in school-age child care;

* * * * *

Eligible child care provider means:

(1) A center-based child care provider, a family child care provider, an in-home child care provider, or other provider of child care services for compensation that—

(i) Is licensed, regulated, or registered under applicable State or local law as described in § 98.40; and

(ii) Satisfies State and local requirements, including those referred to in § 98.41 applicable to the child care services it provides; or

(2) A child care provider who is 18 years of age or older who provides child care services only to eligible children who are, by marriage, blood relationship, or court decree, the grandchild, great grandchild, siblings (if such provider lives in separate residence), niece, or nephew of such provider, and complies with any applicable requirements that govern child care provided by the relative involved;

English learner means an individual who is an English learner, as defined in section 8101 of the Elementary and Secondary Education Act of 1965 or who is limited English proficient, as defined in section 637 of the Head Start Act (42 U.S.C. 9832);

* * * * *

Family child care provider means one or more individual(s) who provide child care services for fewer than 24 hours per day per child, in a private residence other than the child's residence, unless care in excess of 24 hours is due to the nature of the parent(s)' work;

* * * * *

Lead Agency means the State, territorial or tribal entity, or joint interagency office, designated or established under §§ 98.10 and 98.16(a) to which a grant is awarded and that is accountable for the use of the funds provided. The Lead Agency is the entire legal entity even if only a particular component of the entity is designated in the grant award document;

* * * * *

Programs refers generically to all activities under the CCDF, including child care services and other activities pursuant to § 98.50 as well as quality activities pursuant to § 98.53;

* * * * *

Sliding fee scale means a system of cost-sharing by a family based on income and size of the family, in accordance with § 98.45(k);

* * * * *

Teacher means a lead teacher, teacher, teacher assistant, or teacher aide who is employed by a child care provider for compensation on a regular basis, or a family child care provider, and whose responsibilities and activities are to organize, guide, and implement activities in a group or individual basis, or to assist a teacher or lead teacher in such activities, to further the

(3) The clarification that assistance received during the time an eligible parent receives the exception referred to in paragraph (f) of this section will count toward the time limit on Federal benefits required at section 408(a)(7) of the Social Security Act (42 U.S.C. 608(a)(7)).

(g) Include in the triennial Plan the definitions or criteria the TANF agency uses in implementing the exception to the work requirement specified in paragraph (f) of this section.

19. In § 98.40, redesignate paragraph (a)(2) as (a)(3), revise newly redesignated paragraph (a)(3), and add new paragraph (a)(2).

The addition and revision read as follows:

§ 98.40 Compliance with applicable State and local regulatory requirements.

(a) ***

(2) Describe in the Plan exemption(s) to licensing requirements, if any, for child care services for which assistance is provided, and a demonstration for how such exemption(s) do not endanger the health, safety, or development of children who receive services from such providers. Lead Agencies must provide the required description and demonstration for any exemptions based on:

(i) Provider category, type, or setting;

(ii) Length of day;

(iii) Providers not subject to licensing because the number of children served falls below a State-defined threshold; and

(iv) Any other exemption to licensing requirements; and

(3) Provide a detailed description in the Plan of the requirements under paragraph (a)(1) of this section and of how they are effectively enforced.

* * * * *

EXCERPT: 6-22-11 DHSS PRESENTATION ON DSHP-PLUS INITIATIVE

Populations Included in Expansion

- Nursing Facility/Institutionalized
- HCBS groups
  - Existing E/D and AIDS waiver participants; existing 1915c waivers will be "folded into" the 1115 waiver
- Money Follows the Person (MFP) will be incorporated into the DSHP-Plus expansion
- Other full benefit dual eligibles in the community
- Medicaid for Workers with Disabilities (MWD)

HOME
Delaware's Governor
The General Assembly
Courts

SERVICES
Division of Research
Subscription Services
Monthly Regulatory Subscription Service
Legislation Notification Services

INFORMATION
Delaware Code
Administrative Code
Delaware Regulations
Cumulative Tables
City and Town Charters

Your search for '701 unit count' in 'CumulativeTables' view returned 10 document(s)

Search: Go Advanced

Department	Title	
Education\Office of the Secretary	701 Unit Count	20 DE Reg. 602(02/01/2017)(Proposed)
Education\Office of the Secretary	701 Unit Count	15 DE Reg. 68(07/01/2011)(Final)
Education\Office of the Secretary	701 Unit Count	14 DE Reg. 1161(05/01/2011)(Proposed)
Education\Office of the Secretary	701 Unit Count	13 DE Reg. 1452(05/01/2010)(Final)
Education\Office of the Secretary	701 Unit Count	8 DE Reg. 1475(04/01/2005)(Final)
Education\Office of the Secretary	701 Unit Count	8 DE Reg. 1070(02/01/2005)(Proposed)
Education\Office of the Secretary	701 Unit Count	4 DE Reg. 1902(06/01/2001)(Proposed)
Education\Office of the Secretary	701 Unit Count	5 DE Reg. 627(09/01/2001)(Final)
Education\Office of the Secretary	701 Unit Count	5 DE Reg. 29(07/01/2001)(Proposed)
Education\Office of the Secretary	701 Unit Count	6 DE Reg. 74(07/01/2002)(Final)

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May 31, 2011

Ms. Susan K. Haberstroh
Education Associate
Department of Education
401 Federal Street, Suite 2
Dover, DE 19901

RE: 14 DE Reg. 1161 [DOE Prop. Unit Count Regulation]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to adopt some discrete amendments to its unit count standards based on the enactment of H.B. 1 in February 2011. In addition, the DOE proposes to delete a reference to a repealed regulation. The proposed regulation was published as 14 DE Reg. 1161 in the May 1, 2011 issue of the Register of Regulations.

SCPD endorses the proposed regulation.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position on the proposed regulation.

Sincerely,

Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

cc: The Honorable Lillian Lowery
Dr. Teri Quinn Gray
Ms. Martha Toomey
Ms. Paula Fontello, Esq.
Ms. Terry Hickey, Esq.
Mr. John Hindman, Esq.
Mr. Charlie Michels
Mr. Brian Hartman, Esq.
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens

§ 4185 Riding on motorcycles.

(a) A person operating a motorcycle shall ride only upon the permanent and regular seat attached thereto, and such operator shall not carry any other person nor shall any other person ride on a motorcycle unless such motorcycle is designed to carry more than 1 person in which event a passenger may ride upon the permanent and regular seat if designed for 2 persons or upon another seat firmly attached to the rear or side of the operator and said motorcycle shall be equipped with passenger footrests.

(b) Every person operating or riding on a motorcycle shall have in that person's possession a safety helmet approved by the Secretary of Safety and Homeland Security (hereinafter "Secretary") through the Office of Highway Safety and shall wear eye protection approved by the Secretary; provided, however, that every person up to 19 years of age operating or riding on a motorcycle shall wear a safety helmet and eye protection approved by the Secretary.

(c) The operator of a motorcycle shall keep at least 1 hand on a handgrip of the handlebars at all times when moving.

(d) A person shall ride upon a motorcycle only while sitting astride the seat, facing forward, with 1 leg on each side of the motorcycle.

(e) No person shall operate a motorcycle while carrying any package, bundle or other article which prevents the person from keeping both hands on the handlebars.

(f) No operator shall carry any person, nor shall any person ride, in a position that will interfere with the operation or control of the motorcycle or the view of the operator.

21 Del. C. 1953, § 4182; 56 Del. Laws, c. 333; 60 Del. Laws, c. 701, § 54; 61 Del. Laws, c. 314, § 1; 70 Del. Laws, c. 186, § 1; 74 Del. Laws, c. 110, § 90; 75 Del. Laws, c. 75, § 1.;

GENERAL ASSEMBLY

Legislation proposed on motorcycle helmet use, violent dogs

Bills have been filed ahead of session starting Jan. 10

MATTHEW ALBRIGHT
THE NEWS JOURNAL

When the General Assembly convenes on Jan. 10, they will be met by some already-filed bills, including one that would require all motorcycle riders to wear a helmet.

Other pre-filed measures include one that would prevent cities and towns from labeling dogs dangerous because of their breed, one that would eliminate the estate tax and one that would provide more special education services to young students.

Current law requires motorcyclists to merely keep a helmet with their motorcycle, but does not require riders to actually wear it unless they are 19 or younger.

Rep. Sean Lynn, D-Dover, and Sen. Gary Simpson, R-Milford, have proposed legislation that would require every motorcyclist to wear a helmet. They cite traffic statistics that show almost half of the 48 people who died in motorcycle crashes in Delaware since 2014 were not wearing helmets.

Lynn sponsored a similar bill 2015 at the urging of a constituent whose husband suffered a traumatic brain injury in a crash without a helmet. But the bill stalled in committee amid opposition from motorcyclists who said it was government overreach.

Lynn argues taxpayers end up paying for the long-term care of those who suffer brain injuries in a crash, so helmets are in the public's interest. He compared helmet laws to laws requiring seat belts.

"This isn't government overreach, this is common sense," Lynn said.

A bill sponsored by Sen. Charles Potter, D-Wilmington North, and Sen. Dave Sokola, D-Newark, would ban local governments from passing ordinances that label all dogs of a specific breed as "dangerous." Owners who have such dogs must follow strict requirements on leashing and keeping the animals indoors or behind secure fences, and can be fined for violations.

There have been fights in some cities across the country over whether certain breeds of dog, like pit bulls and rottweilers, should be considered dangerous. Advocates for such laws say they protect residents, particularly children, but owners of those breeds say they are discriminating against animals

See LAWS, Page 9A

Laws

Continued from Page 1A

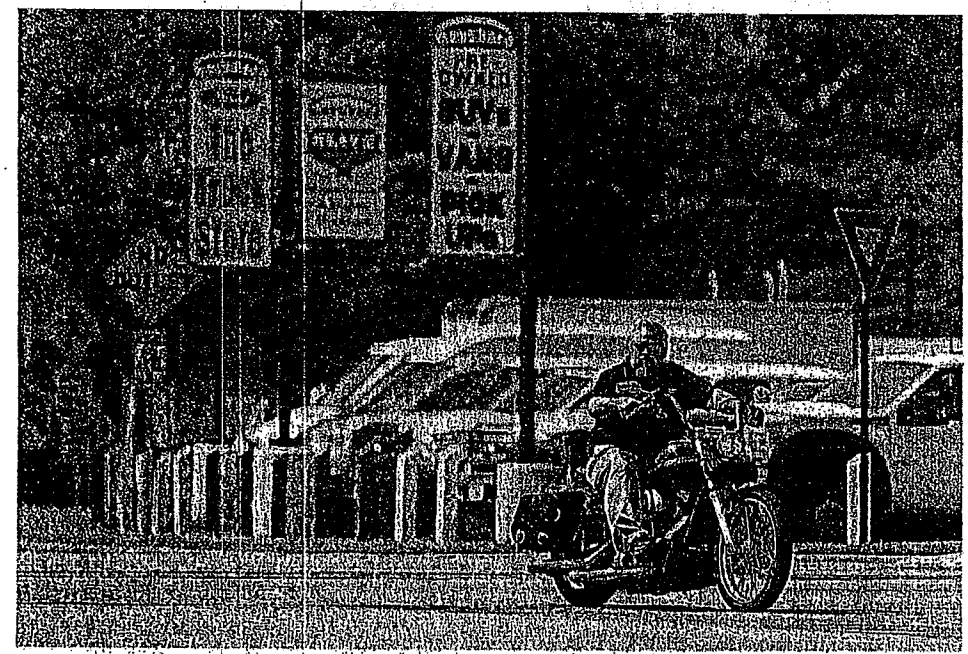
that can be as loving and gentle as any pet.

Potter's bill would prevent towns from imposing such laws. Instead, dogs could only be labeled dangerous based on their individual behavior.

Another bill would bar students from dropping out of school until they are 17 years old. Currently, they can do so at age 16.

Primary sponsor Timothy Dukes, R-Laurel, says the bill was inspired by a constituent who works in schools.

"She sees this as a major problem because a kid realizes at 16 they can just drop out and be gone," Dukes said. "When you look at the stats about what happens to a kid who drops out of school, it's just really staggering. It's very bleak."



SUCHAT PEDERSON/THE NEWS JOURNAL

A motorcyle rider rolls through the intersection of Memorial Drive and Route 13. A proposed bill would require all motorcyclists to wear helmets while on the road.

Dukes said the bill should get bipartisan support. Co-sponsors include members of both parties, including two former education committee chairs.

A slew of Republicans have signed onto a bill to repeal the estate tax,

Rep. Timothy Dukes, R-Laurel

which applies to inheritances of more than $5.12 million. Delaware created an estate tax in 2009, but it has yielded smaller returns than hoped for — in the 2015-2016 fiscal year, it brought in about $9.3 million, according to the Delaware Economic and Financial Advisory Council.

GOP lawmakers have argued the tax hurts the state more than it helps because it drives out wealthy residents who pay the most in taxes. But repealing taxes could be difficult in a year when the state is grappling with a budget hole as big as $350 million.

Rep. David Bentz, D-Newark, is bringing back a bill that did not get a final vote in the last legislative session. It would remove a rule that bars people convicted of felonies from receiving benefits through the Temporary Assistance for Needy Families program, which helps families get by while their breadwinner searches for a job.

Bentz has argued that rule makes it harder for felons to reintegrate into society, which increases the likelihood that they will re-offend.

Rep. Kim Williams, D-Newport, is also re-sponsoring a bill that didn't pass last year. It would provide school districts extra funding for students in the "basic" special needs category in kindergarten through third grade — currently, districts don't get extra money for those students until fourth grade.

Contact Matthew Albright at malbright@delwareonline.com, (302) 324-2428 or on Twitter @TNJ_malbright.

Mandatory helmet bill restarts debate in Delaware

Paul Kalp of Dover suffered a brain injury in a 2012 motorcycle accident. Kalp's injuries caused temporary paralysis, affected his speech and have caused severe emotional strains. SUCHAT PEDERSON/THE NEWS JOURNAL

Jon Offredo, The News Journal 1:05 a.m. EDT March 27, 2015

Delaware's current helmet law requires motorcyclists only to be in possession of a helmet.

(Photo: SUCHAT PEDERSON/THE NEWS JOURNAL)

A yearslong debate is back in Legislative Hall, with a Dover lawmaker sponsoring legislation to mandate all motorcycle drivers and riders wear a helmet.

Current state law requires riders over 19 to have a helmet in their possession.

Rep. Sean Lynn, a Dover Democrat wants to change that. The effort is backed by two Kent County families affected by traumatic brain injuries suffered in motorcycle accidents.

"It's kind of silly that the law would mandate that you have a helmet on the motorcycle, but not on your head," Lynn said. "It seems counterintuitive."

Lynn says helmets, like car seats, seatbelts and not texting while driving, should be a given safety precaution.

But there is strong opposition in Legislative Hall to such a mandatory requirement, with riders and some legislators saying that it is a rider's choice whether or not to wear a helmet.

Since 2014, there have been 15 motorcycle fatalities in Delaware. Of those, six of the victims were wearing helmets. Maryland, Virginia and New Jersey all have mandatory helmet laws. Pennsylvania does not.

Paul Kalp of Dover suffered a brain injury in a 2012 motorcycle accident. Kalp's injuries caused temporary paralysis, affected his speech and have caused severe emotional strains.

"I hit a car bad," said Kalp, a retired Air Force security forces pilot. "Now, I'm nothing."

The National Highway Traffic Safety Administration estimates that helmet use saved the government and individuals more than $3 billion in injuries and treatment costs.

Lynn's legislation faces significant pushback from those who say requiring helmets is another form of government intruding in people's lives. Previous attempts at passing similar legislation in 2007 failed. In 2011 a measure to eliminate the requirement to possess a helmet made it through the General Assembly and was vetoed by Gov. Jack Markell.

The bill will appear before the House Public Safety & Homeland Security Committee on Wednesday.

Gary Hilderbrand, legislative coordinator with ABATE Delaware, a motorcyclist rights group, said a rider's choice is about personal liberty and individual freedom. He said he and other riders have sympathy for families who have had their loved ones involved in accidents.

"We are adults. We should have the right to make the choice," he said. "We get up, go to work, raise families; we play by the rules. We don't get government intrusion.

"We have the right to choose. Just like a woman has the right to choose what happens to their body, we have a right to choose what happens to ours."

But Tammy Kalp, Paul's wife, and Gigi Law of Felton have a different take. A rider's right to choose has lasting consequences for family members who become caretakers after severe accidents.

Buy Photo

Paul Kalp was an Air Force security forces pilot. "Now, I'm nothing," he says. Kalp's injuries caused temporary paralysis, affected his speech and have caused severe emotional strains. *(Photo: SUCHAT PEDERSON/THE NEWS JOURNAL)*

Law's son Brian suffered a traumatic brain injury in 2012 and was in a coma for six weeks and in the hospital for 10 months after an accident while he was on the way to dinner.

"Brian never said, 'Hey, Mom, would you mind being my caretaker for the rest of my life? Then you have to worry about what's going to happen to me after you can no longer take care of me,' " Law, 52, said.

Kalp was injured riding his motorcyle on Saulsbury Road in Dover in September 2012. Kalp said he was observing the posted speed limit but was unable to avoid a car that pulled out in front of him.

The crash's aftermath has affected Kalp's wife, who says Kalp is not the same man she fell in love with.

"It's the hardest thing when you lose someone that you love, and they are gone forever and you can't talk to them again. It's sort of like that because I can never talk to him again," Tammy Kalp said. "But he's also here.

"The man that I fell in love with is gone. He's gone."

Contact Jon Offredo at (302) 678-4271 or at joffredo@delawareonline.com. Follow him on Twitter @jonoffredo (http://www.twitter.com/jonoffredo).

Buy Photo

Tammy Kalp says her husband, Paul, is not the same man she fell in love with after his 2012 motorcycle crash. *(Photo: SUCHAT PEDERSON/THE NEWS JOURNAL)*

THE LAWS

Delaware: Riders under 19 must wear a helmet, and adults must have one in their possession.

Pennsylvania: Riders under 20 must wear a helmet.

New Jersey: All riders must wear a helmet.

Maryland: All riders must wear a helmet.

Virginia: All riders must wear a helmet.

DELAWAREONLINE

Death penalty repeal advances in Delaware Senate

(http://www.delawareonline.com/story/firststatepolitics/2015/03/25/death-penalty-repeal-advances-senate/70451348/)

DELAWAREONLINE

$46 million Delaware casino aid package stalls

(http://www.delawareonline.com/story/news/local/2015/03/26/million-delaware-casino-aid-package-stalls/70512830/)

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Mandatory motorcycle helmet law stuck in committee

4-7-15
NT

JON OFFREDO THE NEWS JOURNAL

A plan to require motorcycle riders in Delaware wear a helmet is in legislative purgatory after lawmakers Wednesday declined to release the bill for a full hearing in front of the House of Representatives.

The legislation now sits in the House clerk's office, where it will stay until brought back into committee, or remain until the 148th General Assembly concludes on June 30, 2016, and possible action on the measure expires.

Rep. Sean Lynn, D-Dover, who introduced the proposal, said he remains optimistic about the chances of the bill in future years.

"Just because it didn't happen today doesn't mean it won't happen next session," Lynn said. "I think we got more done today ... than has been done in a decade."

Current state law requires riders over 19 to have a helmet in their possession. A handful of motorcyclists testified during Wednesday's hearing that it was their choice to wear a helmet or not.

"Laws like this make us more of a nanny state, not a state of free will," said Dave Johnson, a rider from Harrington.

Gary Hilderbrand, legislative coordinator with ABATE Delaware, a motorcyclist rights group, said lawmakers are more concerned with putting a helmet on his head than taking on drivers who put all motorcyclists in danger.

"We've had a lot of brave men and women in this country go to war for us to fight for other nations to not have to listen to dictatorships of their country and government telling them what to do," he said. "I don't need anybody telling me what to do."

Since 2014, 15 motorcycle fatalities have occurred in Delaware. Six victims were wearing helmets. Maryland, Virginia and New Jersey have mandatory helmet laws. Pennsylvania does not.

An attempt to pass similar legislation failed in 2007. In 2011, a measure to eliminate the requirement to possess a helmet made it through the General Assembly and was vetoed by Gov. Jack Markell.

The National Highway Traffic Safety Administration estimates that helmet use saved the government and individuals more than $3 billion in injuries and treatment costs.

The bill gained support of insurance companies, automotive safety groups and family members of those injured in accidents.

Tammy Kalp, whose husband Paul received a traumatic brain injury in 2012 after an accident while he was riding his motorcycle, said Wednesday that she was disappointed that no action was taken on the proposal. Paul Kalp was not wearing a helmet at the time of the accident.

She's hopeful they were able to kick start a conversation about wearing helmets.

"It's already too late for us," she said. "But it's not too late for someone else."

Contact Jon Offredo at (302) 678-4271 or at joffredo@delawareonline.com. Follow him on Twitter @jonoffredo.

Insurance Institute for Highway Safety
Highway Loss Data Institute

Motorcycles

Helmets and antilock brakes make riding less dangerous.

Motorcycle helmet use

January 2017

Motorcycle helmet laws vary widely among the states and have changed a lot in the past half a century. Currently, 19 states and the District of Columbia have laws requiring all motorcyclists to wear a helmet, known as universal helmet laws. Laws requiring only some motorcyclists to wear a helmet are in place in 28 states. There is no motorcycle helmet use law in three states (Illinois, Iowa and New Hampshire).

In the past, many more states had universal helmet laws, thanks to pressure from the federal government. In 1967, states were required to enact helmet use laws in order to qualify for certain federal safety programs and highway construction funds. The federal incentive worked. By the early 1970s, almost all the states had universal motorcycle helmet laws. However, in 1976, states successfully lobbied Congress to stop the Department of Transportation from assessing financial penalties on states without helmet laws.

Low-power cycle is a generic term used by IIHS to cover motor-driven cycles, mopeds, scooters, and various other 2-wheeled cycles excluded from the motorcycle definition. While state laws vary, a cycle with an engine displacement of 50 cubic centimeters or less, brake horsepower of 2 or less, and top speeds of 30 mph or less typically is considered an low-power cycle. Twenty-three states have motorcycle helmet laws that cover all low-power cycles. Twenty-four states and the District of Columbia have laws that cover some low-power cycles.

Table Map **Table: motorcycle helmet laws history**

Hover over map for more detail.

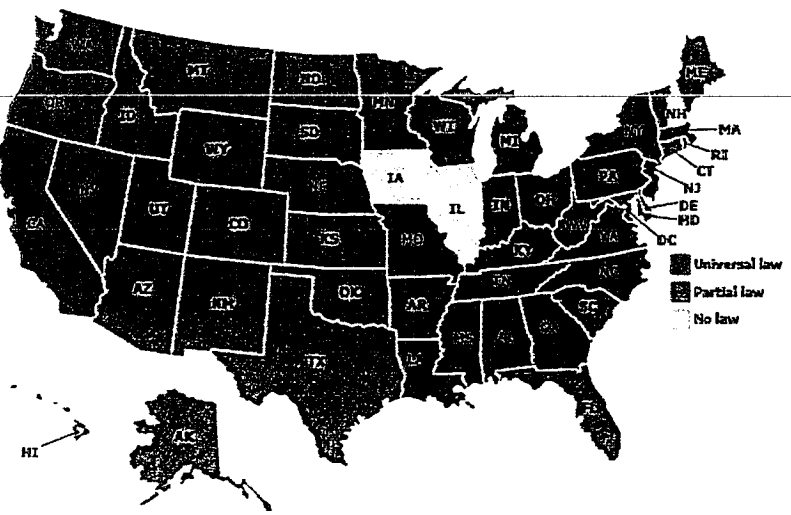

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Table **Map** **Table: motorcycle helmet laws history**

State	Motorcycle helmets	Does the motorcycle helmet law cover all low-power cycles?
Alabama	all riders	yes
Alaska	17 and younger[1]	yes
Arizona	17 and younger	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 1 1/2, or can attain speeds greater than 25 mph are covered by the motorcycle helmet law
Arkansas	20 and younger	yes
California	all riders	yes
Colorado	17 and younger and passengers 17 and younger	yes
Connecticut	17 and younger	yes

State	Motorcycle helmets	Does the motorcycle helmet law cover all low-power cycles?
Delaware	18 and younger[2]	all low-power cycles defined as a moped or triped if the operator is 15 or younger; bicycle helmet acceptable for motorized scooter
District of Columbia	all riders	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 1 1/2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Florida	20 and younger[3]	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph and all low-power cycles operated by those 15 and younger are covered by the motorcycle helmet law
Georgia	all riders	all low-power cycles are covered by the motorcycle helmet law except bicycle helmets are acceptable for electric assisted bicycles
Hawaii	17 and younger	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Idaho	17 and younger	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 5, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Illinois	no law	no law
Indiana	17 and younger	yes
Iowa	no law	no law
Kansas	17 and younger	all low-power cycles except electric assisted bicycles are covered by the motorcycle helmet law
Kentucky	20 and younger[4]	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Louisiana	all riders	yes
Maine	17 and younger[5]	all low-power cycles with an engine displacement greater than 50cc or more than 1,500 watts are covered by the motorcycle helmet law
Maryland	all riders	yes all low-power cycles designed to travel at speeds exceeding 35 mph, scooters with with engine displacement greater than 50cc or brake horsepower greater than 2.7 and mopeds with an engine displacement greater than 50cc or brake horsepower greater than 1.5 are covered by the motorcycle helmet law
Massachusetts	all riders	yes
Michigan	20 and younger[6]	

State	Motorcycle helmets	Does the motorcycle helmet law cover all low-power cycles?
		all low-power cycles with an engine displacement greater than 50cc or can attain speeds greater than 30 mph and all low-power cycles operated by those 18 and younger are covered by the motorcycle helmet law
Minnesota	17 and younger[7]	yes
Mississippi	all riders	yes
Missouri	all riders	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 3, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Montana	17 and younger	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Nebraska	all riders	yes
Nevada	all riders	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
New Hampshire	no law	no law
New Jersey	all riders	yes
New Mexico	17 and younger	all low-power cycles with an engine displacement greater than 50cc or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
New York	all riders	all low-power cycles designed to travel at speeds of 20 mph or greater are covered by the motorcycle helmet law
North Carolina	all riders	yes
North Dakota	17 and younger[8]	yes
Ohio	17 and younger[9]	yes
Oklahoma	17 and younger	all low-power cycles are covered by the motorcycle helmet law except bicycle helmets are acceptable for electric assisted bicycles operated by those 18 and younger
Oregon	all riders	yes
Pennsylvania	20 and younger[10]	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 1 1/2, or can attain speeds greater than 25 mph are covered by the motorcycle helmet law
Rhode Island	20 and younger[11]	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 4.9 or can attain speeds greater than 30 mph are covered by the motorcycle helmet law

State	Motorcycle helmets	Does the motorcycle helmet law cover all low-power cycles?
South Carolina	20 and younger	yes
South Dakota	17 and younger	yes
Tennessee	all riders	yes
Texas	20 and younger[12]	all low-power cycles, except motor assisted scooters with an engine displacement less than than 40cc, are covered by the motorcycle helmet law
Utah	17 and younger	yes
Vermont	all riders	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Virginia	all riders	all low-power cycles operated at speeds greater than 35 mph or with an engine displacement greater than 50cc are covered by the motorcycle helmet law
Washington	all riders	yes
West Virginia	all riders	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law
Wisconsin	17 and younger[13]	all low-power cycles designed to travel at speeds exceeding 30 mph or a Type 1 motorcycle with an automatic transmission with an engine displacement greater than 50cc are covered by the motorcycle helmet law
Wyoming	17 and younger	all low-power cycles with an engine displacement greater than 50cc, brake horsepower greater than 2, or can attain speeds greater than 30 mph are covered by the motorcycle helmet law

[1] Alaska's motorcycle helmet use law covers passengers of all ages, operators younger than 18, and operators with instructional permits.

[2] In Delaware, every motorcycle operator or rider age 19 and older must carry an approved helmet.

[3] In Florida, the law requires that all riders younger than 21 years wear helmets, without exception. Those 21 years and older may ride without helmets only if they can show proof that they are covered by a medical insurance policy.

[4] In Kentucky, the law requires that all riders younger than 21 years wear helmets, without exception. Those 21 and older may ride without helmets only if they can show proof that they are covered by a medical insurance policy. Motorcycle helmet laws in Kentucky also cover operators with instructional/learner's permits.

[5] Motorcycle helmet laws in Maine cover operators with instructional/learner's permits and operators in their first year of licensure. Maine's motorcycle helmet use law also covers passengers 17 and younger and passengers riding with operators who are required to wear a helmet.

[6] In Michigan, the law requires that all riders younger than 21 wear helmets, without exception. Those 21 and older may ride without helmets only if they carry additional insurance and have passed a motorcycle safety course or

have had their motorcycle endorsement for at least two years. Motorcycle passengers who want to exercise this option also must be 21 or older and carry additional insurance.

[7] Motorcycle helmet laws in Minnesota cover operators with instructional/learner's permits.

[8] North Dakota's motorcycle helmet use law covers all passengers traveling with operators who are covered by the law.

[9] Ohio's motorcycle helmet use law covers all operators during the first year of licensure and all passengers of operators who are covered by the law.

[10] Pennsylvania's motorcycle helmet use law covers all operators during the first two years of licensure unless the operator has completed the safety course approved by PennDOT or the Motorcycle Safety Foundation.

[11] Rhode Island's motorcycle helmet use law covers all passengers (regardless of age) and all operators during the first year of licensure (regardless of age).

[12] Texas exempts riders 21 or older if they can either show proof of successfully completing a motorcycle operator training and safety course or can show proof of having a medical insurance policy. A peace officer may not stop or detain a person who is the operator of or a passenger on a motorcycle for the sole purpose of determining whether the person has successfully completed the motorcycle operator training and safety course or is covered by a health insurance plan.

[13] Motorcycle helmet laws in Wisconsin cover operators with instructional/learner's permits.

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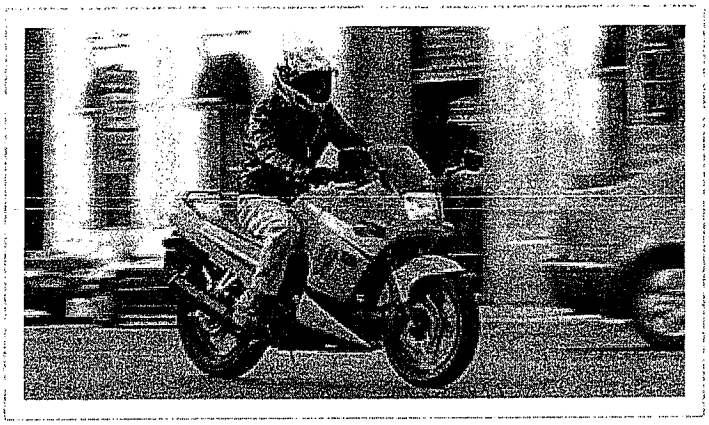
Motorcycle Safety



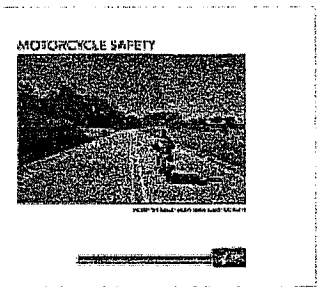
Motorcycle crash deaths are costly, but preventable. The single most effective way for states to save lives and save money is a universal helmet law.

- Helmets saved an estimated 1,630 lives and $2.8 billion in economic costs in 2013.[1]
- The United States could have saved an additional $1.1 billion in 2013 if all motorcyclists had worn helmets.[1]
- Helmets reduce the risk of death by 37%.[1]
- Helmets reduce the risk of head injury by 69%.[2,3]

"Our role is to identify ways to prevent injury and death and rigorously check what works and what does not work. For motorcycle safety, the research shows that universal helmet laws are the most effective way to reduce the number of deaths and traumatic brain injuries that result from crashes."

- Dr. Thomas Frieden, CDC Director

Motorcycle Safety Guide



Motorcycle Safety Guide [PDF - 5 MB]

Note: This document does not contain current data and is included for historical purposes only.

Motorcycle Crash Deaths

Motorcycle Fatality Facts from the International Institute for Highway Safety.

Learn More (http://www.iihs.org/iihs/topics/t/motorcycles/fatalityfacts/motorcycles) >

Additional Information

The Guide to Community Preventive Services: Motorcycle Helmets (http://www.thecommunityguide.org/mvoi/motorcyclehelmets/index.html)

NHTSA: Estimating Lives and Costs Saved by Motorcycle Helmets with Updated Economic Cost Information (http://www-nrd.nhtsa.dot.gov/Pubs/812206.pdf)

NHTSA: Motorcycle Safety (http://www.nhtsa.gov/Safety/Motorcycles)

State-Based Motor Vehicle Data & Information

IIHS: Motorcycle Helmet Laws (http://www.iihs.org/iihs/topics/laws/helmetuse?topicName=motorcycles)

Share the Road with Motorcycles campaign (http://www.trafficsafetymarketing.gov/CAMPAIGNS/Motorcycle+Safety/Share+The+Road)

Drunk Riding Prevention campaign (http://www.trafficsafetymarketing.gov/CAMPAIGNS/Motorcycle+Safety/Stop+Impaired+Riding)

References

1. NHTSA. National Center for Statistics and Analysis. Washington, DC: October 2015. Estimating lives and costs saved by motorcycle helmets with updated economic cost information (Traffic Safety Facts Research Note. Report No. DOT HS 812 206). Available at http://www-nrd.nhtsa.dot.gov/Pubs/812206.pdf (http://www-nrd.nhtsa.dot.gov/Pubs/812206.pdf) . Accessed January 8, 2016.
2. Derrick AJ, Faucher LD. Motorcycle helmets and rider safety: A legislative crisis. *J Public Health Pol.* 2009;30(2):226–242.

3. Liu BC, Ivers R, Norton R, Boufous S, Blows S, Lo SK. Helmets for preventing injury in motorcycle riders. *Cochrane Database Syst Rev.* 2008;(1):CD004333. doi: 10.1002/14651858.CD004333.pub3.

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Content source: Centers for Disease Control and Prevention (http://www.cdc.gov/), National Center for Injury Prevention and Control (http://www.cdc.gov/injury), Division of Unintentional Injury Prevention

PHLR Public Health Law Research

http://publichealthlawresearch.org/product/effect-universal-motorcycle-helmet-laws-behavior

The Effect of Universal Motorcycle Helmet Laws on Behavior

PUBLICATION DATE: Friday, August 22, 2014

The Problem: Motorcycle crashes are a significant public health concern. In 2010, 4,502 drivers died in motorcycle crashes, and deaths related to such crashes increased 55% between 2000 and 2010, according to the CDC (http://www.cdc.gov/Features/MotorcycleSafety/). The same report notes that the economic burden of motorcycle crashes was $12 billion in 2005. The public bears most of these costs through lost tax revenue, increased insurance premiums, and Medicaid spending. Multiple studies (http://www.ncbi.nlm.nih.gov/pubmed/18254047) have shown that the injury and death rate among non-helmeted drivers is much higher than among helmeted

drivers (See Liu BC, Ivers R, Norton R *et al.* Helmets for preventing injury in motorcycle riders. Cochrane Database Syst Rev 2008:1.)

The Law: Washington, DC and 19 states have universal helmet laws, which mandate helmet use for riders and passengers, e.g., Cal Veh Code § 27802 (https://www.dmv.ca.gov/pubs/vctop/d12/vc27803.htm). Twenty-eight states have partial helmet laws, which allow riders and passengers not to wear helmets if they are older than a certain age (ranging from 17 to 20) and possess insurance coverage over a specific dollar amount, see for example Fla. Stat. § 316.211 (3) (http://www.dmv.org/fl-florida/motorcycle-license.php#Helmet-Laws-); MCLS § 257.658 (http://www.michigan.gov/sos/0,4670,7-127-1585_50413-277037--,00.html). Illinois, Iowa, and New Hampshire have no helmet laws. CDC: Motorcycle Helmet Laws By State. (http://www.cdc.gov/Motorvehiclesafety/mc/states/index.html)

The Evidence: A Community Guide review (http://www.thecommunityguide.org/mvoi/motorcyclehelmets/helmetlaws.html) found that states with universal helmet laws experienced substantial increases in helmet use and decreases in fatal and non-fatal injuries compared to states with partial or no laws. The study also found that states that repealed universal helmet laws and replaced them with partial or no laws experienced sharp decreases in helmet use and increases in fatal and non-fatal injuries, see Guide to Community Preventive Services: Motorcycle Helmet Laws (http://www.thecommunityguide.org/mvoi/motorcyclehelmets/helmetlaws.html). The reviewers identified 69 studies with 78 study arms. Sixty-seven of the study arms evaluated motorcycle helmet use within the United States. The remaining study arms examined Australia, Italy, New Zealand, Spain, and Taiwan. The selected studies measured helmet use, non-fatal injuries (both total and head-related), total fatalities, and head-injury-related fatalities, as well as fatalities per individual crash, registered motorcycle, and vehicle miles traveled. The review

included multiple study designs: ten study arms were interrupted time series, 14 were panels, 13 were time series or before-after with concurrent comparison groups, 39 were before-after, and 2 were cross-sectional. The reviewers observed that regardless of the study design and potential source of bias, universal helmet laws were consistently effective in increasing helmet use and decreasing both fatal and non-fatal injuries. The reviewers also found that partial laws are more difficult to enforce than universal laws, and are ineffective in motivating motorcyclists to wear helmets. An economic review, based on 22 studies, found that benefits to universal helmet laws heavily outweighed the costs.

The Bottom Line: According to a Community Guide systematic review, there is substantial evidence to support the effectiveness of universal helmet laws in increasing helmet use among motorcyclists, and to support that universal helmet laws reduce deaths, injuries and economic costs attributable to motorcycle crashes. Partial laws do not achieve any reduction in deaths, injuries or costs.

Impact: Effective

U.S. Department of Transportation
National Highway Traffic Safety Administration

TRAFFIC SAFETY FACTS
Research Note

NHTSA
www.nhtsa.gov

DOT HS 812 206

October 2015

Estimating Lives and Costs Saved by Motorcycle Helmets With Updated Economic Cost Information

Summary

In 2013, an estimated 1,630 lives were saved in the United States by motorcycle helmets; an estimated 715 additional fatalities could have been prevented if all motorcyclists[1] had worn helmets. The lives saved resulted in an estimated $2.8 billion saved in economic costs, and $17.3 billion in comprehensive costs,[2] by helmet-wearing motorcyclists. An additional $1.1 billion could have been saved in economic costs, and $7.2 billion in comprehensive costs, if all motorcyclists had worn helmets.

The National Highway Traffic Safety Administration annually provides information on the number of lives saved by the use of DOT-compliant motorcycle helmets, as well as the potential number of lives that could have been saved at 100-percent helmet use. In addition, the economic costs saved by those wearing helmets, and how much could have been saved had all riders worn helmets, are also estimated. This information is provided for each State as well as the nation as a whole. A recently published report, *The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised)* (Blincoe, Miller, Zaloshnja, & Lawrence, 2015), updated the cost information used with these estimates.

This Research Note provides information on how NHTSA determines estimates of lives and costs saved by the use of motorcycle helmets, principally presenting updated economic cost estimate data. The Appendix details the process for calculating these estimates.

Background

The process NHTSA uses to calculate these estimates is detailed in *Determining Estimates of Lives and Costs Saved by Motorcycle Helmets* (NHTSA, 2011). The cost information in that document came from a number of reports published more than a decade ago (Blincoe, 1994; NHTSA, 1988; and Blincoe, Seay, Zaloshnja, Miller, Romano, Luchter, & Spicer, 2002). The information in these documents has recently been combined and updated in Blincoe, Miller, Zaloshnja, and Lawrence (2015), which provides not only updated economic cost estimates, but also cost estimates relating to lost quality of life. The combined economic and quality of life costs are referred to as "Total Costs" or "Comprehensive Costs." This new economic data enables an update of the procedure used to estimate the lives and costs saved by wearing motorcycle helmets, and the lives and costs that could be saved at 100-percent helmet use. The report of Blincoe and colleagues (2015) provides costs associated with various types of crashes (e.g., police reported/unreported, crashes that involve speeding, crashes involving bicyclists, costs that occurred as a result of crashes and costs saved due to safety equipment use).

Methodology

NHTSA's National Center for Statistics and Analysis (NCSA) published *Calculating Lives Saved by Motorcycle Helmets* (Deutermann, 2005) that presented the formulas and calculations for estimating the number of lives saved by motorcycle helmets. While this document was published in 2005, the effectiveness estimates (37% for riders [operators] and 41% for passengers) and method remains current.

NHTSA's methodology to estimate the number of motorcyclists saved by helmets, and the associated costs, is based on the number of motorcyclist fatalities. Using the effectiveness estimates of motorcycle helmets and the number of motorcyclist fatalities, the number that would have died but were saved because they wore a helmet can be calculated. The number of fatalities is obtained from the Fatality Analysis Reporting System (FARS) database, a census of all traffic fatalities in the United States. Motorcyclists whose injuries were prevented by helmets, as well as those that could have been prevented, are calculated in a similar manner.

[1] Motorcyclist is the term used to reference both the motorcycle rider (operator) and the motorcycle passenger.

[2] The economic or human capital costs represent the tangible losses resulting from motor vehicle crashes, the value of resources that are used or that would be required to restore crash victims, to the extent possible, to their pre-crash physical and financial status. These are resources have been diverted from other more productive uses to merely maintain the status quo. These costs include medical care, lost productivity, legal and court costs, insurance administrative costs, workplace costs, travel delay, and property damage. Comprehensive costs are made up of these economic costs plus the estimated costs associated with lost quality of life. In cases of serious injury or death, medical care cannot fully restore victims to their pre-crash status, and the human capital costs fail to capture the relatively intangible value of lost quality-of-life that results from these injuries. In the case of death, victims are deprived of their entire remaining lifespan. In the case of serious injury, the impact on the lives of crash victims can involve extended or even lifelong impairment or physical pain, which can interfere with or prevent even the most basic living functions.

For every motorcyclist traffic fatality, a number of other motorcyclists receive injuries of various levels. Helmets are effective at preventing injuries as well as fatalities, and these must also be accounted for when calculating the economic costs prevented by helmets. Because NHTSA does not have data on the number and severity of motorcyclists injured in each State, the number of motorcyclists receiving serious and minor injuries are estimated, based on the number of fatalities in each State.

Previously, NHTSA economic estimates (Blincoe et al., 2002) used the year 2000 as the base year for economic estimates, and adjusted for inflation. Blincoe, Miller, Zaloshnja, and Lawrence (2015) updated this using 2010 as the cost base year. A change in the relative frequency of the levels of injury severity was also introduced. In the 2011 NCSA report, the estimated injuries were categorized into two groups based on their Maximum Abbreviated Injury Score (MAIS): minor (MAIS 1), which made up 63 percent of motorcyclist injuries, and serious (MAIS 2 through 5), which made up the remaining 37 percent. Blincoe, Miller, Zaloshnja, and Lawrence's report (2015) provides frequency estimates for each individual MAIS injury level, rather than grouping those who were seriously injured. This enables the estimation of the number of injured people at each individual MAIS level, rather than grouping MAIS levels 2 through 5. Note that because there are not effectiveness estimates for each MAIS level, the total estimate of the number of motorcyclists prevented from being injured does not change. The benefit is that the costs saved and savable can now be estimated more precisely. Finer detail on the distribution of injuries enables more accurate estimates of costs saved by the wearing of motorcycle helmets.

Note that:

- Costs that were prevented by the use of motorcycle helmets *would* have occurred had the motorcyclists not worn helmets.
- Preventable costs were those that *did* occur, but could have been prevented by the use of helmets. Since they are costs that were experienced, these preventable costs are a portion of the estimated reported cost of motorcyclist crashes.

Table 1 shows the estimated relative incidence of each injury level for reported motorcyclist crashes, separately by helmet use.

Table 1
Relative Injury Incidence in Reported Crashes, by Helmet Use

MAIS Level	Helmeted	Unhelmeted
1	0.64	0.62
2	0.22	0.23
3	0.12	0.14
4	0.01	0.01
5	0.01	0.01

Source: The economic and societal impact of motor vehicle crashes, 2010 (Revised) [Note: Shown are rounded values, obtained from the incidence of motorcyclists at each injury level in Tables 10-4 and 10-5.]

NHTSA has estimated that the effectiveness of helmets in preventing fatalities is 0.37 for riders and 0.41 for passengers (Deutermann, 2005). While there are not different effectiveness estimates for riders and passengers that are injured, there are two separate estimates based on the level of injury. NHTSA estimates helmets are 8 percent effective in preventing minor/MAIS 1 injuries, and 13 percent effective in preventing serious/MAIS 2 – 5 injuries (NHTSA, 1988). This latter estimate was developed using data from combined AIS 2 through 5 injured motorcyclists. Separate estimates of the effectiveness of motorcycle helmets in preventing each individual level of MAIS 2 through 5 injured motorcyclists have not been developed.

Another feature of the new method is that estimates of costs due to lost quality of life were added (Blincoe, Miller, Zaloshnja, & Lawrence, 2015). Previous cost estimates had included economic costs only. Using this new information, both economic and comprehensive (economic plus quality of life) costs are able to be provided.

Finally, cost estimates are available for non-fatally injured motorcyclists by helmet use. Even within an MAIS level, those injured who were unhelmeted have higher estimated costs than those who were helmeted, both economic and comprehensive. The differences are greater at higher injury levels. For fatalities, however, the economic and comprehensive costs are the same regardless of helmet use. The economic and comprehensive costs per injury level/fatality, by helmet use, are in Table 2. These values are those that appear in Blincoe, Miller, Zaloshnja, and Lawrence (2015) in 2010 dollars. For subsequent data years, these values are adjusted for inflation (see Appendix, Economic Impact).

Table 2
Economic and Comprehensive Unit Costs per Injured Motorcyclist, by Injury Level and Helmet Use, 2010

Helmet Use	Injury Level	2010 Costs	
		Unit Economic Cost	Unit Comprehensive Cost*
Helmeted	MAIS 1	$18,079	$30,915
	MAIS 2	$48,186	$220,580
	MAIS 3	$184,941	$759,107
	MAIS 4	$328,872	$1,701,424
	MAIS 5	$1,190,011	$4,909,241
	Fatal	**$1,381,645**	**$9,090,622**
Unhelmeted	MAIS 1	$18,941	$32,926
	MAIS 2	$49,258	$227,273
	MAIS 3	$184,639	$763,673
	MAIS 4	$352,587	$1,852,270
	MAIS 5	$1,617,283	$7,564,608
	Fatal	**$1,381,645**	**$9,090,622**

Source: *The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised)*, Tables 10-6 and 10-7.
*Comprehensive costs consist of Economic and Lost Quality-of-Life Costs.

It is important to note the differences between the Blincoe, Miller, Zaloshnja, and Lawrence (2015) cost report and the costs presented in this research note. Most importantly, costs covered in this research note relate specifically to those costs prevented and preventable due to helmet use. The Blincoe report, on the other hand, presents costs realized due to various types of motor vehicle crashes *in addition* to costs prevented and preventable by motorcycle helmets.

An additional difference involves the crashes that are included in the cost estimation. Costs in this present research note are estimates of *reported* crashes only. FARS data, on which these estimates are based, is a census of fatal crashes which are required to be reported through law enforcement. This research note also uses the General Estimates System GES data to estimate the number of people injured at each MAIS level and is also reported data. This differs from the Blincoe report which bases estimates on *reported* data, but then adjusts them to account for unreported crashes. There are larger percentages of unreported injured at lower injury levels, so differences between all crashes and reported crashes are greater at lower injury levels.

The economic report presents estimates of all costs generated by crashes involving motorcycles, in addition to those specifically prevented and preventable by motorcycle helmets (Blincoe, Miller, Zaloshnja, & Lawrence, 2015, p. 187, Table 10-8). Finally, the costs reported in Blincoe (2015) are costs for the calendar year 2010. While those are the base costs used in this present research note, they have then been indexed for inflation to represent 2013 costs (to agree with the 2013 data used).

Results

In 2013, after adjusting for inflation, the *economic* cost to society for each motorcyclist fatality was $1.48 million, and the *comprehensive* cost of each fatality was $9.71 million. Nearly 85 percent of this *comprehensive* amount is attributable to lost quality of life. The loss of a life clearly has a tragic emotional impact on the family and friends of the deceased. The substantial economic loss, some immediate but much of it realized over upcoming years, is an additional burden they must bear. Helmets worn by motorcyclists saved an estimated 1,630 lives in 2013; an additional 715 lives could have been saved had all motorcyclists worn helmets. Forty-one percent of fatally injured motorcyclists in 2013 were unhelmeted. According to the National Occupant Protection Use Survey (NOPUS), the use of DOT-compliant helmets remained at 60 percent in 2013, unchanged from the previous year.

The overall *economic* cost savings in the United States due to helmet use was approximately $2.8 billion in 2013, and an additional $1.1 billion could have been saved if all motorcyclists had worn helmets. The overall *comprehensive cost* savings, including both economic costs and lost quality of life, was $17.3 billion, and an additional $7.2 billion in comprehensive costs could have been saved at 100-percent helmet use.

Table 3 presents the number of fatally injured motorcyclists as well as the percentage of them that wore helmets, by State, for the 2013 crash year. It is this number, fatally injured helmeted motorcyclists, on which the estimates of costs saved and numbers of motorcyclists prevented from being killed and injured are based. Also presented in the table are the estimated number of lives saved by helmets, and those that could have been saved at 100-percent helmet use; the economic costs saved and savable at 100-percent helmet use; and comprehensive costs (economic plus quality of life costs) saved and savable at 100-percent helmet use.

Texas had the highest number (491) of motorcyclist fatalities in 2013, while the District of Columba had the fewest, 3. Motorcycle helmet use rates in fatal crashes ranged from a high of 100 percent in the District of Columbia to a low of 7 percent in Maine. The number of lives saved by motorcycle helmets is a combination of both the number of riders, and the percentage of those wearing helmets. The largest number of motorcyclists' lives saved was in California (248), a State with 92-percent helmet use. Only 1 life was saved by helmets in Maine, with its low helmet use rate as well as having a relatively small number of motorcyclist fatalities.

Currently 19 States and the District of Columbia have universal helmet laws. Helmet use in fatal crashes in States with universal helmet laws averaged 91 percent in 2013, while in the remaining States helmet use averaged 38 percent. There were about 11 times as many unhelmeted motorcyclist fatalities in States without universal helmet laws (1,704 unhelmeted fatalities) as in States with universal helmet laws (150 unhelmeted fatalities) in 2013. States with universal helmet laws saved an average of 48 lives because more motorcyclists wore helmets, and could have saved an average of 3 more per State if all motorcyclists wore helmets. The States without universal helmet laws saved an average of 21 lives per State, and at 100-percent use could have saved, on average, an additional 21 per State. This highlights the effect of the higher use rates in States with universal helmet laws. Without such a law, only about half of those that could be saved, were saved, because of lack of helmet use. Looking at economic costs that were saved, and those that could have been saved, in States with universal helmet laws, 94 percent of the costs that *could* have been saved *were* saved by motorcyclists wearing helmets. In States without universal helmet laws, only 48 percent of possible costs that could have been saved actually were.

For further information on how the costs discussed in this Research Note were estimated, see Blincoe, Miller, Zaloshnja, and Lawrence (2015).

Table 3

Motorcyclist Fatalities, Helmet Use, Lives Saved, and Additional Savable at 100% Helmet Use, Costs Saved by, and Savable at 100% Helmet Use, 2013

State	Motorcyclists Helmets Used	Helmet Not Used	Unknown	Helmet Use Rate in Fatal Crashes (Known)	Total Fatals	Number of Fatals Prevented	Additional Fatals Preventable at 100% Use	*Economic Costs Saved	*Additional Econ Costs Savable at 100% Use	**Comprehensive (Econ + QoL) Costs Saved	**Add'l Comp Costs Savable at 100% Use
Alabama	78	1	1	99%	80	47	0	$68,906318	$526,439	$425,735,600	$3,387,347
Alaska	7	2	0	78%	9	4	1	$8,066,420	$1,350,093	$49,592,233	$8,678,427
Arizona	62	83	6	43%	151	38	32	$58,904,081	$46,220,396	$362,784,791	$297,273,448
Arkansas	19	39	3	33%	61	12	15	$16,990,268	$20,799,759	$104,966,844	$133,920,305
California	409	34	10	92%	453	248	13	$497,743,329	$22,734,044	$3,018,976,515	$146,232,159
Colorado	31	55	1	36%	87	19	21	$33,044,995	$35,946,901	$206,548,215	$231,675,693
Connecticut	22	21	10	51%	53	16	10	$36,603,224	$21,424,612	$229,299,479	$138,212,740
Delaware	13	7	0	65%	20	8	3	$12,941,090	$4,338,027	$80,743,785	$27,943,468
Dist. of Col	3	0	0	100%	3	2	0	$5,107,923	$0	$31,971,215	$0
Florida	238	237	10	50%	485	144	90	$242,338,532	$143,538,390	$1,499,154,993	$924,689,050
Georgia	107	5	4	96%	116	66	2	$101,024,654	$2,778,741	$624,045,386	$17,889,073
Hawaii	10	19	0	34%	29	6	7	$10,899,551	$11,983,247	$66,551,785	$76,843,672
Idaho	12	12	1	50%	25	7	5	$10,582,766	$6,186,178	$65,187,135	$39,785,979
Illinois	35	113	4	24%	152	22	43	$41,882,998	$75,462,606	$256,318,102	$486,642,769
Indiana	18	82	14	18%	114	12	35	$17,847,712	$49,982,061	$111,203,434	$321,865,241
Iowa	10	31	0	24%	41	6	12	$9,936,524	$18,073,121	$62,286,778	$116,488,868
Kansas	15	18	2	45%	35	9	7	$15,334,545	$11,315,840	$95,901,536	$72,947,902
Kentucky	28	59	0	32%	87	17	22	$23,178,082	$29,953,854	$144,441,583	$192,850,149
Louisiana	66	18	2	79%	86	40	7	$63,554,709	$10,611,647	$396,843,574	$68,363,930
Maine	1	13	0	7%	14	1	5	$935,045	$7,454,288	$5,805,147	$47,929,912
Maryland	56	5	1	92%	62	34	2	$68,557,722	$3,707,736	$429,043,701	$23,899,006
Massachusetts	31	5	4	86%	40	20	2	$42,957,929	$4,257,668	$268,943,948	$27,468,615
Michigan	64	67	7	49%	138	40	26	$59,543,227	$38,066,351	$371,520,551	$245,165,569
Minnesota	16	34	11	32%	61	12	15	$20,912,890	$26,800,746	$130,840,613	$172,746,694
Mississippi	36	3	0	92%	39	22	1	$28,668,029	$1,424,736	$178,391,695	$9,162,155
Missouri	66	7	1	90%	74	40	3	$61,088,669	$3,946,713	$381,396,735	$25,422,018
Montana	12	22	1	35%	35	7	8	$11,028,170	$12,357,302	$68,644,353	479,526,426
Nebraska	12	1	1	92%	14	8	0	$12,380,000	$634,776	$77,454,608	$4,092,713
Nevada	48	7	2	87%	57	30	3	$45,923,563	$4,071,699	$285,995,111	$26,202,356
New Hampshire	7	17	0	29%	24	4	6	$7,571,303	$11,265,125	$47,227,598	$72,549,645
New Jersey	51	2	3	96%	56	32	1	$66,510,301	$1,599,197	$415,710,906	$10,306,311
New Mexico	13	20	8	39%	41	9	9	$13,450,994	$13,050,944	$83,603,448	$83,959,761
New York	147	16	7	90%	170	91	6	$186,784,286	$12,370,232	$1,162,145,805	$79,584,511
North Carolina	170	17	2	91%	189	102	6	$152,407,814	$9,326,474	$948,913,345	$60,024,622
North Dakota	5	3	1	63%	9	3	1	$5,563,042	$2,049,788	$34,758,099	$13,209,304
Ohio	43	87	2	33%	132	26	33	$39,093,462	$48,752,662	$243,480,189	$314,022,202
Oklahoma	15	77	0	16%	92	9	29	$13,666,107	$42,468,769	$85,413,945	$273,624,854
Oregon	32	2	0	94%	34	19	1	$29,930,651	$1,132,983	$185,899,850	$7,283,806
Pennsylvania	84	94	4	47%	182	52	35	$87,707,463	$58,978,022	$548,106,529	$379,978,099
Rhode Island	5	6	0	45%	11	3	2	$5,266,367	$3,858,641	$32,772,603	$24,828,132
South Carolina	43	106	0	29%	149	26	39	$36,172,401	$53,837,751	$224,923,619	$346,229,030
South Dakota	7	15	0	32%	22	4	6	$6,822,603	$8,820,479	$42,621,452	$56,816,345
Tennessee	126	11	0	92%	137	75	4	$109,657,800	$5,890,134	$684,264,243	$37,942,003
Texas	187	279	25	40%	491	118	109	$190,947,887	$174,623,436	$1,194,883,265	$1,125,864,593
Utah	12	19	0	39%	31	7	7	$9,860,720	$9,449,263	$61,365,411	$60,788,930
Vermont	5	2	0	71%	7	3	1	$5,153,366	$1,280,583	$32,107,614	$8,246,427
Virginia	76	3	0	96%	79	45	1	$83,044,487	$1,995,066	$520,508,635	$12,868,415
Washington	69	3	1	96%	73	42	1	$75,334,849	$1,992,955	$470,594,313	$12,839,304
West Virginia	16	8	0	67%	24	9	3	$12,999,083	$3,963,071	$80,816,479	$25,490,840
Wisconsin	21	62	2	25%	85	13	23	$20,499,487	$36,969,830	$127,891,452	$238,091,588
Wyoming	4	5	0	44%	8	2	2	$4,579,076	$3,606,525	$28,720,307	$23,284,142
Nation	**2,663**	**1,854**	**151**	**59%**	**4,668**	**1,630**	**715**	**$2,789,852,511**	**$1,123,228,901**	**$17,287,318,553**	**$7,235,138,549**
Puerto Rico	17	25	0	40%	42	10	9	$18,511,970	$16,844,793	$115,620,013	$108,555,188

*Economic Costs include lost produtivity, medical costs, legal and court costs, emergency service costs (EMS), insurance administration costs, congestion costs, property damage, and workplace losses.

**Comprehensive Costs include Economic Costs plus valuation for lost quality-of-life (QoL).

Cost data from Blincoe, Miller, Zaloshnja, & Lawrence, 2015.

Source: Fatality Analysis Reporting System 2013 Annual Report File (ARF); Bureau of Labor Statistics; Blincoe et al., 2015.

Motorcyclist Fatalities (Riders and Passengers) Helmet Use, FARS 2013, Lives and Costs Saved and Savable (Based on 2013 Cost)

Shaded States are those with laws requiring helmet use for all motorcyclists, at the time of publication.

State costs are adjusted for relative per-capita income; dollar amounts for the nation will not equal the sum of the States.

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U.S. Department of Transportation

National Highway Traffic Safety Administration

This research note and other general information on highway traffic safety may be accessed by Internet users at: www-nrd.nhtsa.dot.gov/CATS/index.aspx

Appendix:
Calculating Lives and Costs Saved by Motorcycle Helmets

The process, formulae, and calculations used to estimate the number of lives saved and savable by motorcycle helmets, and the associated costs, were detailed in NCSA, 2011 (Appendix). This appendix uses the same process and formulas, with the following adjustments.

- Updated (2013) motorcycle fatal crash data
- Updated economic cost numbers with data from Blincoe, Miller, T. R., Zaloshnja, E., and Lawrence, 2015 (Revised)
- Updated inflation factor with information from the Bureau of Labor Statistics website
- Incidence of MAIS injury level now ascertained separately by helmet use
- Revised cost breakdown to use each MAIS level, rather than combining MAIS 2-5 into "serious" injury, as well as helmet use
- Added calculations and information on comprehensive cost numbers

The information needed to calculate these estimates is:

- For a given year, the number of motorcyclist fatalities, subdivided by helmet use and role (rider or passenger). This data would come from FARS. If you wish to look at States individually, you would also need this information subdivided by State.
- The number of motorcyclist fatalities for each of the past 5 years, subdivided by helmet use. This data is also from FARS.
- The estimated number of motorcyclists injured for each of the past 5 years, subdivided by helmet use. This data comes from NASS GES.
- The appropriate cost inflation factor, obtained from information on the Department of Labor's Bureau of Labor Statistics website (see below).

Motorcyclist Fatalities and Estimating the Number of Lives Saved

Data is obtained from FARS for the year of interest (Table A1) by helmet use and role.

Table A1
Motorcyclist Fatalities by Person Type and Helmet Use (Unknown Helmet Use Distributed, 2013)

	Operator	Passenger	All Motorcyclists
Helmeted	2,620	131	2,752
Unhelmeted	1,779	138	1,916
Total	**4,399**	**269**	**4,668**

Source: FARS 2013 ARF
Unknown helmet use has been distributed proportionally by role (operator or passenger).

The number of lives that were saved by motorcycle helmets is estimated using the number of helmeted fatally injured motorcyclists and the effectiveness estimate. For motorcycle operators, helmets have an estimated effectiveness of 0.37. First, the potential operator fatalities are calculated:

$$OperatorFatalities_{Potential} = \frac{OperatorFatalities_{Helmeted}}{(1 - 0.37)}$$

Using the number of helmeted operator fatalities above (2,620), this is:

$$OperatorFatalities_{Potential} = \frac{2{,}620}{(1 - 0.37)} = 4{,}159$$

The number of potential fatalities less the number actual fatalities gives the number of lives saved by helmets. In this case, 4,159 – 2,620 = 1,539

For motorcycle passengers, helmets have an effectiveness of 41 percent. So, in 2013, the calculations for the number of motorcycle passenger lives saved are estimated by:

$$PassengerFatalities_{Potential} = \frac{131}{(1 - 0.41)}\ 222$$

The number of motorcycle passenger fatalities prevented is 222 – 131 = 91

So the total number of lives saved by motorcycle helmets nationwide in 2013 is 1,539 + 91 = 1,630

For ease of presentation, values are rounded at each step calculated in examples in this Appendix. Therefore small differences may occur between values calculated here and those presented elsewhere, or when adding individual States compared to the national total.

Estimating additional preventable fatalities at 100-percent helmet use

The additional lives that could be saved if all motorcyclists had worn helmets are calculated using the number of unhelmeted fatally injured motorcyclists and the effectiveness estimate.

$$MotorcyclistFatalities_{Unhelmeted} \times Effectiveness_{role}$$

For operator fatalities, using the number of unhelmeted operator fatalities from Table A1, this is 1,779 × 0.37 = 658

Had all of these 1,779 riders that died in crashes been wearing helmets, 658 (37 percent) of them would have survived.

The number of additional lives that could have been saved if all passengers had worn helmets is:

$$138 \times 0.41 = 57$$

Therefore, a total of 715 additional lives (658 operators and 57 passengers) could have been saved had all motorcyclists worn helmets.

Estimating the total number of Motorcyclists Injured

The method used to estimate costs saved by motorcycle helmets requires information on injury severity. NCSA maintains a number of crash data files. The Fatality Analysis Reporting System (FARS) is a census of fatal crashes in the United States. The General Estimates System (GES), part of the National Automotive Sampling System (NASS), is a sample of reported traffic crashes to which weights are applied in order to obtain national estimates. Data from both of these systems are used together to estimate the number of motorcyclists by role (passenger or operator), helmet use, and injury severity for Maximum Abbreviated Injury Scale (MAIS) levels 1 through 5. MAIS 6 is a fatal injury, and FARS data is used in that case. Since the GES data is not collected in every state, these calculations allows for lives and cost saved estimates for each State, rather than only on a nationwide basis.

The initial step is to determine the total number of motorcyclist fatalities (from FARS) and the estimated number injured (from GES), separately by helmet use, using the most recent five years of data. Fatality counts in Table A2 exclude those with unknown helmet use, since it is the proportion required here, not a numerical count.

The ratio of injured motorcyclists to fatalities, by helmet use, is calculated for each year, and then the average of the five injury-to-fatality ratios is calculated. Using 5 years, rather than only the most recent, gives a better estimate as it controls for the year-to-year variability inherent in any sampling system. The numbers presented in Table A3 are rounded, while the actual calculations are based on unrounded numbers.

For helmeted motorcyclists, this is:

$$\frac{23.04 + 20.93 + 19.98 + 20.75 + 20.25}{5} = 20.99$$

For unhelmeted motorcycles, this is:

$$\frac{16.23 + 14.57 + 14.12 + 14.38 + 14.82}{5} \doteq 14.82$$

These ratios give us the number of injured motorcyclists for every motorcyclist fatality. So, there are about 21 injured, helmeted motorcyclists for each helmeted motorcyclist that dies in a traffic crash. The appropriate ratio is then used to estimate the number of injured motorcyclists, by helmet use as well as role

Table A2
Total Motorcyclist Fatalities and Injured, 2009–2013

Year	Fatalities		Injured		Injury to Fatality Ratio	
	Helmeted	Unhelmeted	Helmeted	Unhelmeted	Helmeted	Unhelmeted
2009	2,506	1,963	57,748	31,860	23.04	16.23
2010	2,614	1,904	54,708	27,740	20.93	14.57
2011	2,737	1,893	54,669	26,730	19.98	14.12
2012	2,813	2,039	58,365	29,324	20.75	14.38
2013	2,663	1,854	53,934	27,482	20.25	14.82
Total	—	—	—	—	**20.99**	**14.82**

Source: FARS 2009–2012 Final File, 2013 ARF and GES 2009–2013

(rider or passenger). Multiplying each of the helmeted values in Table A1 by 20.99, and each unhelmeted value by 14.82 results in:

Table A3
Estimates of Motorcyclists Injured, by Person Type and Helmet Use, 2013

	Operator	Passenger	All Motorcyclists
Helmeted	55,001	2,757	57,758
Unhelmeted	26,368	2,040	28,408
Total	**81,369**	**4,798**	**86,166**

Estimating the number of injured motorcyclists at each injury level

Previously, the process used to estimate the number of injured motorcyclists allowed estimates separating injured into two groups, minor (MAIS 1) and seriously (MAIS 2-5) injured motorcyclists. Using relative incidence of injury level in reported crashes, provided in Blincoe, Miller, Zaloshnja, and Lawrence (2015), estimation of the number of injured motorcyclists at each individual MAIS level is now possible. The relative incidence of injury at each MAIS level is shown in Table A4 (which is the same as Table 1, and repeated here for convenience).

Table A4
Relative Injury Incidence in Reported Crashes, by Helmet Use

MAIS Level	Helmeted	Unhelmeted
1	0.64	0.62
2	0.22	0.23
3	0.12	0.14
4	0.01	0.01
5	0.01	0.01

Source: The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised) [Note: Shown are rounded values, obtained from the incidence of motorcyclists at each injury level in Tables 10-4 and 10-5.]

Using this incidence of motorcyclists by injury level and helmet use status, 64 percent of injured helmeted motorcyclists are estimated to be injured at MAIS level 1, 22 percent at MAIS level 2, twelve percent at MAIS 3, and one percent at each MAIS levels 4 and 5. For example, if there were 100 injured helmeted motorcyclists in a given state in one year, the estimated number of those with MAIS 1 injuries would be 64, with 22 MAIS 2, 12 MAIS 3, and 1 each at MAIS 4 and MAIS 5. For injured motorcyclists that were unhelmeted, similar calculations would be made using the second column in Table A4.

So, given 55,001 helmeted operators injured (from Table A3):

Number of MAIS 1 helmeted motorcycle operators:

$$0.64 \times 55{,}001 = 35{,}201$$

Number of MAIS 2 helmeted motorcycle operators:

$$0.22 \times 55{,}001 = 12{,}100$$

Number of MAIS 3 helmeted motorcycle operators:

$$0.12 \times 55{,}001 = 6{,}600$$

Number of MAIS 4 helmeted motorcycle operators:

$$0.01 \times 55{,}001 = 550$$

Number of MAIS 5 helmeted motorcycle operators:

$$0.01 \times 55{,}001 = 550$$

Calculations would be similar for unhelmeted motorcycle operators, and helmeted and unhelmeted motorcycle passengers. (Note that for the results in these calculations, the rounded incidence values presented above in Table A4 were used. In calculations for estimates of annual lives and costs saved in motorcycle crashes, the unrounded ratios using incidence values from Table 10-2 of Blincoe et al. [2015] are used.) Table A5 presents the estimates for motorcyclist by MAIS level, role, and helmet status.

Table A5
Estimates of Motorcyclists Injured, by Person Type, Helmet Use, and MAIS level, 2013

	Operator		Passenger	
	Helmeted	Unhelmeted	Helmeted	Unhelmeted
MAIS 1	35,201	16,348	1,764	1,265
MAIS 2	12,100	6,065	607	469
MAIS 3	6,600	3,692	331	286
MAIS 4	550	264	28	20
MAIS 5	550	264	28	20

Estimating the number of motorcyclists prevented from being injured because of motorcycle helmets, at each injury level

The number of motorcyclists whose injuries were prevented by helmets is estimated using the same process that was used for estimating the number of lives saved (above), but at each MAIS level. Recall that the effectiveness estimates for saving lives were 37 percent for operators and 41 percent for passengers. The effectiveness estimate for preventing a motorcyclist from receiving a minor injury is 8 percent and for preventing a seriously injured motorcyclist (MAIS 2–5), 13 percent. The estimate for the effectiveness of motorcycle helmets in preventing *injuries* is the same for both operators and passengers. Note that distributing injured motorcyclists by each MAIS level will not affect the estimated *total number* of motorcyclists prevented from being injured, since the effectiveness estimate is the same for all MAIS levels 2 through 5. However, the *cost* estimates differ by MAIS level, so the amount of money saved (and savable at 100% helmet use) is better estimated by separating those injured by MAIS level.

To estimate the number of motorcyclists whose helmets prevented them from receiving a serious (MAIS level 2 through 5)

injury, the number of helmeted motorcyclists is used. First the number of potentially seriously injured is estimated:

$$Seriously\ Injured_{Potential} = \frac{Seriously\ Injured_{Helmeted}}{(1 - 0.13)}$$

Using the estimate of helmeted, seriously injured motorcyclists above, the sum of both operators and passengers at MAIS levels 2 through 5 (20,793[3]), this is:

$$Seriously\ Injured_{Potential} = \frac{20{,}793}{(1 - 0.13)} = 23{,}900$$

The number of potential seriously injured, less the number actual seriously injured, gives the number of seriously injured prevented by helmets. In this case, 23,900 – 20,793 = 3,107. Again, these calculations are being shown using rounded numbers, whereas during the actual calculations rounding would not occur until presenting the final value.

The number of potential minor injured (MAIS 1) motorcyclists is:

$$Minor\ Injured_{Potential} = \frac{Minor\ Injured_{Helmeted}}{(1 - 0.08)}$$

Using the estimate of helmeted minor injured motorcyclists above (35,201 + 1,764 = 36,965), this is:

$$Minor\ Injured_{Potential} = \frac{36{,}965}{(1 - 0.08)} = 40{,}179$$

The number of potential minor injured, less the number actual minor injured, gives the number of minor injured prevented by helmets. In this case, 40,179 – 36,965 = 3,214.

Estimating the number of additional motorcyclists prevented from being injured at 100-percent Helmet Use, at each injury level

The number of motorcyclists whose injuries could have been prevented if all had worn helmets is estimated using the same method as previously shown for motorcyclist fatalities. Again, there are not different injury effectiveness estimates for riders and passengers. There are, however, different effectiveness estimates for the two levels of injury. The number of injured motorcyclists that could have been prevented is calculated as:

$$MotorcyclistsInjured(Injurylevel)_{Unhelmeted} \times Effectiveness_{InjuryLevel}$$

From Table A5, there were 11,080 unhelmeted motorcyclists who were seriously injured. The estimate of the number of additional motorcyclists whose serious injuries could have been prevented is:

$$11{,}080 \times 0.13 = 1{,}440$$

[3] This is obtained by adding together all seriously injured helmeted motorcyclists. From Table A5, these values are 12,100 + 6,600 + 550 + 550 + 607 + 331+ 28 + 28 = 20,793.

And for those with minor injuries, this is:

$$17{,}613 \times 0.08 = 1{,}409$$

Economic Impact

Cost savings are calculated by multiplying the number of motorcyclists who were prevented from being injured or killed by the associated economic cost. The cost bases, as well as detailed information on how they were estimated, come from *The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised).* Costs associated with motorcycle injuries are different from those for general (all vehicle) crashes, because the injuries motorcyclists suffer differ from the general injuries at each MAIS level. See chapter 10 of Blincoe, Miller, Zaloshnja, and Lawrence (2015) for the reasoning on costs associated with motorcyclist MAIS level injuries.

The costs in Blincoe, Miller, Zaloshnja, and Lawrence (2015) use 2010 crash data, and are expressed in 2010 dollars. Costs in the present research note use 2013 crash data, and adjust for inflation, from 2010 dollars to 2013 dollars, in order to agree with the 2013 FARS data.

The required inflation factor is obtained using data from the Department of Labor's Bureau of Labor Statistics, at its website at http://data.bls.gov/cgi-bin/surveymost?cu.

To obtain the needed values, place a check in the first item's box ("U.S. All items, 1982–84=100 – CUUR0000SA0") then scroll to the bottom and click "Retrieve data." If necessary, you can modify the range of years in the "Change Output Options" section at the top of the screen. If the table presented does not have a column labeled "Annual," check the box for "include annual averages," and click "Go."

For the inflation factor, divide the value for "Annual" for the relevant data year (2013) by that of the base year index (2010 for our calculations, since the known value is the cost per fatality and injured in year 2010 dollars). For example, to convert 2010 dollars to 2013, the values are 232.957/218.056 = 1.068. The cost at each MAIS level or fatality is multiplied by the inflation factor to get the current-year cost per fatality or injury. The 2013 economic cost per fatality, then, is inflated from year 2010 dollars to year 2013 dollars by:

$$\$1{,}381{,}645 \times 1.068 = \$1{,}475{,}597$$

Table A6 presents the dollar values associated with each fatality and MAIS level, for both economic costs and comprehensive costs, used in the present research note. Note that, for simplicity and clarity, the values in Table A6 use the rounded value of 1.068 as the inflation multiplier. When calculating estimates, the unrounded 218.056/232.957 would be used.

State and/or national cost savings are then estimated by multiplying the number of motorcyclists who were prevented from being killed or injured separately by each MAIS level (including those fatally injured) by the corresponding economic and comprehensive costs, and summing all injury levels. For example,

Table A6
Economic and Comprehensive Unit Costs per Injured Motorcyclist, by Injury Level and Helmet Use, 2010 and 2013

Helmet Use	Injury Level	2010 Costs		2013 Costs	
		Unit Economic Cost	Unit Comprehensive Cost*	Unit Economic Cost	Unit Comprehensive Cost*
Helmeted	MAIS 1	$18,079	$30,915	$19,308	$33,017
	MAIS 2	$48,186	$220,580	$51,463	$235,579
	MAIS 3	$184,941	$759,107	$197,517	$810,726
	MAIS 4	$328,872	$1,701,424	$351,235	$1,817,121
	MAIS 5	$1,190,011	$4,909,241	$1,270,932	$5,243,069
	Fatal	**$1,381,645**	**$9,090,622**	**$1,475,597**	**$9,708,784**
Unhelmeted	MAIS 1	$18,941	$32,926	$20,229	$35,165
	MAIS 2	$49,258	$227,273	$52,608	$242,728
	MAIS 3	$184,639	$763,673	$197,194	$815,603
	MAIS 4	$352,587	$1,852,270	$376,563	$1,978,224
	MAIS 5	$1,617,283	$7,564,608	$1,727,258	$8,079,001
	Fatal	**$1,381,645**	**$9,090,622**	**$1,475,597**	**$9,708,784**

Source: *The Economic and Societal Impact of Motor Vehicle Crashes, 2010 (Revised)*, Tables 10-6 and 10-7, adjusted for inflation using data from Department of Labor's Bureau of Labor Statistics to estimate 2013 costs (see text).
*Comprehensive costs consist of Economic and Lost Quality-of-Life Costs.

earlier it was estimated that nationwide, 1,630 lives were saved by motorcycle helmets in 2013. This resulted in an economic cost savings (in 2013 dollars) of:

$$\$1,475,597 \times 1,630 = \$2,405,223,110$$

and a comprehensive cost savings of:

$$\$9,708,784 \times 1,630 = \$15,825,317,920$$

that can be attributed to helmets having prevented fatalities. The economic and comprehensive cost savings at each MAIS level for injured motorcyclists would be calculated in the same way, using the number of motorcyclists prevented from being injured and the corresponding dollar amounts for helmeted injured motorcyclists. Finally, all injury level and fatality costs are summed to estimate a total cost savings from the use of motorcycle helmets.

To calculate the economic and comprehensive costs that could have been saved had all motorcyclists been wearing helmets, the cost savings for each fatality and injury level is multiplied by the number of lives that could have been saved, or the number of motorcyclist who received injured that could have been prevented.

The economic cost savings for fatalities that could have been prevented by 100-percent helmet use is:

$$\$1,475,597 \times 715 = \$1,055,051,855$$

The comprehensive cost saving for fatalities that could have been prevented by 100-percent helmet use is:

$$\$9,708,784 \times 715 = \$6,941,780,560$$

The complete additional cost savings for fatalities and injured motorcyclists preventable at 100-percent helmet use (for the nation, a State, or other grouping) would be calculated by summing the dollar amounts for fatalities and each injury level.

Again, because of rounding used for ease of presentation, the additional dollar amount that could have been saved had all motorcyclists worn helmets differs from the amount presented in Table 3 as well as other published values.

Numbers in the above examples are national totals. For the data in Table 3 for individual States, the number of fatalities by helmet use for each State is used. The dollar amount is adjusted for each state using a ratio of the per-capita personal income in the specific state to the national average per-capita personal income. The rationale for this method is explained in *A Model for Estimating the Economic Savings from Increased Motorcycle Helmet Use.* Depending on the number of motorcyclist fatalities in each State, summing the State costs may differ from the cost estimate based on the national total. The national totals presented in Table 3 are calculated directly from the national counts and cost estimates, and are calculated without intermediate rounding.

ADVOCATES FOR HIGHWAY & AUTO SAFETY

MOTORCYCLE HELMETS

4,668 killed

IN MOTORCYCLE CRASHES IN 2013

$66 billion

SOCIETAL HARM FROM MOTORCYCLE CRASHES

Motorcycle Helmet Laws

Motorcycles are the most hazardous form of motor vehicle transportation.[1] In 2013, 4,668 motorcyclists were killed. Additionally, 88,000 more were injured on our nation's roads in 2013. NHTSA estimates that helmets saved the lives of 1,630 motorcyclists in 2013 and that 715 more lives in all states could have been saved if all motorcyclists had worn helmets. The number of motorcycle crash fatalities has more

than doubled since a low of 2,116 motorcycle crash deaths in 1997. All-rider helmet laws increase motorcycle helmet use, decrease deaths and injuries and save taxpayer dollars.

Helmets Save Lives & Reduce Health Care Costs

- According to a 2012 Government Accountability Office (GAO) report, "laws requiring all motorcyclists to wear helmets are the only strategy proved to be effective in reducing motorcyclist fatalities."In states without an all-rider helmet law 59% of the motorcyclists killed were not wearing helmets, as opposed to only 8% in states with all-rider helmet laws in 2013.

- Annually, motorcycle crashes cost $12.9 billion in economic impacts, and $66 billion in societal harm as measured by comprehensive costs based on 2010 data. Compared to other motor vehicle crashes, these costs are disproportionately caused by fatalities and serious injuries.

- Motorcycle helmets are currently preventing $17 billion in societal harm annually, but another $8 billion in harm could be prevented if all motorcyclists wore helmets.

- Per vehicle mile traveled, motorcyclists were more than 26 times more likely to die in a traffic crash than occupants of passenger cars.

- In Michigan, which repealed its all-rider law in 2012, there would have been 26 fewer motorcycle crash deaths (a 21% reduction) if the helmet mandate was still in place, according to the University of Michigan Transportation Research Institute. Additionally, in the remainder of the year after the helmet repeal was enacted

(April of 2012), only 74% of motorcyclists involved in crashes were helmeted, compared to 98% in the same time period of the previous four years.

- In states with an all-rider helmet law, use of a helmet resulted in economic costs saved to society of $725 per registered motorcycle, compared with $198 per registered motorcycle in states without such a law.
  - Helmets are currently saving $2.7 billion in economic costs annually.

- In 2013, motorcyclists represented 14% of the total traffic fatalities, yet accounted for only 3% of all registered vehicles in the United States.

- By an overwhelming majority (80%), Americans favor state laws requiring all motorcyclists to wear helmets.

- Motorcycle helmets reduce the risk of head injury by 69% and reduce the risk of death by 42%.

- When crashes occur, motorcyclists need adequate head protection to prevent one of the leading causes of death and disability in America — head injuries.

For a full list of citations, please download our Motorcycle Helmet Fact Sheet [http://saferoads.org/wp-content/uploads/2015/07/2015-06-09-Motorcycle-Helmet-Fact-Sheet-FINAL.pdf] .

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Motorcycle Helmet Fact Sheet (PDF) [http://saferoads.org/wp-content/uploads/2015/07/2015-06-09-Motorcycle-Helmet-Fact-Sheet-FINAL.pdf]

Delaware House of Representatives
Rep. Debra Heffernan

For Immediate Release:
January 5, 2017

Contact: Jen Rini
Work: (302) 744-4399

Heffernan bill bans organ transplantdiscrimination

Measure helps ensure Delawareans with disabilities are not denied life-saving healthcare

DOVER – Delawareans with mental or physical disabilities would not be denied organ transplants on the sole basis of a disability under proposed legislation from Rep. Debra Heffernan, D-Brandywine Hundred.

Transplant centers consider a variety of medical and psychosocial criteria when evaluating organ transplant candidates.

But people with disabilities have reported discrimination early on in the process, which has prevented them from being placed on the official transplant waiting list. A 2008 survey out of Stanford University found that 85 percent of the 88 transplant centers surveyed considered neurodevelopmental status as a factor in determining transplant eligibility at least some of the time.

Take Amelia Rivera, a toddler from New Jersey with an intellectual disability and rare genetic disorder. Amelia's family was told by a children's hospital that the child was not eligible for a kidney transplant as a result of her disability, according to a policy brief from the Autistic Self Advocacy Network.

House Bill XX would attack such discrimination and protect Delawareans with disabilities so they would not be deprived of transplant services or referrals, nor would they be barred from an organ transplant waiting list.

"All Delawareans have a right to health care. People should not be denied life-saving organ transplants on the basis of a disability," Heffernan said. "There is the misconception that people with disabilities are unable to manage post-operative treatment plans and therefore are less likely to benefit from a transplant. That's just not true. People with disabilities can live healthy, long lives after organ transplants with help from family and other support systems."

Rep. Melanie George Smith, D-Bear, and Senate Majority Whip Nicole Poore, D- New Castle, have signed on as co-sponsors of the measure.

Similar legislation has passed in New Jersey and California. Pennsylvania and Massachusetts are working through measures, as well.

According to the United Network for Organ Sharing, 471 Delawareans were waiting for organ transplants as of Dec. 30, 2016. Nationwide, 119,168 people are in need of a life-saving organ transplant and, on average, 22 people die daily while waiting.

HB xx has been assigned to the House Health and Human Development Committee. The General Assembly returns to session on January 10.

###

Christie signs bill banning hospitals and doctors from denying disabled people organ transplants

By Susan K. Livio | NJ Advance Media for NJ.com
Email the author | Follow on Twitter
on July 18, 2013 at 1:18 PM, updated July 18, 2013 at 6:46 PM

TRENTON — Hospitals and doctors would be prohibited from taking a patient's mental or physical disability into account when being considered for an organ transplant under a bill Gov. Chris Christie signed into law today.

The legislation stemmed from the experience of Amelia Rivera, 5, of Stratford, who was diagnosed with a developmental disability known as Wolf-Hirschorn syndrome and needed a kidney transplant. But in January 2012, a doctor at the Children's Hospital of Philadelphia informed Amelia's parents that she was not a candidate for a transplant because of her disability.

The hospital later apologized, and emphasized that it did not have a policy of disqualifying people with disabilities as potential transplant candidates.

According to a recent blog post by Amelia's mother, Chrissy, both mother and child are undergoing tests to prepare the young girl to receive her mother's kidney.

"People with developmental disabilities should not be treated as second-class citizens," said Senate President Stephen Sweeney (D-Gloucester), one of the bill's sponsors. "Their disabilities do not make them any less human or worthy of respect and common decency. They should be afforded the same rights as anyone would want when entering a hospital."

The bill, (S1456), permits a mental or physical disability to be taken into account by a physician or surgeon to the extent that disability may have a medical effect on the transplant's success, but an outright denial because of a disability alone is illegal. People may go to court to seek a judge's help in enforcing the law, if necessary.

"It is incomprehensible that a doctor or surgeon would just rule someone out for a transplant based solely on their physical or mental capacity," said Sen. Joseph Vitale, (D-Middlesex), also a sponsor. This legislation will fix that, without the government interfering in important decisions that have to be made by doctors and patients and their families."

RELATED COVERAGE

- **Bill to prevent discrimination against disabled people in need of transplants gets panel approval**
- **Sweeney wants to prevent hospitals from denying organ transplants to the disabled**

Should a Mental Disability Keep Patients Off Organ Transplant Lists?

JAN. 25, 2017, at 5:00 p.m.

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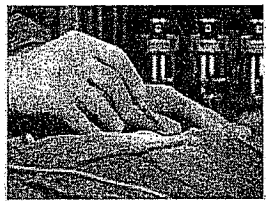
By Dennis Thompson
HealthDay Reporter



(HEALTHDAY)

WEDNESDAY, Jan. 25, 2017 (HealthDay News) -- Pressure is mounting for the U.S. organ donation network to tackle one of the thorniest ethical questions it's ever faced -- whether a person with intellectual disabilities should be denied access to a transplant.

A bipartisan group of 30 legislators from the U.S. Congress petitioned the Department of Health and Human Services in October to "issue guidance on organ transplant discrimination with regards to persons with disabilities," according to a new opinion piece in the Jan. 26 *New England Journal of Medicine*.

The legislators' request follows several highly publicized cases in which people with intellectual disabilities have either fought to receive a transplant or have been outright denied a place on a waiting list, said co-author Dr. Scott Halpern. He's an associate professor of medical ethics and health policy at the University of Pennsylvania's Perelman School of Medicine.

Around 120,000 people are waiting for a donated organ that's needed to save their lives, and every 10 minutes another person is added to the list, the U.S. Department of Health and Human Services says.

Every day, 22 people on the waiting list die without receiving a new organ, according to federal statistics.

Because of the constant shortage, the nation's system of organ banks -- the Organ Procurement and Transplantation Network, managed by the United Network for Organ Sharing (UNOS) -- has to be stringent about who is given a place on the waiting list, Halpern said.

"It's very well established that transplant centers can and should deprioritize patients whose own conditions or social supports make them less likely to promote the viability of the organ by adhering to complicated medical regimens following transplantation," he said.

"That would constitute a waste of an organ that would not allow it to benefit the person to whom it was allocated and would deprive someone else who could have benefited," Halpern explained.

In recent years, transplant centers have struggled with whether an intellectual difficulty should prevent a person from receiving a donated organ, the authors noted.

A 3-year-old New Jersey girl named Amelia Rivera made headlines in 2012 when she was denied a kidney transplant because she has Wolf-Hirschhorn syndrome, a genetic disorder that caused severe intellectual impairment, the authors said. Following an online campaign that drew more than 50,000 people to her cause, she received the transplant.

That same year, a 23-year-old Pennsylvania man with autism named Paul Corby was permanently denied a heart transplant. His hospital group, Penn Medicine, denied the operation "given his psychiatric issues, autism, the complexity of the process, multiple procedures and the unknown and unpredictable effect of steroids on his behavior," according to a letter from the hospital.

The debate revolves around two main questions, Halpern said.

First, the decision to transplant an organ into a patient with intellectual disabilities will often mean that another patient with no such impairment will die for lack of a transplant. Halpern doesn't think much of that argument, however.

"Clinicians ought not to be making decisions about the quality of lives of patients," he said. "Those are value judgments that patients and family members have the authority to make."

Noted medical ethicist Arthur Caplan agreed. "I think we need to be generous in terms of where we draw the line," said Caplan, founding head of the NYU Langone Medical Center's Division of Bioethics in New York City.

A trickier question involves whether intellectually disabled people can care for themselves properly following the transplant, so their donated organ isn't wasted.

Transplant recipients must participate in postoperative recovery programs and take complicated regimens of immune-suppressing drugs to keep their bodies from rejecting the new organ, Halpern said.

"There are reasonable concerns that patients with cognitive impairment may be among those for whom adherence to medical regimens would be suboptimal, but there is a real paucity of data to support those concerns," Halpern said.

National studies have shown that children with intellectual disabilities fare just as well as other kids following a transplant, but those children have parents or caregivers on hand to make sure they stick to their treatment, the authors said.

There have been no solid studies of transplant outcomes among adults with mild intellectual disability, for whom concerns about adherence to treatment would be better founded, the article stated.

Halpern said UNOS needs to beef up the available evidence by requiring that more data be reported on transplant patients with intellectual disabilities.

He also called for the establishment of regional review boards to examine the evidence on "edge cases" and provide guidance to transplant centers.

"That's not to say the review board should have the authority to tell a transplant center what to do," Halpern said. "The virtue of an independent regional review board would be to provide some objective guidance for transplant centers to consider in a listing decision."

Caplan disagreed with the idea of a review board, arguing instead for the creation of clear lines that would define who is and isn't eligible for a transplant.

"I'm not very excited about handing this off for a new kind of committee," Caplan said. "I think this is going to have to be a policy issue for UNOS and they're not going to be able to punt it over to another committee."

UNOS declined to comment on the article.

Existing federal anti-discrimination laws likely will "push toward inclusion in a way this piece doesn't cover," Caplan predicted. "I think the law and Congress are both pointing in that direction.

"Hopefully the editorial will prod movement," Caplan concluded. "It's just been kicked around with a lot of saber-rattling in terms of lawsuits and finger-pointing. Patients and their families deserve clear guidance."

More information

For more on organ donation and transplants, visit the U.S. Department of Health and Human Services (https://www.organdonor.gov/about/facts-terms/donation-faqs.html).

Tags: mental health (//www.usnews.com/topics/subjects/mental-health)

Many agree Delaware special ed bill is needed, but there's no money for it

Matthew Albright and Jessica Bies, The News Journal Published 3:08 p.m. ET Jan. 25, 2017 | Updated 23 hours ago

(Photo: Jason Minto/The News Journal)

Special education advocates say Delaware's school funding system is denying important help to almost 2,500 of the state's youngest students.

Rep. Kim Williams, D-Newport, is sponsoring a bill she says would fix that. Yet, despite widespread support, it is one of many proposals that has little chance of passing because of a projected $350 million state budget gap.

"I know money is an issue for the state," Williams said. "But we invested all of this money into our early learning programs, and yet we have that void there in our elementary schools. This is something we really need to change."

Williams' bill would provide school districts extra money for students in grades K-3 who are in the "basic" special needs category.

Students with "basic" special needs have conditions like minor developmental delays or dyslexia. There are two other categories for more serious disabilities, "intensive" and "complex."

Districts get extra funding from the state for all students classified as "intensive" or "complex," regardless of age. But they get no extra money for students who qualify as "basic" until the students reach fourth grade.

Williams pushed a similar bill last year that faced almost no opposition but never got a final vote — lawmakers did not find money to pay for it.

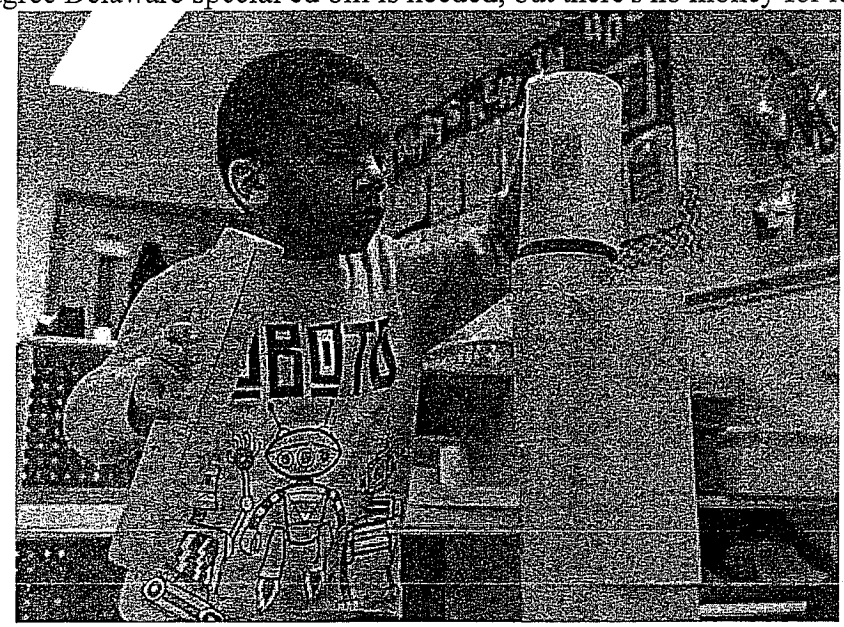
The state's fiscal picture is even grimmer this year.

MORE: Get a sense of the size of the state's budget problem (/story/news/politics/2017/01/12/markell-budget-taxes/96487754/)

MORE: See Delaware's role in a special education lawsuit before the U.S. Supreme Court (/story/news/education/2016/11/23/supreme-court-special-education/94284980/)

Acknowledging this, Williams tweaked the bill this year to phase in the services — and their costs. In the 2017-2018 school year, it would cost the state $1.7 million and districts $650,000; by 2020-2021, the state would be paying $12.2 million and districts would be paying $4.5 million.

Williams and her supporters say the price tag is well worth it. Students who don't get help with their special needs early in their academic career could have a weak foundation for the rest of their lives.



A student plays with cylinders and building blocks at Appoquinimink Preschool Center in Middletown. *(Photo: Jason Minto/The News Journal)*

"If they don't have the basic skills there by third grade, it sets them up to have a more challenging time all the way through," Williams said. "If we're really serious about this, we'll find a way to get the resources."

(Photo: File photo)

That could be tough because of the budget hole, says Sen. Harris McDowell, D-Wilmington North, co-chair of the budget-writing Joint Finance Committee.

"This is something we should do because the value of reaching kids in the early years is proven," said McDowell, who co-sponsored last year's bill. "But we have to be able to afford it."

STORY: Amid drama, 2 Wilmington Housing board members quit (/story/news/local/2017/01/25/wilmington-housing-authority-board-quit/97031102/)

STORY: Crucial Middletown Senate election will be Feb. 25 (/story/news/politics/2017/01/24/senate-election-middletown/97002834/)

Williams argues this omission is particularly glaring because the state has focused much of its resources and energy on early education. It has beefed up its pre-K system and pushed to get more students reading by the third grade.

Research shows the later a student is given special education services, the less likely they are to transition out of special education and the more likely they are to become involved in the criminal justice system and miss benchmarks like high school graduation, college, employment and more.

A 2015 study by the National Center for Analysis of Longitudinal Data in Education Research, identifies grade three as a crucial pivot. Between pre-K and third grade, about 41 percent of students were able to "graduate" from special services, the study found. After grade three, only about 26 percent of students transition out. The rest remain in special education for the rest of their academic careers.

Paraprofessional Julie Poore works with students at their make believe Home Depot store front at Appoquinimink Preschool Center in Middletown. *(Photo: Jason Minto/The News Journal)*

Josette McCullough, director of student services at Appoquinimink School District, said there is a real gap in services for students with basic special education needs. The bill would help districts close it by providing enough money for the resources and materials needed to serve those kids. The bill could also, potentially, reduce class sizes, McCullough said.

"I am an advocate for kids getting what they need," McCullough said. "House Bill 12 will support districts by providing funding, just as they do from grades 4-12 — the money earned will be provided directly to students with identified needs."

The very possibility of extra funding is exciting, she said, and like Williams, she has been involved in the effort to get the bill passed. McCollough was in Dover when Williams introduced the bill last week and is part of a committee developing Delaware's Special Education Strategic Plan, as is Michele Marinucci, director of student services for the Woodbridge School District.

Marinucci said under the current system, children with special education needs are getting the same amount of funding that students without special needs are getting in grades K-3.

"This is obviously a concern, since a child with special education needs, needs more instructional support, accommodations, and modifications than a typically advancing peer," she said.

Not only that but under the current setup, it's not only special education students that are suffering but likely their peers, whose teachers are being pulled in multiple directions trying to serve students at different levels.

"By not providing the level of staffing support at the early levels that our students need, we are putting our teachers in a much more challenging position of meeting the needs of all of their students — while also potentially compromising the outcomes of our struggling learners," Marinucci said. "Research also supports that the earlier the intervention, the greater the likelihood of closing the gap; this means that a child who is identified with basic special education needs and is appropriately served at an early age may not need to continue to receive special education services for the long term."

That could be one of the bill's selling points.

McCullough said earlier identification and support for students with basic special education needs could mitigate long-term costs.

Alex Eldreth, policy and community outreach director for Autism Delaware, said his group enthusiastically supports the bill. He hopes it will prevent students from becoming dissatisfied with school because they aren't getting enough help to succeed.

"You're pretty much formed in your opinions of education by third grade," Eldreth said. "If these students have a supportive environment that really helps meet their needs, that can go a long way."

Williams' bill plays into a larger drive to provide more resources to at-risk kids in public schools. The Wilmington Education Improvement Commission has been pushing hard for the state to provide more resources for students who live in poverty or are learning English as a second language; the Commission also backed William's special needs bill last year.

Contact Matthew Albright at malbright@delawareonline.com, (302) 324-2428 or on Twitter @TNJ_malbright. Contact Jessica Bies at (302) 324-2881, jbies@delawareonline.com or on Twitter at @jeessicajbies.

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148TH GENERAL ASSEMBLY

FISCAL NOTE

BILL:	HOUSE BILL NO. 30
SPONSOR:	Representative K. Williams
DESCRIPTION:	AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO PUBLIC SCHOOLS.

ASSUMPTIONS:

1. This Act shall be effective the fiscal year after its enactment.
2. This Act will change the level of funding supporting students in basic special education in grades Kindergarten through Third Grade from 1 unit of funding for every 16.2 pupils to 1 unit of funding for every 8.4 pupils.
3. This legislation will generate an additional 136.54 state units of funding for students in grades Kindergarten through Third Grade that are enrolled as basic special education along with an additional 2.4 units for Related Services.
4. A state unit of funding is $78,068 while the local share of personnel costs is assumed at $28,497. Other employment costs are assumed at 30.08%.
5. Related Services funding, as defined by 14 Del. C. §1716A, for K-3 Basic Special Education is 1 unit of funding for every 57 units where the unit value is equal to a 10-month teacher with ten years of experience at the Master Degree level on the state supported salary schedule.
6. Overall costs are assumed to growth 2.0% annually.

Cost:	State Share	Local Share
Fiscal Year 2016:	$10,788,500	$3,959,200
Fiscal Year 2017:	$11,400,300	$4,038,400
Fiscal Year 2018:	$11,628,300	$4,119,200

Office of Controller General
February 16, 2015
MSJ:MSJ
0271480005

(Amounts are shown in whole dollars)

149th GENERAL ASSEMBLY
FISCAL NOTE

BILL:	HS 1 to HOUSE BILL NO. 12
SPONSOR:	Representative K. Williams
DESCRIPTION:	AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO PUBLIC SCHOOLS.

Assumptions:

1. This Act shall be effective beginning with the fiscal year after its enactment.
2. This Act will change the level of funding supporting students in basic special education in grades Kindergarten through Third Grade from 1 unit of funding for every 16.2 pupils to the following:
    - 1 unit of funding for every 14.2 pupils for the 2017-2018 school year;
    - 1 unit of funding for every 12.2 pupils for the 2018-2019 school year;
    - 1 unit of funding for every 10.2 pupils for the 2019-2020 school year; and
    - 1 unit of funding for every 8.4 pupils for the 2020-2021 school year.
3. This legislation will generate an additional 21 state units of funding for students in grades Kindergarten through Third Grade that are enrolled as basic special education for school year 2017-2018 with 145 units generated for school year 2020-2021 upon full implementation.
4. A state unit of funding is estimated at $82,889 while the local share of personnel costs is assumed at $30,623. Other employment costs are assumed at 31.49%.
5. Overall costs are assumed to grow 2.0% annually.

Cost:

	State Share	Local Share
Fiscal Year 2018:	$1,759,000	$650,000
Fiscal Year 2019:	$4,173,000	$1,542,000
Fiscal Year 2020:	$7,636,000	$2,821,000
Fiscal Year 2021:	$12,294,000	$4,542,000

Prepared by Michael Morton
Office of the Controller General
1/17/17
#1161490006

Thursday, January 26, 2017 - 5:40am

Heffernan bill would raise minimum school attendance age to 18 years

By Kelli Steele

In an effort to encourage students to graduate high school, the age at which students must attend school would be increased to 18 under legislation unveiled Wednesday.

Sponsored by Rep. Debra Heffernan, House Bill 55 would raise the age requirement for compulsory school attendance in Delaware from 16 to 18 over a two-year period. Currently, a student who is 16 years old or older is not legally required to be enrolled in school. The draft legislation is similar to House Bill 244, which was introduced in the 146th General Assembly.

"We stress over and over how invaluable an education is to being successful in life. We see more and more of that in the 21st century, a high school diploma is no longer optional. It really is the minimum education for young people today who want economic success and independence," said Rep. Heffernan, D-Brandywine Hundred South. "As we continue working to improve our educational system, we need to have students staying to complete their coursework."

HB 55 incorporates the option for alternative routes to completing high school for youth age 16 and older. The alternative learning plans would include age-appropriate academic rigor and the flexibility to incorporate the child's interests and manner of learning. The plans could include paths such as independent study, private instruction, performing groups, internships, community service, apprenticeships, and on-line courses.

According to the National Center for Education Statistics, 24 other states require school attendance until students are 18. Another 11 states require attendance until students reach 17. Maryland's General Assembly passed a law in 2012 increasing its age from 16 to 17 in 2015 and to 18 later this year.

NCES notes that in 2014 the median earnings of young adults (ages 25-34) with a high school diploma ($30,000) was 20 percent higher than the median earnings of those without a high school diploma ($25,000).

"Ensuring that students continue their education is critical for their personal economic futures," said Rep. Heffernan, a former Brandywine School Board president. "This bill not only will provide the requirement that students get that education in school, but allow flexibility for them to seek alternative plans to complete their coursework."

The measure would be phased in over two years, with a one-year interim period in which the required school attendance age would be 17 years beginning September 1, 2018, and increasing to 18 years the following September. The bill also would increase the age for truancy to coincide

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- Magnolia man charged with terroristic threats directed at social workers
- Local man arrested for Aug. 2016 bank robbery in Ocean City
- Lawmakers again eye school testing opt out bill
- Millsboro woman arrested for stealing from Harrington Royal Farms

with the school attendance age changes.

The proposal also preserves an exemption allowing a child to be excused from required attendance at the request of the child's parent or legal guardian with written support from a qualified health professional. It also allows an exemption for children who graduate from high school before they turn 18.

HB 55 was drafted with input from the state Department of Education and has been assigned to the House Education Committee.

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- Facial hair: a turn-on, or a turn-off?

Table 5.1. Compulsory school attendance laws, minimum and maximum age limits for required free education, by state: 2015

State	Age of required school attendance	Minimum age limit to which free education must be offered	Maximum age limit to which free education must be offered
Alabama	6 to 17	5 [1]	17 [2]
Alaska	7 to 16 [3]	5	20
Arizona	6 to 16 [4]	5	21
Arkansas	5 to 18	5	21
California	6 to 18	5	21
Colorado	6 to 17	5	21
Connecticut	5 to 18 [5]	5	21
Delaware	5 to 16	5	21
District of Columbia	5 to 18	5 [6]	† [7]
Florida	6 to 16	4	—
Georgia	6 to 16	5	20
Hawaii	5 to 18	5	20
Idaho	7 to 16	5	21
Illinois	6 to 17	4	21 [8]
Indiana	7 to 18	5	22
Iowa	6 to 16 [9]	5	21
Kansas	7 to 18	5	†
Kentucky	6 to 18	5	21
Louisiana	7 to 18	5 [10]	20 [11]
Maine	7 to 17	5 [12]	20
Maryland	5 to 17	5	21
Massachusetts	6 to 16	3 [13]	22
Michigan	6 to 18	5	20
Minnesota	7 to 17	5	21
Mississippi	6 to 17	5	21
Missouri	7 to 17 [14]	5 [15]	21
Montana	7 to 16 [16]	5	19
Nebraska	6 to 18	5	21
Nevada	7 to 18	5	†
New Hampshire	6 to 18	—	21
New Jersey	6 to 16	5	20
New Mexico	5 to 18	5	—
New York	6 to 16 [17]	5	21
North Carolina	7 to 16	5	21
North Dakota	7 to 16	5	21
Ohio	6 to 18	5	22
Oklahoma	5 to 18	5 [18]	21
Oregon	7 to 18	5	19 [19]
Pennsylvania	8 to 17	6 [20]	21
Rhode Island	6 to 18 [21]	5	21
South Carolina	5 to 17	5	22
South Dakota	6 to 18 [22]	5	21
Tennessee	6 to 18	5	†
Texas	6 to 18	5	26
Utah	6 to 18	5	—
Vermont	6 to 16 [23]	5	—
Virginia	5 to 18	5	20
Washington	8 to 18	5	21
West Virginia	6 to 17	5	22
Wisconsin	6 to 18	4	20
Wyoming	7 to 16 [24]	5	21

—Not available. In this state, local education agencies determine their maximum or minimum age, or the information is not available in the statute.
† Not applicable. State has not set a maximum age limit.
[1] In Alabama, the parent or legal guardian of a 6-year-old child may opt out of enrolling their child by notifying the local board of education, in writing, that the child will not be in school until he or she is 7 years old.
[2] In Alabama's city school systems, students are entitled to admission until age 19.
[3] Alaska requires that students attend until they are 16 or complete 12th grade.
[4] In Arizona, students must attend until they are 16 or complete 10th grade.
[5] In Connecticut, the parent of a 5-or 6-year-old child may opt out of enrolling their child until he or she is 7 by signing an option form.
[6] District of Columbia students who are at least 3 years old on or before September 30 are eligible for admission to the preK-3 program. A student who is 4 years old before September 30 is eligible for the preK-4 program, and a student who is 5 years old or before September 30 is eligible for kindergarten.
[7] An adult student who is a resident of the District of Columbia is eligible for free instruction in the schools.
[8] In Illinois, reenrollment is denied to any child 19 years of age or older who has dropped out of school and who cannot, because of age and lack of

State	Age of required school attendance	Minimum age limit to which free education must be offered	Maximum age limit to which free education must be offered

credits, attend classes during the normal school year and graduate before his or her 21st birthday.
[9] In Iowa, children enrolled in preschool programs (4 years old on or before September 15) are considered to be of compulsory attendance age.
[10] Each city and parish school board may provide for a child younger than 5 to enter kindergarten if that child has been identified as gifted by the state guidelines.
[11] In Louisiana, admission must be granted to any student who is 19 years of age or younger on September 30 or 20 years old on September 30 and has sufficient course credits that he or she will be able to graduate within one school year of admission or readmission.
[12] In Maine, students must be at least 5 years old before October 15, or 4 years old by October 15 if they are enrolled in a public preschool program prior to kindergarten (where offered).
[13] Each school committee establishes its own minimum age for school attendance.
[14] Missouri requires attendance until 17 or the completion of 16 credits toward high school graduation.
[15] A child between 5 and 7 years old in Missouri may be excused from attendance at school if a parent or guardian submits a written request.
[16] In Montana, attendance is required until students are 16 or complete 8th grade.
[17] In New York, the boards of education in the Syracuse, New York City, Rochester, Utica, and Buffalo school districts are authorized to require children who are 5 years old on or before December 1 to attend kindergarten unless the parents elect not to enroll their child until the following September, or the child is enrolled in a non-public school or home instruction. New York local boards of education may require 16-and 17-year old students who are not employed to attend school.
[18] In Oklahoma, children who are least 4 years old but not older than 5 on or before September 1 may attend either half-day or full-day programs in their district.
[19] In Oregon, a district may admit a student who has not yet turned 21 if he or she requires additional education to receive a diploma.
[20] The board of school directors in any school district may establish kindergarten programs for children between the ages of 4 and 6.
[21] In Rhode Island, the compulsory age is 16 if a student has an alternative learning plan for obtaining a high school diploma or its equivalent.
[22] In South Dakota, the compulsory age limit is 16 if a child enrolls in a general education development test preparation program that is school-based or for which a school contracts, and the child successfully completes the test or reaches the age of 18.
[23] In Vermont, individuals who are at least 20 years old may enroll in high school if they do not yet have their diploma. Individuals who between the ages of 16 and 20 may enroll in the General Educational Development Program.
[24] Wyoming requires students to attend school until they are 16 or complete 10th grade.
SOURCE: Education Commission of the States, *Free and Compulsory School Age Requirements in the United States*, retrieved June 15, 2015, from http://www.ecs.org/clearinghouse/01/18/68/11868.pdf.

Compulsory Education

More than 150 years have passed since Horace Mann helped Massachusetts establish a statewide system of education that eventually led to the requirement that all children attend public school. In 1852, Massachusetts became the first state to pass compulsory school attendance laws, and by 1918, all states required children to receive an education.

Compulsory Education Requirements

Today, every state and territory requires children to enroll in public or private education or to be home-schooled. More than half—32 states—require students to begin their education by age 6. Some states' set their age requirements as low as age 5 and as high as age 8. All children are required to continue their education into their high school years, with 26 states setting the cutoff age at 16. The remaining states require students to stay in school through age 17 or 18.

Compulsory education laws vary greatly from state to state. While some states use a student's date of birth to determine the beginning and ending dates for compulsory education, other states require a student to begin school if he or she will turn 6 during the school year and require a student to remain in school until completion of the school year in which he or she turns 17. Four states—Arizona, Montana, Vermont and Wyoming—require students to remain in school through a specified grade. Most states allow parents to petition their local school board or principal for a waiver of these requirements under certain circumstances, such as enrollment in a vocational education program or an institution of higher education or early completion of required coursework.

Kindergarten Enrollment

States and territories also set a minimum age for children to enroll in kindergarten, which is typically one or two years earlier than the compulsory education age. Every state or territory with a policy on this issue has established age 5 as the minimum age. However, six states—Colorado, Massachusetts, New Hampshire, New Jersey, New York and Pennsylvania—leave this decision up to local education agencies. In addition to the age requirement, each state also sets a date by which students must have attained the specified age in order to attend kindergarten. The cutoff dates range from August 1 in Indiana and Missouri to Jan. 1 in Connecticut and Vermont.

The School Age Debate

School attendance ages are often controversial. Many early childhood experts argue that if policymakers establish early cutoff dates for kindergarten, they should also establish aggressive school readiness programs to ensure students' success. Others argue that because there has been an increased emphasis on early childhood development and school readiness, we should continue to challenge children at a younger age. Some experts assert that age may be an arbitrary indicator or measure of a child's ability to succeed in school and should not be used at all. Others point out that when a state considers legislation, such as Nebraska, allowing younger children to enter kindergarten, policymakers must understand that there is likely to be a large increase in the number of children entering kindergarten during the first year of the new policy, thereby straining already tight school district budgets and increasing the need for teachers.

The age through which students must attend school can also be controversial. To encourage more students to attend institutions of higher education and to decrease dropout rates, juvenile crime and teen pregnancy, some state legislatures have increased the school attendance requirement to age 17 or 18. Opponents are concerned about forcing students to be in the classroom against their will. They say that these students may become disruptive and may require teachers and principals to spend more time and resources disciplining such students for disruptive or violent behavior and truancy. They also point out that there probably will be a greater need for funding, teachers and classrooms for alternative education.

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Raising the Compulsory School Attendance Age

Purpose: To express support for raising to 18 the minimum age at which a student is allowed to leave compulsory education and to provide school leaders and policymakers recommendations that would ensure its successful implementation.

Issue: In recent years, the drop-out rate in US schools, currently estimated at 20% overall and overrepresented among low income, Black, and Latino students, has gained a great deal of attention, because of its impact on the students and on the communities in which they live. Research indicates that students who drop out of schools are more likely to be unemployed, earn dramatically lower salaries when they do work, and are more likely to become involved in the criminal justice system.

In an attempt to curb the drop-out rate, governors and state legislators are considering raising the compulsory school attendance age under state law from 16 or 17 to 18 years of age. According to the Department of Labor, seventeen states and the District of Columbia have already raised the minimum age at which a student is legally allowed to leave compulsory education to 18. Thirteen more states are considering legislation to raise the compulsory school attendance age. The trend continues to grow as governors and state legislators consider the impact of the dropout on tax revenues in the context of an economic recession. Other countries are experiencing the same trend toward a higher compulsory school attendance age.

Opponents of this policy argue that:

- It interferes with parents' rights to make educational choices for their children
- It raises the burden on taxpayers and increases the cost of education
- It represents an intrusion of the government into the lives of individuals
- It fails to retain students who are already disengaged from their schools
- It creates disruptions in the classroom (by students who are forced to stay in school against their will).

Supporters of this policy argue that:

- Coupled with supports for struggling students, it curtails the drop-out rate (according to one study, 25% of potential dropouts remain in school because of compulsory schooling laws)
- It enables students to earn higher wages in the future (because they attend school longer)
- It affords students additional benefits, such as better health and better satisfaction with their lives
- It reflects the realities of the 21st century, with an increased need for higher levels of education.
- It increases the prosperity of the states and the nation
- It promotes social mobility by enabling students of poverty to stay in school longer and complete their education.

Consistent with its efforts to advance student achievement for all and close the achievement gap, NASSP affirms its support for raising the minimum age at which a student is allowed to leave compulsory education to 18 ,provided the following recommendations are implemented.

NASSP Guiding Principles:

- NASSP believes that all students should graduate from high school with the skills to help them succeed in postsecondary education and the workplace.
- In a 2007 Achievement Gap position statement, NASSP affirmed its commitment to closing the achievement gap and offered recommendations to help policymakers and school leaders address it.
- In a 2009 position statement *Preparing All Students for Postsecondary Success,* NASSP expressed support for challenging graduation requirements and provided recommendations for federal, state, and local policymakers to help schools ensure that all students met those high standards.

- *Breaking Ranks II* and *Breaking Ranks in the Middle* provide school leaders with a framework for improving the performance of each student by implementing best practices through collaborative leadership and professional learning communities; creating relevance through personalizing the environment; and addressing issues of rigor through curriculum, instruction, and assessment.
- In a February 2009 position statement *Preparing All Students for Postsecondary Success,* NASSP expressed support for challenging graduation requirements and provided recommendations for federal, state, and local policymakers to help schools ensure that all students meet those high standards.
- NASSP has identified a number of high-achieving middle level and high schools serving large numbers of low-income students. Access to rigorous coursework for all coupled with intensive and personalized supports are key components of Breakthrough Schools. Those schools offer valuable lessons on how they raised expectations and supported their students in the process.
- NASSP has been a long-time supporter of policies that seek to promote equity and excellence, including the work of Pathways to College Network, the Data Quality Campaign, Adolescent Literacy, National Standards and Assessments, the National Forum to Accelerate Middle Grades Reform, and the National High School Alliance.

Recommendations

Federal Leaders
Create a separate funding stream to improve student achievement in middle level and high schools, reduce the number of high school dropouts, and ensure that all students graduate from high school with the skills they need to succeed in college and the workforce.

State and District Leaders
Make every effort to increase the maximum compulsory age for school attendance to 18 for all students who have not already completed the requirements for a high school diploma.

Implement a systemic transition plan for all students and encourage collaboration between elementary, middle level, and high schools.

Target resources to middle level and high schools with high student-mobility rates and significant proportions of low-income students, English language learners, students with disabilities, and low-achieving students to help all students meet high expectations.

Provide funding for graduation coaches, counselors who focus solely on at risk students. They monitor student's academic progress and attendance and work with teachers to identify those who are falling behind or at risk of doing so. Graduation coaches also focus on getting parents involved and will make home or workplace visits with parents.

Provide at-risk students with nonmonetary incentives for staying in school.

Provide funding and technical assistance to help schools address the educational and social needs of students who would otherwise be tempted to drop out prior to their 18th birthday.

Provide incentives to high schools that increase their graduation rates and to middle schools that increase the number of promoted students who are adequately prepared for high school.

Provide ongoing and targeted professional development to teachers and school leaders to increase their capacity to engage students in their own education.

Build a drop-out recovery system for older students who are willing to go back to school to complete their education.

Implement a significant literacy initiative that supports students from early childhood through their high school years.

Allow schools to give some students, particularly English language learners and students with disabilities, more time to complete graduation requirements.

Ensure that students have access to academic supports that will help them stay on track toward graduation, including:

- Challenging core curricula at the middle level that are aligned with the high school curricula and will help students get on target for college and career readiness by the end of grade 8
- Counseling services for middle level and high school students that provide information and assistance about the requirements for high school graduation, college admission, and career success
- Personalized academic plans to support completion of middle level requirements and progress toward graduation
- Targeted and tiered interventions for middle level and high school students who are falling behind
- Online learning opportunities
- Extended learning time during the school day, week, and year
- Job shadowing, internships, and community service
- In-school and community-based social supports, such as counselors, social workers, and mental health services.

School Leaders
Create small units in their schools, where anonymity is eliminated.

Create a personal plan for progress for each student to support his or her talents and interests. Review the plan often to ensure that the school takes individual needs into consideration.

Offer career and technical education or curriculum-based service learning.

Assign a personal adult advocate to each student.

Engage families as partners in their students' education.

Help coordinate the delivery of physical and mental health and social services for students in conjunction with agencies in the community

Provide intensive interventions to students who are at risk of dropping out.

Promote policies and practices that recognize diversity and offer substantive, ongoing professional development to help educators appreciate issues of diversity.

Promote and convey a sense of caring so that students know that teachers have a stake in student learning.

Resources

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Adopted May 7, 2010

Print

CLASP: Policy Solutions That Work for Low-Income People (http://www.clasp.org/)

Compulsory Attendance Until 18 Not Enough to Address H.S. Dropout Problem

Jan 26, 2012

By Rhonda Tsoi-A-Fatt Bryant (http://www.clasp.org/experts?id=0003)

In his State of the Union address, President Obama challenged governors to raise the compulsory school attendance age to 18 years. Currently, only 20 states have such a requirement and another eleven states mandate school attendance until age 17. The remaining states require attendance until 16, but many, such as Kentucky and Delaware, are now debating a change and have introduced legislation to raise the age.

It is important to ensure that high school students complete their education. Failure to do so has significant impact on them as individuals as well as on the economic viability of our communities and our nation. Raising the compulsory student attendance age, however, doesn't go far enough to assure that students complete high school. Preventing dropout requires far more than a statute that makes it illegal to do so. In fact, there is a lack of substantive evidence to demonstrate that raising the compulsory school attendance age alone significantly affects high school completion.

To truly impact the high school dropout rate, raising the compulsory student attendance age must be coupled with other key actions:

- Increase school supports for struggling students
- Create multiple pathways to attain a high school diploma, including competency-based instruction, strong career and technical education models, and alternative programs
- Ensure that compliance policies do not put truant students and dropouts into the juvenile justice system
- Train effective teachers to work diligently with struggling students
- Increase the number of school counselors available to work with students
- Create incentives to high schools to increase their graduation rates
- Build a dropout recovery system to reengage older students to complete their education
- Provide wrap-around services in schools for students to meet their needs in areas of physical and mental health, social services, housing assistance, etc.

Addressing the high school dropout crisis comes at a cost, which Congress and the Obama Administration must acknowledge and address. If policymakers are serious about being a nation that ranks first in educating its students, we must make the necessary investments to ensure a quality education for even our struggling students. These investments must begin in middle school, where we know there are the greatest opportunities for dropout prevention, and span all the way to dropout recovery for older students who want to come back and complete their education. The reauthorization of the Elementary and Secondary Education Act presents an opportunity to boldly address the national issue of high school dropout through meaningful reforms that signal our commitment to well-educated students and a well-prepared workforce. It is our hope that Congress and the Administration will make reauthorization of ESEA a priority in 2012.

See CLASP's recommendations for **ESEA reform (http://www.clasp.org/admin/site/publications/files/ESEA-Recommendations2010.pdf)** to impact high school dropout.

1-28-12 NS

OPINION
The News Journal

Howard L. Griffin, President and Publisher
David F. Ledford, Executive Editor
John Sweeney, Editorial Page Editor

OUR VIEW

School dropout problem needs to be revisited

State Rep. Debra Heffernan made the right choice this week to delay a bill on school dropouts.

The representative has the right target – getting more students to graduate from high school. However, as she acknowledged, some more work has to be done before the bill is brought to a vote.

MORE THAN JUST COST

Rep. Heffernan wants to raise the age a student can leave school from 16 to 18. Several of her colleagues worried the bill as it now stands would be costly.

That's true, but it's not the point. Keeping more than 1,400 would-be dropouts a year in school until they are 18 will add to costs. But society as well as the dropouts pay a much higher cost in lost earnings and wasted talent.

The challenge is to make the extra years worthwhile. It is beyond the education system's purview to fix society's problems. Students drop out for a variety of reasons. They range from a problematic home life to learning difficulties not previously spotted. A simple command to stay in school would push a number of the would-be dropouts toward a high school diploma. However, for a greater number, they would spend the extra years marking time, and that only extends the problem.

It would be better to attack the dropout problem with all of the tools that the education system has available. That would include tracking and adjusting the student's progress long before he or she becomes a dropout candidate.

We encourage Rep. Heffernan to come back to the problem because she has recognized dropping out imposes severe limits over a lifetime.