ALASKA STATE LEGISLATURE
SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
April 11, 2001
2:51 p.m.

MEMBERS PRESENT
Senator Lyda Green, Chair
Senator Loren Leman, Vice Chair
Senator Gary Wilken
Senator Jerry Ward
Senator Bettye Davis

MEMBERS ABSENT

All Members Present

COMMITTEE CALENDAR

SENATE BILL NO. 135
"An Act relating to mental health information and records; and providing for an effective date."
MOVED CSSB 135(HES) OUT OF COMMITTEE

SENATE BILL NO. 116
"An Act relating to the Alaska temporary assistance program; and providing for an effective date."
MOVED CSSB 116(HES) OUT OF COMMITTEE

CONTINUATION OF MEDICAID PRESENTATION BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

PREVIOUS COMMITTEE ACTION

SB 135 - See HESS minutes dated 4/9/01.

SB 116 - See HESS minutes dated 4/9/01.

WITNESS REGISTER

Elmer Lindstrom
Special Assistant
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Explained the provisions of CSSB 135(HES).

Bob Labbe, Director

Division of Medical Assistance
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Provided information about the Medicaid Program.

John Sherwood
Division of Medical Assistance
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Provided information about the Medicaid Program.

Jim Nordlund, Director
Division of Public Assistance
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Explained the changes in CSSB 116(HES).

Commissioner Karen Perdue
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Provided information on the Medicaid Program.

Mary Diven
Division of Medical Assistance
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Provided information on the Medicaid Early Screening and Detection Program for Breast and Cervical Cancer.

ACTION NARRATIVE

TAPE 01-32, SIDE A
Number 001

CHAIRWOMAN LYDA GREEN called the Senate Health, Education & Social Services Committee meeting to order at 2:51 p.m. All members were present. The first order of business to come before the committee

was SB 135.

#SB 135

SB 135-MENTAL HEALTH INFORMATION AND RECORDS

SENATOR WARD moved to adopt CSSB 135(HES), Version C, as the working document of the committee. There being no objection, the motion carried.

CHAIRWOMAN GREEN asked Mr. Elmer Lindstrom to describe the changes made in the committee substitute.

MR. ELMER LINDSTROM explained that in December of 2000, a legislative audit was released that took the Department of Health and Social Services (DHSS) to task for its inability to gather client-specific data from community mental health centers for persons served with general fund grant dollars. Community health centers are funded through two mechanisms; one being Medicaid and the other a grant-in-aid program. DHSS has very good data on clients served through Medicaid but the same type of data is not collected for services provided with grant-in-aid dollars. Legislative Budget and Audit (LBA) pointed out that DHSS ought to know the cost per client, who is served, the services provided and the outcomes of clients who receive services from the grant-in-aid dollars. DHSS concurs with the legislative audit, however the statute is very ambiguous as to DHSS's authority to collect that information, which CSSB 135(HES) will clarify. DHSS has a lot of experience dealing with confidentiality issues; virtually every division has confidential records. He is frequently asked by the legislature why DHSS cannot make more information available rather than being accosted for leaking information.

SENATOR LEMAN asked if DHSS has a system for archiving or purging records that are no longer useful.

MR. LINDSTROM said he does not know the exact procedure but he guessed that most records are ultimately archived or destroyed.

CHAIRWOMAN GREEN referred to page 30 of the legislative audit and read:

> Without this ability, the Department of Health and Social Services cannot identify the total population of mental health clients served, nor detect if Medicaid payments are being made for clients also funded through state grants.

She noted that feeds in with cost containment efforts underway by

the Legislature. She pointed out that regarding confidentiality, the same information is required of an insurance company. She informed committee members that Pat Davidson from Legislative Budget and Audit was present to answer any questions members may have.

CHAIRWOMAN GREEN said that SB 135 is prospective and she is concerned that many people are being asked to offer information but have refused. She asked Mr. Lindstrom if it would be helpful to put a retroactive clause in the bill.

MR. LINDSTROM clarified that the committee substitute contains a retroactive clause. He stated that although a retroactive clause makes sense on a conceptual level, providers have resisted providing that information in the past. A working group made up of DHSS employees, providers and consumers has been assembled to determine which data should be provided. He expressed concern that the working group may come up with a slightly different data set than what is required in the bill. DHSS would prefer not to have the retroactive clause as it is likely to generate opposition.

Number 619

CHAIRWOMAN GREEN commented that the information requested in the bill is what the legislature needs. She asked if SB 135 should include any other information that DHSS needs.

MR. LINDSTROM said in an ideal world, without the retroactive clause, DHSS will probably have good baseline data for several years in the future if it begins on July 1. It would be useful for DHSS collect retroactive data but he suspects that may not be possible as a practical matter.

CHAIRWOMAN GREEN asked if there is any way to frame it in terms of disputed claims.

MR. LINDSTROM said he did not know and would need time to get more information.

CHAIRWOMAN GREEN decided to leave the retroactive clause in the bill and pass it on to the Senate Judiciary Committee, where Mr. Lindstrom could present that information.

SENATOR WARD moved CSSB 135(HES) from committee with individual recommendations. There being no objection, the motion carried.
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CONTINUATION OF THE MEDICAID PRESENTATION BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

MR. BOB LABBE, Director, Division of Medical Assistance, Department

of Health and Social Services, informed the committee that he would continue to provide background information on the Medicaid program and focus on the potential expansion of Medicaid services. [During his discussion, Mr. Labbe referred to a DHSS handout entitled Medicaid Financing.]

MR. LABBE explained that the Medicaid program contains variations in the amount of the state match for different services. The basic match rate is 60.13 percent; that rate fluctuates every year, based on how Alaska's per capita income compares to the national average per capita income. Some Medicaid services, however, have a fixed federal match rate: 90 percent for family planning services; 100 percent for services provided to Alaska Natives; and 72 percent from the block grant for the Denali Kid Care program. The Denali Kid Care program rate will vary every year based on the change in the underlying Federal Medical Assistance Percentage (FMAP) rate, as those two are linked.

CHAIRWOMAN GREEN asked what determines the fluctuation in the rate.

MR. LABBE said it is based on how Alaska's per capita income compares to the national per capita income. The formula is based on data that is fairly old. For example, 1993-1995 data was used for the 1999 formula.

MR. LABBE said the rates can go up or down, but DHSS is concerned that this is a risk area for Alaska because the federal government has changed how it will calculate per capita income in general. The new calculation will take effect next year; that change will negatively impact Alaska so the federal match rate will decrease. DHSS is working with Alaska's congressional delegation on that issue right now to avoid a drop next year.

CHAIRWOMAN GREEN asked when that will impact the State of Alaska's budget.

MR. LABBE said the change will take effect in October of 2001 so it will affect the 2002 state budget. He pointed out the same problem occurred last year because Senator Murkowski had secured a three-year arrangement for Alaska that expired. It is an area that DHSS has spent a lot of time on.

MR. LABBE informed the committee that Pro-Share is part of DHSS's Medicaid financing, but it is being phased out. DHSS has been allowed to send funds out to certain public facilities and the money was returned as a match. The federal government is curtailing that process.

MR. LABBE explained that the next section contains data on the number of eligible clients in each category (children, adults, the elderly, and the disabled) and the costs to serve those clients. That data is used to project what changes might be on the horizon. This model shows the difference between the impact of new clients versus the impact of new costs. If the number of clients stays constant, the budget may increase because of increased costs and vice versa.

CHAIRWOMAN GREEN asked if DHSS has any ability, if the federal agency reduces its match, to reduce the state portion.

MR. LABBE replied if the federal share goes down, DHSS will need more state funds to equal the amount of the expenditures. The other option would be to lower the expenditures and services.

CHAIRWOMAN GREEN asked if any legislation ties the amount of state funds to potential changes in federal funding.

MR. LABBE said there was a language section, which was taken out in the past when this subject was dealt with, that allowed DHSS to continue budgeting the general fund at the match, assuming if the federal funds didn't materialize, more general funds would be made available.

CHAIRWOMAN GREEN asked if DHSS has the ability to go the other way if, for example, the federal match dropped 5 percent mid-year.

MR. LABBE stated DHSS pays the total amount for services and is then reimbursed. If the federal match dropped, DHSS would have to decide how to handle it.

MR. LABBE referred to page 38 of the handout, entitled Fiscal Year Analysis, and noted DHSS served 76,664 Alaskans last year; this year the number is 81,178 and about 5,000 people per month have become eligible.

CHAIRWOMAN GREEN asked how that translates to the general fund amount and the federal match.

Number 1415

MR. LABBE said it is in DHSS's supplemental appropriation. He thought the general fund amount is $9 million while the total amount of federal and other funds is $80 million. The next chart shows the trend line for eligible children from 1996 through 2002. The eligible number increased in 1999 because of the Denali Kid Care program but DHSS projects that number will taper off. The

number of adults receiving services continues to trend downward, primarily due to welfare reform. The number of elderly receiving services has continued to increase but it has not increased as much as one might expect given the demographics. He believes that is because the income standards have remained flat while the younger retirees tend to have more income and assets. The number of disabled clients continues to increase - that is the most expensive group.

CHAIRWOMAN GREEN asked why the number continues to increase.

MR. LABBE said he believes the increase is due to multiple factors. First, the baby boom generation is aging. Second, technology has allowed people to survive medical conditions they would not have survived in the past. Third, medical services in Alaska have improved so people are staying in the state.

CHAIRWOMAN GREEN asked if that number includes Tax Equity and Fiscal Responsibility Act (TEFRA) clients.

MR. LABBE said it does include TEFRA children as well.

SENATOR WILKEN suggested that DHSS determine the slope of that line in relation to the increase or decrease of the population.

MR. LABBE said it would be good to get that information but acknowledged that it is a little harder to get census data on the disabled population.

CHAIRWOMAN GREEN asked if Senator Wilken was referring to the change in the general population.

SENATOR WILKEN said he was.

MR. LABBE explained the next chart contains the number of eligible clients by month and the payment amount by month. The overall cost in FY 01 is $4.4 million over FY 00. The next chart compares the amount of state and federal funds spent between 1991 and 2000. The general fund costs have increased slightly but much less so than the federal fund costs. DHSS has become much more aggressive in claiming 100 percent of the federal reimbursement for Indian Health Service (IHS) clients. The next chart (page 45) is a bar graph of Medicaid expenditures by fund source. Again, the state funds have remained relatively flat compared to federal funds.

MR. LABBE discussed the Medicaid expenditures by category of services.

CHAIRWOMAN GREEN noted the chart reinforces the fact that the highest cost is for the disabled and the elderly.

MR. LABBE pointed out that the elderly receive Medicare so their expenses are lower for hospital and physician services because Medicare is the primary payer. Medicare does not pay for nursing home expenses so that is a big ticket item.

SENATOR LEMAN asked what kind of expenses would fall in the waiver costs category.

MR. JOHN SHERWOOD, Division of Medical Assistance, said that waiver costs provide for care coordination, respite care, chore services, payment for services in an assisted living facility, and rehabilitation services for the developmentally disabled.

Number 1796

CHAIRWOMAN GREEN asked if those services are part of the wrap-around concept where clients remain in the home.

MR. SHERWOOD said they are. He explained that these services are for people who would qualify for a nursing home or an institutional setting but have opted to be cared for in the community.

MR. LABBE added that nursing home expenditures have remained flat relative to waivers yet nursing homes cost about five times as much per person. Regarding the developmentally disabled population, Harborview is no longer operating so more of the expenditures show up on the community-based side of Medicaid. He noted that is a growing area.

CHAIRWOMAN GREEN asked if anything will cause the number of disabled participants to decrease or whether those clients are disabled to the extent that they will not leave the program unless they move.

MR. LABBE said the only thing on the horizon is a new effort called "ticket to work," which focuses on getting persons with disabilities into the workforce. The state has received grant funds from the federal government to develop that program. Some of the coordinators are now working in employment offices.

CHAIRWOMAN GREEN asked if putting the disabled clients into another program is being addressed in another bill.

MR. JIM NORDLUND said it could be related to that.

MR. LABBE said the next chart reiterates the issue on nursing home costs, which have remained flat relative to the waiver costs, which continue to grow. DHSS does rate adjustments in the facilities as rates increase. The patient base has dropped but costs rise.

CHAIRWOMAN GREEN asked about the flat base.

MR. LABBE explained the number of patient days spent in nursing homes has decreased over the last several years because people are being served in community settings.

CHAIRWOMAN GREEN asked if clients are moving into nursing homes later in life.

MR. LABBE said that is true of some clients but alternative services are available so clients do not need a nursing home setting as soon. He noted that pharmacy costs are one of the largest components of growth in the Medicaid program, which is a national issue. He expects that issue to be addressed with the debates on the Medicare prescription drug benefit. He pointed out that the use of prescription drugs increases as more sophisticated drugs are being developed to handle conditions. That has helped reduce inpatient hospital costs.

CHAIRWOMAN GREEN said the same applies to the mentally ill population. She asked whether this would gradually fall off if the Medicare changes are adopted.

MR. LABBE said it is hard to tell right now. DHSS anticipated that a Medicare prescription drug benefit would help the state costs in the sense that people on Medicaid who get Medicare would receive that benefit. The current proposal by President Bush, which he says is temporary, would exclude Medicaid clients. However, the full discussion of a prescription drug benefit for seniors would help the state if that ever occurs. He expects that debate to take at least a couple of years.

CHAIRWOMAN GREEN said that will cost "big bucks."

COMMISSIONER PERDUE pointed out that both the U.S. House and Senate have included earmarks in the budget for that. The Senate has put in $300 billion while the House put in $500 billion for prescription drug plans this year. President Bush's Helping Hands program is much more modest.

MR. LABBE said the next chart shows an increase to 100 percent for payments to tribal programs. The Native health system is growing so DHSS is trying to maximize the use of that program to the extent

possible. He indicated that DHSS pays for those services and is then reimbursed by the federal government. The next chart shows Medicaid payments by district. The following chart shows the number of providers in each district and the amount paid to those providers.

COMMISSIONER PERDUE clarified that the number of eligible clients in each district is the number of people who have actually signed up for services.

MR. LABBE said the last page (57) contains the program areas that DHSS does not currently cover. A bill is before the committee (SB 38) to cover services for breast and cervical cancer. There has been discussion within the department about covering services for TB infected individuals. That is a small group. Community based care for persons with Alzheimer's and related disorders is one that the Long Term Care Task Force recommended. He noted a proposal is being discussed to cover services for children aging out of foster care.

CHAIRWOMAN GREEN asked what age group that would cover.

MR. SHERWOOD answered that it would be for children who age out of state custody, which is usually at age 18.

MR. LABBE explained that Medicaid would provide health care coverage until those children turn 21.

CHAIRWOMAN GREEN asked if the federal government chose 21.

MR. LABBE said it is an option the federal government offered to the states.

MR. SHERWOOD said he did not think it has to be 21; services could be provided to age 19.

CHAIRWOMAN GREEN commented that families are generally able to cover their children until age 22 or 23 so she was wondering why that isn't consistent. She asked if the state could opt for 22 or 23.

MR. SHERWOOD said he believes 21 is the maximum.

MR. LABBE said another area of great interest to disability advocates is coverage for working disabled individuals to a higher income level. The bill that passed a few years ago allows those individuals to receive Medicaid Services if their income is up to 250 percent of the poverty level. The new proposal is to remove

that limit altogether. He said the problem, for the most part, is insurability of persons with disabilities in the workforce.

CHAIRWOMAN GREEN asked if the income constraint is not a good indicator for that population because of the difficulty of purchasing insurance.

MR. LABBE said the other piece of that is the scope of the coverage that Medicaid provides, such as personal attendant care, which may not be covered by most insurance companies.

CHAIRWOMAN GREEN pointed out that those costs are often a routine part of settlements.

MR. LABBE said several states have begun to cover the parents of children who are covered under programs similar to Denali Kid Care. Research has shown that if parents have access to coverage, they are more likely to get coverage for their children. Another possible expansion of services to adult Medicaid clients could be preventive and restorative dental services. Currently, Medicaid covers immediate relief of pain and infection so it is a very limited benefit. Some Medicaid clients have very serious problems, and a number of problems could be avoided if preventive care was offered.

CHAIRWOMAN GREEN asked if, under the current program, clients with dental problems must be treated in the emergency room.

MR. LABBE said dentists will provide immediate service, but the current program does not cover annual check-ups for adults.

CHAIRWOMAN GREEN asked if any permutation of that is possible.

MR. LABBE said adult dental service is on the options list and that is covered, but the current statutory definition is limited to immediate relief of pain. He stated that a bill in Congress [H 600], called the Family Opportunity Act, was part of the President's proposal.

TAPE 01-32, SIDE B

MR. LABBE said that bill would cover disabled children at up to 300 percent of the federal poverty level. Right now, children of higher income levels can be covered only if they need institutional care. H 600 would cover a broader group in that it would include any child that meets the test for disability. That bill has not yet passed Congress but it may be an option after the end of the year. H 600 also includes home and community based care services

for children under 21 with psychiatric disorders.

CHAIRWOMAN GREEN asked if the 300 percent of poverty level standard would apply to the parents' income.

MR. LABBE said it applies to the family's income. He added there could be a family premium of up to 5 percent of income charged. There could also be some co-pay and the states could also enroll the child in a health plan offered through an employer as long as the employer was paying at least 50 percent of the cost.

CHAIRWOMAN GREEN asked if the state could supplement the premium to the employer.

MR. LABBE said it could.

CHAIRWOMAN GREEN said she wishes that was being done with a lot of the options.

MR. LABBE said this is something new so they will see how it plays out. He pointed out that every year there seems to be a new option, and there seems to be a lot of national interest on ways to deal with uninsured and health care issues.

MR. LABBE said that was the end of his presentation.

The committee took a brief at-ease.

CHAIRWOMAN GREEN called the committee back to order. The committee took up SB 116.

#SB 116

SENATOR WARD moved to adopt CSSB 116(HES) as the working document of the committee (Version J). There being no objection, the motion carried.

CHAIRWOMAN GREEN asked Mr. Jim Nordlund to come forward.

MR. JIM NORDLUND, Director of the Division of Public Assistance, DHSS, explained that the only difference between Version J and the previous version adopted by the committee is the addition of language on page 1, line 11, that reads, "unless the second needy parent is determined under regulations of the department to be physically or mentally unable to perform gainful activity." He explained that language is the status quo of the way both the AFDC and ARAP programs operated. If one parent is incapacitated in a two-parent family, the benefit will not be cut in half during the

summer months.

Number 2183

SENATOR LEMAN asked what standard is used by the Division of Public Assistance to determine physical or mental disability for purposes of work.

MR. NORDLUND replied that definition is in regulation and is in committee members' packets.

CHAIRWOMAN GREEN noted it is in 7 AAC 45.235. She asked if, when the legislature passed its welfare reform legislation several years ago, it was ahead of Congress and, by the time the federal government implemented its law, Alaska's law was a little bit askew. Although DHSS has used the standard in the federal law, the court has said the statute must be corrected so this language confirms what DHSS has been doing.

MR. NORDLUND said that is correct. He pointed out the critical issue in the court case was removing the language that refers to the unemployment of the family's principal wage earner. That is the last remnant of the old AFDC law. When that "bath water" was thrown out, the "baby" went with it, the "baby" being a category of folks that had always been exempted.

CHAIRWOMAN GREEN said she has worked closely with DHSS to get this legislation to the point where DHSS can live with it until next year, when this subject will be revisited.

There being no further discussion, SENATOR WARD moved CSSB 116(HES) from committee with individual recommendations. There being no objection, the motion carried.
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The committee took a brief at-ease.

TAPE 01-33, SIDE A

CHAIRWOMAN GREEN called the meeting back to order at 4:05 p.m. All members were present. She announced that the committee would hear information from DHSS on the Breast and Cervical Cancer Early Detection Program. The conversation about this topic will be generic as the committee does not have the bill [SB 38] before it at this time. Time permitting, DHSS will also talk about Medicaid funding for Alzheimer's and Dementia diseases and any other programs that Alaska has had the opportunity to participate in but has chosen not to.

COMMISSIONER KAREN PERDUE, Department of Health and Social Services, informed committee members that Mary Diven would give an overview of the screening program and the treatment program option and how they fit together.

CHAIRWOMAN GREEN noted the National Council of State Legislatures published a basic primer on the federal Medicaid program that is an excellent source of information.

MS. MARY DIVEN, DHSS, gave the following overview of the screening program. The Center for Disease Control (CDC) runs the Breast and Cervical Cancer Early Detection Program, which is designed to reduce mortality and morbidity from breast and cervical cancer by early detection; screening a large population of women who are low income and groups of women who are the least likely to go in for annual screening. The CDC runs programs throughout most of the state and women can get access through public health centers. Some diagnostic providers will, once a woman is screened and found to have a likelihood of cancer, do a diagnosis of that cancer. Because there is no funding through the CDC for treatment of those cancers, last October Congress passed legislation allowing for treatment through a Medicaid option with an enhanced state match, for those women diagnosed through the CDC program and for women who have no insurance to pay for treatment.

CHAIRWOMAN GREEN asked Ms. Diven to review for the committee the purpose for the original CDC screening program and to explain why this program was set up.

MS. DIVEN answered that low income women and women among certain minority populations were dying from breast and cervical cancer in larger numbers because they were not getting annual pap smears and mammograms. The CDC set the program up to reduce the mortality rate by trying to detect the cancers early.

CHAIRWOMAN GREEN asked if the CDC or public health system has always collected data on diagnoses of breast cancer and whether that information is saved in a database.

COMMISSIONER PERDUE said DHSS started a cancer registry in Alaska in the last couple of years.

MS. DIVEN noted the first data from that registry is being compiled now.

CHAIRWOMAN GREEN explained that she is trying to find out what CDC's original purpose was and how we have segued to where we are.

COMMISSIONER PERDUE replied that CDC's original intent was not to collect data, it was to provide the screening. She clarified that screening means that actual mammography and pap smears are done to find out if women have the disease.

CHAIRWOMAN GREEN took a brief at-ease.

MS. DIVEN said the private diagnostic providers are: the Anchorage Neighborhood Health Center, Eastern Aleutian Tribes in Cold Bay, the Cordova Community Medical Center, two providers in Eagle River, the Interior Neighborhood Health in Fairbanks (screening only), and Family Planning in Kachemak Bay.

CHAIRWOMAN GREEN asked how a woman gets to the diagnostic provider.

MS. DIVEN answered a woman can go to a screening provider for a clinical breast exam, a mammogram if the woman is age-eligible, and a pap smear. If there's an abnormality on the pap smear, she will go to a diagnostic provider - a gynecology provider. If the results of the clinical breast exam are abnormal, she will get a diagnostic mammogram or a fine needle aspiration to determine whether the lump is a cyst or a cancerous lump.

CHAIRWOMAN GREEN asked how women find out about this early detection service.

MS. DIVEN told the committee there is a general outreach program and each community designs its own outreach. Some providers do "in reach." They look through their client records to see if their female clients are age and income eligible. In Anchorage, the YWCA has a large outreach project named Encore. The YWCA works with the ministerial association and does outreach from downtown through Mountainview and Muldoon to reach women in the lowest income zip codes. The two organizations have group gatherings where a provider gives information to women and a list of providers to go to. The church or other groups make arrangements to transport the women for screening services. In addition, coupons are given to women in public assistance offices and job placement offices. In Fairbanks, outreach is done through the public health center. In Anchorage, coupons have gone out in utility bills to women living in lower income zip codes. Coupons are also enclosed in newsletters for various groups, for example in Asian American newsletters.

CHAIRWOMAN GREEN asked if this program would not necessarily apply to a woman who goes to her doctor with a problem and then realizes how much the diagnosis and treatment will cost and says, "I can't afford this."

MS. DIVEN answered this would only be for women screened through this federal program.

CHAIRWOMAN GREEN asked how many women are screened each year.

MS. DIVEN answered a little more than 4,000.

CHAIRWOMAN GREEN asked if Alaska Native women are eligible through the CDC screening but use the Indian Health Service (IHS) if they need further treatment.

MS. DIVEN answered yes, as do women with health insurance.

CHAIRWOMAN GREEN asked Ms. Diven to explain how this program will work for women who have health insurance that get a CDC screening.

MS. DIVEN referred to a chart she provided to the committee that provides a side-by-side comparison of eligibility requirements for the screening program and eligibility requirements for the treatment program. One of the goals of the CDC program is to encourage women who may not be getting screenings because their deductible is too high to get a screening. However, those women would not be eligible for the treatment program because their insurance will pay for it. Many insurance companies do not cover preventive services, including pap smears, so women would be eligible for a pap smear. Insurance companies must pay for mammograms under state law. So, women with insurance are not eligible for treatment because they have coverage.

COMMISSIONER PERDUE added that regarding the issue of the deductible, the concept behind the screening program is to get as many women as possible to get screening because the earlier they are diagnosed, the better their outcomes are. So, the reason for the difference between the screening program and the treatment program is that the CDC is trying to encourage the screening.

MS. DIVEN clarified that women with insurance are not eligible for the treatment program because they already have coverage so it would be considered double dipping.

CHAIRWOMAN GREEN asked if, regarding the screening, women can be uninsured or underinsured, but regarding treatment, a woman is not eligible if underinsured, only if uninsured.

MS. DIVEN said that's correct. She repeated that Alaska Native women are eligible for the screening but the treatment would be covered at an IHS facility.

CHAIRWOMAN GREEN asked whether this would refer to someone who lives in an area where there is no Indian Health Service facility but there is a local hospital.

MS. DIVEN explained that according to the federal guidelines, a Native American woman who lives in New York City where there's no Indian Health Service facility available would be eligible. If that woman lives in Bethel where there is an IHS facility available, she would not be eligible.

CHAIRWOMAN GREEN asked if this is not as applicable to Alaska as it might be in a high population area with pockets of Native Americans.

COMMISSIONER PERDUE said yes.

MS.DIVEN added that regardless, the federal government will pay 100 percent of the cost. Even if the CDC determined that access here was too limited to be applicable, it would not cost state general funds, all IHS payments are 100 percent reimbursable.

MS. DIVEN then explained that income and insurance eligibility for the screening program is checked every year. Clients sign an agreement that says they are income eligible and their insurance eligibility is checked. For the treatment program, eligibility is limited to the duration of treatment for that cancer and then eligibility ends.

CHAIRWOMAN GREEN expressed concern that the end of treatment for a particular cancer is a very sketchy date.

MR. LABBE agreed. He said this program differs from the typical approach, in terms of tying eligibility to the completion of treatment. Usually a client's income either goes up or some other factor makes the client ineligible. In this case, DHSS plans to use its contractor who does high risk case management to track, with the physician and the patient, the course of treatment. At the time treatment is determined to be concluded, DHSS would be notified and coverage would be terminated.

CHAIRWOMAN GREEN asked if that client would be covered if she is diagnosed with ovarian cancer six months later.

MS. DIVEN said if her breast cancer treatment is not over, she is, but if her breast cancer treatment is over, she would not be.

CHAIRWOMAN GREEN pointed out that ovarian cancer is connected to

breast cancer so if there is a tie to the previously diagnosed condition, it raises questions as to how we know where to start, where to end, and how to forecast the number of eligible people.

MS. DIVEN asked if Chairwoman Green was referring to the health care financing document with the questions and answers. She noted that document was done by a federal agency and it raised as many questions as it answered.

CHAIRWOMAN GREEN said breast cancer patients are often still undergoing care six years after they are diagnosed. If something were to happen after the treatment was concluded, for example a metastasis, it could be tied to the breast cancer. She expressed concern about what this approach does to the out years. She said if the legislature opens up this program up to people based on a diagnosis, then it needs to clearly define what else is included. She said the Medicaid program is inconsistent, unfair and discriminatory.

COMMISSIONER PERDUE replied that the health business is frustrating in that someone is always just outside of the line. The system is a patchwork of care and the lines are arbitrary. She said she receives probably one letter per week from a person with an incredibly sad story who was not eligible. She added that the need is so tremendous that Congress, in its wisdom, has said there is no other way, absent a universal access discussion, to get access to this care. Commissioner Perdue said that 26 women are diagnosed each year in Alaska with cervical cancer so she would guess the number of cases of ovarian cancer is similar.

CHAIRWOMAN GREEN indicated that her concern is that once a woman has been diagnosed with breast cancer, she is checked for ovarian cancer as part of the follow-up.

MS. DIVEN stated that whether a direct causal relationship exists is probably determined by the physician and eligibility determinations would come under the managed care piece. Regarding the asset-testing question, this is a public health screening program and the goal is to detect the cancers as early as possible to increase the survival rate. For the treatment program, the memo from the Health Care Financing Administration says that asset testing is prohibited because it's tied to the screening program.

CHAIRWOMAN GREEN asked if other Medicaid programs are tied to any CDC screening programs or whether this is a hybrid. She said it's a catch-22 though and may as well be tied to one's driver's license as it makes no sense to say it's got to be done one way because it's tied to the CDC program.

COMMISSIONER PERDUE said it's a little more direct than that.

CHAIRWOMAN GREEN was not sure.

MR. LABBE said the cash assistance program is somewhat analogous in that it guaranteed Medicaid eligibility historically. A person on SSI or AFDC qualified for Medicaid.

CHAIRWOMAN GREEN stated those programs are needs-based and clients have to lay out their assets: bank accounts, and real estate. This program requires nothing and doesn't even allow anyone to ask.

COMMISSIONER PERDUE said that the early detection program is most similar to TEFRA.

CHAIRWOMAN GREEN asked if income is disregarded under the TEFRA program.

COMMISSIONER PERDUE explained the income of the child is considered; the income of the parents is disregarded. The concept is the same in that the treatment is a major expense so it will have a major impact on the family.

MR. LABBE said for example, treatment for a disabling condition.

COMMISSIONER PERDUE pointed out the family can have a fair amount of money, but the child's income is what determines eligibility.

CHAIRWOMAN GREEN felt the concept is not the same because the early detection program is for the adult who has made the choice, for whatever reason, legitimate or poor, to not have insurance coverage. She expressed concern that every time we go down this path we remove another group of people from an insurance pool. The Denali Kid Care program took 17,000 people out of the insurance pool and as we ratchet down the number of people who buy insurance, we make it less possible in a state of so few people, many of whom are under self-insured plans already, to get reasonably priced insurance. She maintained that participants of health care plans have been sliced out to such a fine point already that she can't imagine how the comprehensive health insurance will continue to be funded. She said this is a bigger problem than the extension of CDC free screening to breast and cervical cancer and funding health care based on a diagnosis, which she thinks is a very, very dangerous path to go on because she is not an advocate of socialized medicine.

COMMISSIONER PERDUE commented that the small population in Alaska

plus the high number of federal insurees, such as active military and veterans, already chops out a higher proportion of people from the private insurance market than in any other state so that is one variable Alaska has always faced. Plus, Alaska has a higher number per capita of small business people, businesses of 25 employees or less or self employed, and lots of seasonal people. Alaska has had a heck of a road with this pool and the only product out there for that individual who gets sick and needs the coverage is the Comprehensive Health Insurance Association (CHIA), which requires a waiting period to protect the actuarial cherry picking of the pool.

CHAIRWOMAN GREEN said she would prefer to see legislation go in a direction to really help people with insurance over a long term, not just for one diagnosis and the duration of that illness. She asked if, while a women is covered under this insurance, she were to break her ankle, whether she would be covered for that under auxiliary services.

MS. DIVEN said she would be.

Number 397

SENATOR LEMAN expressed concern that people ought to assert some responsibility. He said when he hears testimony from people who say they can't afford insurance and he sees how they spend their money, he wonders how to help them make good lifestyle choices so that insurance can be provided. He questioned how much income a person would receive and be at 250 percent of the poverty level.

CHAIRWOMAN GREEN said it is about $50,000 for a family of four.

SENATOR LEMAN thought that at $50,000 a person ought to be able to participate and share in a cost to be a participant in responsibility. He noted the state is not doing anything to encourage people to make the right choices and while this program may be for a good cause the state needs to get people to plan because bad things might happen.

COMMISSIONER PERDUE pointed out that one problem is that the cost of insurance depends on the profession a person chooses. A small business person might purchase insurance through the Alumni Association or the latest small employer coverage pool but the premium will be much higher than coverage for a state employee or school district employee. The cost of insurance is very discriminatory to the profession people choose. In Alaska a lot of people are attached to the formal insurance system (federal and state) and then there are a lot of small markets that are unorganized. The cost is very high for some of those insurances.

SENATOR LEMAN agreed regarding full service insurance but he asked about catastrophic insurance coverage because a $30,000 hit or a $100,000 hit will devastate a lot of people. Most people can work off a $1,000 cost. He noted if the state had a fund that could cover catastrophic illnesses that everybody participates in to avoid adverse selection, then everybody in the world might want to come to Alaska if they've got bad things happening and that fund would be driven into bankruptcy. If that could be avoided, part of everyone's permanent fund dividend could go into a fund. If you take the 100,000 people who are uninsured or severely underinsured, times $2,000, the fund would have $200 million. That could be a good source of money for catastrophic care.

SENATOR DAVIS said she appreciates the fact that Chairwoman Green wants to look at spending for the Medicaid program and she understands Senator Leman's comment about personal responsibility, but the CDC decided to put monies out there so people could get screened because there is a need. People died because they weren't diagnosed early enough to get the treatment that they needed. When people are screened early and get treatment, they have a better chance of surviving. She said she knows people, through work and personal relationships, who could not afford even $1000 for a catastrophic illness program. Many people don't draw a permanent fund dividend because their checks are being taken from them. They might owe the IRS or student loans or they might have owed a debt that someone got first dibs at their dividend. This early screening program applies to a small group of people. Of the 4,000 people screened, 35 were diagnosed. Those 4,000 people wouldn't have come for screening had they had insurance or the money to pay for it. They would have gone somewhere privately because they wouldn't want to come to the public trough. She thought a program such as Senator Leman described would take some time to work out. In the meantime, 70 women could benefit from this Medicaid option at a cost of $175,000 to the state. She felt it would be worth doing while the legislature begins to work on a long term program.

SENATOR DAVIS said she has a problem with bringing new clients into the program and then being forced to cut services. She suggested working on that area and suggested that a long term task force is a viable solution.

CHAIRWOMAN GREEN said her frustration is how to justifiably say the program will cover only these two diagnoses if a person is at 250 percent of the poverty level when people with different diagnoses are at 135 percent of the poverty level and don't qualify for anything. Suddenly an arbitrary rate is applied to this group of breast and cervical cancer clients. However, the state is under

the constraints of the federal Medicaid instruction packet. She noted 70 women will be eligible; 28 of those are Alaska Native women who will receive services from the IHS, leaving 42 women. The state will pay $175,000 and the federal government will match that up to about $525,000. That will cover about $10,000 to 12,000 per woman for the life of that breast cancer incident, which she is sure is woefully inadequate.

COMMISSIONER PERDUE said it will cover that amount for one year.

CHAIRWOMAN GREEN said that would cover maybe 1/7 or 1/10 of the cost of surgery, and would not include oncology, radiation, or chemotherapy.

MR. LABBE said DHSS served about 300 women last year in the Medicaid program who had breast and cervical cancer. He looked at the individual recipient dollars and they range $173 to $69,000. The numbers are based on the fiscal year, so the $173 cost might have been for one doctor's visit at the end of the fiscal year or before the person moved out of the state. The high number was probably due to the fact that client had many services during that one year. But using that range, DHSS came up with those estimates by determining an average across all services to come up with a per member, per month or per year cost.

CHAIRWOMAN GREEN asked if DHSS is dealing with the range of the full true and complete fee that the hospital charges for that service.

MR. LABBE said it is not. DHSS sets rates for hospital payments. It generally reimburses the fair rate for reasonable cost rather than actual charges. Regarding the physician schedule, DHSS pays a fee that is typically lower than the charges and yet physicians are willing to see Medicaid patients. Physicians are not required to participate in the Medicaid program, it is voluntary.

COMMISSIONER PERDUE clarified that about 6,000 providers are enrolled in the Medicaid program.

CHAIRWOMAN GREEN asked if that includes clinics, doctors, nurses, therapists, masseuses, chiropractors, and doctors.

COMMISSIONER PERDUE said it does. She hoped that many insurance companies are not paying 100 percent.

CHAIRWOMAN GREEN said she admires DHSS for getting those rates but they have nothing to do with the reality of what it costs to go to the hospital for the rest of the world. She estimated that any

surgical procedure that requires a surgeon, a back-up, an anesthesiologist, after care, and one night in a hospital, would cost a minimum $15,000 to $20,000. So, the information that says the state is going to pay for coverage for breast and cervical cancer is not really accurate.

COMMISSIONER PERDUE responded by saying that based on DHSS's experience of 300 women a year that are already covered, the per unit cost per year is x. It's not saying that a full blown stage 3 cancer costs x amount, it is saying the public cost on average, based on experience, is this number.

CHAIRWOMAN GREEN said that this is an entitlement program. DHSS has forecast 42 non-Native Alaska women coming in the door. If 7 come in, it'd be a great year but, if 117 come in, the door is open. DHSS could have estimated $10 or $500,000 as the state fund amount.

COMMISSIONER PERDUE explained that it's based on the number of women who have been screened over a period of years.

CHAIRWOMAN GREEN asked what the prediction was for the number of children who would be insured under Denali Kid Care when that program started.

COMMISSIONER PERDUE said it is right at the predicted level.

CHAIRWOMAN GREEN asked if that number was 17,000.

COMMISSIONER PERDUE said it was.

CHAIRWOMAN GREEN said she never heard that.

COMMISSIONER PERDUE said that was the number when the program was ramped up.

MR. LABBE agreed and said DHSS started out assuming a smaller number based on the data it had from the Census Bureau.

CHAIRWOMAN GREEN said the fiscal note implies that the cost will continue to go up every year and asked whether that is based on an increase in the cost of services, an increase in the number of people coming through the door or whether it is a reduction in the federal portion.

MR. LABBE said the projected cost increases were essentially an estimate of DHSS's traditional expectation, an 8 percent increase, which is a mix of more people and higher costs of services. It was

not an elaborate analysis of this particular group.

CHAIRWOMAN GREEN noted that after five years the increase is substantial and, based on everything else, the program is not likely to go up and level off so the expectation is that there will be more and more money each year. She asked what assurance the state has that the federal government will maintain its level of participation.

COMMISSIONER PERDUE said it is in federal statute.

CHAIRWOMAN GREEN asked if DHSS has a contract for a period of time.

TAPE 01-33, Side B

MR. LABBE thought that Congress might change the statute when it appropriates the money.

COMMISSIONER PERDUE added the statutes don't expire but they're silent on the question of how long they're in place. She has never seen Congress repeal one in terms of what coverage they offer.

CHAIRWOMAN GREEN asked if Congress has reduced the federal participation rate.

COMMISSIONER PERDUE said Congress has not but that is a possibility.

MR. LABBE said the match formula has not been changed since the program started.

COMMISSIONER PERDUE commented that one of the variables in the program is what Senator Green was describing and that is the stacking effect. Some of the 42 women won't leave the program after one year because they're not well, and new women will come in. DHSS doesn't know how many and how fast they'll move through the system, but some will not make it. The cost will increase to some degree because it won't have just 40 new people every year.

CHAIRWOMAN GREEN said the general time-frame with breast cancer is five years before one goes back to pre-cancer status. She asked how CDC developed the part of the program where treatment is considered complete.

COMMISSIONER PERDUE said DHSS will have to work on that should this bill pass, and it will be difficult. DHSS will have to rely on physicians for that determination.

CHAIRWOMAN GREEN asked if DHSS has any choice in when treatment ends or whether that is in the federal guidelines.

COMMISSIONER PERDUE said that is an area where DHSS has some flexibility as opposed to the income or the assets.

CHAIRWOMAN GREEN was unsure how DHSS could say "no more" at a certain point. This is a method by which government will pay off care providers, hospitals, doctors, oncologists, and radiologists for a pittance of their charges and leave this person debt free. It's just cost shifting at its best. She questioned why the state does not do that for prostrate, colo-rectal, and all the other cancers patients.

COMMISSIONER PERDUE said cost shifting already occurs with uncompensated care.

CHAIRWOMAN GREEN asked what the requirement is for hospitals in Alaska for admittance of a patient.

COMMISSIONER PERDUE said if a person in this state needs surgery, their expectation is they would not be denied service. Patient dumping laws do not allow that. A lot of hospitals have a financing plan for elective care. Hospitals can write off charity and bad debt when they determine there is no way to get the money.

CHAIRWOMAN GREEN said this Medicaid plan is the worst conceived plan she's ever read. It's wrong, unfair, and discriminatory and does nothing but tell providers how much they'll accept for services. Chairwoman Green asked for suggestions of other ways to resolve this problem. She said she would prefer to double the state's portion and tell the Medicaid people thanks, but no thanks, we want to craft our own plan and allow people to pay a premium, to pay a co-pay, and to allow corporations to get involved. She noted the State of Georgia is designing a private/public program similar to that.

SENATOR DAVIS noted the State of Georgia is putting a lot of money into that program.

CHAIRWOMAN GREEN agreed it's a huge amount, hundreds of millions of dollars. She again commented that she would prefer a method other than Medicaid because she has a very difficult time saying that we can hold everyone else with a life-threatening illness to an income standard of 133 percent of the federal poverty level but breast and cervical cancer patients are held to an income standard of 250 percent. She asked Commissioner Perdue if she can think of any other way to create a supplement plan.

COMMISSIONER PERDUE said DHSS used to have a catastrophic illness program, which might still be on the books. It wasn't for one particular diagnosis. Right now, under Chronic and Acute Medical Assistance (CAMA), the state only covers certain diagnoses. CAMA has been cut back and this year hospitals are being cut out of CAMA.

CHAIRWOMAN GREEN repeated that she would rather take a different approach to this problem but if no other approach is available, this program will have to have a sunset date. She pointed out that this bill came before the committee with five "no recommendations."

SENATOR DAVIS said she recommended "do pass" and intends to do so in the future.

CHAIRWOMAN GREEN indicated she was originally shown five "no recommendations," which is not a very good indication of the level of support. She asked if there is any way to coordinate this program with CHIA.

COMMISSIONER PERDUE informed Chairwoman Green that patients would have to deal with the waiting period issue, which is a big problem for people in need of emergent treatment.

CHAIRWOMAN GREEN asked if Medicaid coverage is retroactive for preexisting conditions.

MR. LABBE replied it is retroactive for up to 90 days.

SENATOR LEMAN suggested requiring a higher co-pay for people at the higher income level.

CHAIRWOMAN GREEN said a similar proposal was discussed in '92-'93.

SENATOR LEMAN said it's taken a long time and we still haven't gotten results.

COMMISSIONER PERDUE said many other states haven't either.

CHAIRWOMAN GREEN noted co-pays and premiums cannot be used with this program.

COMMISSIONER PERDUE agreed because that would upset the federal match.

MR. LABBE informed the committee the breast and cervical treatment program through Medicaid has a modest co-pay of 5 percent of

outpatient hospital allowed charges, which isn't really significant. The inpatient rate is $50 a day, up to $200 per admission.

CHAIRWOMAN GREEN asked how much 5 percent of the allowable outpatient hospital charges would be?

MR. LABBE said it would depend on the charge. Outpatient services are usually chemotherapy or radiation but the patient must pay 5 percent for each visit.

COMMISSIONER PERDUE maintained that the dilemma is if you limit the percent of poverty for the treatment program, you'd have to limit it for the screening program as well.

MS. DIVEN agreed they have to be tied together.

CHAIRWOMAN GREEN asked if it has to be at or below the 250 percent level.

COMMISSIONER PERDUE asked if Chairwoman Green would want to offset the cost to the screening program with state general funds.

SENATOR LEMAN suggested using a voluntary contribution pool. He guessed many Alaskans would like to contribute to that.

CHAIRWOMAN GREEN suggested using tobacco tax settlement money to augment this. She said she would truly like to do the right thing because this is a very difficult problem. She knows there is great pressure for this bill to be heard and passed.

COMMISSIONER PERDUE said there is no logic to fashioning a program that doesn't take advantage of the treatment cost sharing because the treatment is more expensive than the screening.

CHAIRWOMAN GREEN noted if they are tied together the available pool of people coming in for screening will be reduced.

COMMISSIONER PERDUE clarified that if screening eligibility is lowered, federal money will be left on the table. It would be less expensive for the state but it doesn't make sense to not take advantage of the ratio for the treatment program.

CHAIRWOMAN GREEN said she spoke to staff in Senator Murkowski's office who told her of the fairly large range the state has in other Medicaid programs, regarding the match.

COMMISSIONER PERDUE said the state can't have two different

standards for the screening.

SENATOR LEMAN said not unless the state does a supplemental program and that could be funded a number of ways. He again suggested a voluntary contribution pool.

CHAIRWOMAN GREEN noted there is free and reduced cost screening around the state and vans travel throughout the state to provide mammograms in November because it is breast cancer awareness month.

COMMISSIONER PERDUE maintained that from a public health point of view it makes sense to make the screening widely available so people have access to it.

CHAIRWOMAN GREEN said she has a great deal of frustration that people get to an age of risk and choose not to do anything on their own. She asked Commissioner Perdue and DHSS staff for any ideas about how to restructure this program. She felt a one year sunset date is a bit unsatisfactory because it will leave people in the lurch. She pointed out that she believes it is important to document what is being done and to submit reports to the legislature so that it knows exactly what's happening and what the actual costs are.

COMMISSIONER PERDUE said DHSS could supply those.

Number 349

SENATOR LEMAN said he is interested in significant correlations between certain behaviors and breast cancer, and what can be done to discourage those behaviors. He expressed concern that if the state invests in treatment, it ought to encourage behaviors to prevent the disease. He pointed out there's a very high correlation between lung cancer and smoking.

COMMISSIONER PERDUE pointed out Alaska's health data from the last decade shows the obesity rate in Alaska is growing fast and that is a risk, as well as smoking and poor diet.

CHAIRWOMAN GREEN agreed the obesity problem is nationwide.

COMMISSIONER PERDUE said all of the risk factors for cancer are unknown. It could be genetic or environmental, as well as diet and smoking.

CHAIRWOMAN GREEN announced that the committee would meet again on Wednesday and Friday of next week.

SENATOR WILKEN asked Chairwoman Green if DHSS would do a presentation on the Alzheimer's program next week.

CHAIRWOMAN GREEN said it would.

SENATOR DAVIS asked whether Chairwoman Green intends to schedule SB 38.

CHAIRWOMAN GREEN said she has not yet decided.

SENATOR DAVIS requested that Chairwoman Green schedule SB 38 for a hearing.

SENATOR WILKEN acknowledged the committee is struggling with balancing the needs of this group with the fiscal realities of the state and offered to help wherever possible.

CHAIRWOMAN GREEN thanked all participants and adjourned the meeting.