

An Economic Analysis of Medical Amnesty

Thomas Grubb

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1 Introduction

Starting on college campuses in the early 2000's, medical amnesty policies have formed a fast growing subset of the so called "Good Samaritan" laws. In order to encourage youth to seek help in potentially life threatening circumstances involving alcohol, states have recently put medical amnesty laws in place which allow underage drinkers (UDs) to request medical assistance without fear of legal repercussions. The standard arguments for and against these policies are clear. Advocates for medical amnesty argue that these policies will help lead to a decrease in avoidable alcohol related deaths and injuries. On the other hand, critics are quick to point out that these laws perpetuate illegal underage drinking, and argue that other platforms should be used to prevent UD's from being in an alcohol related emergency in the first place; see, for instance, opinions expressed in [24]. In the current paper we examine the former argument to see whether or not it holds up to empirical evidence.

There are clear and pressing motivations for examining the effectiveness of medical

amnesty policies. Despite the illegality of underage drinking, 34% of American teenagers report drinking alcohol by the age of 15, with that number approaching 80% by the the age of 20 [20]. More striking is that roughly 90% of this alcohol is consumed in the form of binge drinking, defined roughly as having 5 or more drinks in a two hour session [5], [16], [22]. So not only are UDs drinking alcohol in dangerous amounts, they stand to lose the most when calling for help in these situations. In fact underage drinking in 2010 was indirectly involved in over 4,300 deaths of teens and young adults [6], and accounted for economic costs of roughly \$24.3 billion to the United States as a whole [19]. In light of this data it would be prudent for governing bodies to put policies in place to help reduce the harm and loss of life caused by underage drinking. Evaluating the effectiveness of medical amnesty laws is the first step in determining which type of policy is best suited for this purpose.

2 Background

Good Samaritan laws have existed in the United States since the 1960's. While this paper will not serve as an exhaustive discussion of Good Samaritan laws in their full generality, we find it prudent here and below to discuss some aspects of the big picture in order to compare and contrast with the current state of medical amnesty laws. California led the way with Good Samaritan laws in 1959 with a bill protecting medical practitioners from liability when rendering emergency medical care. Following this precedent, similar Good Samaritan Laws protecting selected individuals giving emergency medical assistance were passed throughout the United States in following years; at this point, all 51 US jurisdictions

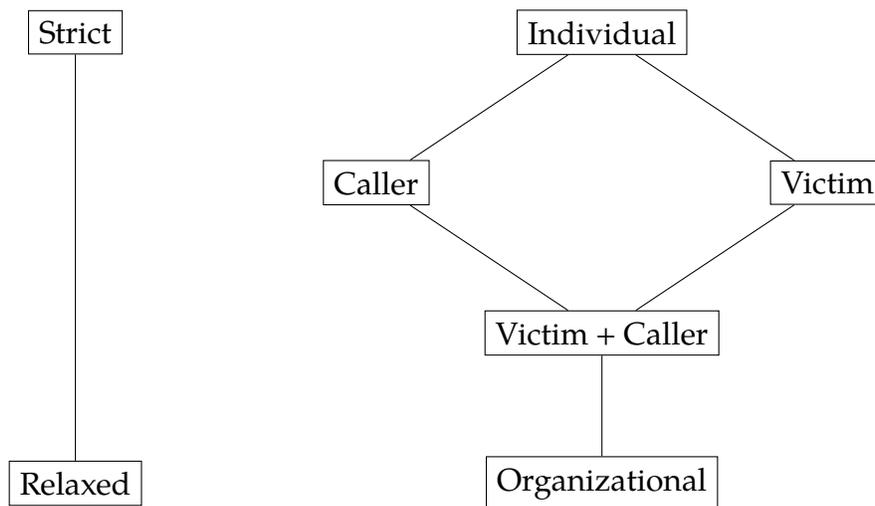
offer medical practitioners some level of protection under a Good Samaritan clause [3].

With the medical precedent set, the use of Good Samaritan laws has dovetailed to other situations. Despite the different specific application of these laws, all such laws have the common thread of seeking to increase altruistic behavior in emergency situations. In 1996 the Federal Bill Emerson Good Samaritan Food Donation act was passed, which protects individuals from liability when donating to food banks in an attempt to encourage charitable grocery contributions to entities such as Feeding America [8]. As of June, 2016, all but 3 US jurisdictions have passed Good Samaritan type laws in order to increase naloxone access to laypeople in an effort to prevent death from opioid overdose [7]. Our last example is medical amnesty with respect to alcohol, the focus of this paper. Currently, 35 of the 51 US jurisdictions have some form of medical amnesty in place in order to reduce UD death rates from alcohol overdose; see Table 1 of the Appendix for a complete list with references to the original legislation.

Medical amnesty in the United States has largely been a product of activism on college campuses. According to a survey of the Students for Sensible Drug Policy, over half of colleges and universities in the United States have some form of medical amnesty policy, independent of state legislation. The importance of college students in this movement is exemplified by Michigan's state policy, which was passed in large part due to lobbying by the Associated Students of Michigan State University [10]. Several initiatives have since been started, including the Medical Amnesty Initiative and the Call 911 initiative to spread similar medical amnesty policies to remaining states and campuses.

Like any Good Samaritan law, medical amnesty laws vary in the amount of protection they offer. In large part this protection is broken down into two categories; first is who is

covered by medical amnesty, and second is the extent to which medical amnesty removes consequences for underage drinking. One of the largest issues of contention with regards to medical amnesty is who should be covered by the policy. Listed below are the various degrees of coverage, ordered from strictest to most relaxed:



- Individual - Medical amnesty only applies to an individual seeking medical assistance for him or her self.
- Victim - Medical amnesty only applies to the person to whom medical assistance is given.
- Caller - Medical amnesty only applies to the person who called for help.
- Victim+Caller - A combination of the previous two policies. (This is often a grey area; some “Caller” policies will apply “Victim+Caller” if the Caller is a friend or peer of the victim)

- Organizational - Medical amnesty applies to the organization at which the victim was present. This would, for example, give some protection to a fraternity or social club hosting a party at which someone needed medical assistance.

On top of variation in coverage, medical amnesty policies differ in the amount of liability that is removed. There is a much wider range of policies in this aspect; under some medical amnesty policies, the covered parties face absolutely no repercussions; under other policies there will be merely a lessening in repercussions, such as a compulsory visit to a health and wellness mentor.

3 Literature Review

Empirical studies of Good Samaritan laws can be found in the literature, although they are quite sparse. Mapel and Weigel conducted the first study of the original Good Samaritan laws in [14]; this work was later expanded on by Brandt in [3]. In the latter work, Brandt casts a skeptical view towards the efficacy of Good Samaritan laws, highlighting that Good Samaritan laws have rarely been brought up in judicial proceedings. Furthermore, while Good Samaritan laws *allow* individuals to give emergency medical assistance, there is no compulsion to do so. Brandt argues that instead of “right to act” legislature we need “duty to act” legislature, as seen in Virginia, in order to give victims the aid that they need. As it stands, “duty to act” laws are much less common than the original “right to act” laws; for this reason Brandt calls Good Samaritan laws “the legal placebo” in that they assuage the fears of medical practitioners but do not produce any concrete results. Brandt goes on to give a further legal analysis of Good Samaritan laws in comparison to common law

statutes, but does not give any empirical evidence to support his claim.

Perhaps the most studied variant of the Good Samaritan law is with respect to opioid overdose. In [18], Rees et al examine the effect of Naloxone Access Laws and drug related Good Samaritan laws on deaths caused by opioid overdose. Naloxone Access Laws allow first responders (and in some cases laypeople) to administer naloxone in life threatening situations without fear of civil or criminal liability; the Good Samaritan laws allow victims to seek out help without fear of criminal repercussions for drug use. The difference between the two laws is reminiscent of the difference between caller protection and victim protection with respect to medical amnesty. In their study, Rees et al. use Poisson regression and a difference in difference type model to find a statistically significant and negative relationship between Naloxone Access Laws and opioid related deaths. Specifically, Naloxone Access Laws were associated with a decrease in opioid deaths of roughly 10%. The relationship between Good Samaritan laws and deaths is also negative, but not statistically significant.

While [18] is the most complete study of Good Samaritan laws with respect to opioid overdoses, Rees et al. cite several smaller studies in their work. In [9] and [2], Haegerich et al. and Bao et al. respectively study the impact of more preventative measures on drug overdoses, and find strong evidence that prescription drug monitoring programs decrease both opioid use and opioid overdoses. In [1], Albert et al. study the impact of Project Lazarus, a community based program in Wilkes County, North Carolina which sought to decrease opioid related deaths in several ways. The study found that deaths decreased dramatically after the implementation of Project Lazarus, although the sweeping nature of the program makes it impossible to isolate the specific impact of the Naloxone Access

Law that went along with it. Finally, in [23], Walley et al. conduct a similarly local study based on the Overdose Education and Naloxone Distribution program in Massachusetts, and find that Naloxone Access Laws do significantly decrease the number of opioid related deaths over a given time period.

In contrast to the study of Naloxone Access Laws, there is little in the literature regarding medical amnesty. Lewis and Marchell conduct the most recognized medical amnesty study in [13], which examines the impact of Cornell University's medical amnesty policy specifically. Between 2001 and 2004, a survey was conducted on Cornell's campus, which collected information on how many times a student called for help because of an alcohol related emergency. The survey results show a significant increase in alcohol related EMS calls from 2001 (pre medical amnesty) to 2004 (two years post medical amnesty). Reasonable (but not conclusive) evidence is also given to support that this increase is an actual result of medical amnesty, and not a result of some confounding factor, such as an increase in overall drinking rates. Lewis and Marchell conclude that Cornell's medical amnesty policy succeeded in lowering barriers for UDs to call for help.

There is one other important takeaway from the Lewis and Marchell study. Many opponents of medical amnesty argue that no sane person would hesitate to call for help in a life threatening situation, regardless of the criminal repercussions. One aspect of the survey was dedicated to answering this question specifically, and found that of students who declined to call for help in such a situation, a significant percentage failed to do so specifically because they did not want to get the victim, the organization, or themselves in trouble. This provides evidence that medical amnesty is indeed an important policy to have on college campuses, although the authors recognize that it should be accompanied

by educational programs to prevent these situations in the first place.

Two other studies similar to [13] can be found in the literature. In [17], Oster-Aaland et al. conduct a survey of 2,500 midwest college students regarding emergency situations regarding alcohol. The students were split into four groups; a control group, a group which was shown an educational video regarding alcohol overdose before the survey, a group which was told that a state had a Medical Amnesty program prior to the survey, and a combination of the latter two. Students then read a hypothetical scenario in which an underage drinker required medical assistance, and were asked whether or not they would call emergency medical services for the victim. The study found that only 57% of the control group would be willing to call for help, whereas 74% of the Medical Amnesty group would call for help. Finally, in [11], Kharasch et al. examine the number of times an underage drinker was admitted to an emergency policy before and after the passing of a Medical Amnesty policy at an unspecified university. The study finds a 56% increase in emergency department visits, without a major increase in the overall drinking level of the university's students.

Apart from the previous surveys, little has been done to quantify the efficacy of medical amnesty on a large scale. The Medical Amnesty Initiative claims that the adoption of these policies has increased alcohol related EMS calls by 700% [21], but given the bias of the organization, the absence of supporting data, and the more modest results found in [13], the current author finds that claim absurd. More quasi-studies can be found by examining legislative analysis conducted prior to the passing of medical amnesty policies; see for instance Michigan's analysis [15]. The claims made for and against medical amnesty are more sensible, but again are disappointingly unsubstantiated by any reference to a data

source.

4 Economic Theory

There is straightforward economic theory motivating arguments for and against medical amnesty. A simple cost/benefit analysis leads one to believe that medical amnesty will increase the number of individuals seeking help in life threatening situations. This can be modeled in the language of [12], in which Landes and Posner develop an economic theory of Good Samaritan laws and rescue situations. With the passing of a Medical Amnesty law, states are both decreasing the expected cost accrued by an altruistic rescuer, and increasing the probability of a successful rescue. According to Landes and Posner, this will in turn cause more bystanders to be willing to help a victim of alcohol overdose, and hence will allow more victims to receive the medical attention they need.

On the other hand, a simple application of Becker's crime model highlights the potential negative side to medical amnesty policies; see [4] for a simple introduction to the model. With the passing of medical amnesty policies, jurisdictions are effectively decreasing the expected cost of underage drinking, both by decreasing the chances of detainment and by lessening the severity of the subsequent punishment. The model predicts that as a result of this, underage drinking rates should increase with the passing of medical amnesty laws. However, for this to provide a nonnegligible increase in underage drinking rates, potential UDs must take into account the possibility that they will need medical assistance by the end of their drinking. Under the assumption of perfect information this may hold, but anecdotally it seems far fetched that a person's decision to drink will hinge

on their ability to receive medical attention without liability at the end of the night.

5 Methodology

Our main tool for studying the efficacy of Medical Amnesty programs will be the difference in difference technique. For each state we have two groups to study: a “control” group consisting of 21-24 year olds whose alcohol overdose rate is assumed to be independent of Medical Amnesty laws, and an “experimental” group consisting of 17-20 year olds. For each state we will choose a year Y and measure the difference in the short run average death rate due to accidental poisoning in each age group before and after Y . If the state has passed a Medical Amnesty law prior to 2014, then the year Y will be the year that the Medical Amnesty bill was passed. Otherwise, we select Y uniformly at random from the years 2009 to 2013. Our main regression is then

$$\begin{aligned} \Delta DeathRate_{j,a} = & \beta_0 + \beta_1 MAP_j + \beta_2 Underage_a + \beta_3 MAP_j * Underage_a \\ & + statedummies + yeardummies \end{aligned}$$

Here $\Delta DeathRate_{j,a}$ is the difference in the death rate per 100,000 for age group a before and after the specified year for state j . MAP_j is a dummy variable determining whether or not a Medical Amnesty policy was passed in state j , and $Underage_a$ is a dummy variable determining which age group a is. We will use a full set of state dummies and year of implementation dummies to account for fixed effects and for trends in death rates over time. The main object of interest will be the coefficient on the interaction term $MAP_j *$

Underage_a. This coefficient will be used to determine whether or not Medical Amnesty laws have had an observable impact on the death rate of underage drinkers; we expect the sign on this coefficient to be negative, indicating that Medical Amnesty laws lower the overdose rate for underage drinkers.

The death rate statistics for this regression comes from the CDC's WONDER database. Because of the sensitive nature of the data, there are several obstacles that are encountered in running this regression. First of all, the CDC restricts access to all death rates below a certain threshold in order to prevent disseminating information which could be used to identify certain individuals. As a result, the number of deaths per year in a given state due solely to alcohol overdose is not accessible, hence the use of ICD-10 Death Codes X40-X49: "Accidental poisoning by and exposure to noxious substances." This includes alcohol overdose as a subcategory, but also includes overdose from other drugs and medications. Even after broadening the cause of death, data was still unavailable for Hawaii, Montana, Nebraska, North Dakota, South Dakota, Vermont, and Wyoming.

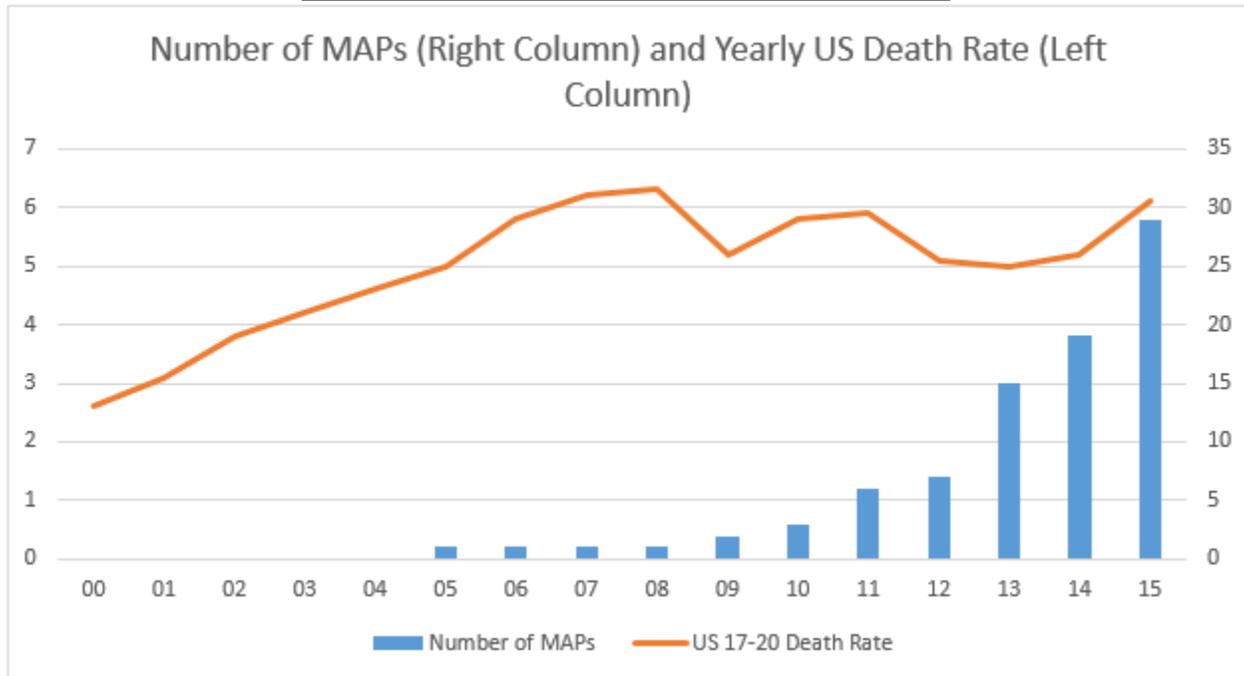
The generality of this death code introduces a source of possible bias in either direction in the obvious way. Furthermore, due to the relative proximity in time of Medical Amnesty legislation, there are instances in which the death rate for a state is taken over only one or two years. This short time span, combined with the fact that most death rates are relatively small, give rise to another potential variance issue for the regression.

Apart from death rates, we also need to use the year in which each state passed its Medical Amnesty law. In Table 1 we provide references to the original legislation, from which one can verify the dates of implementation and nature of the bills online. This process was made significantly easier thanks to online resources from the Medical Amnesty

Initiative and from *Aware Awake Alive*. We note that some states with a current Medical Amnesty program were not treated as such for the regression, as death rates were not available for the years 2015 and on.

Below we give summary statistics for the data examined:

	Age 17-20	Age 21-25
Average Death Rate	5.9	14.1
Average Change	-.17	1.8



In the graph we have the US average death rate for 17-20 year olds in a given year, plotted with the number of statewide Medical Amnesty policies in place for that year. While this relationship is not exactly what the current regression will examine as the death rate is measured nationally, one might expect to see a more apparent downward trend in the death rate if Medical Amnesty policies truly helped save the lives of UDs.

Now for the regression results. We have omitted both state dummies and year of im-

plementation dummies:

Source	SS	df	MS	Number of obs	=	86
Model	656.013629	44	14.9094007	F(44, 41)	=	2.50
Residual	244.299516	41	5.95852479	Prob > F	=	0.0019
Total	900.313145	85	10.5919194	R-squared	=	0.7287
				Adj R-squared	=	0.4374
				Root MSE	=	2.441

ddeath	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
underage	-2.596154	.6770141	-3.83	0.000	-3.963412	-1.228896
MAP	2.998982	2.499672	1.20	0.237	-2.049209	8.047173
underage_MAP	1.702036	1.076732	1.58	0.122	-.4724674	3.87654

As one can see, the coefficient on the interaction term is the opposite sign that we expected. It is statistically insignificant, but not by much. We find it unlikely that medical amnesty policies have been the cause of an increase in death rates due to underage drinking, but it does seem that the policies have had no significant positive effect in the short time since their enactment. This gives preliminary support to Brandt’s “legal placebo” argument with regards to Good Samaritan Laws in general, although a regression with a cleaner data set would be necessary before any concrete conclusions may be made. A nice side note is the negative and statistically significant coefficient on the *Underage* term. This signifies that underage drinking deaths have been going down relative to the control group over the last several years.

6 Conclusion

In a perfect world there are many ways in which this analysis could have gone better. Ideally we could have gotten yearly data on alcohol overdoses alone. This would have

allowed us to run a panel regression as opposed to a simple difference in difference measure. Moreover, the increased timespan would have likely given more precise estimates, and the narrower death statistics would have decreased the chance of bias in our estimates. If given the specific data I would have liked to run a Poisson regression, using the number of deaths in a given year as a dependent variable. Another way to improve this regression is simply to wait a few years. Many states have very recently passed a medical amnesty policy (2015 and beyond). Waiting several years will allow more yearly death rates to become available and will make the impact of medical amnesty policies more clear.

7 Appendix

7.1 Table 1

Below we list the 50 states and the year in which a Medical Amnesty bill was passed (if applicable). We also provide a reference to the corresponding legislation which was passed.

State	Year	Resource
Alabama	2015	House Bill 208
Alaska	-	-
Arizona	-	-
Arkansas	2015	Senate Bill 543
California	2010	Assembly Bill 1999
Colorado	2005	House Bill 05-1183
Connecticut	-	-

Delaware	2013	Senate Bill 116
Florida	-	-
Georgia	2016	House Bill 965
Hawaii	2015	Senate Bill 982
Idaho	2016	House Bill 521
Illinois	2015	House Bill 1336
Indiana	2014	Senate Bill 227
Iowa	-	-
Kansas	2016	Senate Bill 133
Kentucky	2013	Senate Bill 13
Louisiana	2014	Senate Bill 224
Maine	2015	HP 181 LD 263
Maryland	2014	House Bill 416
Massachusetts	-	-
Michigan	2012	House Bill 4393
Minnesota	2013	House Bill 946
Mississippi	-	-
Missouri	-	-
Montana	2015	House Bill 412
Nebraska	2015	Legislative Bill 439
Nevada	2015	Senate Bill 464

New Hampshire	-	-
New Jersey	2009	Assembly Bill 3160
New Mexico	-	-
New York	2011	Bill Number A02063C
North Carolina	2013	Senate Bill 20
North Dakota	2011	Century Code Title 5 Chapter 5-01
Ohio	-	-
Oklahoma	2013	Senate Bill 1
Oregon	2014	House Bill 4094
Pennsylvania	2011	Senate Bill 448
Rhode Island	-	-
South Carolina	-	-
South Dakota	2016	House Bill 1078
Tennessee	-	-
Texas	2011	Senate Bill 1331
Utah	2013	Senate Bill 233
Vermont	2013	House Bill 65
Virginia	2015	Senate Bill 892
Washington	2013	House Bill 1404
West Virginia	2015	Senate Bill 523
Wisconsin	2015	Assembly Bill 808

Wyoming	-	-
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